Maternal and Child Health Services Title V Block Grant

Northern Mariana Islands

FY 2026 Application/ FY 2024 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

Commonwealth Healthcare Corporation
Commonwealth of the Northern Mariana Islands
1178 Hinemlu' St. Garapan, Saipan, MP 96950

CEO-L25-900

July 22, 2025

Laura Kavanagh, M.P.P.
Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
US Department of Health & Human Services
5600 Fisher Lane Rockville, MD 20857

Subject: **HRSA Announcement No. HRSA-26-001 / Tracking No. 240804**

Dear Ms. Kavanagh,

On behalf of the Commonwealth of the Northern Mariana Islands' (CNMI) Commonwealth Healthcare Corporation (CHCC), I am pleased to submit the FY 2026 MCH Title V Block Grant Application/FY 2024 Annual Report. This submission reflects our continued commitment to improving the health and well-being of mothers, infants, children, including children with special health care needs, and families across the CNMI.

As part of this year's application cycle, we have completed our comprehensive MCH Needs Assessment. This assessment was conducted with key stakeholders, community partners and families, and it provides a detailed understanding of the strengths, challenges, and priority needs within our MCH system. The findings from the needs assessment have informed our priorities and strategies for the next five years, ensuring our efforts are data-driven and aligned with the unique needs of our communities.

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

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

Sincerely,

Esther Lizama Muña, PhD, MHA, FACHE
Chief Executive Officer
State/Territorial Health Official

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Telephone: (670) 236-8201/2 FAX: (670) 233-8756

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 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms",* OMB NO: 0915-0172; Expires: December 31, 2026.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Overview of the CNMI Title V Program

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

The CHCC is the only health department in the CNMI and provides all public health services, including direct, enabling and infrastructure building to all islands within the territory.

The CHCC Division of Public Health Services unit is comprised of 6 sections:

- Maternal, Infant, Child & Adolescent Health (MICAH) Programs
- Non-Communicable Disease Programs
- Communicable Disease Program
- Environmental Health & Disease Prevention (EHDP)
- Data, Surveillance, and Performance Management
- Health Promotions & Partnerships

Each of these sections includes several programs and provides services for the entire CNMI population. The MICAH Programs section is comprised of the following programs:

- Adolescent & Reproductive Health
- WIC Program
- Children with Special Health Care Needs (CSHCN)
- Home Visiting Program
- MCH Program
- ERASE Maternal Mortality

The State Systems Development Initiative (SSDI) and the Pregnancy Risk Assessment Monitoring System (PRAMS) were restructured into the Data, Surveillance, and Performance Management section under Public Health.

CNMI MCH Program Family Engagement and Partnerships

The CNMI Maternal and Child Health (MCH) Program emphasizes strong family and community involvement in all aspects of its work. Family engagement is coordinated largely through the Family-to-Family Health Information Center (F2F HIC), which empowers parents and caregivers of children with special health care needs (CSHCN) through training, peer support, and leadership opportunities. Parent leaders actively participate in key advisory committees to shape program policies and decisions.

The program collaborates closely with local groups—including church and women’s organizations—to extend support and advocacy. New initiatives like the PATCH Program engage teens to improve adolescent healthcare experiences. Partnerships with Commonwealth Health Care Corporation providers and mobile clinics increase access to care on remote islands, addressing barriers like transportation and provider shortages.

Regionally, CNMI works with Pacific Island health organizations to share expertise and strengthen health systems. National partnerships with CDC, HRSA, and other agencies provide critical funding, training, and technical support for immunization, chronic disease prevention, and maternal-child health programs.

These coordinated efforts have improved data-driven interventions, workforce capacity, healthcare access, community engagement, and emergency response, advancing the health of CNMI’s mothers, children, and youth.

Summary of FY 2024 Activities by Health Domain

Women's Maternal Health
In FY2024, the end of the Public Health Emergency and Medicaid Presumptive Eligibility prompted CNMI's MCH Program to enhance strategies preserving preventive care access for women ages 18–44. Despite stable preventive service rates (~57% through 2022), utilization declined to 54.5% in 2023, with CHCC-specific service use dropping sharply from 50% to 21.5%. Pap test rates also fell 37% from 2023 to 2024.
Strategies included:

- Mobile Clinic expansion on Saipan and Rota, reaching 252 women on Saipan and 185 women in Rota.
- Targeted outreach via a new Health Promotion Unit, generating 24,000+ digital impressions during Women's Health Month.
- Policy and workflow updates in collaboration with outpatient clinics.

The Family Planning program maintained steady service to 14.7% of women, crucial amid Medicaid coverage disruptions. The MCH Program aims to improve access and reach 63% preventive service utilization by 2030 through sustained mobile health, partnerships, outreach, and data monitoring.

Perinatal and Infant Health
Focus on breastfeeding and early prenatal care aligned with national performance goals:

- **Breastfeeding:**
  - 93.5% infants ever breastfed (above U.S. average 83.2%)
  - Exclusive breastfeeding rose slightly to 11.6% but remains below the U.S. average (44.2%)

Strategies included peer specialist support, lactation supplies, clinical consultations, and community engagement during World Breastfeeding Week.

- **Prenatal Care:**
  - 68% initiated prenatal care in the first trimester (up 7 points from 2023)
  - Preterm birth rate fell from 10.5% to 7.5%, and low birthweight rate from 10.5% to 7.3%

Service navigation via Community Health Workers improved Medicaid enrollment, referrals, and care continuity. Workplace breastfeeding policy efforts are planned for FY2025.

Child Health
Priority Need 4 targets child obesity through improved nutrition and physical activity:

- Physical activity among ages 6–11 rebounded to 60.7% in 2023, a 17-point rise since 2021.
- A new Registered Dietitian led nutrition initiatives, including CNMI's first Produce Prescription pilot at CHCC Women's Clinic for pregnant women.
- Community events (e.g., a 5K Fun Run) maintained youth engagement despite some program pauses.
- Well-child visits and vaccination clinics continued outreach, supporting 23 school-based vaccination clinics.

Adolescent Health
Focus on preventive visits, coping skills, and transition to adult care revealed challenges:

- Preventive visit rates dropped from 42.4% (2020) to 27.3% (2024).
- Transition service receipt slightly declined from 41.7% to 39.6%.

Strategies included:

- School-based screenings and health education reaching 1,328 students.
- The PATCH peer education program held six workshops, increasing teen and parent engagement.
- Sexual and reproductive health services expanded, with increased teen and first-time male teen participation.
- Ongoing efforts to improve transition to adult care through partnerships with schools and youth programs.

Children with Special Healthcare Needs (CSHCN)
Efforts focused on family support and healthcare transitions:

- The Family-to-Family Health Information Center provided peer support, training, and outreach, reaching ~1,000 community members.
- Transition education in schools boosted special education students receiving transition info from 34.4% (2023) to 78.5% (2024).
- Medical home access remains limited (~12.5% overall), but 41% among families engaged with F2F.

Cross-agency collaborations enhanced family engagement and system navigation.
Despite challenges from policy changes and utilization declines, CNMI's MCH Program made meaningful progress across maternal, perinatal, child, adolescent, and special healthcare needs domains in FY2024. Sustained investments in mobile outreach, data-driven strategies, community partnerships, and workforce development remain critical to improving health and achieving long-term goals.

5 Year Comprehensive Needs Assessment Activities & Priorities for 2025- 2030

In FY2025, the CNMI conducted a comprehensive Title V needs assessment, in alignment with the mission to improve the health and well-being of mothers, infants, children, youth—including those with special healthcare needs—and their families. This assessment, required every five years to secure Title V funding, aimed to identify priority health needs for CNMI's MCH populations and guide program goals, objectives, and resource allocation for 2025–2030.
The multi-method assessment process included:

- A review of existing data sources such as prior needs assessments, program reports, and administrative records.
- Administration of priority health issue surveys to youth and professionals, collecting approximately 2,900 responses from Saipan, Tinian, and Rota.
- Community engagement through interviews and focus groups held on Saipan, Tinian, and Rota, where participants examined survey findings and shared insights based on their lived experiences to contextualize and validate priority health concerns.

The final set of priorities for 2025- 2030 identified through the needs assessment is summarized in the table below:

Table A. Final Priorities by MCH Domain

Woman/Maternal
• Access to preventative medical visits • Access to mental health services
Perinatal/Infant
• Education and services to help prevent premature births and low birthweight • Education and support to help with breastfeeding
Child
• Access to healthy physical activities
Adolescent
• Bullying prevention and support • Access to teen pregnancy and sexually transmitted infection (STI) prevention services
Children with Special Health Care Needs
• Access to care coordination and navigation of healthcare and community programs • Parent training • Access to specialty healthcare services
Cross-Cutting
• Clear communication about health services and supports available in each area

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

MCH Block Grant funds are used to support the overall MCH efforts in the Commonwealth of the Northern Mariana Islands (CNMI). Primarily, the Block Grant funds support Enabling Services to improve and increase access to health care and improve health outcomes of the CNMI MCH population. The types of enabling services supported include Care/Service Coordination for pregnant women and Children of Special Healthcare Needs, Laboratory Supplies for Newborn Screening, Eligibility Assistance, Contraceptive Supplies, Health Education and Counseling for Individuals, Children, and Families, Outreach, and Referrals.

Public Health Services and Systems are also supported through MCH Block Grant dollars. Supporting activities and infrastructure to carry out core public health functions in the CNMI is critical for the efforts being made towards improving population health. Specifically, the MCH Block Grant funds are used to support policy development, annual and five-year needs assessment activities, education and awareness campaigns, program development, implementation and evaluation. Additionally, funds are utilized to support workforce development towards building capacity among MCH staff, nurses, and partners who impact CNMI Title V priorities.

III.A.3. MCH Success Story

Empowering Teens as Health Advocates through the PATCH CNMI Program

In a powerful demonstration of cross-sector collaboration to improve adolescent health, the CNMI MICAH Programs, in partnership with the CNMI Division of Youth Services (DYS) and with funding support from the Association of Maternal and Child Health Programs (AMCHP), successfully implemented the PATCH CNMI Teen Educator Program in 2025.

PATCH—Providers and Teens Communicating for Health—is a nationally recognized program designed to equip youth with the tools, knowledge, and confidence to be active participants in their own healthcare. Through a 20-hour intensive training, utilizing DYS village youth centers, the MICAH Programs trained 10 Teen Educators, representing high schools throughout Saipan, to lead peer workshops and serve as youth health advocates in their communities.

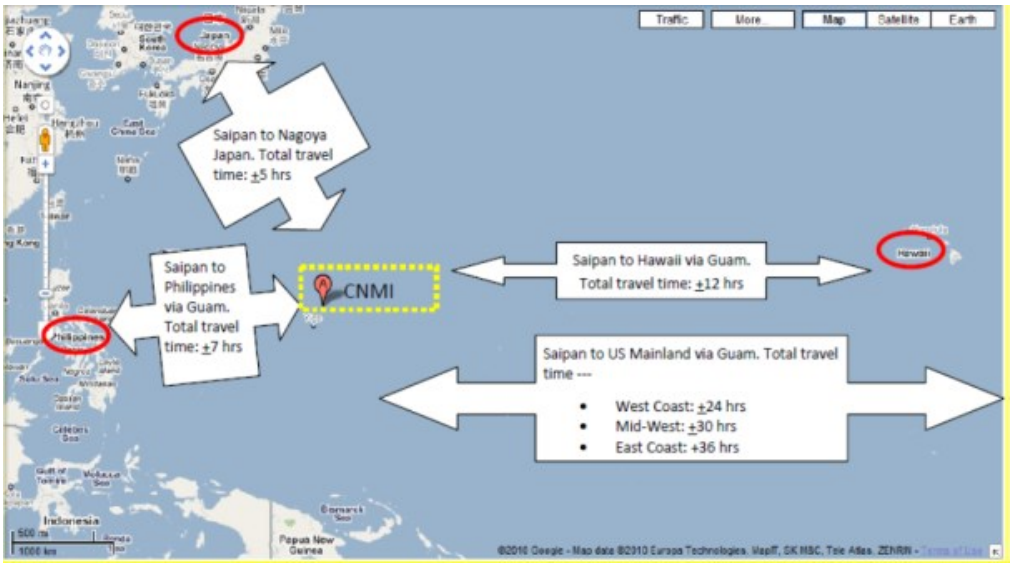
The Teen Educators now serve in dual roles: educating their peers on navigating healthcare systems, making informed health decisions, and advocating for their needs; and conducting outreach to community organizations, healthcare providers, and youth-serving agencies. Their workshops aim to build adult providers' capacity to deliver youth-friendly, respectful, and inclusive services—ultimately improving the way adolescents' access, receive, and experience healthcare in the CNMI.

This collaborative effort, supported by AMCHP funding, directly aligns with CNMI's Title V Maternal and Child Health priorities by promoting adolescent health, strengthening youth engagement, and supporting systems that are responsive to young people's needs. The PATCH CNMI program demonstrates how partnerships between public health, youth services, and national organizations can create lasting impact by empowering youth as leaders and advocates in shaping a healthier future for their communities.

III.B. Overview of the State

III.B.1. State Description

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



In October 2011, Public Law 16-51 dissolved the Department of Public Health and created the Commonwealth Healthcare Corporation (CHCC). CHCC is a quasi-governmental corporation, and while it is a part of the CNMI Government, it is semiautonomous. The CHCC is the operator of the Commonwealth's healthcare system and the primary provider of healthcare and related public health services in the CNMI. This law transferred all the functions and duties of the CNMI Department of Public Health including management of federal health related grants to the Commonwealth Healthcare Corporation, so that the CHCC is the successor agency to the now defunct Department of Public Health. The only hospital in the CNMI is also administered by CHCC. The CHCC is governed by a Board of Trustees and managed by the Chief Executive Officer (CEO) of CHCC. The CEO is the authorized representative for all federal grants, including the CNMI MCH Title V Program. On December of 2023, the CHCC underwent a re-organization to better align and improve the integration of services and functions leading to the fulfillment of the CHCC's overall mission. As a result, the re-organization consists of the following sections: 1) Executive Administration, 2) Financial, 3) Business & Quality Assurance, 4) Ancillary & Support Services, 5) Medical, 6) Population Health, and 7) Nursing. Under each domain there are main functional areas and/or service lines assigned with the intent to establish a unified oversight, accountability, and implementation of a system approach. The approach to population health was revamped and expanded as a core functional area under the organization that includes the integration of the following services: Clinical, Public Health Services and Mental Health Services, along with its assigned management accountability that all work together to improve and optimize the health of our community and therefore, population. The CNMI MCH Title V Program falls within the Population Health Services section and is administered

under the oversight and direction of the Director of Public Health Services.

Demographics

2020 US Census Update for the Northern Mariana Islands

In October of 2021, the US Census Bureau released data on the population of each municipality and district for the Northern Mariana Islands, and the population change between 2010 and 2020. Table 3 below outlines the changes in the population highlighting a 12.2% decrease in the total population for the Northern Mariana Islands. Population change by island includes a 34.8%, 25.1%, and 10% decrease in the population sizes for the islands of Tinian, Rota and Saipan, respectively[i].

Table 1. Population of the Commonwealth of the Northern Mariana Islands: 2010 and 2020

Geographic area	Population		Change (2020 less 2010)	
	2010	2020	Number	Percent
Commonwealth of the Northern Mariana Islands	**53,883**	**47,329**	**-6,554**	**-12.2**
Northern Islands Municipality	**0**	**7**	**7**	**X**
District 4	0	7	7	X
Rota Municipality	**2,527**	**1,893**	**-634**	**-25.1**
District 7	2,527	1,893	-634	-25.1
Saipan Municipality	**48,220**	**43,385**	**-4,835**	**-10.0**
District 1	15,160	13,633	-1,527	-10.1
District 2	6,382	5,489	-893	-14.0
District 3	15,624	14,115	-1,509	-9.7
District 4	3,847	3,416	-431	-11.2
District 5	7,207	6,732	-475	-6.6
Tinian Municipality	**3,136**	**2,044**	**-1,092**	**-34.8**
District 6	3,136	2,044	-1,092	-34.8

Source: US Census Bureau

Single ethnic groups that accounted for the majority population in the CNMI were identified as Filipino (33 percent), followed by Chamorro (25 percent) and Chinese-except Taiwanese (7 percent). Carolinians make up about 5 percent of the total population. Asians were the largest group representing nearly half of the total population. Other Asians make up 7 percent of the total population. Native Hawaiian and Other Pacific Islanders made up about 14 percent and Caucasians less than 2 percent. About 7 percent of CNMI's population were of two or more ethnic origins or races and All Others. In the CNMI, the Chamorro and Carolinian groups are the native indigenous groups of the territory.

Table 2 provides a breakdown of the MCH population based on data from the 2020 US Census and Table 3 illustrates the historical U.S. census data for the MCH population and CNMI population by ethnicity respectively.

Table 2: MCH Population in 2020

Population	2020	% of total Population
Under 5 years	3,218	6.8
Children (5- 14)	7,920	16.7
Adolescents (15-19)	3,834	8.1
Women (15-44)	9,237	19.5

Source: U.S. Census Bureau

Table 3: CNMI Population by Ethnicity, 1990 – 2020.

Ethnicity	1990	2000	2010	2020
Chamorro	12,555	14,749	12,902	12,001
Carolinian	2,348	2,652	2,461	2,271
Filipino	14,160	18,141	19,017	15,456
Chinese	2,881	15,311	3,659	3,270
Caucasian	875	1,240	1,343	1,015
Other Pacific Islanders	3,663	4,600	3,437	6,393
Other Asians	4,291	5,158	4,232	3,328
Others	2,572	7,370	6,832	3,595

Source: U.S. Census Bureau

CNMI has a large percentage of the population that are uninsured. The 2020 U.S. Census reports the uninsured population in the CNMI at 35 percent, while the uninsured rate in the United States is at 8.4 percent[ii]. A challenge with the uninsured population is the status of the immigrant contract workers who are ineligible for Medicare and Medicaid. In the CNMI, based on 2020 US Census data, residents with Medicaid/public coverage constitute about 35 percent of the population, while the Medicaid rate of the U.S. at 21.1 percent[iii].

Economy

Since 1998, the CNMI's economy has suffered one long continuous, downward spiral. A variety of factors contributed to the current circumstance, including the loss of tourism-related business, the effects of rising fuel costs across all of the CNMI, the closing of the garment manufacturing industry, and the implementation of federal Public Law 110-229, which removed local control over immigration. In 2020, the United States Government Accountability Office (GAO) published a report to US congressional committees which indicated growth in the CNMI's economy in 2016 and 2017, based on estimates of gross domestic product (GDP). However, the GAO reports a drop in GDP as a result of sharp decreases in tourist spending following severe damages to the CNMI caused by super typhoon Yutu in 2018[iv]. Real gross domestic product (GDP) for the CNMI decreased 29.7 percent in 2020 after decreasing 11.3 percent in 2019. Furthermore, the CNMI economy was substantially affected by the COVID–19 pandemic due to its effects on spending by consumers, visitors, businesses, and governments[v].

According to the 2020 U.S. Census, the median household income increased from $23,839 in 2009 to $31,362 in 2019. The percentage of families in poverty decreased from 44.4 percent in 2009 to 33.7 percent in 2019. However, it should be noted that 38 percent of the total CNMI population and 42 percent of families with children below 18 years of age reported incomes below the poverty level. In comparison, the US Census Bureau reports 11.6 percent of the population in the US live under the poverty level[vi].

Healthcare for the MCH Population

Commonwealth Healthcare Corporation (CHCC)

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

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

services and increasing access to healthcare, the large uninsured population coupled with minimal funding support from the CNMI government to address indigent care costs continues to challenge the CHCC.
By the end of 2023, the CHCC had an estimated 950 personnel employed. The CHCC provides 100 percent of inpatient services and roughly 80 percent of ambulatory services in CNMI.

- *Services for Pregnant Women, Mothers, Infants*

The Women's and Children's Clinics located at Commonwealth Health Center (CHC) provides comprehensive primary and preventive services for MCH target groups. There are currently five OB/GYN working at the CHCC Women's Clinic and two nurse practitioners and five midwives. There are currently six pediatricians and one nurse practitioner at the Children's Clinic. The MCH Program supports services at both clinics such as case management of high-risk patients, development of educational materials including posters and brochures, and provides staff to assist with developmental screenings and health coverage applications. The HIV/STD screening program, Family Planning Program, and Breast and Cervical Cancer screening program are also offered through the Women's Clinic. Dental health services are made available to women and infants through the CHCC Dental Clinic. Additionally, the CHC hospital maintains the CNMI's only emergency room department and birthing facility and includes the following inpatients units: Obstetrics, Nursery, NICU, Labor & Delivery, Pediatrics. Behavioral health services such as substance use treatment services, counseling, and other behavioral health supports are available via the Community Guidance Center or the Psychiatry providers accessed via the outpatient clinics. Oncology services became available to the CNMI community in 2020 with the first CNMI Oncology Center being established. The MCH Program provides enabling services such as transportation, translation, referrals, incentives, community awareness, and educational materials. Through home visiting initiatives, the MCH Program helps families navigate through state programs. The majority of families seek assistance for WIC, NAP, and Medicaid.

- *Services for Children and Adolescents*

Primary and preventive healthcare services for children and adolescents are provided at the Children's Clinic. Confidential sexual and reproductive healthcare for adolescents is offered through the Family Planning program through service sites at the Women's Clinic, Rota Health Center, Tinian Health Center, and during clinic outreach events. Dental health services are also provided at CHCC Dental Clinic. Vaccinations are made available through the Immunization and Vaccines for Children (VFC) program, which oversees enrollment of VFC sites throughout the CNMI. VFC sites, which include private clinic providers, provide vaccinations to children and adolescents.

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

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

Early intervention services for infants and toddlers with special healthcare needs ages zero to three years are provided through a collaborative effort of the CNMI Public School System and the Commonwealth Healthcare Corporation. Funding for services for early intervention services is provided through Part C of the Individuals with Disabilities Act. The CNMI Public School System is designated by the CNMI Governor as the Lead Agency for carrying out the general administration, supervision, and monitoring of the early intervention program and activities in the CNMI. Services for children with special healthcare needs age three to five years are provided through the CNMI Public School System's Early Childhood Program and for those ages five through 21 years through the Part B, Special Education Program. The following services are available for children with special healthcare needs in the CNMI: audiology services, occupational therapy, physical therapy, service coordination, sign language services, speech-language pathology services, vision services, psychological services, and counseling. According to the CNMI Public School System School Year 2023-2024, 1,108 children with special needs were served. There were 78 infants and toddlers enrolled in Early Intervention Services, 82 children ages 3-5 served through early childhood special education, and 948 children and adolescents ages 6-21 were served through special education[vii].

As a joint effort formalized through an Interagency Agreement, the CHCC MCH Program provides service coordination for infants and toddlers who are enrolled in Early Intervention Services. The CNMI Title V MCH Program facilitates and/or supports programs for the early identification of children from birth through five and supports referrals of children with special healthcare needs to Early Intervention services. For the school year 2023- 2024, there were a total of 170 referrals made to the Early Intervention program, with 82 qualifying for services of which 68 were identified with a developmental delay and 14 were qualified due to an established condition.

Rota Health Center

The Rota Health Center (RHC) is the only medical facility on the island of Rota, serving the entire population of approximately 1,800 residents. Medical providers from the Commonwealth Healthcare Corporation (CHCC) Family Care Clinic regularly rotate into the RHC to deliver care in the outpatient clinic, while rotating Emergency Department providers from Saipan are scheduled to see urgent care and walk-in patients.

RHC is staffed with seven nurses, two medical providers, one laboratory technician, one phlebotomist, one pharmacy technician, two radiologic technicians, one dental assistant, and one dental therapist. In FY 2023, the center expanded its oral health services through the recruitment of a full-time Dental Therapist.

The Rota Health Center houses emergency services, outpatient clinics, pharmacy, laboratory, and radiology units. Public Health programs—including Family Planning, Breast and Cervical Cancer Screening, and HIV/STD Screening—are also available on-site.

Behavioral health services are available at the RHC and include screening, assessment, referral, and limited on-island counseling for mental health and substance use concerns. These services are provided through a combination of in-person care and telehealth support from CHCC Behavioral Health Services based in Saipan. The integration of behavioral health into primary care at RHC ensures residents have access to holistic care despite the island's remote setting.

Tinian Health Center

The Tinian Health Center is located on the island of Tinian, serving the island’s population of approximately 2,000 residents. The center operates emergency services, an outpatient clinic, pharmacy, laboratory, and radiology units. Public Health programs—including Family Planning, Breast and Cervical Cancer Screening, and HIV/STD Screening—are also offered on-site.

Clinical staffing at the Tinian Health Center currently includes 11 nurses, two nurse practitioners, one family practice physician, one pharmacy technician, and one radiologic technician.

Behavioral health services are available at the Tinian Health Center and include mental health and substance use screenings, brief interventions, referrals, and limited counseling services. These services are delivered through a combination of on-island providers and telehealth support from CHCC Behavioral Health Services based in Saipan. This integrated model ensures that residents of Tinian have access to essential behavioral health care, despite geographic limitations.

Mobile Clinic Services

In the fall of 2022, the CHCC began offering primary and preventive health services via a mobile clinic. Prior to 2022, the last time mobile clinic services were provided on Saipan was in 2018, prior to typhoon Mankhut and Yutu. In 2020, the CHCC began the procurement process to purchase a new and larger mobile clinic unit to as part of efforts to expand access to preventive health services and for reaching the underserved within the population. The CHCC mobile clinic serves as an extension of the outpatient clinic services available via CHCC and offers routine adult, well-woman, well child, family planning services. Community Health Workers (CHWs) were recruited to coordinate outreach services and to work with

medical providers from the outpatient clinics in scheduling outreach events. The CHCC mobile clinic services the island of Saipan. During FY 2024, the mobile clinic served a total of 252 adult women, for services that included: health screening, immunizations, family planning and women health checks. Additionally, during the same time period, the mobile clinic served a total of 58 children from ages 0 – 17 years for well child health checks and immunizations.

Federally Qualified Health Center (FQHC)

Kagman Community Health Center (KCHC)

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

Tinian Isla Community Health Center (TICHC)

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

The CHCC Division of Public Health is prioritizing formalizing partnerships with the CNMI FQHCs as part of efforts to improve access to preventive and primary care services for the MCH population in the CNMI through collaboration and coordination of services. In April of 2024, an agreement outlining a partnership for expanding vaccinations, particularly for the CNMI child and adolescent population, between the CHCC Public Health and the CNMI FQHCs was completed. Efforts to expand and improve partnership between the health department and the FQHCs continue.

Private Clinics

In addition to the CHCC clinics and the FQHCs, the CNMI has five private clinics that also provide preventive healthcare to the MCH population. The CNMI currently has 7 private dental clinics on the island of Saipan.

Challenges that Impact Access to Healthcare

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

Uninsured Population

CNMI has a large percentage of the population that is uninsured. The rate of uninsured population in the CNMI is at 35 percent, according to the most recent US Census estimates for 2020 that was released in 2022. There essentially was no change in the uninsured rate compared to the 2010 estimate of 34 percent. In 2013, CNMI Public Law 17-92 was passed, which released employers from the responsibility for providing health insurance coverage to non-U.S. qualified workers (legally-present foreign workers). The estimated percentage of foreign workers in the CNMI is 41 percent[viii], a significant percentage of the workforce.

Inter-Island Medical Referral Services

The Tinian Health Center and the Rota Health Center, both operating under the CHCC organizational structure, have limited

providers and no on-island specialized services. As such, inter-island referrals to Saipan for higher levels of care are coordinated and supported through a partnership between the CHCC and the Mayor's Offices of Rota and Tinian. The CHCC covers the cost of airfare for referred patients from Tinian or Rota, while the respective Mayor's Office pays for hotel accommodations and subsistence expenses for the patient and one escort.

As part of this referral process, pregnant women from Rota and Tinian are routinely relocated to Saipan at 32 weeks gestation to complete the remainder of their pregnancy and deliver at the CHCC hospital. This ensures access to appropriate obstetric care and safe delivery services that are not available on the outer islands.

Off-island Referrals

On January 31, 2023, Public Law 22-33 was signed into law, transitioning the Medical Referral Office from the CNMI Office of the Governor to the Commonwealth Healthcare Corporation. The Medical Referral program now operates as the Health Network Program providing airfare, housing, and transportation assistance to qualified individuals.

Treatment services, including access to diagnostic services, not readily available in the CNMI are handled through the CNMI Health Network Program (HNP), which was formerly known as the Medical Referral Program. Patients are referred to healthcare facilities in Guam, Philippines, Korea, Taiwan, Hawaii, or the US mainland. In 2004 the number of off-island medical referrals was 437 patients and since that time the number of referrals has increased steadily to 565 patients in 2007, 924 patient referrals in 2009, and 1,117 patients in 2010. There was a 155% increase in the number of patients referred for off-island care between 2004 and 2010. In an interview with the CNMI Medical Referral Office Director, Ronald Sablan, it was noted that the rise in medical referral patients is largely attributed to a lack of medical maintenance among patients. Patients are increasingly forgoing preventive care and seeking medical attention when health conditions or diseases are at their worst stages and requiring care not readily available on island[ix]. An economic crisis that began in the year 2000 impacted both the CNMI population's ability to be able to access healthcare, more importantly, preventive healthcare and government spending, including spending on healthcare. In the year 2000, the CNMI's garment manufacturing industry began to slowly close its doors until it eventually completely phased out in 2006. In addition to this, tourism, the CNMI's second largest industry experienced a major decline in the early 2000's. Economic recovery was noted by growth in gross domestic product beginning in 2012 through 2016 and the tourism sector reporting visitor arrivals increases of 39.9% over the four-year period[x]. However, the improvements in the tourism market were short lived when the CNMI was devasted by Super Typhoon Yutu in 2018 and further impacted by the COVID-19 pandemic. It has been noted that a priority for addressing the challenges to the CNMI economy is to restore the visitor industry. Studies have shown that unemployment rates are linked to preventive healthcare utilization, with increases in unemployment corresponding to decreases in individuals completing preventive health services such as pap smears, mammograms, and annual checkups[xi].

Recent data shared with CNMI Public Health by the Health Network Program (HNP) reveals that in 2024, a total of 943 residents were referred for medical care outside the Northern Mariana Islands—a stark reminder of the ongoing challenges in accessing specialized care locally. Among these, pediatric cases accounted for 88 referrals, representing 9% of the total. These children were primarily sent off-island to receive specialized services not available in the CNMI, with most receiving treatment at Rady Children's Hospital in California. Additional pediatric care was also provided through Shriner's Children's Hospital in Honolulu and select providers in Guam. The high number of off-island referrals in key areas such as cardiology, diagnostic radiology, and pediatrics underscores the urgent need to strengthen local healthcare infrastructure and capacity to reduce the burden on families and ensure timely, accessible care for all residents—especially the most vulnerable.

Health Coverage for MCH Population

As a territory, enrollment in the ACA is not available. However, enrollment into the Medicaid program is enhanced for eligible persons. The CNMI Medicaid program is unique to the CNMI and other US territories and jurisdictions. The program is

“capped” by the US federal government and limited to a set dollar amount allotted to the CNMI. This limited funding severely affects access, cost, and quality of health care for all residents of the CNMI. The current state plan limits use of CHIP money to the event where the general program has exhausted its standard funding. This is a federal restriction imposed on the CNMI based on information verified by local health officials. CHCC is the primary provider for all Medicare and Medicaid beneficiaries in the CNMI, thus restrictions on services are currently enforced on private clinics.

Medicaid

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

The framework for Medicaid financing in the CNMI resembles that of the fifty states: the cost of the program (up to a point) is shared between the federal government and the Territory, and the federal government pays a fixed percentage of the CNMI Medicaid costs. However, unlike the 50 states, the federal government pays a fixed percentage of the CNMI Medicaid costs within a fixed amount of federal funding. If CNMI Medicaid expenditures exceed the territory’s federal Medicaid cap, which was $6.3 in FY 2017, the CNMI becomes responsible for 100 percent of Medicaid costs going forward. This situation results in the suspension of healthcare services or the ceasing of payments to providers until the next fiscal year. Moreover, the CNMI historically has received a relatively low fixed percentage, which is known as the Federal Assistance Percentage, or FMAP. The FMAP rate for the CNMI is set at 55%, lower than most of the 50 states. This means that the CNMI will get 55 cents back from the federal government for every dollar spent on the Medicaid program up to the federal cap. The formula by which the FMAP is calculated for the 50 states is based on the average per capita income for each state’s relative to the national average. Thus, the poorer the state, the higher the federal share, or FMAP, is for the jurisdiction in a given year. However, due to the statutory restrictions on Medicaid financing for the Northern Mariana Islands, the FMAP that was provided the CNMI is not based on per capital income of residents, thus, the CNMI’s FMAP does not reflect the financial need of the CNMI in the same ways that the 50 states’ financial needs if represented. Through a number of legislations made recently, the FMAP rate for the CNMI was temporarily increased from 55% to 83% from FY2020 through FY2022. In December of 2023, the Consolidated Appropriations Act of 2023 made the 83% FMAP rate for the CNMI permanent, along with most of the other territories.

According to the Medicaid and CHIP payment and Access Commission (MACPAC), in fiscal years 2011 thru 2017, the federal spending for Medicaid in the Northern Mariana Islands exceeded the annual funding ceiling. This spending reflects the use of the additional funds available under the PPACA. The CNMI Medicaid Office had exhausted the additional funds made available by the PPACA in April 2019. However, recent supplemental federal funds have been made to the CNMI, beginning with the FY2020 appropriations package, signed into law in December 2019 and then the Families First Coronavirus Response Act, effective March 2020.

These supplemental funds raised the CNMI’s FY2020 Medicaid funding allotments From $6.9 million to $63.1 million, FY 2021 allotment from approximately $7.1 million to $62.3 million, and the FY 2022 allotment to $64 million. For FY 2022, the Centers for Medicare & Medicaid Services (CMS) interpreted the effect of the supplements that provided federal Medicaid funding to the territories comparable to the annual federal capped funding provided for FY 2021. This resulted in the FY2022 and FY2023 Medicaid cap for the CNMI being placed at $64 million and $66 million respectively.

Private Insurance

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

from denying coverage due to health status or other factors.

Policies and Regulations that impact MCH Populations

Public Law 01-33 School Immunization Act of 1979.

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

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

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

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

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

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

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

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

Public Law 22-33 "To establish the Health Network Program (HNP) under the Commonwealth Healthcare Corporation (CHCC); to provide for the orderly transition of medical referral services
administration and operations to CHCC; to write off outstanding balances of medical referral
promissory notes; and for other purposes."

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III.B.2. State Title V Program

III.B.2.a. Purpose and Design

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

The CHCC Maternal and Child Health Bureau was formed in 2014 to address the needs of the CNMI MCH population, transformation of the MCH Title V Block Grant, and link all opportunities between MCH programs to work through challenges common across programs since the transition of the Corporation into a semi-autonomous agency. Since then, the CHCC has gone through re-organization and in 2021, the MCHB was restructured under the CHCC Division of Public Health Services (PHS) unit into the Maternal, Infant, Child and Adolescent Health (MICAH) Programs section, with WIC and Immunization services integrated within the unit. In FY 2023, the Division of Public Health underwent a subsequent restructuring as part of efforts to strengthen the CNMI's Public Health foundational capabilities in alignment with the Foundational Public Health Services (FPHS) framework. The Immunization program was re-organized into the Communicable Disease Programs section and two new Public Health sections were established: 1) Data, Surveillance, and Performance Management; and 2) Health Promotions & Partnerships.

The Division of Public Health Services mission statement is "to improve quality of life, health and wellbeing of CNMI residents by providing services that meet and support community needs and values". The Division's vision is "to work in partnership to ensure communities and families residing in the CNMI have the resources they need to improve quality of life and wellbeing". The Division is working to finalize the strategic plan to align with the re-organization. This work is being conducted in FY2024 through support from the Association of State & Territorial Health Officials (ASTHO).

The CHCC is the only health department in the CNMI and provides all public health services, including direct, enabling and infrastructure building to all islands within the territory.
The CHCC Public Health Services unit is comprised of 6 sections:

- Maternal, Infant, Child & Adolescent Health (MICAH) Programs
- Non-Communicable Disease Programs
- Communicable Disease Program
- Environmental Health & Disease Prevention (EHDP)
- Data, Surveillance, and Performance Management
- Health Promotions & Partnerships

Each of these sections includes several programs and provides services for the entire CNMI population. The MICAH Programs section is comprised of the following programs:

- Adolescent & Reproductive Health
- WIC Program
- Children with Special Health Care Needs (CSHCN)
- Home Visiting Program
- MCH Program
- ERASE Maternal Mortality

The State Systems Development Initiative (SSDI) and the Pregnancy Risk Assessment Monitoring System (PRAMS) were restructured into the Data, Surveillance, and Performance Management section under Public Health.

Beginning in the latter part of 2019, the CHCC initiated efforts for a health system redesign in which a clinical integration approach for impacting population health was adopted. Activities as part of this effort experienced some delay as a result of prioritization of COVID-19 response. However, as health department activities transitioned out of pandemic response, focus was redirected towards initiatives to further integrated care efforts. This approach to care considers a wide range of influences and interrelated conditions that impact the health of populations over the life course, identifies systematic disparities in their patterns of occurrence, and applies the resulting understanding to improve the health and well-being of those in our population. This strategy also is intended to shift the focus of a coordinated public health- clinical partnership to prevention, multiple determinants of health, cross-systems action and partnerships, and understanding the needs and solutions necessary through community outreach. MICAH programs, and the MCH Title V Program, contribute population based and enabling services, supported by evidence, into this clinical integration implementation.

Strategies identified within the CNMI MCH Title V State Action Plan are designed to: 1) improve access to comprehensive primary and preventive healthcare; 2) provide health promotion to reduce the incidence of preventable diseases, morbidities, and mortalities; 3) reduce barriers and increase access to preventive, screening, and treatment services; 4) improve coordination across programs that serve MCH populations.

In addition, the MCH Title V program is responsible for:

- Action plan development for each priority identified for each MCH population domain.
- Monthly progress reports on each priority for each MCH target population group.
- Monthly MCH Team meetings and learning sessions for review of priority progress to identify barriers, successes, and opportunities for collaboration.
- Ongoing quality improvements, such as partnership building, community engagement, resource allocation, and meeting effectiveness.
- Evaluation of the performance management and quality improvement infrastructure resulting in the revision and expansion of program processes.

III.B.2.b. Organizational Structure

The Maternal and Child Health (MCH) Title V program in the Commonwealth of the Northern Mariana Islands (CNMI) is situated within the Commonwealth Healthcare Corporation (CHCC), the principal public health and medical services provider for the territory. This organizational placement carries significant implications for the program's responsiveness to needs assessment findings.

Strengths

- **Centralized Healthcare Hub:** Being housed within CHCC positions the Title V program at the heart of the CNMI's healthcare delivery system. This proximity facilitates streamlined coordination with clinical services and other health departments, allowing for timely access to patient data, integration of services, and direct influence on care protocols affecting maternal and child health.
- **Access to Clinical Expertise and Infrastructure:** CHCC's status as the primary healthcare provider means the Title V program can leverage existing medical infrastructure, including hospital facilities, specialty clinics, and professional staff. This enhances the program's capacity to implement clinical interventions identified in the needs assessment without the need to build parallel structures.
- **Integrated Data and Reporting Systems:** Placement within CHCC allows the MCH program to utilize centralized health information systems, improving the accuracy and timeliness of data collection, which is critical for monitoring and responding to evolving MCH needs identified through assessments.

Opportunities

- **Cross-Program Collaboration:** CHCC houses various health programs, offering Title V the opportunity to partner effectively with other departments such as immunization, nutrition, behavioral health, and chronic disease management. This fosters multidisciplinary approaches to complex MCH issues like obesity, mental health, and substance abuse, which often require integrated interventions.
- **Resource Sharing and Funding Leverage:** The Title V program can collaborate on grant applications, joint training, and community outreach initiatives with other CHCC programs. Such collaborations may maximize limited resources and increase the program's impact by broadening service reach and sharing expertise.
- **Policy Influence:** Being embedded within the main healthcare entity potentially enhances Title V's influence in institutional and territory-wide health policy decisions, allowing it to advocate for maternal and child health priorities based on assessment findings.

Challenges

- **Competing Priorities within CHCC:** As one program within a larger healthcare organization, Title V may face challenges in prioritization, particularly when competing with acute care or other pressing health issues within CHCC. This could limit the agility and funding allocation needed to fully address MCH needs identified in assessments.
- **Bureaucratic Complexity:** Operating within a large, multifaceted healthcare system can introduce layers of bureaucracy, potentially slowing decision-making and implementation of responsive actions, particularly for innovative or cross-sector initiatives.
- **Limited External Partnerships:** While CHCC provides an internal network, the Title V program's placement might inadvertently limit direct engagement with external agencies or community-based organizations that also play critical roles in MCH outcomes, potentially reducing opportunities for broader community-driven responses.

The placement of the MCH Title V program within CHCC in the CNMI offers substantial strengths, notably in service integration, resource access, and data sharing, which enhance its ability to respond effectively to needs assessment findings. The organizational structure also presents opportunities for expanded collaboration and policy advocacy. However, challenges remain in balancing competing priorities and navigating organizational complexity, which could

hinder rapid response and innovative approaches. Strategically leveraging CHCC's internal networks while proactively fostering external partnerships will be critical for maximizing the Title V program's impact on maternal and child health in the CNMI.

III.B.3. Health Care Delivery System

III.B.3.a. System of Care for Mothers, Children, and Families

The Commonwealth of the Northern Mariana Islands (CNMI) maintains a multifaceted but resource-constrained system of care designed to support the health and well-being of mothers, infants, children, adolescents, and families. Anchored by the Commonwealth Healthcare Corporation (CHCC), the CNMI's integrated public health and hospital system, this network of services strives to deliver coordinated, culturally sensitive, and accessible care across all life stages. The CNMI's small, geographically isolated island setting brings both a unique cohesiveness in community-based care and significant challenges in ensuring consistent access to specialized services and workforce sustainability.

Key Components of the State System of Care

The system of care for the MCH population includes:

Prenatal and Postpartum Services: Prenatal care is centralized through CHCC and its affiliated health centers, providing routine screenings, nutrition counseling, and risk assessment. The Family Planning Program, in coordination with Title V, supports reproductive health education and postpartum services.

Primary and Preventive Child and Adolescent Care: Pediatric and adolescent care is provided through community-based clinics offering immunizations, well-child visits, developmental screenings, and oral health services. Schools partner with public health programs to deliver health promotion and preventive services, including the School-Based Health Program.

Newborn Screening and Infant Mortality Prevention: CNMI conducts newborn bloodspot screening and hearing tests in line with federal guidelines. However, barriers such as delayed lab result turnaround due to off-island processing remain a challenge. Infant mortality is monitored through vital statistics and targeted public health interventions.

Behavioral and Mental Health Services: Behavioral health care is offered through CHCC's Community Guidance Center, which provides counseling, crisis intervention, and substance use disorder treatment. However, adolescent mental health resources and early intervention services are limited due to a shortage of trained providers.

Immunization and Injury Prevention: The Immunization Program maintains high coverage rates through community outreach and school mandates. The Title V Program collaborates with emergency services and public safety partners to promote injury prevention and child passenger safety education.

Oral Health and Nutrition: The Oral Health Program conducts school-based screenings and fluoride varnish applications. The WIC program enhances nutrition for women, infants, and children, reinforcing preventive care from a young age.

Bereavement Care and Maternal Morbidity: Title V has begun to address maternal mental health and bereavement care, though systematic support for families experiencing loss remains limited. Data collection related to maternal morbidity is improving, with efforts to track severe maternal outcomes and preventable deaths.

Public Health Infrastructure and Title V's Role

The CHCC Public Health Services Division serves as the cornerstone of the CNMI's public health infrastructure, with the Title V Maternal and Child Health Services Block Grant Program playing a central role in guiding priorities, filling service gaps, and aligning community health needs with evidence-based strategies. The Title V program provides critical funding, data analysis, technical assistance, and capacity building to improve outcomes for high-risk populations, including those facing socioeconomic, geographic, and cultural barriers to care.

Through its needs assessment and stakeholder engagement efforts, Title V ensures community voices shape local public health priorities. Title V is actively engaged in reducing maternal morbidity and mortality through quality improvement initiatives, supporting perinatal regionalization, and enhancing provider education and protocols.

Strengths of the System

- Integrated public health and hospital system (CHCC), facilitating care coordination
- High levels of community engagement and cultural competence in care delivery

- Strong immunization rates and early childhood screening programs
- Effective WIC and family planning programs reaching medically underserved populations
- Title V leadership in data-driven planning and interagency collaboration

Gaps and Areas for Improvement

- Limited access to specialty care and subspecialty maternal-fetal and pediatric services due to geographic isolation
- Insufficient behavioral health services for adolescents and postpartum women
- Gaps in systematic bereavement care, maternal morbidity surveillance, and oral health follow-up
- Workforce shortages in key areas such as mental health, speech therapy, and neonatal care
- Challenges in inter-island service delivery and transportation for remote communities

Addressing Needs of Medically Underserved and High-Risk Populations

The CNMI's population includes significant numbers of individuals who are medically underserved, especially in outer islands such as Rota and Tinian. The Title V program, in partnership with local agencies, ensures these communities receive outreach, telehealth support, and periodic mobile clinics. Programs are tailored to serve individuals with limited English proficiency ensuring fair access and care that is respectful and aligned with community values.

III.B.3.b. System of Services for CSHCN

The Commonwealth of the Northern Mariana Islands (CNMI) remains committed to developing and strengthening a comprehensive, community-based system of services that supports Children with Special Health Care Needs (CSHCN) and their families. Through a collaborative framework led by the CNMI Title V Maternal and Child Health (MCH) Program, the CNMI continues to make progress across the six core outcomes defined by the National Survey of Children's Health (NSCH), while addressing the challenges that persist in our island context.

1. Families as Partners in Decision-Making

A cornerstone of the CNMI's approach to CSCHN services is the active engagement of families as equal partners in decision-making. The MCH Program facilitates family-professional partnerships through engaging with parent leaders from the CNMI Family to Family Health Information Center (F2F), which provides input into program planning, service delivery, and policy development. Family representatives serve on advisory boards and participate in care coordination meetings. Despite this progress, barriers such as limited understanding of rights, stigma, and language remain. Continued investment in culturally competent family education and advocacy training is needed to further empower families.

2. Medical Home

The concept of a medical home—where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective—is gradually being implemented in the CNMI. Primary care providers across the Commonwealth, particularly those under the Commonwealth Healthcare Corporation (CHCC), are increasingly adopting care coordination models. Title V supports this effort through training and technical assistance, yet the full implementation of the medical home model remains a gap due to workforce shortages, especially in pediatrics and behavioral health. Families from the islands of Tinian and Rota in the CNMI often experience difficulties in accessing consistent primary care.

3. Adequate Health Insurance

Most children in the CNMI are covered under Medicaid or the CNMI State Children's Health Insurance Program (CHIP). However, insurance coverage for specialized services—such as occupational therapy, behavioral health services, and out-of-territory care—can be limited or delayed due to administrative and fiscal constraints. Title V assists families in navigating the healthcare system and in obtaining referrals and authorizations for specialty services. Nonetheless, the CNMI continues to advocate for improved insurance parity and streamlined access to services for families with CSHCN.

4. Early and Continuous Screening

Early identification and continuous screening of developmental, behavioral, and chronic health conditions are supported by the CNMI's Newborn Screening Program and the Early Intervention Program (EIP), housed by the CHCC and Public School System (PSS), respectively. Title V also partners with Head Start, Early Head Start, and

the CNMI Child Care Development Funds (CCDF) to conduct developmental screenings and facilitate referrals. While screening rates have improved, the CNMI faces persistent gaps in timely diagnostic evaluations and specialty care follow-ups due to limited on-island providers and reliance on off-island referrals. Enhancing local diagnostic capacity remains a key priority.

5. Ease of Community-Based Services

Community-based services in the CNMI are delivered through a network of government and nonprofit organizations. Title V plays a coordination role among these organizations, helping to ensure that services are accessible and responsive to family needs. Nevertheless, transportation, language barriers, and provider shortages—particularly in Rota and Tinian—continue to limit ease of access.

6. Transition to Adult Care

Transitioning youth with special health care needs to adult services is an emerging area of focus in the CNMI. Currently, transition planning is inconsistent and often lacks formal protocols or provider coordination. The Title V Program has initiated a pilot project to develop transition policies and tools, in collaboration with pediatric and adult primary care providers. Youth engagement, provider training, and transition readiness assessments are being explored, though resources to sustain these efforts remain limited. Additionally, the CNMI is working with the CNMI Public School System to reach families and share information and support on transition. Strengthening the transition infrastructure is a recognized priority in upcoming fiscal years.

Addressing the Needs of Underserved and High-Risk CSHCN

The CNMI's geographic isolation and small population contribute to the challenges faced by medically underserved and high-risk populations, including children with multiple disabilities, those in poverty, and those residing on the islands of Rota and Tinian. These children often experience delayed diagnoses, fragmented care, and limited access to therapeutic services. Title V uses a health for all approach to prioritize outreach and coordination efforts for families, with targeted technical assistance, transportation support, and service navigation provided through community health workers.

Public Health Infrastructure and the Role of Title V

The CNMI Title V Program is housed within the CHCC's Division of Public Health Services and collaborates closely with other divisions, including Behavioral Health (Community Guidance Center), and CHCC outpatient clinics. Title V also works in tandem with the Medicaid Program, the Public School System, and early intervention partners to create an integrated public health infrastructure supporting CSCHN.

Title V serves as a convener, connector, and catalyst—bringing together stakeholders to align strategies, collect and analyze data, improve workforce capacity, and reduce service silos. It coordinates service coordination for CSCHN and monitors system performance using performance measures aligned with NSCH core outcomes.

While the CNMI has made meaningful strides in developing a more responsive system for CSHCN, gaps remain in workforce, specialty services, transition planning, and fair access across islands. The CNMI Title V Program continues to play a pivotal role in advancing these efforts through leadership, coordination, and strategic investment in infrastructure and family engagement. Through sustained commitment, cross-sector collaboration, and culturally tailored interventions, the CNMI seeks to build a truly integrated and accessible system of care for all children with special health care needs.

III.B.3.c. Relationship with Medicaid

The Commonwealth of the Northern Mariana Islands (CNMI) became a U.S. territory in 1978, with its Medicaid program established in 1979. It operates a 100% fee-for-service system with one hospital and no deductibles or co-payments. CNMI does not run a Medicare Part D plan; instead, it receives a separate Enhanced Allotment Plan (EAP) grant to provide Part D drugs to dual-eligibles.

CNMI is the only U.S. territory that participates in the Supplemental Security Income (SSI) program, and Medicaid eligibility is tied to SSI. Individuals receiving SSI automatically qualify for Medicaid upon completing a simple application.

While Medicaid financing in CNMI follows the federal-state cost-sharing model, it differs in two major ways. First, federal funding is capped annually under Section 1108, regardless of enrollment or service needs—unlike the uncapped funding states receive. Second, CNMI's Federal Medical Assistance Percentage (FMAP) was historically fixed and not based on income. Before the ACA, it was capped at 50%, despite CNMI's low median household income of $19,958 (vs. $63,179 nationally in 2010). MACPAC estimated that applying the state FMAP formula would have qualified CNMI for a maximum of 83%.

The Consolidated Appropriations Act of 2023 permanently raised the FMAP to 83% for CNMI, Guam, American Samoa, and the U.S. Virgin Islands, and temporarily set Puerto Rico's at 76% through 2027.

Despite improvements, CNMI's capped federal funding continues to threaten coverage and strain providers. Congress has repeatedly intervened with emergency funds, boosting CNMI's Medicaid allotment from around $7 million to over $60 million in both FY2020 and FY2021.

Table I. Annual Federal Capped Funding FY2024-2025
($ in millions)

	FY19	FY20	FY21	FY22	FY23	FY24
CNMI	7	63	62	64	66	93
Total	**$7**	**$63**	**$62**	**$64**	**$66**	**$93**

In FY 2024, Congress appropriated an additional $27 million to CNMI Medicaid to cover financial shortfalls from FY 2023 and FY 2024, including disaster and emergency response costs. While these temporary funds offered short-term relief, they contribute to ongoing "funding cliffs" that require repeated congressional action.

On September 24, 2021—just before the end of FY 2021—CMS informed CNMI that FY 2021 would serve as the base year for calculating territorial Medicaid allotments under section 1108(g)(2)(E), affecting funding from FY 2022 onward.

Additionally, Section 5112 of Public Law 117-328 (Consolidated Appropriations Act, 2023) amended the Social Security Act to mandate 12 months of continuous Medicaid and CHIP eligibility for children under 19, effective January 1, 2024.

Recent CNMI Medicaid State Plan Amendments:

- May 20, 2020 (COVID-19 Emergency Response):
  Allowed more flexible income determination for eligibility, authorized presumptive eligibility (PE) decisions by the State Medicaid Agency (SMA), hospital, and public health centers, and granted 12 months of continuous eligibility for children under 19.
- May 20, 2020 (COVID-19 Optional Group & Flexibilities):
  Expanded coverage to include the new optional COVID-19 testing group, maintained residency for displaced individuals, extended the reasonable opportunity period, allowed 90-day drug supplies and early refills, extended prior authorizations without clinical review, permitted exceptions to the preferred drug list during shortages, and enabled telehealth reimbursement at 80% of the face-to-face rate.
- June 9, 2020:
  Allowed cost-based reimbursement for hospital services provided via telehealth by the Commonwealth Healthcare Corporation (CHCC), under the existing state plan protocol.
- May 28, 2021 (Effective Jan 1, 2021):
  Removed the five-year waiting period for Medicaid eligibility for COFA migrants lawfully residing in CNMI, in accordance with agreements between the U.S. and the Freely Associated States (FSM, RMI, and Palau).

The end of Presumptive Eligibility contributed to lower Medicaid enrollment.

In FY 2023–2024, CNMI Medicaid enrolled 13,075 children (ages 1–17) and 8,864 women of reproductive age (15–44), including qualified non-U.S. citizens. By the end of the fiscal year, total enrollment reached 21,939, including children, women of reproductive age, and eligible non-citizens such as Freely Associated State (FAS) migrants and pregnant women with legal status.

Enrollment by age group is shown in the tables below.

Table 1: 2023 & 2024 Medicaid Enrolled Children by age, 1-17 years, CNMI

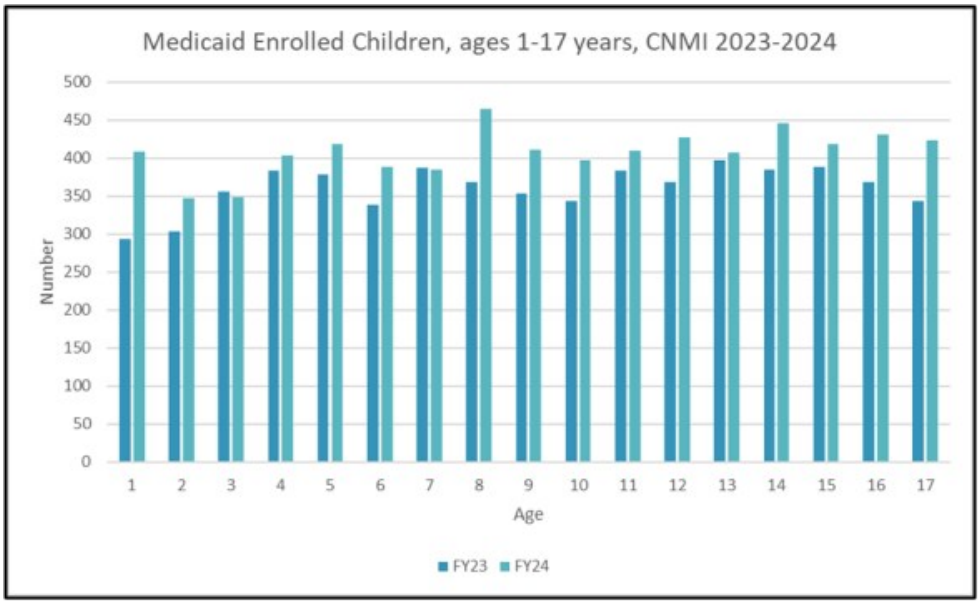
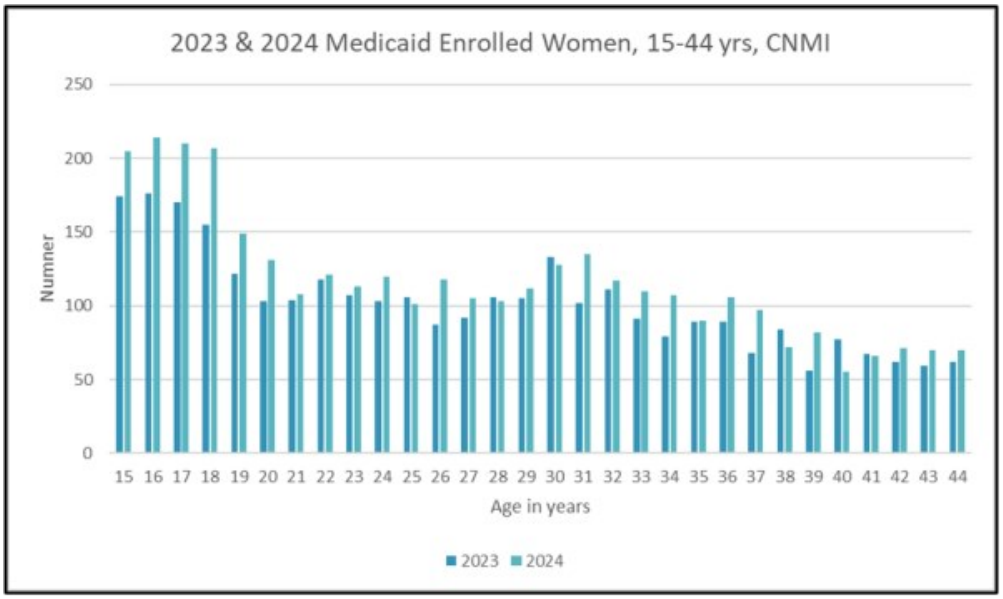


Table 2: 2023 & 2024 Medicaid Enrolled Women of Reproductive Age, 15-44 years, CNMI



The CNMI MICAH and Medicaid programs share a mission to expand access to quality care for underserved populations. Medicaid provides coverage for low-income residents, while MICAH, under Title V, focuses on mothers, infants, children, adolescents, women of reproductive age, and Children with Special Health Care Needs (CSHCN).

Their partnership is formalized through an interagency agreement outlining shared responsibilities, including referrals, Medicaid reimbursement, data sharing, and staff training. Medicaid shares annual eligibility data with MICAH, helping identify and assist eligible individuals. This collaboration creates a more coordinated and accessible system of care for families.

Enhancing Access Through Community-Based Support

To address persistent barriers to care—such as lack of insurance, transportation, and low health literacy—MICAH hired a Community Health Outreach Worker (CHOW) in FY 2024. The CHOW supports clients by helping them apply for Medicaid, coordinating health and social service referrals, and conducting follow-ups to ensure timely care. This role has improved care navigation for prenatal, postnatal, and pediatric clients, especially Children with Special Health Care Needs (CSHCN).

To streamline access further, MICAH maintains a standing Memorandum of Understanding (MOU) with the CNMI Medicaid Office. This agreement, aligned with Section 509(a)(2) of Title V and Section 1902(a)(11) of Title XIX of the Social Security Act, ensures coordination between Title V and Medicaid programs for shared populations.

Under the MOU, the CHOW is authorized to visit the Medicaid Office up to three times per week to submit and monitor applications on behalf of MCH clients. This direct coordination accelerates processing and reduces delays, which is critical for time-sensitive services like prenatal and specialty care for CSHCN.

This partnership strengthens integration between Title V and Medicaid and reflects CNMI's commitment to improving access and efficiency for its most vulnerable maternal and child health populations.

Supporting Families of CSHCN

As part of the MICAH unit, the CNMI Family-to-Family Health Information Center (F2F) supports families of Children with Special Health Care Needs (CSHCN) in navigating Medicaid enrollment. Staff assist with completing applications, collecting documentation, and coordinating with the Medicaid Office to reduce delays in accessing specialty care and early intervention services.

Children with CSHCN who receive Supplemental Security Income (SSI) are automatically renewed for Medicaid annually, without reapplying. This simplifies the process for families and ensures continuous coverage. F2F staff help families understand and access this benefit, including support with SSI enrollment when eligible.

To promote early access to services, MICAH distributes newborn care packets monthly to the OB Ward at the Commonwealth Healthcare Corporation (CHCC). These packets are given to families before hospital discharge and include Medicaid applications, Title V and community program brochures, PRAMS information, and MICAH contact details. This outreach helps ensure early enrollment and timely connection to preventive services like well-child visits, immunizations, and developmental screenings.

Medicaid Structure and Off-Island Referral System

The CNMI Medicaid Program operates under a 100% fee-for-service model, reimbursing enrolled providers for covered services. When care is unavailable locally—such as subspecialty services, advanced diagnostics, or surgery—eligible enrollees may be referred off-island. These referrals are reviewed and approved by the CHCC Health Network Review Board. MICAH supports this process by confirming medical necessity, collecting documentation, and assisting families with logistics.

The partnership between CNMI's Title V MCH and Medicaid programs is essential to the care system for vulnerable populations, particularly CSHCN. Through formal agreements, shared staff, coordinated outreach, and data-driven efforts, the programs work together to expand access, reduce barriers, and connect families to needed services. Continued investment in this collaboration is key to improving outcomes for mothers, children, and youth with special health care needs.

III.B.4. MCH Emergency Planning and Preparedness

Northern Mariana Islands Emergency Management Structure

Homeland Security and Emergency Management: The CNMI Homeland Security and Emergency Management (HSEM), located within the Office of the Governor, is the emergency management agency for the territory. The CNMI Governor has direct authority over the CNMI HSEM which serves as the coordinating agency for all emergency management services, federal emergency management agencies, the private sector, and nongovernmental organizations.

The HSEM develops and maintains the CNMI All-Hazards Emergency Operations Plan, which establishes the shared framework for the CNMI's response to and initial recovery from emergencies and disasters. CNMI agencies responsible for providing emergency assistance are organized into 18 functional groups, emergency support functions (ESF). Each ESF outlines responsibilities of state agencies and partners for emergency functions and provide additional detail on the response to specific types of issues and incidents.

The purpose of the CNMI All-Hazard Emergency Operations Plan (EOP) is to establish the CNMI Emergency Operations System which organizes the CNMI's response to emergencies and disasters while providing for the safety and welfare of its people. It sets forth lines of authority, responsibilities and organizational relationships, and shows how all actions will be coordinated among the CNMI, its various Municipalities and the Federal Government. The EOP is designed as an "ALL HAZARDS" plan and applies to all hazards identified in the Hazard Identification Risk Assessment found in the CNMI State Standard Mitigation Plan (SSMP)[i]. The CNMI EOP defines operational structures to perform the following functions:

- Coordinate emergency management plans at the federal, state, and local government levels. Outlines the activation and coordination processes of the CNMI's Emergency Operations Center (EOC) and associated functions.
- Effectively utilize government (federal, state, and local), non-governmental organizations, and private sector resources through the response mission arena of emergency management.
- Provide a system for the effective management of emergencies, including describing how people (unaccompanied minors, individuals with disabilities and others with access and functional needs, and individuals with limited English-speaking proficiency) and property are protected.

Public Health/Hospital Emergency Preparedness Program: The CHCC public health and hospital Emergency Disaster Plan (EDP) outlines how the health department and hospital will manage the impacts of an emergency and execute duties assigned by the CNMI EOP. The lead division for emergency management under the CHCC is the Public Health/Hospital Emergency Preparedness Program (PHHEPP) which is located under the office of the Chief Executive Officer. PHHEPP works to prevent, mitigate, plan for, respond to, and recover from natural and human-caused health emergencies and threats. The PHHEPP is also responsible for the coordination of the CNMI Medical Reserve Corps (MRC) that provides volunteers to assist with emergency operations.

CHCC/Health Department Functions in the CNMI EOP: Within the CNMI EOP, the CHCC is the lead agency for the ESF8 functions, Health and Medical Services. In this role, the CHCC is responsible for coordinating, communicating and serving as the liaison with federal and response agencies concerning public health and medical emergencies. It leads the coordination and facilitation of public health support of individuals and communities under evacuation, quarantine, or isolation for incidents involving the release of chemical, biological, radiological, nuclear, and explosive materials; natural and man-made disasters; and major disease outbreaks. The CHCC is responsible for public information and risk communication prior to, during, and following a public health or medical emergency to the CNMI EOC. Additionally, the CHCC is responsible for public health screening, testing, vaccination, treatment and other public health services during a public health medical emergency requiring the services. The CHCC serves in support capacity for the following ESFs: 2 (Communications), 5 (Information and Planning), 6 (Mass Care), 10 (Oil and Hazardous Materials Response), 11 (Agriculture and Natural Resources), 14 (Long-term Community Recovery), 16 (Volunteers and Donations), 17 (Cyber and Critical Infrastructure Security).

Maternal & Child Health (MCH): Both the CNMI EOP and the CHCC EDP have limited language that specifically addresses the needs of maternal and child health. There is also minimal language for those with access and functional needs, which can include pregnant women and children.

When an imminent or actual emergency occurs, the CNMI HSEM coordinates the CNMI's response through the activation of the CNMI Emergency Operations Center (EOC). During an emergency, the CHCC establishes an emergency response structure to coordinate the CHCC's activities using the Incident Command Structure Agency Operations Center (AOC). The PHHEPP is responsible for training staff to fulfill the leadership roles in the AOC for planning, operations, and logistics sections chiefs, as well as section staff. Staff of the Division of Public Health Services have been trained and served on emergency management leadership and support roles before and during the pandemic as part of the CHCC AOC.

The CNMI's Title V Director has served as the AOC Operations Chief for Vaccinations with various Title V staff members supporting operations sections/functions, communications, and planning.

AMCHP Emergency Preparedness and Response Learning Collaborative (ALC): In 2021, the CNMI participated in the AMCHP Emergency Preparedness and Response Learning Collaborative opportunity to address emergency preparedness for the MCH population. CNMI participants included representatives from MCH Title V along with staff members from the CHCC PHHEPP.

Participation in the ALC resulted in the identification of strategies for strengthening MCH focused activities within the CHCC EDP and the EOP, including the following:

Strategy: Integrate MCH considerations into state/territory EPR Plan
Strategy: Develop a plan to gather epidemiologic/surveillance data on women of reproductive age and infants to guide action

These activities are on-going work to implement the strategies continues into FY2024-2025.

Title V Preparedness Efforts: The CNMI's Title V Director works collaboratively with the CHCC PHHEPP Director in supporting emergency preparedness and response training and in developing communications plans and other strategies for improve CNMI wide emergency preparedness and for responding to threats, including those that impact the MCH populations. in During the recent COVID-19 pandemic, the Title V Director was involved in CNMI-wide vaccination planning discussions including the identification and implementation of vaccination for priority populations, including: healthcare workers, first responder, teachers and childcare workers, the man'amko (elderly), and worked to expand population access in a phased approach as vaccine availability moved from limited to broad supply.

The Title V Director was significantly involved in the development of standard operating procedures which operationalized COVID-19 mass vaccination operations and that served as the framework for vaccine points of dispensing (PODs) during the initial and subsequent phases of the COVID-19 vaccination roll out. Additionally, working collaboratively with the CHCC AOC Communications team, the Title V Director led a team to support the development of standard operating procedures, a vaccination registration data system framework, reporting metrics, and facilitated training to establish a CNMI COVID-19 vaccination call center as part of strategies to ensure information and access to vaccinations were communicated as widely and quickly as possible to the CNMI Population.

Throughout the pandemic, Title V Programs provided leadership for their programs to develop policies and procedures in alignment with CDC and CHCC guidance, federal and local mandates, and the Governor's executive orders. Adaptations to programs had to be implemented for the health and safety of staff, families, and the community.

The following information describes recent efforts that demonstrates the extent that CNMI MCH Title V program participates in developing and coordinating plans that enhance CNMI wide preparedness for addressing impacts of disasters and threats to the MCH populations:

Newborn Metabolic Screening- staff worked closely with the CNMI hospital nursery department, pediatricians and the CHCC laboratory to ensure that specimen collection prior to discharge for babies born. Staff monitored screening results to ensure that follow-up services were initiated timely to minimize risk for loss to follow-up. Additionally, what use to be a limited weekly window for collecting specimens at the nursery ward was modified to enable a 7-day specimen collection to further reduce the risk for loss to follow-up of babies born outside the specimen collection window.

Newborn Hearing Screening staff continued to work to ensure babies had a hearing screening before discharge after birth. The EHDI Program Coordinator worked closely with the hospital nursing staff to ensure that babies who were referred for follow-up or diagnostic audiological screening services were seen and not lost to follow-up. There were some challenges during the initial phases of the pandemic in conducting annual calibration for hearing screening equipment as the off-island vendors from Oregon were not able to enter the CNMI to perform services due to travel quarantine protocols. To address this, program had to negotiate loaner equipment and work to send equipment to the state of Oregon to complete annual equipment calibration requirements. However, in 2022, travel restrictions and quarantine protocols were lifted and on-site calibration of the hearing screening equipment resumed.

Home Visiting services were modified to tele-home visits, following guidance from HRSA and in compliance with the CNMI Governor's executive orders. Home visitors continued to provide services and continue participant recruitment throughout the pandemic by utilizing video conferencing or phone access. Support was offered to families who did not have means to connect virtually by providing them prepaid cellular cards and mobile phone units to access weekly home visits. Emergency

supplies were also made available to program participants, including infant diapers, wipes, disinfecting supplies, and grocery store vouchers for food. In July of 2022, the program leadership adopted a tiered approach based on household risk factor for severe disease for transitioning services back to face to face home visits, in alignment with the easing of COVID-19 restrictions in the CNMI.

WIC waivers were extended by the USDA, allowing the CNMI WIC Program and its clinic to provide all services remotely by phone, mail, and electronic correspondence. The CNMI WIC had fully implemented eWIC in 2018 which enable families to continue accessing food benefits via electronic transfer benefits (EBT) throughout the pandemic. The CNMI WIC worked with WIC enrolled vendors to implement the WIC-to-go services allowing WIC participants to purchase WIC approved products over the phone and to schedule pick up. The project aimed to cut shopping time and also minimize time spent in public places as part of social distancing measures.

Immunization services and activities focused on routine vaccinations continued throughout the pandemic. The CNMI Immunization program strengthened its outreach activities and worked closely with public and private schools to monitor vaccination rates and coordinate mobile vaccination activities to ensure that kids are kept up to date with routine vaccine recommendations.

Early Intervention Program is the CNMI's IDEA Part C program. Services were modified to phone visits and/or videoconferencing via the Zoom platform and then transitioned back to face to face at the start of the 2022 school year.

Children with Special Healthcare Needs Program offered parent/peer support services through telephone and videoconferencing and gradually transitioned back to face to face services by the summer of 2021. Learning sessions and trainings for parents of CSHCN and service providers were conducted virtually through Zoom. Despite COVID-19, Shriner's outreach clinics were successfully completed on Saipan twice in 2021.

Group Prenatal Care Group prenatal visits were suspended due to COVID-19 pandemic restrictions and social distancing requirements that made it difficult to coordinate face to face visits for groups of 8 to 10 women and their partners. Access to equipment and internet connection were challenges identified and made it difficult for group prenatal care to successfully transition to virtual sessions. Additionally, a virtual platform made it impossible for screenings and measurements to be conducted. The MCH program coordinated the transition all group prenatal clients to the CHCC Women's Clinic for prenatal care to be accessed.

COVID-19 Lessons: The COVID-19 pandemic identified gaps in planning and operations as well as resulted in the development of innovative strategies to address them. Timely and accurate information was a priority area identified to be able to effectively communicate information regarding COVID and to dispel misinformation about vaccinations through linguistically and culturally appropriate information. Title V staff worked closely with medical providers to produce social media messaging and public awareness videos to promote information from trusted messengers on the benefits of vaccination. Social media posts and videos promoting vaccinations among pregnant and breastfeeding women, children and teens were developed and aired on the local cable news network as well as the local movie theater. A call center was established through telephone number (670) 682-SHOT [7468] as a centralized communication hub for community members to be able to speak to a live representative.

PRAMS & COVID-19: In 2021, the CNMI began the implementation of its PRAMS project and in 2022 was able to secure IRB approval of the survey protocol through a reliance agreement with the Hawaii Department of Health IRB. The CNMI PRAMS samples 100% of all resident births in the territory and will began with 2022 births. Included in the CNMIs PRAMS questionnaire are questions about experiences with prenatal care, delivery, postpartum care, infant care during the pandemic, and COVID-19 vaccinations. The data collected during the initial year of the CNMI PRAMS was made available to the CNMI in June of 2024. The information gathered in the COVID-19 module of the questionnaire will be utilized to inform the CNMI preparedness planning and activities specific to the MCH population.

[i] Commonwealth of the Northern Mariana Islands. (2018). Standard State Mitigation Plan. Retrieved on July 16, 2023 from https://opd.gov.mp/library/reports/2018-cnmi-ssmp-update.pdf

III.C. Needs Assessment

III.C.1. Five-Year Needs Assessment Summary and Annual Updates

III.C.1.a. Process Description

Executive Summary

The mission of Title V is to improve the health and well-being of the nation's mothers, infants, children, and youth – including children and youth with special health care needs – and their families. Every five years, states and jurisdictions are required to conduct a comprehensive needs assessment to receive Title V funding. The primary purpose of this needs assessment is to identify priority needs for the Commonwealth of the Northern Mariana Islands (CNMI) Maternal and Child Health (MCH) populations. The results will inform decisions related to program goals and objectives and to allocate state and local resources for the years 2025-2030.

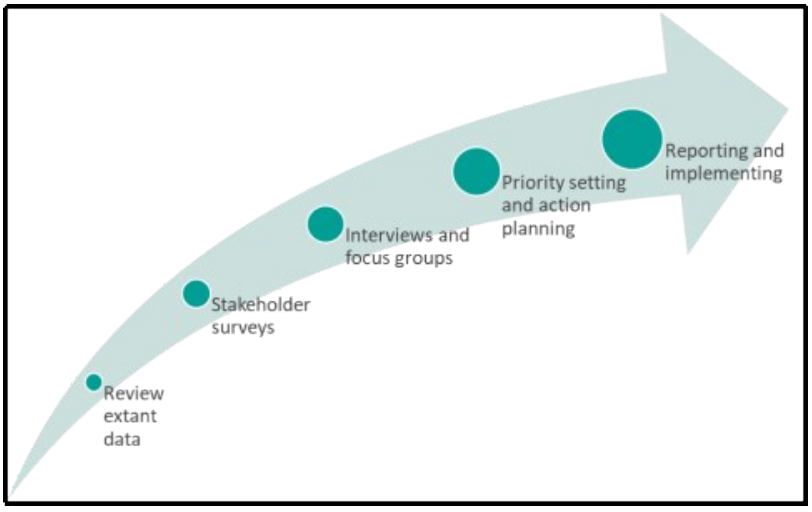
The multi-method needs assessment included:

- Scan of pre-existing sources which included needs assessments, program materials, reports, and administrative data
- Priority health issues surveys for youth and professionals garnering 2,900 responses across Saipan, Tinian, and Rota
- Interviews and focus groups on Saipan, Tinian, and Rota during which community members reviewed the priority health issues survey results and then discussed them in relation to their lived experiences.

Next, a priority setting meeting was held with 46 community members and public health decision-makers. These representatives were presented with an overview of the needs assessment process and data. They then self-selected into groups organized by the MCH domains. Employing an adapted strategy grid method, the groups identified the top three priorities based on their level of importance/urgency and feasibility.

In the final step of the needs assessment, the MCH Steering Committee, reviewed the priority needs and recommendations gathered with the surveys, interviews, focus groups, and strategy grid method. From these sources, the Steering Committee made a final selection of priorities deemed to be strategically sound, operationally viable, and likely to contribute to improved health outcomes for women, children, and families across the Commonwealth. The figure on the following page visually displays the needs assessment process. The table that follows summarizes the final set of priorities by MCH domain.

Figure A. Needs Assessment Process



The final set of priorities identified through the needs assessment is summarized in the table below.

Table A. Final Priorities by MCH Domain

Woman/Maternal
• Access to preventative medical visits • Access to mental health services
Perinatal/Infant
• Education and services to help prevent premature births and low birthweight • Education and support to help with breastfeeding
Child
• Access to healthy physical activities
Adolescent
• Bullying prevention and support • Access to teen pregnancy and sexually transmitted infection (STI) prevention services
Children with Special Health Care Needs
• Access to care coordination and navigation of healthcare and community programs • Parent training • Access to specialty healthcare services
Cross-Cutting
• Clear communication about health services and supports available in each area

Needs Assessment Methods

The needs assessment applied a mixed method approach with quantitative and qualitative data to develop a holistic description of MICAH strengths and needs in the CNMI.

Scan of Pre-existing Sources

With the goal of minimizing the burden of the assessment by leveraging information the community already had, the needs assessment began with an inventory and scan of extant documents and data relevant to MCH in the CNMI. The review included needs assessments, program materials, reports, and administrative data. A summary of the sources reviewed is in **Appendix A**.

Priority Health Issues Surveys for Youth and Professionals

The scan of pre-existing sources demonstrated that multiple recent, rigorous, health-focused surveys had been conducted with parents, caregivers, and adult community members in the CNMI. Thus, the assessment limited new, project-specific surveying to: 1) paid professionals situated in relevant organizational and community settings (e.g., public education, community health programs), and 2) adolescents whose perspectives were not adequately reflected in the extant data. Survey response rates are reported in **Table 1** below. Detailed reports summarizing the results overall and by island are provided in **Appendix B**. The paid professionals survey report also displays points of data triangulation (i.e., common findings) with the sources reviewed in the scan. Triangulation demonstrated strong alignment between the results of the professionals survey and extant sources.

Table 1. Priority Health Issues Survey Response Rates

Survey	Overall	Saipan	Rota	Tinian
Professionals	140	118	12	10
Youth	2760	2492	213	55

Interviews and Focus Groups

To further enrich understanding of MICAH strengths and needs in the CNMI, interviews and focus groups were conducted on Saipan, Tinian, and Rota. During these discussions, priority health issues survey results pertinent to the person/group were presented. Participants were then asked to share if/how the results were reflective of their perspectives and experiences, *why* the priorities are important in the CNMI's current context, and to offer recommendations for *how* the priorities could be addressed. **Table 2** on the following page summarizes the qualitative data gathered for the assessment (n=74 participants). An example focus group protocol is provided in **Appendix C**. Data garnered from the interviews and focus groups were analyzed for key themes. A report with focus group results disaggregated by island is provided in **Appendix D.**[1]

[1]Adult participants over the age of 18 provided verbal consent. All PATCH Teens had parental consent to engage in the full scope of PATCH activities prior to joining the program. The teens were informed that their participation was voluntary, and their responses kept confidential. They also verbally consented to participate. Interview and focus group participants received gift cards for gas or groceries to thank them for their time.

Table 2. Summary of Qualitative Data Collected During the Site Visits

Island	Data Collection Type	Participant Type	Participant Count
Saipan	Intercept interviews	Women of childbearing age	17 women, collectively parenting 39 children
Saipan	Interviews	Health providers - nurses, doctor	3 providers
Saipan	Interviews	Community health workers - WIC provider, HOME Visitor, CGC outreach worker	3 CHW
Saipan	Focus group	Mental health providers and program administrators	5 staff members
Saipan	Focus group	Public school educators and administrators	4 staff members
Saipan	Focus group	Parents with CSHCN	7 parents
Saipan	Focus group	Faith community leaders	5 leaders
Saipan	Focus group	PATCH Program teens ages 15-18	10 teens
Rota	Focus group	Health providers (3) Health clinic resident director (1) HOME Visitor (1)	5 staff members
Rota	Focus group	Community members	5 adults
Tinian	Focus group	Health providers (2) Health clinic resident director (1) HOME Visitor (1) Public school counselor (1)	5 staff members
Tinian	Focus group	Community members	5 adults

Priority Setting Meeting

Finally, a priority setting meeting was held at the end of the site visit. At the meeting, 46 community members and decision-makers were presented with an overview of the needs assessment process and the quantitative and qualitative data sources and findings. Printed handouts with the quantitative and qualitative data sources and findings were also provided. Then they self-selected into groups organized by the MCH domains (see **Table 3** on the following page).

Table 3. MCH Title V Domains

Domain	Description
Women/maternal health	The health of women prior to, during, and between pregnancies
Perinatal/infant health	20 weeks gestation to <1 year
Child health	1-9 years old
Adolescent health	10-17 years old
Children with special healthcare needs (CSHCN)	Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount that goes beyond which is required by children generally
Cross-cutting/system building	Addresses program capacity and/or the systems-building needs of the CNMI.

Figure 1 on the following page displays an overview of the needs assessment methods as presented to stakeholder meeting attendees. The pink circle labeled “priority setting and action planning” indicated the present stage at which stakeholders were contributing to the assessment.

Stakeholder meeting attendees were then instructed to use an adapted strategy grid method[1] to identify domain-specific priorities for the next five years and actions to execute them. Specifically, they were presented with a four-quadrant matrix structure in which the horizonal axis ranged from low to high *feasibility* and the vertical axis ranged from low to high *importance/urgency*. For each priority identified in the surveys and qualitative data, the domain-specific working

groups used sticky notes to position the priority within the matrix and offer the logic underlying their selections (see **Figure 2**). After the first work session, the groups presented their top three priorities to the larger whole. Then they returned to their domain-specific groups for a second work session during which they identified concrete actions they believed should be implemented in the next five years to address the priorities. These priority actions were then presented to the larger whole.

[1] Duttweiler, M. 2007. *Priority Setting Tools: Selected Background and Information and Techniques*. Cornell Cooperative Extension as cited in the National Association of County and City Health Officials Guide to Prioritization Techniques.

Figure 1. Needs Assessment Methods as Presented at the Stakeholder Meeting

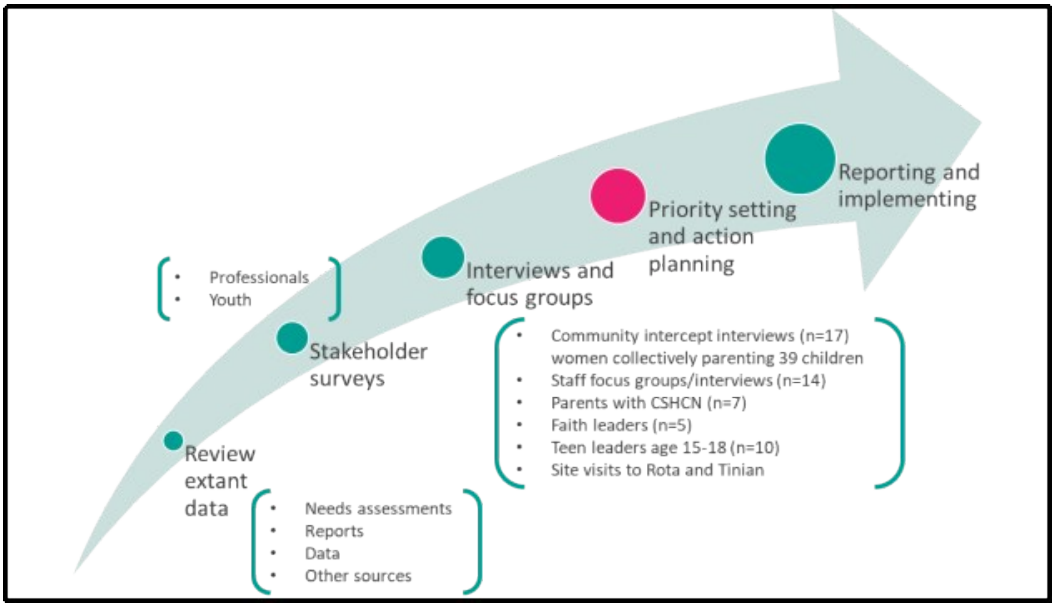
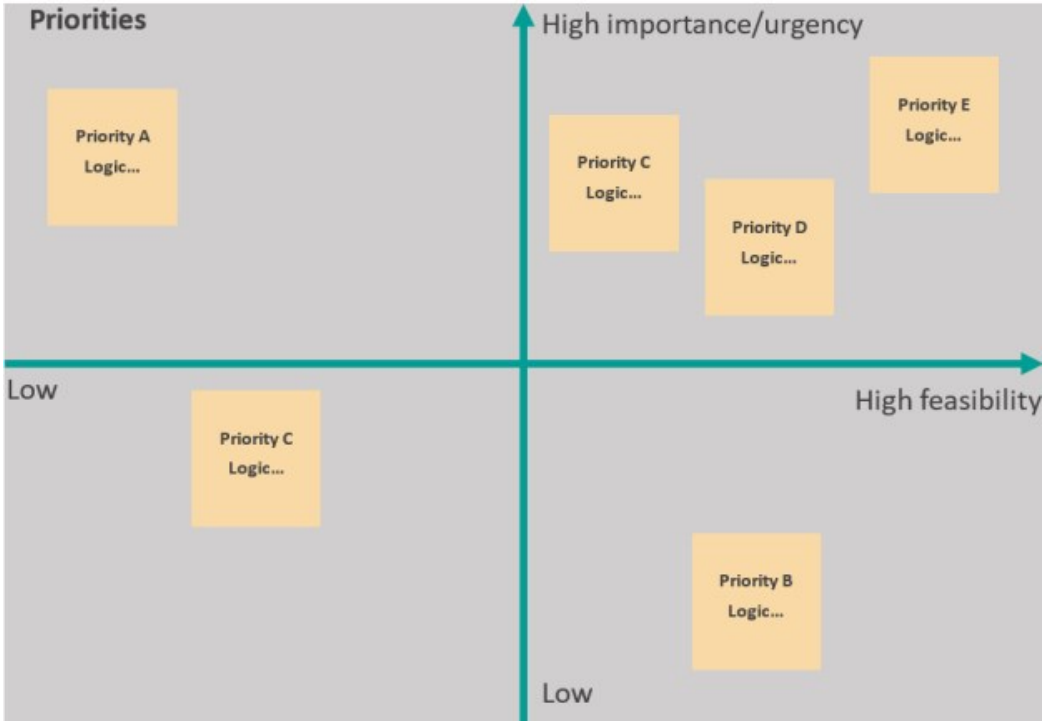


Figure 2. Strategy Grid Structure that Stakeholders Used to Prioritize Needs



MCH Needs Assessment Priority Recommendations by Steering Committee

The Steering Committee, consisting of both internal and external partners and stakeholders, plays an essential role in guiding and overseeing the 5-year needs assessment. The Steering Committee was tasked with making a final selection of

priorities that are specific, measurable, achievable, relevant, and time bound.

Guided by the priority needs and recommendations gathered with the surveys, interviews, focus groups, and strategy grid priority setting process, the Steering Committee selected a final set of top priorities that are strategically sound, operationally viable, support efficient resource use, and align with the MCH Title V Block Grant application guidance. Perhaps most important, the Steering Committee believes the priorities are well-positioned to contribute to improved health outcomes for women, children, and families across the Commonwealth.

III.C.1.b. Findings

III.C.1.b.i. MCH Population Health and Wellbeing

MCH Population Health and Wellbeing

The Commonwealth of the Northern Mariana Islands is a unique setting for delivery of Title V services. Key contextual factors are described in the following sections.

The CNMI is a small, geographically isolated island jurisdiction. The Commonwealth of the Northern Mariana Islands (CNMI) is located in the northwestern Pacific Ocean approximately 3,700 miles west of Hawaii and 125 miles north of Guam. The CNMI consists of a chain of 14 islands with a total land area of 176.5 square miles spread out over 264,000 square miles of the Pacific Ocean. The CNMI's total area could be compared to two and a half times the size of Washington, D.C. The nearest U.S. tertiary medical center for referral is in Honolulu, Hawaii, which is over eight hours away by air. The population of the CNMI lives primarily on three islands, the major island being Saipan (population 43,385), followed by Tinian (2,044) and Rota (1,893).[1]

The CNMI is comprised of a richly varied population made up of people from many different backgrounds, languages and ways of life. Single community groups that accounted for the majority population in the CNMI were identified as Filipino (33%), followed by Chamorro (25%) and Chinese-except Taiwanese (7%). Carolinians make up about 5% of the total population. Asians were the largest group, representing nearly half of the total population. Native Hawaiian and Other Pacific Islanders made up about 14% and Caucasians less than 2%. About 7% of CNMI's population were of two or more ethnicities or races and "all others". In the CNMI, the Chamorro and Carolinian groups are Indigenous to the territory. [2]

The CNMI Medicaid program differs from the US mainland and publicly funded health insurance is inaccessible to many. The program is "capped" by the U.S. Federal Government and limited to a set dollar amount allotted to the CNMI. In addition, US territories are capped by legislation on the percentage of Federal Medical Assistance Program (FMAP) funding for the Medicaid program. Prior to the pandemic, this limited funding severely affected access, cost, and quality of health care for residents of the CNMI, heavily influencing public perspectives about the availability of healthcare.[3] Also of note, only US citizens qualify for Medicaid coverage and in 2013, CNMI Public Law 17-92 released employers from the responsibility of providing health insurance coverage to non-U.S. qualified workers (legally present-foreign workers). In the CNMI, approximately 40% of the population is comprised of foreign workers.[4]

The CNMI's economy has struggled to gain traction in recent decades. A variety of factors have undermined the CNMI's economy since the mid-2000s. The closing of the garment manufacturing industry and the implementation of federal Public Law 110-229 in 2008 which removed local control over immigration seriously hampered the manufacturing sector. Super Typhoon Yutu struck the CNMI in October 2018, exacting massive destruction to homes, businesses, and infrastructure. The COVID-19 pandemic followed, gutting the tourism industry. According to US Census 2020 data, 38% of

people in the CNMI lived in poverty, nearly four times the poverty rate for the US overall (11.4%).

Women/Maternal Health Domain

The CNMI continues to make steady progress in advancing prenatal, postpartum, and maternal health, while also identifying key areas for continued improvement. More women are receiving early prenatal care, with rates peaking at 67% in 2021, and postpartum visit rates reached 67% in 2022—both positive indicators of growing engagement in maternal health services. Notably, smoking during pregnancy has seen a significant decline, and preventive dental visits during pregnancy have gradually improved. While fluctuations in severe maternal morbidity and postpartum depression highlight persistent challenges, CNMI remains committed to improving maternal health outcomes through strengthened care coordination, expanded mental health screening, and increased access to preventive services. Ongoing efforts to monitor trends such as e-cigarette use and enhance data quality will support more targeted interventions and continued progress in maternal and child health.

Prenatal and Postpartum Care

- **First Trimester Prenatal Care** (NOM 1 & SPM 1)**:** There was a general increase in the percentage of women receiving prenatal care in the first trimester, peaking at **67% in 2021**, but declined gradually to **61% by 2023**. This still falls short of the Health People 2020 baseline of 77.1%, and target of 84.8%.
- **Postpartum Visit (PPV-B):** In 2022, **67%** of women attended a postpartum checkup and received recommended care.

Maternal Health Outcomes

- **Severe Maternal Morbidity (SMM)** (NOM 2)**:** Rates fluctuated significantly, rising from **122 per 10,000 deliveries in 2020** to **293 in 2023**, signaling a worsening trend and greatly surpassing the Healthy People 2020 target of 64.4 per 10,000.
- **Maternal Mortality (MM)** (NOM 3)**:** There was **1 reported maternal death (174 per 100,000) in 2021**, but no deaths in other years from 2019-2023.

Healthy Behaviors During Pregnancy

- **Alcohol Use During Pregnancy** (NOM 10)**:** Alcohol use was reported at **1% or lower** in most years, except in **2023 (4%).**
- **Smoking During Pregnancy** (NPM 14.1)**:** Smoking rates showed significant improvement, dropping from **4% to 2%** in recent years. However, e-cigarette or vape use is generally on the rise within the CNMI population, and thus the CNMI MCH Title V program is closely monitoring this trend through HVSO data.

Maternal and Preventive Health

- **Postpartum Depression (PPD)** (NOM 24)**:** Reports of depressive symptoms, approximately 23.1%, according to CNMI PRAMS.
- **Preventive Medical Visits** (NPM 1)**:** Slight variation in rates, with **55-57%** of women aged 18-44 having a preventive medical visit annually. Efforts remain below the optimal levels.
- **Preventive Dental Visits During Pregnancy** (NPM 13.1): These visits remained relatively low but showed a slight improvement from **29% in 2019 to 38% in 2023.**

Perinatal/Infant Health Domain

The CNMI continues to make meaningful progress in several key maternal and child health indicators, particularly in promoting healthy early childhood practices. Breastfeeding rates remain a strong point, with 94% of infants ever breastfed in

2023—well above the target of 81.9%. Exclusive breastfeeding through 6 months has also improved significantly, reaching an all-time high of 11% in 2023 after a low of 0% in 2021. WIC data similarly show a gradual increase in breastfeeding at 6 months, from 40% in 2022 to 43.2% in 2023. Safe infant sleep practices are also trending in a positive direction, with more mothers reporting safe sleep behaviors such as placing babies on their backs and avoiding soft bedding. Despite these gains, emerging challenges remain. The rates of low birthweight, preterm births, and infant mortality have risen in recent years and now exceed Healthy People 2020 targets. Particularly concerning are the increases in post-neonatal and preterm-related infant deaths. These trends underscore the urgent need to strengthen perinatal care, enhance health system readiness, and prioritize early intervention strategies to ensure every child in the CNMI has the healthiest start possible.

Positive Trends:

- **Breastfeeding rates** are notably high, with **96% of infants ever breastfed in 2023**, exceeding the **target of 81.9%**.
- Exclusive breastfeeding through 6 months showed a significant improvement in **2023**, recording an all-time high at **11% and low at 0.0% in 2021**; but still remains below the **25.5% target**.
- The **percentage of WIC infant breastfed at 6 months** shows a gradual increase from 40% in 2022 to 43.2% in 2023 but remains below the target of 60.6%.
- **Safe sleep practices** are also seeing gradual improvement. In **2022, 51%** of mothers reported placing their babies on their backs to sleep, while **30%** reported not using soft objects or loose bedding in the crib. However, only **15%** reported that their babies always slept alone in safe environments, indicating more room for progress.

Emerging Challenges

- The **percentage of low birthweights (LBW) babies** has **significantly increased from 6% in 2019, to 11% in 2023**; well above HP 2020 **target of 7.8%**.
- Similarly, the **preterm birth (PTB) rate** reached **12 per 1,000 in 2022** and remained at **11 per 1,000 in 2023**, exceeding the HP 2020 **target of 9.4%**.
- **Infant mortality (IM)** rates have worsened, increasing from **4 per 1,000 in 2019** to **14 per 1,000 in 2023**, well above the Healthy People 2020 target of 6.0 per 1,000 live births.
- The **rate of post-neonatal deaths** (from 28 days to under 1 year) increased significantly to **9 per 1,000 in 2022** and slightly dropped to **7 per 1,000 in 2023**, but both figures remain much higher than the HP 2020 target of 2 per 1,000.
- **Preterm-related infant deaths** dramatically increased in 2021, reaching **696 per 100,000** and remained high at **344 per 100,000 in 2023**.

Child Health Domain

Child health outcomes in the CNMI reflect encouraging progress alongside areas for continued focus. Notable gains have been made in increasing physical activity among children, improving access to mental health treatment, and raising vaccine completion rates—demonstrating the impact of ongoing public health efforts. At the same time, opportunities remain to further strengthen child health by addressing persistent challenges such as dental caries and childhood obesity. These areas are now key priorities for future intervention and investment.

Areas of Improvement

- **Vaccination Rates**
- Completion of the 7-vaccine series by age 2 increased from **56% in 2019** to **81% in 2023**, exceeding the HP 2020 **target (80%)**.

- Annual flu vaccination among children rose from 51% in 2019, to 81% in 2023, surpassing the HP 2020 target of 70%.
- **Access to Health Care**
    - Children unable to obtain needed care decreased from 6% to 3%.
    - The percentage of uninsured children dropped from 22% in 2019 to 6% in 2021, but then rose again to 20% by 2023.
- **Mental Health Services**
    - Children with behavioral/mental conditions receiving treatment rose sharply from 8% in 2021 to 67% in 2023, showing significant progress.
- **Physical Activity**
- The share of children aged 6-11 active for 60+ minutes daily increased to **61% in 2023**, up from **44% in 2021** *(* - data should be interpreted with caution)*.

Areas of Concern

- **Dental Health**
- The percentage of children with decayed teeth or cavities increased from **13% in 2019** to **25% in 2023**, indicating worsening oral health.

Obesity

- Obesity rates among adolescents (ages 10-17) were high at **19% in 2023**.
- Among high school students (grades 9-12), rates were even higher, with **22%-23%** reported as obese.

Child Mortality

- The child mortality rate (ages 1-9) fluctuated, reaching a high of **45 per 100,000 in 2021** before dropping to **31 per 100,000 in 2023**, yet remaining above HP 2020 targets.

Medical Home Access

- Only **13-14%** *(* - data should be interpreted with caution)* of children with special healthcare needs had a medical home, far below the HP 2020 **target of ~55%**.

General Health Status

- The percentage of children reported in excellent or very good health fell from **81% in 2019** to **72% in 2021**, then modestly rebounded to **78% in 2023**.

Adolescent Health Domain

The CNMI has seen encouraging progress across several key adolescent and child health indicators in recent years. Access to mental health services improved significantly, with the percentage of children receiving treatment for behavioral or emotional concerns rising from 8% in 2021 to 67% in 2023. Vaccination rates remain a major success, with flu coverage jumping to 81% and HPV vaccine completion surpassing the WHO's 2030 target. Teen birth rates have declined overall since 2019, and more youth with special health care needs are receiving support as they transition to adult care. Additionally, fewer children are reporting unmet health care needs. While these trends are promising, challenges remain in dental health, preventive care utilization, and insurance coverage stability. These findings point to both progress and opportunity as the CNMI continues to invest in a healthier future for its youth.

Positive Trends

- **Mental Health Services:** A large increase in access- children receiving treatment for mental/behavioral conditions rose from **8% in 2021** to **67% in 2023** *(* - data should be interpreted with caution)*, showing strong gains in addressing adolescent mental health.

High Vaccination Rates

- Flu vaccine coverage increased from **28% in 2021** to **81% in 2023**, exceeding the HP 2020 target.

- HPV, Tdap, and meningococcal vaccines maintained high coverage – **above 95% consistently since 2019**.
- The CNMI is the only jurisdiction among the US-affiliated Pacific Islands to have already met the WHO's 2030 goal for HPV vaccination series completion. As of December 2023, the CNMI had a **completion rate of 91.8% for the HPV vaccination** series among adolescent girls aged 13-17, **surpassing the WHO 2030 goal** of 90%.
- **Teen Birth Rate:** In **2019**, teen birth recorded **22 per 1,000**, declining to **13 per 1000 in 2021**, then increasing to **17 per 1,000 in 2023**.
- **Transition to Adult Care (for youth with special health care needs):** Services to support health care transition rose from **51% in 2019** to **71% in 2023** *(* - data should be interpreted with caution)*, an increase of 16 percentage points from the HP 2020 baseline.
- **Access to Health Care:** Children unable to obtain needed health care decreased from **6% to 3%** *(* - data should be interpreted with caution)*, indicating improvement.

Areas of Concern

- **Dental Health:** The percentage of youth with cavities increased to **25% in 2023**, up from **13% in 2019**. Preventative dental visits were low, at just **37%**.
- **Preventive Medical Visits:** Rates recorded a substantial decline from **42% in 2019** to **27% in 2023** *(* - data should be interpreted with caution)*, – far below the HP 2020 target of **75.6%**.
- **Medical Home Access (CSHCN):** peaked at **14% in 2022** *(* - data should be interpreted with caution)*, and dropped slightly to **13% in 2023**, significantly below the HP 2020 target of **54.8%**.
- **Obesity:** About **19%** of adolescents were obese in **2023**, with a notable peak of **24% in 2021**. Many youths reported being overweight and not getting regular physical activity.
- **Insurance Coverage:** The uninsured rate amount children decreased to **6% in 2021**, but rose again to **20% by 2023**, suggesting instability in health coverage access.

Children with Special Healthcare Needs (CSHCN) Domain

The CNMI is seeing a gradual increase in the proportion of children with special health care needs (CSHCN), rising from 6% in 2019 to 8% in 2023, signaling growing awareness and identification of children who may require additional services and support. While access to coordinated care and medical homes remains a challenge—with reported system performance and diagnosis rates notably low—these findings highlight critical opportunities to strengthen care coordination and improve service delivery for families. Efforts are underway to address data quality issues within this domain, including enhancing data collection tools and methods to ensure more accurate, complete, and actionable information. The CNMI remains committed to improving systems of care for CSHCN, building on areas of strength such as youth transition support, and using data-informed strategies to guide future investments in family-centered, accessible care.

Key Findings

- The proportion of children with special health care needs is rising, from **6% in 2019** to **8% in 2023**.

Access to coordinated care is declining:

- The percentage of CSHCN receiving care in a well-functioning system dropped to **0% in both 2021 and 2023 (down from 3% in 2019)** *(* - data should be interpreted with caution)*.
- Only **13%** of families report having access to a medical home, and **60%** report having a personal doctor or nurse.

Diagnosis of specific conditions remain low:

- Autism Spectrum Disorder (ASD) diagnoses were reported at **~2%**.
- ADD/ADHD diagnoses ranged from **2% to 4%** across the years *(* - data should be interpreted with caution)*.

Support for transitions to adult care:

- **51%** *(* - data should be interpreted with caution)* of CSHCN received services to support their transition to adult healthcare, which is a relative strength.

Challenges Identified

- System performance is poor: For System of Care, the CSHCN program reported **3%** of CSHCN receiving care in a well-functioning system. However, MCH-JS data source indicated “interpret with caution” due to insufficient data.
- Medical home access remains far below national goals, with a continued gap in coordinated, family-centered care.
- Low diagnosis rates may reflect under-screening or under reporting of developmental and behavioral conditions like ASD and ADHD.
- There is a growing population of CSHCN, increasing demand on already limited services.

III.C.1.b.ii. Title V Program Capacity

III.C.1.b.ii.a. Impact of Organizational Structure

In the Commonwealth of the Northern Mariana Islands (CNMI), the Title V Maternal and Child Health (MCH) program is located within the Maternal, Infant, Child, and Adolescent Health (MICAH) Program, under the Population Health Services Division of the Commonwealth Healthcare Corporation (CHCC)—CNMI’s unified health system. Unlike many U.S. states where Title V may be situated within a separate public health department, CNMI’s integrated health system model provides both clinical care and public health services under one corporate and administrative structure. This unique positioning presents distinct strengths, opportunities, and challenges in the implementation of the Title V program.

Strengths

The centralized structure of CHCC allows the Title V MCH program to collaborate seamlessly across clinical services (e.g., Women’s Clinic, Pediatric Clinic, Dental, Behavioral Health) and public health programs (e.g., Immunization, Family Planning, HIV/STD, WIC, and Epidemiology). This co-location enhances real-time communication, interdisciplinary referrals, shared data systems, and joint case management. For example, the Title V team works closely with the Early Intervention Program (Part C) and Family-to-Family Health Information Center to coordinate care for Children with Special Health Care Needs (CSHCN), streamlining access to assessments and therapies.

Furthermore, CHCC’s structure promotes cross-program workforce sharing, allowing the Title V program to utilize Community Health Workers (CHWs), Health Educators, and public health nurses in various roles that support maternal and child health goals. This flexibility strengthens the MCH response to emerging needs and enhances capacity to reach rural and underserved populations, particularly in Rota and Tinian.

Opportunities

Being part of CHCC enables the Title V program to leverage institutional support for initiatives such as telehealth expansion, workforce development, and data modernization. For instance, Title V benefits from CHCC's leadership in integrating telehealth technologies for behavioral health and specialty pediatric consultations—a direct response to gaps identified in the needs assessment.

The unified health system also fosters opportunities for interagency agreements—such as the MOU between MICAH and the CNMI Medicaid Office—that allow CHWs to assist with application processing and eligibility support. These collaborations not only expedite service access but also enhance coverage continuity for MCH populations.

Additionally, CHCC’s organizational framework provides Title V a platform to participate in strategic planning and health system transformation efforts, including those related climate change resilience, and emergency preparedness—ensuring MCH priorities are represented in broader health initiatives.

Challenges

Despite the advantages of integration, CNMI’s small health system faces significant resource and staffing limitations. The centralized structure can lead to competing priorities across departments, sometimes diluting the focus on MCH-specific initiatives. Program visibility and dedicated staffing for MCH can be constrained by broader institutional demands, especially during public health emergencies such as typhoons or disease outbreaks.

Additionally, although CHCC houses many services under one roof, infrastructure and capacity limitations—particularly on the islands of Tinian and Rota —still hinder access to specialty care, behavioral health, and diagnostic services. While the organizational structure supports coordination, geographic and logistical barriers remain key challenges that Title V must navigate to implement its goals effectively across the Commonwealth.

Title V’s placement within CHCC—a fully integrated health system—offers a strong foundation for collaboration, cross-program efficiency, and service integration. This structure has enabled the CNMI MCH program to adapt responsively to the findings of the 2025 Needs Assessment, particularly in areas such as care coordination for CSHCN, prenatal outreach, and adolescent mental health. Moving forward, optimizing interdepartmental communication, securing dedicated MCH staffing,

and continuing to strengthen partnerships with Medicaid, Education, and community-based organizations will be critical for sustaining and expanding MCH services throughout the CNMI.

III.C.1.b.ii.b. Impact of Agency Capacity

Agency Capacity

The CHCC, through its various divisions, including the Division of Public Health, Women and Children's Clinic and the Community Guidance Center, provides 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. Internal program collaboration and partnership with community organizations make it possible to bring health services out into the community, including through a mobile clinic. This work is supplemented by enabling services including outreach, case management, and health promotion efforts. 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 Centers. The services are based on standards of care aligned with US guidelines (e.g., American College of Obstetricians and Gynecologists).
The Breast and Cervical Cancer Screening Program (BCSP) provides breast and cervical cancer screening services at no cost to women that meet the program's criteria. Eligibility assistance and transportation are provided to clients; transportation includes air fare for clients from Rota and Tinian to receive 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 through awareness months.

Comprehensive women's health and gynecological services are provided at the Women's
Clinic and Rota and Tinian Health Centers. Health screenings such as blood sugar, blood pressure, weight, etc. are conducted during community events by the Division of Public Health as a mechanism for expanding access to preventive services and for early identification, treatment, and management of non-communicable diseases.

Perinatal/Infant Health and Child Health. Health services for infants include screenings, assessments, and education on a variety of health areas (e.g., growth monitoring, screening for health issues and developmental delays, breastfeeding, etc.). Services are aligned with US guidelines provided by the Centers for Disease Control, and American Academy of Pediatrics.

Well baby/child exams are provided at the Children's Clinic. Services 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. These visits include breastfeeding promotion.

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. Programs within MICAH and across the Division of Public Health Services collaborate with WIC on many initiatives including breastfeeding support and encouraging prenatal care.

Newborn Hearing Screening is conducted for all newborns born at the CHCC before hospital discharge after birth and follow-up screenings and diagnostic audiological evaluations provided at the Children's Clinic.

The Immunization Program ensures availability and accessibility of vaccination services.
Immunization is provided at through the Public Health Immunization Clinic and private clinic locations. The Public Health

Clinic is open for walk-ins and open on Saturdays, improving accessibility. Programs within the MICAH unit work to provide awareness on the importance of immunization.

The Immunization Program also enforces the CNMI school health certificate requirement for all children enrolled in a CNMI school or licensed childcare facility. A school health certificate is an annual requirement and children who are entering the CNMI school system for the first time are required to complete a physical examination, including hearing and vision screening, and must receive vaccination in line with CDC immunization recommendations.

The School Dental Program administered through the CHCC Dental Clinic 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 schools, including Rota and Tinian, are bussed to the Dental Clinic to receive dental services. Services include a full mouth examination in which they are assessed for caries and periodontal diseases, sealant application, and education. The children receive 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 CHCC Dental Clinic provides general dentistry services such as sealant application, fluoride tablets, education/counseling, community outreach activities, cleaning, extraction, and fillings. The Dental Clinic, along with four private dental clinics, accepts children enrolled in the Medicaid Program for their restorative treatment needs.

Adolescent Health. Preventive and primary health care services for adolescents are provided at the Women's Clinic, Children's Clinic, and through Mobile Clinic outreach. In addition, much work for this population is done in collaboration with the Public School System (PSS). Mental health and social services are provided through the Community Guidance Center (CGC).

Efforts around adolescent health have been focused on the avoidance of risky health behaviors such as drugs, alcohol, and unsafe sex. The MICAH Programs work closely with the Family Planning Program. In addition, they collaborate with the Community Guidance Center (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 Healthcare Needs (CSHCN). Services are set up to promote an integrated service delivery system for CSHCN from birth to 21 years of age and their families. The CSHCN Program under MICAH works collaboratively and cooperatively with other CNMI 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 MICAH program, the hospital, the Special Education Program, and the Early Intervention Services Program. The CSHCN 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. Contractual services, such as the audiologist, provide services that are not otherwise available. Specialty teams from Shriners Children’s Hospital visit the CNMI 2 to 3 times a year. Shriners Hospital for Children's Hawai‘i is part of an international pediatric healthcare system of hospitals, clinics, ambulatory surgery centers and global outreach. The CNMI also partners with Rady’s Hospital for Children, San Diego through the CNMI’s Health Network Program. This hospital provides comprehensive medical treatment and surgery from birth to 18 years old. This hospital has specialized groups that provide services in cardiology, neurology, gastroenterology, orthopedics, and select surgeries. The CNMI relies heavily on overseas contractors and medical referrals to meet the needs of this priority population off-island, which is very expensive.

Cross-cutting. The CHCC Dental Clinic described above provides services for all MICAH populations.

The MICAH Program works closely with the Medicaid office to promote eligibility and enrollment. A designated staff member helps with filling out Medicaid applications, assists with expediting application processing, and also provides translation assistance for those with limited English. MICAH receives referrals for uninsured people from the CHCC Women's and Children's clinics, Part C: Early Intervention Services Program, MIECHV Home Visiting Program, and the Family Planning Program, among others. Screening for insurance is also conducted during Mobile Clinic outreach events in which community members seen during outreach are provided Medicaid application assistance as needed. The partnership between the MICAH program and the CNMI Medicaid program includes referrals, Medicaid reimbursement for services eligible under the Medicaid State Plan, data sharing, and training. The Medicaid program provides eligibility and enrollment information to the MICAH program on an annual basis or when requested. Additionally, the Medicaid program allows for the processing and expediting of MICAH client applications and provides training to MICAH program staff on Medicaid eligibility and application processing. In addition, MICAH has also devoted a staff member to assist clients with enrollment in the CHCC income-based sliding fee program to provide discounted services to those that qualify.

CHCC Division of Public Health Services continues to improve its data capacity to better serve the community's health needs. The CNMI MCH State Systems Development Initiative (SSDI) Project enhances the ability to collect, analyze, and utilize reliable data to support the CNMI Title V MCH Block Grant program. The SSDI Project continues to lead data collection and analysis efforts for MCH needs assessment, National Outcomes Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs), and Evidence-based or Informed Strategy Measures (ESMs). The SSDI project is committed to addressing health disparities, social determinants of health, and advancing access to health care services through an improved data management plan, removal of silos, and utilization of data analysis and business intelligence tools for better decision-making, resource allocation and improved health outcomes. The SSDI project is involved in the planning, development and implementation of Data Governance for setting internal standards to inform data policies and regulations, ensuring data quality and availability for informed-decision-making, including standard operating procedures for processing, sharing, storing, safeguarding, and disposing of data.

The MCH trend analysis dataset is developed by SSDI to collect data and monitor the health experiences of the MCH population by tracking encounters involving the National Performance and Outcome Measures, State Performance Measures, and Evidence-based or- Informed Strategy Measures for informed-decision-making. Surveillance efforts consist of identifying emerging or new cases affecting the MCH population through CNMI Syndromic Surveillance Report.

The CHCC's Health Information Technology (HIT) department continues to collaborate with the vendor Medsphere regarding upgrades to CareVue Electronic Health Record (EHR) and Revenue Cycle Management (RCM) system. Carevue is a centralized EHR system utilized throughout the CHCC system, including the Rota and Tinian sites. The system is utilized by SSDI to access healthcare encountered data to inform primary and preventive care utilization analysis, types of conditions and diagnosis, and other performance and outcomes indicators collected and reported by the CNMI MCH Title V program.

Upgrades to Carevue included electronically transmitting drug prescription (eRx), improvements to the patient data displays for easy access to patient age, weight, height, BMI and BMI percentile, and firewall security updates. These upgrades provide CHCC clinicians with additional functionality including modern graphical user interfaces, automated clinical support, and a suite of pre-built interfaces to third-party applications and devices. With the addition of the RCM system, CHCC is able to significantly improve its overall revenue and expenditures tracking system. According to CHCC HIT, Electronic Case Reporting (eCR) is another priority function within the CareVue EHR that they are pursuing.

In August of 2022, the CNMI MICAH Programs applied and successfully obtained funding to support the CNMI SSDI efforts through 2027. Goals for this time period are provided below.

Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming.

Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability.

Goal 3: Enhance the development, integration, and tracking of community health factors to inform Title V programming.

Goal 4: Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

The CNMI Title V Maternal and Child Health (MCH) Program, housed within the Maternal, Infant, Child, and Adolescent Health (MICAH) Program at the Commonwealth Healthcare Corporation (CHCC), carries out the core public health functions of assessment, policy development, and assurance through a team of committed and skilled public health professionals. As reflected in Form 7, the Title V workforce public health educators/health promotions specialists, data specialists, community health workers (CHWs), case managers, family leaders, and program managers and administrators. This interdisciplinary team forms the foundation for advancing maternal and child health outcomes in the CNMI.

Capacity of the Title V Workforce to Address Title V Priorities

While the number of staff directly funded by Title V is limited with just 6.5 FTEs, the CNMI Title V program strategically leverages personnel from other MICAH and Public Health programs with aligned goals to deliver services and implement strategies aimed at improving maternal and child health outcomes. This collaborative, integrated approach allows the program to maintain essential services and advance priorities despite workforce constraints.

The Title V workforce structure is aligned with CNMI's identified priority needs, including: increasing access to early prenatal care, supporting families of children with special health care needs (CSHCN), improving adolescent mental health and well-being, and strengthening early childhood screening and developmental support services.

Community Health Workers (CHWs)—funded through a combination of Title V and other MICAH programs—play a vital role in community outreach, Medicaid application assistance, referrals, and follow-up services. Their presence across the islands of Saipan, Tinian, and Rota supports accessibility, coordinated, and community-based care.

Public health nurses and medical assistants, though not funded by Title V, are engaged in coordinating clinical referrals and conducting outreach programs such as well child checks and immunizations and preconception care or family planning visits, helping to bridge clinical and public health services.

Family leaders and parent advisors, including parents of CSHCN, are involved in education workshops, case management support, and advisory roles, ensuring that family-centered care remains central to Title V programming.

Epidemiology staff, shared across CHCC's Division of Public Health, provide surveillance, data analysis, and performance monitoring of Title V measures, supporting data-informed decision-making and continuous quality improvement.

This multidisciplinary and cross-programmatic model strengthens the CNMI's capacity to address MCH needs comprehensively and cost-effectively. By maximizing shared human resources and aligning efforts across programs with overlapping objectives, the Title V program is able to implement evidence-based strategies and maintain high-impact services across all five MCH population domains.

Strengths and Needs of the Title V Workforce (Including Epidemiology)

Strengths:

- Bilingual and culturally attuned staff that reflects the varied population representing many different backgrounds and identities of the CNMI (primarily Chamorro, Carolinian, and Filipino communities).
- Strong CHW infrastructure that supports outreach and continuity of care in remote and underserved areas.
- A dedicated epidemiology team capable of generating data dashboards, conducting needs assessments, and supporting National Performance Measure (NPM) tracking.

Needs:

- Limited depth in specialized epidemiology skills (e.g., maternal mortality review, geospatial analysis).
- Small team size limits surge capacity during emergencies or staff leave.
- Retention challenges for highly trained staff due to geographic isolation and salary competition from mainland U.S. employers.

Unique Skillsets or Composition of Title V Staff That Facilitate Priority Efforts

The CNMI Title V workforce is uniquely composed to meet the demands of a remote, island-based system with limited

specialty care options. Notably:

- Family-to-Family (F2F) parent leaders embedded in the program bring firsthand experience navigating care for CSHCN, ensuring that Title V programming remains family-centered.
- CHWs are trained not only in health education and outreach but also in Medicaid application processing, an essential role given that lack of insurance remains a top barrier to care.
- Staff are cross-trained in multiple roles (e.g., health education, case management, and navigation) due to the CNMI's limited public health workforce pool, providing flexibility and continuity of service delivery.

Impact of Organizational Changes on Title V Workforce Capacity

The integration of Title V within CHCC's broader Population Health Services Division has strengthened coordination between public health and clinical care. It has enabled:

- Easier referral systems between Title V and programs such as WIC, Immunization, Family Planning, clinical services, and the Behavioral Health Unit.
- Shared training opportunities and staff collaboration across programs.
- Closer alignment between Title V and health system performance goals under the CHCC Strategic Plan.

However, this integration also presents challenges:

- Competing demands on shared staff and physical resources can strain program-specific focus.
- Ongoing health workforce shortages, particularly in Tinian and Rota, impact Title V's reach and responsiveness.

Planned areas for continued development include:

- Expansion of remote work and telehealth coordination training.
- Recruitment of additional CHWs for the islands of Rota and Tinian.
- Developing dedicated Title V training modules for onboarding and continuing education.

Engagement of Parents and Family Members on Title V Staff

As of FY 2024, the CNMI Title V program includes 11 paid family members of children with special health care needs serving in CHCC as Family-to-Family advisors and program assistants. Their roles include:

- Leading parent support workshops.
- Assisting families with Medicaid applications and health system navigation.
- Participating in advisory committees to provide input on Title V program planning and evaluation.

Additionally, the Family to Family Health Information Center, a program under the MICAH section, employs a Family Support Peer Specialist to help family access community service, training and education workshops, clinical care, and other resources.

Plans to Strengthen the CNMI MCH Workforce

Recruitment and Retention

The CNMI MCH Program is committed to strengthening and sustaining its workforce by prioritizing staff development, wellness, and recognition. Strategies include:

- Investing in employee wellness and recognition programs to support staff morale, retention, and overall job satisfaction. These efforts are designed to foster a positive work environment and reduce burnout.
- Enhancing training and capacity-building opportunities through targeted professional development, on-site workshops, and participation in regional and national learning collaboratives.
- Supporting local workforce development by encouraging and assisting current staff to pursue advanced degrees, certifications, or continuing education in public health, maternal and child health, or related fields.

These efforts reflect the program's commitment to building a resilient, skilled, and motivated Title V workforce capable of responding to CNMI's evolving MCH needs.

The CNMI MCH Program is enhancing its training and professional development approach by leveraging a Learning Management System (LMS) to deliver accessible, consistent, and scalable public health and MCH-related training opportunities.

- Utilizing a Learning Management System to deliver asynchronous and hybrid training modules on key MCH topics such as perinatal health, behavioral health screening, telehealth coordination, and cultural humility. The LMS allows for self-paced learning and improved tracking of staff competencies.
- Conducting an annual workforce training needs assessment to identify emerging skill gaps and tailor LMS content to

meet evolving staff and program needs.
- Partnering with HRSA, MCHB training centers, and regional public health training institutes to integrate evidence-based learning modules into the LMS and supplement virtual offerings with in-person capacity-building workshops.
- Providing targeted training for Community Health Workers (CHWs) and family leaders in trauma-informed care, motivational interviewing, client confidentiality, and navigation support, with plans to standardize these trainings within the LMS for onboarding and continuous education.

This approach supports long-term workforce development by enabling consistent, cost-effective training delivery across all islands and ensuring that staff have access to high-quality learning resources aligned with Title V goals.

The CNMI MCH Program is focused on building a sustainable local workforce by engaging high school students, youth, and college interns in early exposure to public health and maternal and child health (MCH) careers. This pipeline approach is designed to cultivate long-term interest in public health professions and strengthen local capacity.

- Engaging high school students through community health fairs, school-based career talks, and volunteer opportunities to raise awareness of public health and MCH careers at an early stage.
- Hosting college interns and practicum students from Northern Marianas College in nursing, education, and social work programs to gain hands-on experience within the MCH setting.
- Creating structured mentorship and shadowing opportunities through coordination with various local public health programs.
- Collaborating with the CNMI Department of Labor to offer paid internship opportunities for local high school students, providing early exposure to careers in public health and maternal and child health (MCH), while fostering hands-on learning and workforce readiness.

These efforts are critical to developing a homegrown public health workforce that is culturally competent, community-driven, and aligned with CNMI's long-term MCH goals.

Innovative Workforce Partnerships

The Commonwealth Healthcare Corporation's Division of Public Health, has established a strong and growing partnership with the CNMI Department of Labor (DOL) to develop a sustainable local workforce pipeline, with a particular focus on public health, including maternal and child health (MCH) fields.

This collaborative initiative leverages DOL funding to support paid internship opportunities for high school students, helping to reduce financial barriers to participation and increase youth engagement in health-related careers. Under this partnership, the Department of Labor provides wage support for student interns, while Public Health offers a structured and enriching internship experience. Interns are placed within various programs—including MCH, chronic disease prevention, immunization, and environmental health—based on their interests and learning goals.

The CNMI Public Health team provides interns with:

- Hands-on experience in community outreach, public health education, and program support;
- Training and orientation in basic public health principles, professionalism, and health promotion strategies;
- Ongoing mentorship and supervision by public health professionals, including CHWs, nurses, and program managers;
- Opportunities to observe real-world public health operations, such as health fairs, school-based screenings, maternal health education sessions, and data collection activities.

This partnership has created meaningful exposure for youth to public health careers and is intended to spark interest among students to pursue further education in health-related fields.

By connecting education, workforce development, and public service, this partnership exemplifies a model of interagency collaboration that builds capacity and supports the pipeline of future health professionals in the CNMI.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

The purpose of the State Systems Development Initiative (SSDI) is to improve maternal and child health (MCH) outcomes by increasing capacity to collect, analyze, and use reliable data for state/jurisdiction Title V policy and program development. The SSDI project continues to enhance the CNMI's capacity to collect, clean, analyze, and utilize reliable data to improve maternal and child health outcomes. These efforts have enabled the CNMI's Maternal and Child Health (MCH) program to implement data-driven strategies that align with the Title V MCH Block Grant program. The CNMI MCH program is an SSDI grant recipient; SSDI funds facilitates the expansion of data linkages across MCH priority datasets to support improvements in analytical capabilities; strengthen access to and utilization of fair health access data; and the translation of data to guide public health strategies.

SSDI goals aligned with its work plan are describe below:

1. Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title MCH Block Grant to assure data-driven programming.
2. Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability
3. Goal 3: Enhance the development, integration, and tracking of community health factors to inform Title V programming;
4. Goal 4: Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state programs and policy actions related to emergencies and emerging issues/threats, such as COVID-19.

Accomplishment and Barriers

Goal 1: *Strengthen capacity to collect, analyze, and use reliable data for the Title MCH Block Grant to assure data-driven programming*

Objective - By November 30, 2024, and annually through November 30, 2027, the Project will develop at least 2 data reporting products that will be updated on an annual basis.

- Fact Sheet development: For clear and professional presentation, the SSDI Project in concert with the MICAH program managers decided to focus efforts on utilizing the CHCC website to communicate key health information, facts and figures to increase accessibility and enhance patient engagement. Through this approach, the MICAH program can indirectly lead to cost savings, strengthen data capacity, and reach a wider audience to promote the mission of the Maternal and Child Heath Bureau (MCHB).
- The CNMI Maternal and Child Health Surveillance and Monitoring system is a dataset that contains National Performance and Outcome Measures for the Title V MCH Block Grant annual reports; it serves as a vital tool for public health monitoring and evaluation. By providing a comprehensive overview of key indicators over time, this dataset enables public health program managers to identify emerging patterns, track disease trends, detect potential outbreaks early, and assess the effectiveness of health programs. Ultimately, it supports data-driven decision-making to improve maternal and child health outcomes in the CNMI.
- The SSDI Project provided support for the completion of the 5-year Needs Assessment and Title V MCH Block Grant reports by identifying and assessing reliable primary and secondary sources of data relevant to key indicators, such as demographic, health status, program and community input data used to identify community needs and align priorities with the national and outcomes measures.

Goal 2: *Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability*

Objective - By November 30, 2027, there will be an increase of 6 percent, from the FY 2020 baseline of 36 NOMs

with data sources, to 38 NOMs with data sources used to inform the Title V MCH Block Grant Application/Annual Report.

- HRSA recently upgraded its NPMs and NOMs including adding a New Standardize measure available for use when existing NPMs/NOMs don't address a state's identified priority. The SSDI project continues to collaborate closely with Commonwealth Healthcare Corporation's (CHCC) Health and Vital Statistics office (HVSO) to access mortality and morbidity data relevant to maternal and infant health outcomes. In addition, SSDI works with CHCC's Information Technology (IT) division to support the extraction of Electronic Health Record (EHR) data—specifically Body Mass Index (BMI) and blood pressure (BP) metrics—to monitor and prevent risk factors such as obesity and hypertension.
- As part of the SSDI project's efforts to strengthen data infrastructure and promote inter-agency data sharing, the development of a Data Use Agreement (DUA) and Memorandum of Understanding (MOU) between CHCC, the CNMI Public School System (PSS), and Northern Marianas College (NMC) is currently in progress. This process is awaiting clarification and guidance from the Data Governance Committee to ensure compliance with regulatory standards and to support the long-term sustainability of integrated data warehousing and management systems.

Goal 3: *Enhance the development, integration, and tracking of community health factors to inform Title V programming*

Objective - By November 30, 2027, the CNMI MCH Program will report on the use of at least 3 community health factors for identifying improvement opportunities and tracking the CNMI's progress as part of the Title V MCH Block Grant Application/Annual Report. Baseline data is not available.

- The MCH trend analysis dataset serves as a tool to monitor national performance and outcome measures, including those related to tracking of community health factors. This dataset captures key demographic variables such as population group, sex, age, educational attainment, insurance status, and locality. These data enable linkage and analysis to inform program planning, performance monitoring, and health access initiatives.
- MCH trend dashboards provide visual trends, identify disparities, and track performance indicators; it informs data-driven decision-making for annual reporting and the development of targeted interventions to improve maternal and child health outcomes across the CNMI.
- The CNMI MCH Program convened a workgroup consisting of a varied population group of healthcare providers, representatives from governmental and non-governmental organizations; and community stakeholders to assist in identifying community health factors critical community health needs assessment activities and to inform Title V programming.

Goal 4: *Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19*

Objective: Electronic Case Reporting (eCR) for more accurate Public Health reporting: By November 2023, and annually through November 30, 2027, the SSDI project will work to implement electronic case reporting (eCR) for improving the timeliness, accuracy and completeness of data to inform surveillance systems, prevent or contain outbreaks, and implement evidence-base intervention to protect population health.

- The SSDI Project is actively participating in the discussion to enhance the Electronic Health Record (EHR) system by integrating electronic case reporting (eCR) capabilities and functionalities. This involves acquiring a new EHR platform capable of supporting seamless onboarding of eCR features to improve real time disease surveillance, reporting accuracy, and effective public health responsiveness. The upgrade seeks to improve data accuracy, completeness, and timeliness; enhance interoperability across systems and streamline data exchange processes between healthcare providers and public agencies.

SSDI Work Plan for 2025-2030

Goal 1: *Strengthen capacity to collect, analyze, and use reliable data for the Title MCH Block Grant to assure data-driven programming*

Objective *– By November 30, 2024, and annually through November 30, 2027, the SSDI Project will assist in providing training on data collection, analyzing, and reporting.*

Activity 1.1 – Conduct workshops on data collection methods, tools, and best practices

Activity 1.2 – Train staff in survey methods

Activity 1.3 – Build Analytical expertise using statistical software such as SAS and Power BI

Goal 2: *Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability*
Objective - *By November 30, 2027, the SSDI will receive training on enhanced data collection and quality, improve data linkages and integration, and strengthen data analysis and use.*
Activities 2.1 - Develop standardized data collection tools.
Activities 2.2 - Develop and promote the use of unique identifiers across different datasets.
Activities 2.3 - Conduct training on implementing data cleaning and routine data quality audits.

Goal 3: *Enhance the development, integration, and tracking of community health factors to inform Title V programming;*
Objective - By November 30, 2024, and annually through November 30, 2027, the SSDI will develop and promote actionable metrices that aligns with national frameworks
Activities 3.1 – Conduct an inventory of existing metrices on FAD and MCH programs.
Activities 3.2 - Enhance capacity to disaggregate data by race/ethnicity, age, income, etc.
Activities 3.3 - Attend webinars and online training modules to enhance quality assurance processes and data validation checks.

Goal 4: *Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19*
Objective: By November 30, 2027, provide continuous support for the acquisition of new Electronic Health Record (EHR) system and seamless integration of the Electronic Case Reporting (eCR) capabilities.
Activities 4.1 - Attend CHCC Data Governance and Modernization Initiative meetings
Activities 4.2 - Conduct a baseline assessment of existing data collection platforms, tools, and workflows.
Activities 4.3 - Re-engage with members of the Data Governance Committee to promote and highlight the benefits of data governance.

The MCH Jurisdictional Survey (MCH-JS) is a critical source of Federally Available Data (FAD) for U.S. Territories and Freely Associated States. It captures jurisdiction-specific data across key maternal and child health indicators, helping to address the unique needs and challenges faced by insular areas. The survey examines various factors related to child well-being, including health status, visits to health care providers, healthcare costs, and health insurance coverage; it also gathers comprehensive information on health risk behaviors, existing health conditions, and engagement in preventive health practices.

The data collected serve as a critical resource for policymakers, researchers, and public health professionals, by enabling them to identify health disparities, monitor health outcomes, and design evidence-based interventions to improve the maternal and child health population in the CNMI.

While the MCH Jurisdiction Survey provides much-needed federally available data specific to the U.S. Jurisdictions, nearly half of the CNMI MCH-JS findings are labeled “use with caution” because of insufficient sample sizes, which limits their reliability for making population-level decisions.

To address this gap, the SSDI project supports efforts to increase the survey sample size, enhance data quality

through technical assistance, and strengthen targeted strategies such as promoting data linkage, and advocating for capacity building. These activities aim to support the overall data infrastructure and ensure Jurisdictions have access to reliable, actionable information for MCH planning and program development.

By leveraging this survey, CNMI and other jurisdictions can ensure a more accessible, needs-based resource allocation, better targeted program development, and stronger alignment with federal reporting requirements—ultimately contributing to data-driven planning and health access advancement across MCH populations.

III.C.1.b.ii.e. Other Data Capacity

Other MCH data capacity efforts in the CNMI includes the following:

Pregnancy Risk Assessment Surveillance Monitoring System (PRAMS):
The CNMI Pregnancy Risk Assessment Monitoring System (PRAMS) is a joint research project between the Commonwealth Healthcare Corporation (CHCC) and the Centers for Disease Control and Prevention (CDC). It is a population-based surveillance system aimed at understanding maternal attitudes and experiences before, during, and after pregnancy, with the goal of improving maternal and infant health outcomes.

Project Timeline and Key Milestones

2021 – Planning and Preparation Phase

- Initiated the CNMI PRAMS project
- Hired project staff
- Convened the PRAMS Steering Committee
- Finalized the PRAMS research protocol
- Obtained Institutional Review Board (IRB) approval from CDC

July 2022 – Launch of Data Collection

- Began data collection using traditional mail and phone methods
- Sampled live births from CNMI residents

June 2024 – Data Availability

- 2022 PRAMS data made available for analysis by the CDC and shared with CNMI

Late 2024 – National Presentations

- CNMI PRAMS team to present implementation progress and insights at:
- 2024 National PRAMS Grantee Meeting
- 2024 CityMatch Conference

Purpose and Objectives
PRAMS aims to reduce adverse maternal and infant health outcomes and improve health behaviors, policies, and systems. Specifically, CNMI PRAMS seeks to:

- Document estimates and trends in maternal and infant health indicators
- Identify high-risk subpopulations and inform prevention strategies
- Support the HRSA Title V needs assessment and MCH block grant planning
- Guide development of maternal and infant health programs and system changes
- Monitor emerging health issues and trends in mortality and morbidity
- Assist health professionals in applying current research in practice
- Build local capacity by providing reliable, actionable data to inform programs and policies

Significance
By establishing a localized, evidence-based surveillance system, CNMI PRAMS plays a critical role in data-driven public

health decision-making and improving the health of mothers and infants in the Pacific Islands.

Electronic Health Record (EHR) System:
After an internal review and assessment of the current EHR system's functionalities and challenges, CHCC management, following careful consideration, decided to explore options to replace or upgrade the existing system with a more advanced solution that better meets the evolving demands of the healthcare industry.
Transitioning to a new and better Electronic Health Record (EHR) system improves healthcare efficiency by enhancing data integration, streamlining workflows, supporting clinical decision-making, strengthening data security, enabling interoperability, reducing costs, and improving both provider usability and patient engagement.

The decision to upgrade the EHR system aligns closely with the SSDI goals through:

- Enhance Data Capacity
- Improve data Quality
- Facilitates Integration with National Systems
- Promote Data-Driven Programs and Policies
- Strengthens Infrastructure for Health Access Monitoring

Immunization System linkage to EHR- System Interoperability:
In partnership with the Health Information Technology (HIT) Department, the Immunization Program has initiated the first phase of developing HL7 interfaces with the CNMI Immunization Information System (WebIZ). This integration will enhance the accuracy, efficiency, and timeliness of vaccination data capture and reporting at CHCC.

National Electronic Disease Surveillance System (NEDSS) Base System (NBS)
The CNMI CHCC has implemented the NEDSS Base System (NBS), a CDC-developed platform designed to support the standardized collection, management, analysis, and secure sharing of reportable disease data. This system enables efficient electronic data exchange with the CDC and enhances public health surveillance capabilities. The project is led by the CHCC Epidemiology and Laboratory Capacity (ELC) Program, with the goal of improving disease monitoring, outbreak response, and data-driven public health decision-making.

Electronic Vital Registration System (EVRS)-
Through the CNMI Health & Vital Statistics Office (HVSO), the CNMI has implemented its first Electronic Vital Registration System (EVRS)—a modern, digital platform designed to streamline the registration, management, and reporting of vital events such as births and deaths. This implementation enables the CNMI to participate in the Social Security Administration’s Enumeration at Birth (EAB) program, allowing parents to apply for Social Security numbers for their newborns during the birth registration process.

The EVRS significantly enhances interoperability, enabling seamless integration with other CHCC data systems, such as the newborn screening data system, and reducing delays and redundancies across programs. It also improves data accuracy, security, and timeliness, ensuring more reliable vital statistics for health planning and service delivery.

In addition, the system strengthens CHCC’s capacity for morbidity and mortality surveillance, providing real-time access to critical data that supports population health monitoring, informs public health decision-making, and contributes to more responsive and data-driven healthcare across the CNMI.

Early Hearing Detection and Intervention (EHDI) System linkage
In 2020, the Newborn Hearing Screening Data System underwent significant enhancements, representing a major advancement for the CNMI Early Hearing Detection and Intervention (EHDI) Program. As part of these improvements, the

program implemented a data linkage interface with the CHCC Health and Vital Statistics Electronic Vital Registration System (EVRS), enabling more efficient and accurate data integration. The upgraded EHDI system now features a dedicated module for capturing newborn bloodspot screening data, which supports comprehensive monitoring of screening coverage and facilitates the timely identification of infants diagnosed with metabolic conditions at birth.

CNMI MCH Data Source:

Table 1 below presents an overview of the maternal and child health (MCH) data sources utilized by the CNMI Title V MCH Program. These data sources play a critical role in informing annual reporting requirements and guiding the development of evidence-based interventions aimed at addressing health priorities among women and children in the CNMI.

Table 1. CNMI MCH Data Sources

Data Source	Electronic Form	Periodicity	Data Source Linked to Vital Records Birth	Information gathered for
Vital Records Birth	Yes	Monthly		Birth rates, Preterm, early term, birth weights
Vital Records Death	Yes	Monthly	Yes	Maternal and Infant mortality and morbidity
Medicaid	Yes	Annually	No	Title XIX and XII - (Insurance coverage
WIC	Yes	Monthly	No	Breastfeeding rates, Early Childhood BMI, Anemia Screening
Newborn Bloodspot Screening	Yes	Monthly	Yes	NB - Blood Spot screening
Newborn Hearing Screening	Yes	Monthly	Yes	NB Hearing Screening, diagnosis, referrals
Hospital Discharge	Yes	Annually	No	Patient demographic, Diagnoses, Procedures performed, Payer information
PRAMS or PRAMS-Like	Yes	Monthly	Yes	Maternal behaviors, Healthcare utility, Risk factors Birth outcome, SDoH
H.O.M.E. Visiting Program	Yes	Monthly	No	Child development and school readiness, parenting practices, referrals and services use
CHCC Dental/Oral Health Program	Yes	Monthly	No	Preventive services, Access to dental care, Oral disease prevalence
Immunization Weblz	Yes	Monthly	No	Vaccine types, Vaccination Status and age
Family Planning Program	Yes	Monthly	No	Contraceptive use/method, Access to and use of services, Sexual health education, Demographic and insurance status
Developmental Screening	Yes	Monthly	No	Child's developmental milestones, Screening tools used, Screening results, Referrals and follow-ups
Breast and Cervical Cancer Program	Yes	Annually	No	Access to and use of services, Demographic and insurance status, Screening type and dates
CNMI Cancer Registry	Yes	Annually	No	Cancer type, Diagnosis date and stages, Treatment received, Patient demographics and outcomes
Early Intervention Program	Yes	Annually	No	Individualized Family Service Plan (IFSP), Service provided, Screening assessments, develo[mental disabilities, Progress and outcomes
Special Education Program	Yes	Annually	No	Individualized Education Programs (IEP), Disability type, Educational placement, Demographic and evaluation
Public School System	Yes	Annually	No	Youth Risk Behaviors and SPED enrollments
Maternal and Child Health Program	Yes	Annually	No	Access to health services, Prenatal and Postpartum care, Health disparities and risk factors, Maternal and infant health outcome
CNMI Non-Communicable Disease Program	Yes	Annually	No	NCD Hybrid survey, Tobacco use, Physical Activiy, Nutrition, Hypertension, Diabetes

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Program Partnerships, Collaboration, and Coordination

The MICAH Program has been instrumental in forging strong partnerships to enhance disease prevention and public awareness activities. Other strategies to strengthen the MICAH 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; 2) work with partners during island-wide community events which strongly emphasize lifestyle behavioral changes including 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 partnerships with other agencies to ensure continuity of care.

Much of the island-wide work accomplished by MICAH 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. MICAH 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 Public School System (PSS), in particular the Early Intervention Service, is an essential partner to the CSHCN Program. Together, the agencies offer services for children served by the CSHCN Program. A Title V staff member is a member and represents the department on the Interagency Coordinating Council, with membership requiring a governor appointment.

The PSS 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, which leads underage drinking and suicide prevention efforts. The Community Guidance Center also addresses suicide and violence prevention and has strong ties to the federal, state, and community agencies and programs that carry out risky behavior reduction activities.

The MICAH 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 sharing and referrals to care especially for those who are low-income and uninsured.

The CNMI WIC Program, a program within MICAH, is instrumental to current efforts focused on increasing breastfeeding rates, food security, and decreasing childhood overweight and obesity.

Family Planning services include efforts to address unintended pregnancy, preconception health, and preventing risky teen sexual behavior. Currently, MICAH funds are not used for direct family planning services, but rather, support procurement of pharmaceutical supplies such as contraceptives and population-based activities around unintended pregnancy prevention. This unit has strong ties to the programs that work on STD/HIV prevention and services.

The MICAH Program also works with the Immunization Program via interdepartmental activities, such as campaigns focused on increased routine childhood vaccination coverage and seasonal vaccines like influenza and RSV.

Relationships with the Public Health Non-Communicable Disease (NCD) Programs are strong and support work between MICAH projects and programs such as Diabetes, Cancer, Tobacco Control and other chronic disease prevention and health promotion. For example, the partnership has had a longstanding collaboration in addressing healthy weight among children.

The Health Vital Statistics Office (HVSO) is an established partner of the MICAH Program. This long-term relationship has led to the development of MICAH-specific data and resources. The HVSO serves a critical role in providing CNMI birth and death data to Public Health, enabling programs, including MICAH Programs, to use the information to guide interventions, perform surveillance efforts, and evaluate efforts.

The MICAH 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 provide volunteers during events such as school vaccination campaigns and health fairs. All Division programs conduct outreach activities at schools during their health fairs, science fairs, nutrition awareness events, 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.

Regional Partnerships
At the regional level, the Division of Public Health has engaged with organizations such as the Pacific Community (SPC) and the Western Pacific Regional Office (WPRO) of the World Health Organization (WHO). These partnerships facilitate shared learning, technical assistance, and capacity building across Pacific Island jurisdictions. Through these regional partnerships, the CNMI Public Health, inclusive of MICAH programs, participates in strategic planning and policy alignment with other island health systems, promoting regional consistency and evidence-based practices. The CNMI also receives direct support in workforce development, epidemiology training, and health system strengthening.

Additionally, the Division works closely with regional hospitals and public health agencies in Guam, American Samoa, and the Federated States of Micronesia to coordinate responses to communicable disease outbreaks, exchange clinical expertise, and share data to support surveillance and contact tracing efforts.

National Partnerships
Nationally, the CNMI Division of Public Health partners with the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Association of State and Territorial Health Officials (ASTHO), the National Association of Chronic Disease Directors (NACDD), Association of Immunization Managers (AIM), and the Association of Maternal and Child Health Programs (AMCHP). These partnerships provide access to funding, technical guidance, policy support, and training that are instrumental in the development and implementation of public health

programs.

With CDC support, CNMI has launched and sustained key programs in immunization, chronic disease prevention, emergency preparedness, and maternal and child health. CDC's regional project officers provide tailored support that accounts for the CNMI's unique context, ensuring grant activities are both feasible and impactful.

Through HRSA funding, the Division supports increasing access to preventive health services, primary care development, and the integration of behavioral health services in underserved communities. CNMI also participates in national learning collaboratives facilitated by ASTHO and the National Association of Chronic Disease Directors (NACDD) to adopt best practices and innovative approaches to local health priorities.

Impact of Partnerships
These partnerships have enabled CNMI MICAH Programs to:

- Implement data-driven health interventions tailored to the local population;
- Strengthen workforce capacity through technical assistance and training;
- Improve access to preventive and primary care services;
- Increase community engagement in public health initiatives;
- Respond more effectively to public health emergencies.

III.C.1.b.iv. Family and Community Partnerships

Family and Community Partnerships

The MCH Program not only partners with CNMI organizations and agencies, but strives to involve 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. To ensure that services are effectively meeting the needs of the local population, programs under MICAH have taken a collective approach towards involving families in programmatic decision-making. A significant amount of family engagement activities is coordinated through the Family-to-Family Health Information Center (F2F HIC), a unit within the MICAH CYSHCN Program. Since the implementation of the F2F HIC in the CNMI there has been an increased activity around building parents, caregivers, and family capacity around advocacy and empowerment. These are facilitated through informative learning sessions, recruitment of parent leaders to provide peer support, parent leadership training, establishing support groups and providing opportunities to attend national conferences. Additionally, through family engagement activities, CSHCN parent leaders have been recruited to take part and be active members in committees such as the Disability Network Partners, Early Intervention Interagency Council, and the Developmental Disabilities Council.

The MCH Title V Program staff work closely with parent support groups, church leaders, women's groups, and community and traditional leaders. The Family-to-Family Health Information Center (F2F HIC) offers a peer support program for families with CSHCN. A Family Support Specialist and Parent Leaders provide guidance and peer support in addition to actively advocating for CSHCN. The MICAH programs are focused on continuing to build parent/consumer partnerships to improve public input into the entire program and its policies and objectives.

Related advisory committees that MICAH programs are involved in which include family partners as members include the: Interagency Coordinating Council (ICC), CSHCN stakeholder group, H.O.M.E. Visiting Community Advisory Board, EHDI Advisory Board, Disabilities Network Partners, Governor's Council on Developmental Disabilities, Pediatric Mental Healthcare Access Program Advisory Council, and the Head Start Advisory Council. Families and community members also take active roles in the planning and coordinating of annual CNMI wide events, give feedback on annual reports and applications, and contribute in identification of strategies.

Most recently, the MICAH Program launched the Providers and Teens Communicating for Health (PATCH) Program which has recruited Teen Educators from all corners of Saipan to improve adolescent health care experiences for youth in our community. The program aims to improve the way adolescents receive, experience, and utilize health care. It complements existing adolescent health care quality initiatives by providing teen-centered education, awareness, and encouragement to youth and health care professionals.

The MICAH Program in collaboration with other programs under the Division of Public Health Services, maintains strong partnerships with CHCC medical providers in coordinating access to healthcare across the CNMI including Rota and Tinian and maximizing the utilization of the mobile clinic. These collaborative efforts bring vital health services directly to remote areas and assist in eliminating barriers such as transportation and limited provider access. In addition, we work closely to identify the unique health needs of our island community and address specific maternal and child health concerns while providing valuable clinical insights and responses. Through our partnerships, we aim to provide timely, quality care while reinforcing our shared commitment to accessible, community-driven healthcare solutions.

III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

The Commonwealth of the Northern Mariana Islands (CNMI) undertook a comprehensive and participatory process to identify and select its final set of maternal and child health (MCH) priority needs for the 2025–2030 Title V reporting cycle. This process involved multiple data sources, extensive community engagement, and alignment with national and state-level performance objectives to ensure that the selected priorities reflect both community voice and strategic public health goals.

1. Methodologies Used to Rank Identified Needs and Final Selection Process

The CNMI applied a mixed-methods approach to assess and rank its broad set of MCH needs. Quantitative data were collected through local surveillance systems, health service utilization reports, hospital discharge data, WIC records, PRAMS (when available), and federal datasets including the MCH Jurisdictional Survey (MCH-JS). In parallel, qualitative input was gathered through stakeholder focus groups, key informant interviews, and surveys disseminated to families, MCH serving professional, youth, and community-based organizations.

To rank identified needs, the CNMI used an adaptation of the Eisenhower Matrix, assessing the importance and feasibility of addressing identified needs. A multi-sector MCH working group—comprising public health leaders, family representatives, youth, and healthcare partners—reviewed the data, scored each identified need, and reached consensus on the final list of **eleven priority needs**.

2. Emerging or Frequently Cited Needs Not Selected and Rationale

Several emerging or frequently cited issues were considered but not included in the final list of priority needs. These included nicotine use or vaping among teens, access to nutritious food for children, and home visiting services. While important, these issues were not selected because they were either already being addressed through other programs (e.g., vaping through the Public Health NCD Programs or nutrition through the CNMI Nutrition Assistance Program or WIC) or lacked sufficient infrastructure or data at this time to support sustained intervention through the Title V program. Nevertheless, these areas will continue to be monitored and may be elevated in future planning cycles should conditions change.

3. Factors Contributing to Changes Since the Last Five-Year Cycle

Key factors contributing to shifts in the CNMI's priority needs include the lasting impacts of the COVID-19 pandemic on healthcare access and mental health, increased emphasis on fair health access and community engagement, and updated surveillance data. Additionally, improved inter-agency collaboration and feedback from families helped refine focus areas to be more responsive to on-the-ground realities, including the need for culturally competent care and services tailored to remote island communities.

4. Link Between Priority Needs and National/State Performance Measures

Each of CNMI's selected priority needs was intentionally aligned with at least one National Performance Measure (NPM) or State Performance Measure (SPM). For example, the priority need to improve access preventive health services for women aligns with NPM **WWV-Well Woman Visit**, while efforts to provide education and support for breastfeeding connect directly to NPM **BF-A,** percent of infants ever breastfed, **and BF-B**, percent of infants breastfed exclusively through 6 months. This alignment ensures that CNMI's activities are not only locally relevant but also contribute to national benchmarks and broader MCH system improvement goals.

5. Stakeholder and Family Engagement in the Process

Stakeholder engagement was central to the CNMI's needs assessment and priority-setting process. Families, youth, and family-led organizations were actively involved through facilitated listening sessions, online and in-person surveys, and representation on the MCH working group. Their input helped shape not only the selection of priorities but also the development of strategies that are culturally appropriate and community-informed. Feedback from family

leaders emphasized the importance of trust, respect, and practical access to services—elements that have been woven into both the rationale and implementation framework for the CNMI's selected priorities.

III.D. Financial Narrative

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$466,540	$473,287	$466,540	$489,239
State Funds	$0	$0	$0	$0
Local Funds	$0	$0	$0	$0
Other Funds	$487,995	$465,967	$479,204	$463,932
Program Funds	$0	$0	$0	$0
SubTotal	$954,535	$939,254	$945,744	$953,171
Other Federal Funds	$10,877,895	$5,162,601	$7,930,007	$8,902,682
Total	$11,832,430	$6,101,855	$8,875,751	$9,855,853

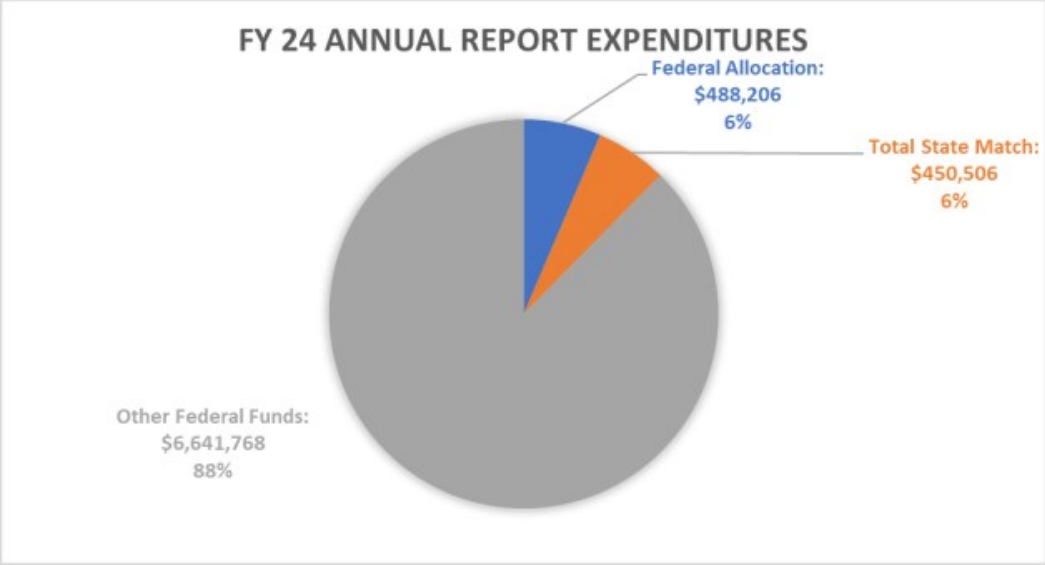
	2024		2025	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$474,000	$488,206	$490,000	
State Funds	$0	$0	$0	
Local Funds	$0	$0	$0	
Other Funds	$459,410	$450,506	$417,385	
Program Funds	$0	$0	$0	
SubTotal	$933,410	$938,712	$907,385	
Other Federal Funds	$7,401,082	$6,641,768	$8,599,630	
Total	$8,334,492	$7,580,480	$9,507,015	

	2026	
	Budgeted	Expended
Federal Allocation	$489,000	
State Funds	$0	
Local Funds	$0	
Other Funds	$414,218	
Program Funds	$0	
SubTotal	$903,218	
Other Federal Funds	$8,086,638	
Total	$8,989,856	

Overview of Expenditures:

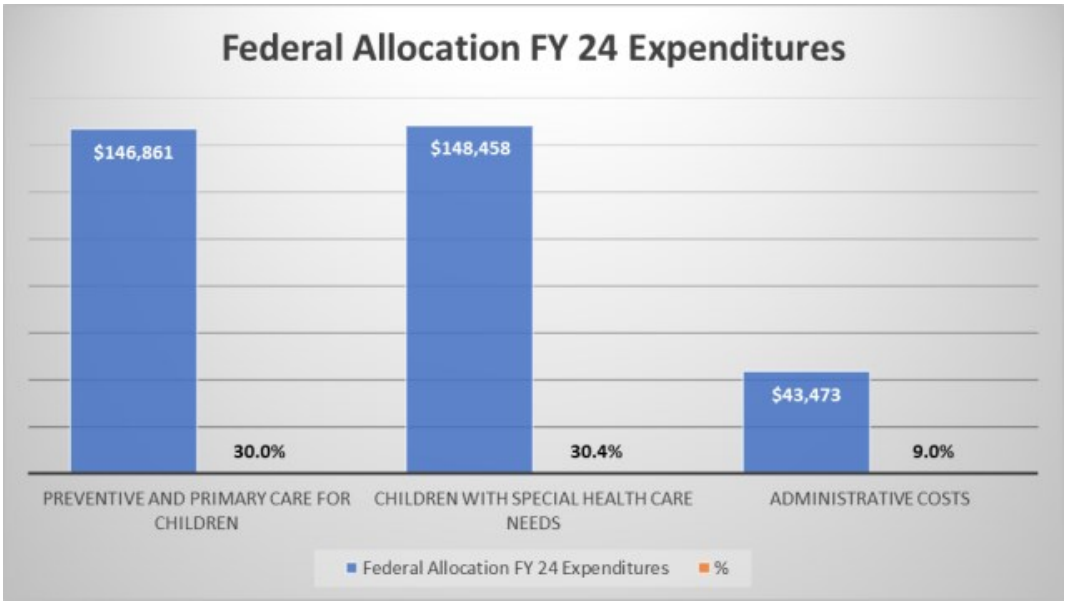
The mission of the CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and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

Below is a chart that displays the CNMI FY 24 Expenditures:



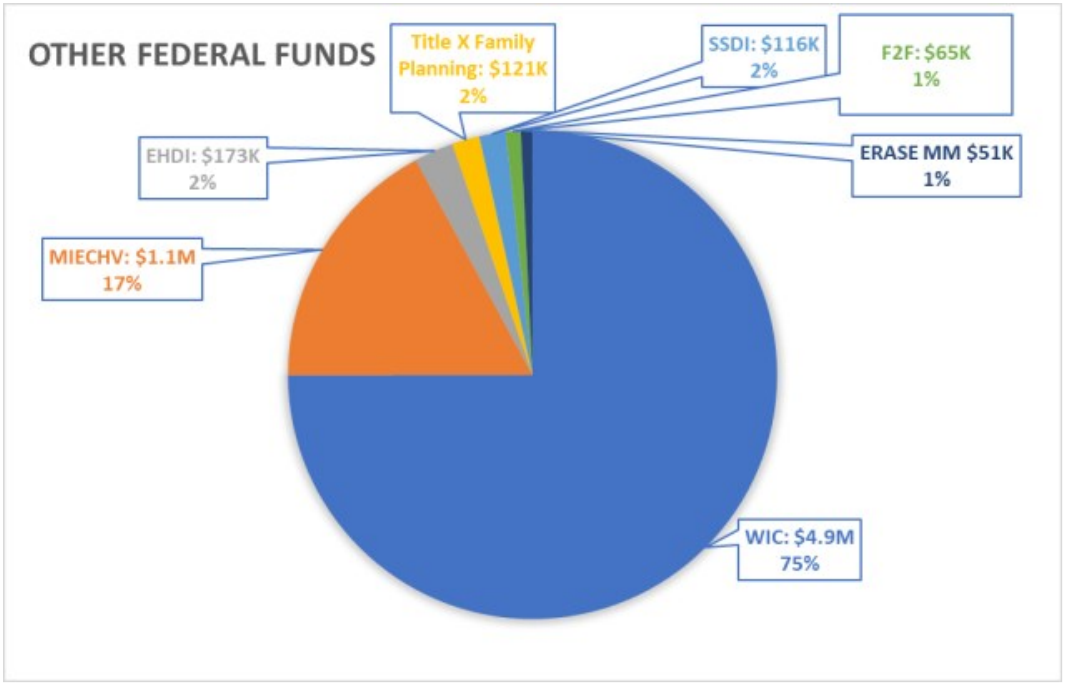
Legislative Requirements Met:

The CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. The MICAH Programs Administrator conducts monthly fund status report that consist of current funds available, funds encumbered, funds expended and the legislative required 30-30-10 percentage status report. The MICAH Programs Administrator develops the Title V Block Grant Budget and continuously monitor and track expenditures to ensure compliance with the legislative financial requirements. Expenses are monitored and tracked through the state's accounting system called the, *Tyler Munis (Enterprise ERP).* The Title V legislation requires a minimum of 30% of the block grant funds to be utilized for preventive and primary care for children and a minimum of 30% of the block grant funds for services for CSHCN. In addition, no more than 10% of the grant may be used for administration costs. The CNMI MCH Program has met the required legislative percentages for FY 24. The chart below provides an overview of the required federal allocation for the FY 24 expenditures.



Other Federal Funds:

The chart below provides an overview of the Other Federal Funds expended that were under the direct authority of the MICAH Programs Administrator which are also listed in Form 2 [Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, MIECHV American Rescue Plan(ARP), Early Hearing Detection and Intervention (EHDI) Programs, Title X Family Planning, Women, Infants and Children (WIC), State Systems Development Initiative (SSDI), Family Professional Partnership/CSHCN (F2F), and the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM)]. The Other Federal Funds total expenditure is $6,641,768.



Total State Match:

The Total State Matching funds in the amount of $450,506 was expended for FY 2024. The majority of the total Other Funds/Total State Match were expended towards personnel salaries for staff at the Commonwealth Healthcare Corporation that provides direct services to the MCH population. Since the Other Funds/Total State Match contribute to direct services, majority of the Title V funds contribute to enabling services and public health services and systems. The actual total amount of in-kind support provided by the CHCC to the maternal and child health population continue to exceed the amount reported on the Title V MCH program expenditures. However, the Title V MCH program will only report budgeted salary percentages that were stated on the proposed non-federal budget.

III.D.2. Budget

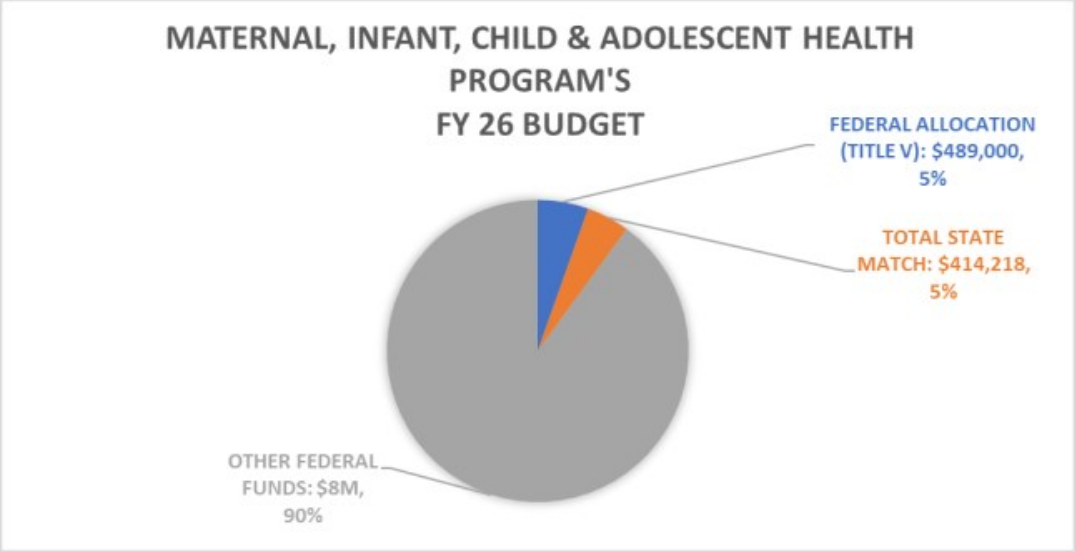
Budget Overview:

The mission of the CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs under the Commonwealth Healthcare Corporation is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and effective partnerships. The MICAH Programs works towards achieving this overarching work through the Commonwealth Healthcare Corporation (CHCC) with its internal and external partnerships; and in FY 2026 estimating a total state MICAH Programs budget of $9M.

The MCH Program's State Action Work Plan has been developed based on the Needs Assessment and current emerging issues. Therefore, the MCH Program's State Action Work Plan determines where the MCH federal grant dollars are budgeted. The MCH grant, all Other Federal Funds under the MICAH Programs, and the Total State Match continues to align its overarching goals and objectives to effectively leverage resources to serve the MICAH population. The Title V funds consist of personnel salaries and fringe benefits that support the following staffing: MICAH Programs Administrator and 3 Community Health Outreach Workers (CHOW) I. In addition, the MCH Program cost shares with other federal program funds to support the following staffing: MICAH Program Manager (Service Coordination), Adolescent & Reproductive Health Program Manager, Family Planning Clinical Coordinator, Health Promotion Specialist, 1 CHOW I, and the MICAH Administrative Specialist. The Title V funds also support 50% of the Public Health Services Director's FTE who serves as the Project Director for the MCH Title V Block Grant. The MICAH Program Manager (Service Coordination) Program Manager is funded 15% under the Title V funds and 85% under the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM). The Adolescent & Reproductive Health Program Manager is funded 27% under the Title V funds and 73% under the Family Planning Program funds. The Family Planning Clinical Coordinator is funded 17% under the Title V funds and 83% under the Family Planning Program funds. The Health Promotion Specialist is funded 50% under the Title V funds and 50% under the Non Communicable Disease Tobacco Local Funds. The CHOW I is funded 50% under the Title V funds and 50% under the Family Professional Partnership/CSHCN funds. The MICAH Administrative Specialist is funded 50% under the Title V funds and 50% under the ACA Maternal, Infant Early Childhood Home Visiting funds.

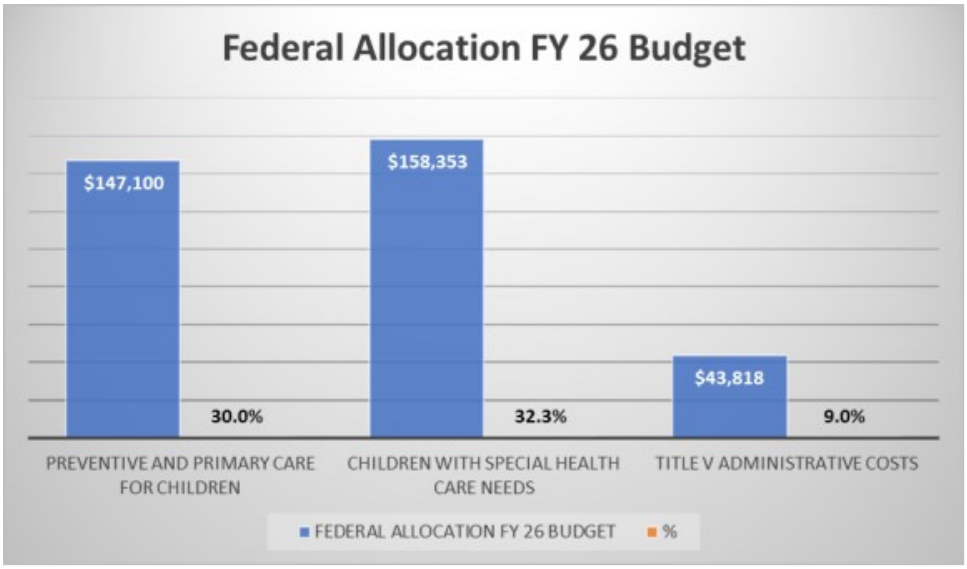
In addition to personnel salaries and fringe benefits, the Title V funds are budgeted towards Public Education and Awareness, Supplies and All Other Costs to support the MCH Programs activities and initiatives stated on the State Action Work Plan. For instance, public education and awareness costs include print, radio, local newspapers, television and social media posts on the importance of preventive screenings, annual preventive visits and prenatal care. Community awareness includes publicizing available services and programs such as, home visiting and other available health services that cater to the MCH population. The MCH Program will continue to educate the community on the importance of preventive screenings among infants, children, adolescents and women populations. Title V funds will be utilized towards family support materials for prenatal care programs, adolescent focused activities, bullying prevention, limiting screentime for children, Women's Health Month, breastfeeding support supplies and other community outreach events that serve the MCH population. Title V funds will be utilized to support the costs of newborn bloodspots and metabolic screenings and newborn screening kits, shipping of specimens for testing, and access for preventive visits for children and pregnant women. Funds are also utilized towards other costs such as travel, dues and subscriptions, license and fees, repairs and maintenance, communication services costs, office space rental, and et cetera.

The chart below provides an overview of the CNMI MICAH's FY 2026 Budget as reported on Form 2.



Legislative Requirements Met:

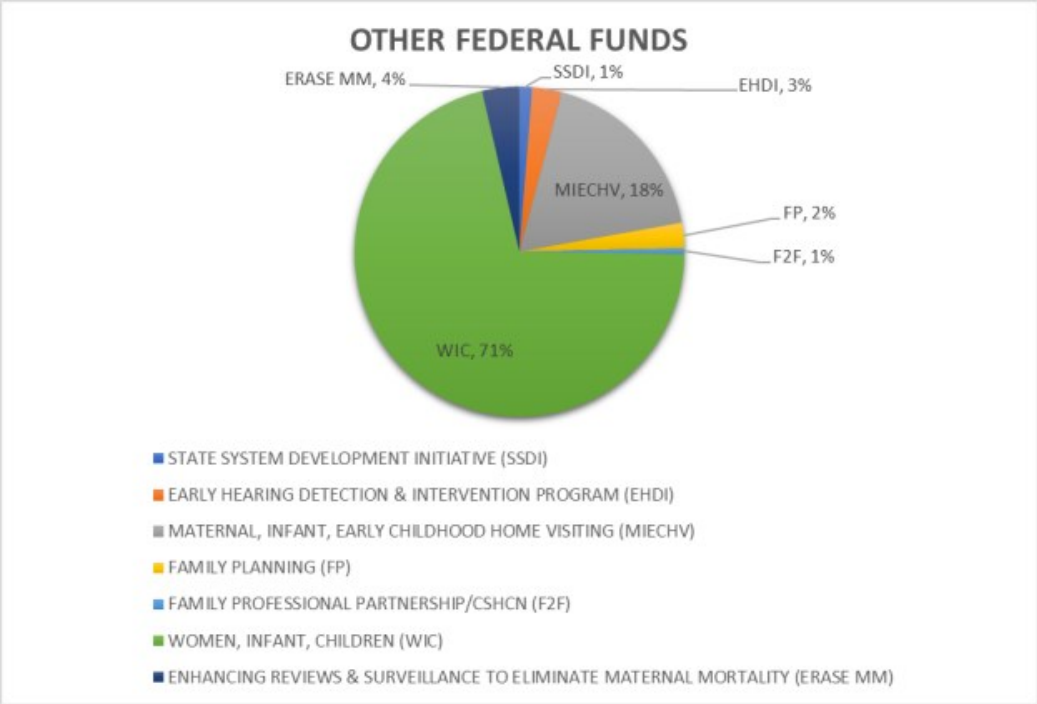
The CNMI MICAH Programs is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. One of the main duties and responsibilities of the MICAH Programs Administrator duties is to continuously ensure that the funds are being budgeted and expended per the minimum required 30-30-10 percentage. The Fiscal Year 2025 Title V Block Grant estimated budget proposal of $489,000 consist of the following types of individuals served: Pregnant Women and Infants less than 1 year of age was budgeted at $118,729 which is at 24% of the total federal award. Preventive and Primary Care for Children was budgeted at $147,100 which is at 30% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Children with Special Health Care Needs was budgeted at $158,353 which is 32.3% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Administrative costs budgeted at $43,818 which is 9% of the total direct costs of the federal grant award. A total of $21,000 was budgeted for All Other Costs such as dues and subscriptions, license and fees, repairs and maintenance, office space rental, utilities and cleaning services. The chart below provides a budget overview of the required federal allocation for the FY 26 Budget.



Other Federal Funds:

The chart below provides an overview of the Other Federal Funds budgeted that are under the direct authority of the MICAH Programs Administrator which are also listed in Form 2 [State Systems Development Initiative (SSDI), Early Hearing

Detection & Intervention Program (EHDI), Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, Title X Family Planning, Family Professional Partnership/CSHCN (F2F), Enhancing Reviews & Surveillance to Eliminate Maternal Mortality (ERASE MM) & Women, Infant & Children (WIC)].



The Other Federal Funds under the control of the MICAH Programs Administrator is responsible for the administration of the Title V program budgeted for the estimated amount of $8,086,638.

Total State Match:

The MCH match is budgeted at $414,218 which is comprised of the Commonwealth Healthcare Corporation in-kind funds which will comply with the required FY1989 Maintenance of Effort amount. Therefore, the Federal-State Title V Block Grant Partnership subtotal is $903,218. The Total State Match funds are budgeted towards personnel salaries and fringe benefits for staff at the Commonwealth Healthcare Corporation that provides direct services to the MCH population. Since the State Match funds contribute to direct services, majority of the Title V funds contribute to enabling services and public health services and systems.

III.E. Five-Year State Action Plan

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

State: Northern Mariana Islands

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

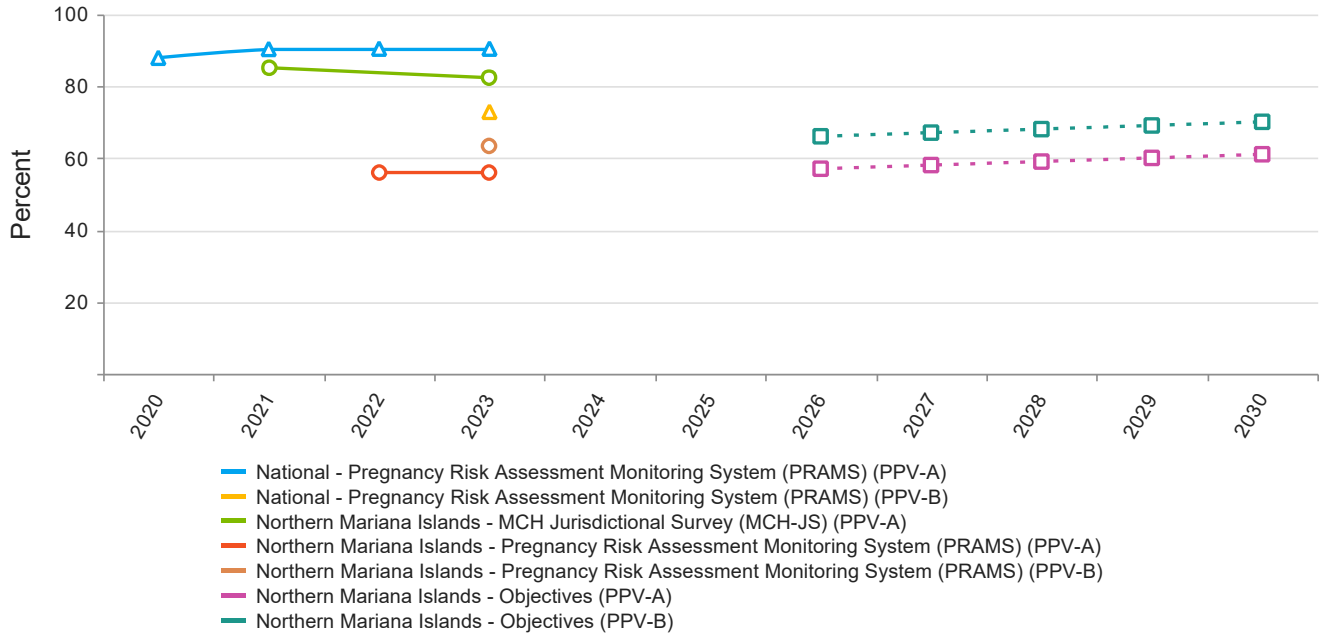
III.E.3 State Action Plan Narrative by Domain

If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.

Women/Maternal Health

National Performance Measures

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	56.0	56.0
Numerator	250	308
Denominator	447	550
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2023	**2024**
Annual Objective		
Annual Indicator	75.1	82.4
Numerator	411	1,007
Denominator	548	1,222
Data Source	MCH-JS	MCH-JS
Data Source Year	2024	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	57.0	58.0	59.0	60.0	61.0

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	67.0	63.3
Numerator	167	188
Denominator	249	296
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	66.0	67.0	68.0	69.0	70.0

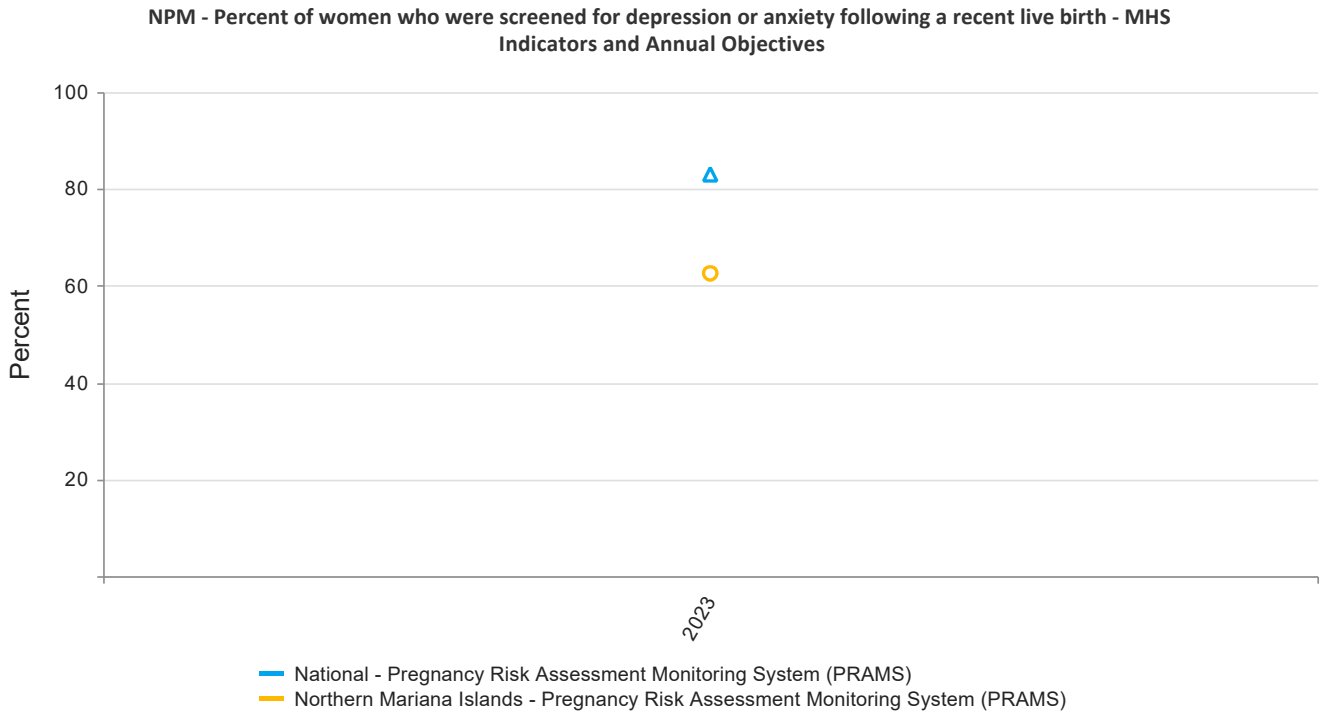
Evidence-Based or –Informed Strategy Measures

ESM PPV.1 - Number of women that are accessing well woman visits, prenatal care visits, and postpartum visits via mobile clinic and other clinical outreach.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5.0	10.0	15.0	20.0	25.0



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	62.6
Numerator	340
Denominator	544
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective					

Evidence-Based or –Informed Strategy Measures

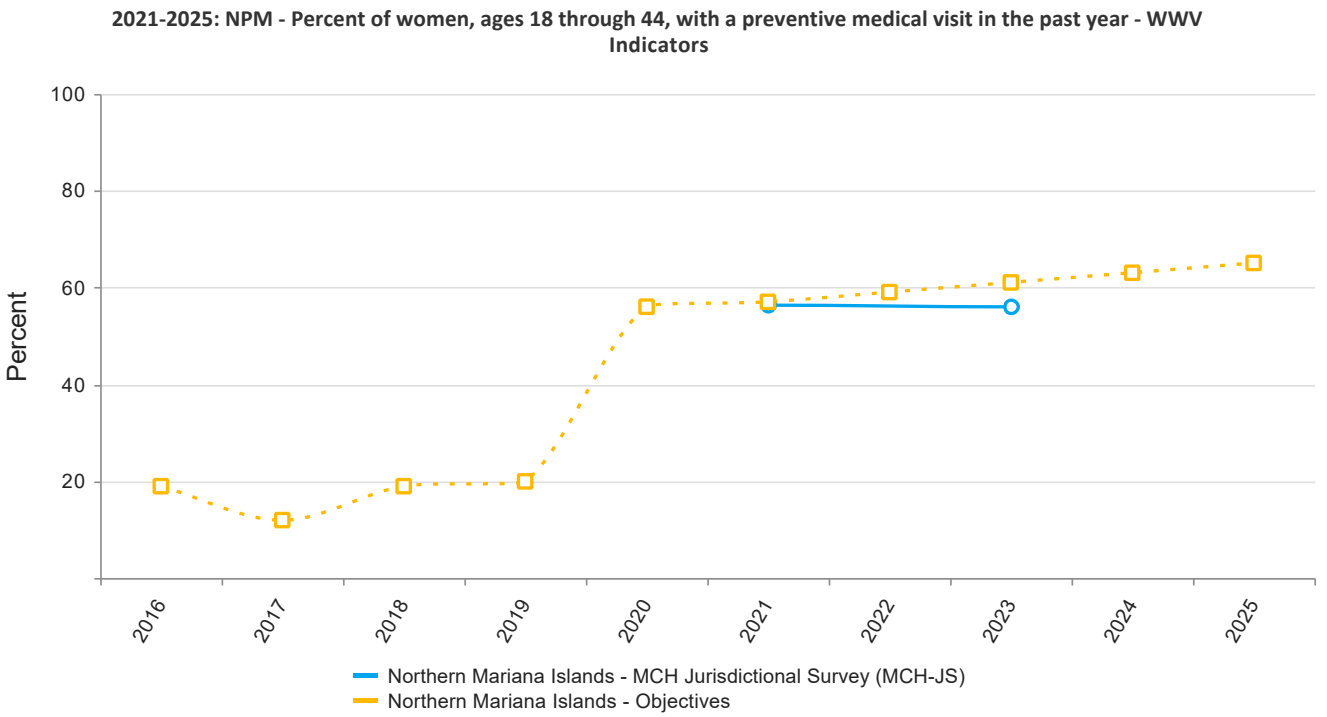
None

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Women/Maternal Health - Entry 1	
Priority Need	
Access to preventative medical visits	
NPM	
NPM - Postpartum Visit	
Five-Year Objectives	
By 2030, increase the percentage of women accessing preventive visits, including postpartum visits, by 5% from baseline.	
Strategies	
Increase access to preventive medical visits, including postpartum, care by expanding mobile clinic and other clinical outreach activities.	
ESMs	**Status**
ESM PPV.1 - Number of women that are accessing well woman visits, prenatal care visits, and postpartum visits via mobile clinic and other clinical outreach.	Active
NOMs	
Maternal Mortality	
Neonatal Abstinence Syndrome	
Women's Health Status	
Postpartum Depression	
Postpartum Anxiety	

State Action Plan Table (Northern Mariana Islands) - Women/Maternal Health - Entry 2	
Priority Need	
Access to Mental Health Services	
NPM	
NPM - Postpartum Mental Health Screening	
Five-Year Objectives	
By 2030, increase the percentage of postpartum women who are screened for depression and referred to services by 6% from baseline.	
Strategies	
Conduct an assessment among clinic providers to identify whether standardized depression screening tools are being utilized.	
ESMs	**Status**
ESM MHS.1 - Number of maternal health clinics that participated in the assessment and survey regarding depression screenings.	Active
NOMs	
Maternal Mortality	
Infant Mortality	
SUID Mortality	
Neonatal Abstinence Syndrome	
Child Injury Hospitalization	
Women's Health Status	
Postpartum Depression	
Postpartum Anxiety	

2021-2025: National Performance Measures



Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	56	57	59	61	63
Annual Indicator	55.5	57.1	57.1	54.5	56.0
Numerator	6,544	7,415	7,415	5,531	6,473
Denominator	11,784	12,993	12,993	10,143	11,568
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2021	2021	2024	2021_2023

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		57	59	61	63
Annual Indicator	25.4	65.4	53.1		
Numerator	1,959	5,047	4,057		
Denominator	7,721	7,717	7,641		
Data Source	CHCC Preventive Visits and US international census	CHCC EHR/RPMS Preventive visits	CHCC CareVue EHR Preventive Visits		
Data Source Year	2020	2021	2022		
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM WWV.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at all CHCC health service sites.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		5	49	53	35
Annual Indicator		65.4	53.1	28.6	21.5
Numerator		5,047	4,057	2,170	1,647
Denominator		7,717	7,641	7,595	7,648
Data Source		CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

The Public Health Emergency officially ended on May 11, 2023, and with it, Presumptive Eligibility for Medicaid concluded on May 31, 2023. Despite these changes, the Maternal and Child Health (MCH) Program has continued its referral mechanisms established across the various MICAH programs to connect uninsured women and children with the MCH Services Coordinator. This coordinator assists eligible individuals in applying for regular Medicaid or the Sliding Fee Program.

In partnership with the CNMI Women's Clinic, the MCH Services Office continues to maintain a dedicated space within the clinic. This co-location supports streamlined patient referrals and enables tandem visits—minimizing loss to follow-up and allowing staff to address barriers to care and other identified risk factors more efficiently.

Even after the end of the Public Health Emergency, collaboration among nurses, providers, and Public Health staff has remained strong, ensuring continuity of services with little to no disruption.

The 2020 Comprehensive MCH Needs Assessment identified "Access to health services—the ability to find and see a doctor when needed" as a key priority for women's health in the CNMI. This aligns with National Performance Measure (NPM) 1, which tracks the percentage of women ages 18 to 44 who receive an annual preventive visit. Data informing NPM 1 comes from the CNMI MCH Jurisdictional Survey, which was originally conducted in 2020 and most recently updated in 2021 (2025).

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

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

Year	2020	2021	2022	2023	2024
Percent	55.5	57.1	57.1	54.5	56.0
Numerator	6,544	7,415	7,415	5,531	6,473
Denominator	11,784	12,993	12,993	10,143	11,568

Source: MCH Jurisdictional Survey

According to the CNMI MCH Jurisdictional Survey, 55.5% of women aged 18 to 44 received an annual preventive visit in 2020. This figure increased slightly to 57.1% in 2021 and remained steady through 2022. However, the 2023 data shows a decline to 54.5%, followed by a modest rebound to 56.0% in 2024. While fluctuations are relatively small, the dip in 2023 represents a notable 2.6 percentage point decrease from the previous two years.

The decline in 2023 may be partially attributed to the expiration of the Public Health Emergency (PHE) on May 11, 2023, which led to the end of Presumptive Eligibility for Medicaid on May 31, 2023. This policy change likely disrupted health insurance coverage for many individuals, including women of reproductive age, potentially reducing access to routine preventive care.

Although 2024 shows a recovery, the data suggests an ongoing need to monitor access to and utilization of preventive health services. Continued investment in outreach, coverage continuity, and culturally relevant care strategies will be essential to ensure that preventive service rates remain stable or improve over time.

To address barriers to care and improve access, the acquisition and use of a mobile clinic has been identified as a key strategy. The mobile clinic is intended to increase accessibility and extend service hours for women's preventive health services across the CNMI. The first outreach event using the mobile clinic was launched by the Health Disparity program on October 3, 2022. During the reporting period, staff supported by the MCH Title V Block Grant worked collaboratively with the CHCC Outpatient Clinics to review policies, update standard operating procedures, and develop a monthly schedule for

mobile clinic outreach.

In addition to services on the main island of Saipan, MCH Title V continued efforts to expand preventive healthcare access for women on the island of Rota. Starting in FY2022 and into FY2024, in partnership with the CNMI Breast and Cervical Cancer Screening Program (BCCSP), Title V supported monthly Women's Health Clinic outreach visits to Rota. These visits provided essential services to the women/maternal population on Rota for services such as Well-Woman Visits, prenatal care, and family planning. There was a total of 185 women from the island of Rota that access preventive health services during these outreach clinics in FY2024.

Evidence Based Strategy Measure 1.1: Percentage of women who report accessing preventive health services at CHCC.

Year	2021	2022	2023	2024
% Served	65.4	53.1	50	21.5
Numerator	5047	4057	3862	1647
Denominator	7717	7641	7717	7648

In 2021, the MICAH programs began tracking data for Evidence-Based/Informed Strategy Measure (ESM) 1.2: the percent of women ages 18 through 44 who access preventive health services at the Commonwealth Healthcare Corporation (CHCC). This includes services provided at CHCC's Family Planning Clinics, Mobile Clinics, and satellite sites on the islands of Tinian and Rota.
Data collection is conducted through CHCC's centralized electronic health record (EHR) system. To identify preventive health visits, MICAH staff utilize a combination of ICD-10 diagnosis codes, provider narrative notes, and chief complaint or purpose of visit (POV) fields. This allows for a comprehensive count of preventive care encounters across all CHCC facilities.
The numerator for this measure includes the number of women ages 18–44 who received preventive services at CHCC, while the denominator is based on the estimated population of women in this age group, as provided by the U.S. Census International Database for the Northern Mariana Islands.
In 2023, 50% of women in the target age group accessed preventive health services through CHCC. However, in 2024, this figure dropped sharply to just 21.5%, representing a 28.5 percentage point decrease from the previous year. This significant decline raises concern and may be attributed to multiple factors, including:
The end of the Public Health Emergency in May 2023, which also ended Presumptive Eligibility for Medicaid.
Increased numbers of uninsured women without alternative coverage.
Ongoing barriers to accessing care such as transportation, limited appointment availability, or lack of awareness about available services.
This decline underscores the need for renewed outreach, service expansion, and systemic interventions to restore access and utilization.
The MICAH program's long-term goal for ESM 1.2 is to increase the percentage of women accessing preventive health services to 63% by the year 2030.

In addition, the MICAH programs look at preventive health utilization accessed by the women/maternal population via the CNMI Family Planning Program (table below).

Percentage of females age 18 – 44 years served by the CNMI Family Planning Program, 2019 – 2024

Year	2019	2020	2021	2022	2023	2024
% Served	16.3	15.1	16.1	13.14	15.4	14.7
Numerator	1262	1164	1241	1,004	1,169	1,143
Denominator	7742	7721	7717	7641	7,595	7,732

Data Source: CNMI Family Planning Annual Report

The Family Planning Annual Report (FPAR) is published annually to outline the reach of the program within the CNMI community and is used to inform analysis conducted by the MICAH programs regarding utilization of preventive health services. The Family Planning program is a key component for providing access to preventive health services within the women population in the CNMI. In 2024, the program served a total of 1,143, 14.7 percent of unduplicated number of women ages 18 through 44 years in the CNMI. The numerator value for this measure is gathered through program encounter data while the denominator is based on population projections made available by the US Census International Database. The report indicates a slight increase decrease in the number and percentage of served in 2024 compared to the year prior.

The MICAH programs also monitor the number of pap tests conducted in the CNMI. Data to inform this indicator is provided by the Diagnostic Laboratory Services (DLS) in Honolulu, where Pap specimens from the CNMI are processed (see table below).

Number of Pap Tests Conducted in the CNMI, 2019 – 2024

CNMI PAP Data	2019	2020	2021	2022	2023	2024
Number of Tests	**1,516**	**1,895**	**2,682**	**1,879**	**1,518**	**947**

Data Source: DLS Hawaii

In Fiscal Year 2024, a total of 947 Pap tests from the CNMI were processed by Diagnostic Laboratory Services (DLS) in Honolulu. This reflects a decrease of 571 screenings compared to the previous year, representing a 37% decline in cervical cancer screening volume.

When comparing broader timeframes—2021–2023 vs. 2022–2024—the data shows a 28% overall reduction in the number of Pap smears conducted in the CNMI. This sustained decline marks a concerning trend in access and utilization of preventive women's health services.

The timing of the drop in screenings coincides with the end of the Public Health Emergency (PHE) on May 11, 2023, which led to the termination of Presumptive Eligibility for Medicaid on May 31, 2023. The loss of this temporary coverage resulted in many women losing access to affordable or no-cost preventive services, including routine cervical cancer screening.

Additional contributing factors may include:

- Insurance disenrollment and delays in reapplication following Medicaid redetermination
- Limited patient outreach or follow-up during the transition period post-PHE
- Health system strain and resource limitations, affecting appointment availability and staffing for routine screenings
- Decreased public engagement in preventive care due to lingering pandemic-era behaviors or misinformation

In response to this concerning trend, MCH, in collaboration with both internal partners (e.g., CHCC Women’s Clinic) and external programs (e.g., Breast and Cervical Cancer Screening Program), continues to focus efforts on increasing public awareness of women’s health, promoting annual visits, and re-engaging women with their healthcare providers.

Targeted strategies include community outreach, patient education, expanded mobile clinic services, and continued referral pathways to improve screening rates and reduce long-term health disparities in the CNMI.

Strategy: Provide community awareness regarding women's preventive health services.

In 2024, community awareness efforts for women's health in the CNMI primarily centered around social media campaigns and activities during CNMI Women's Health Month, celebrated every May. Throughout the month, a total of 52 social media posts were shared, generating an impressive total reach of 24,786 individuals. These posts received 683 likes and reactions and were shared 535 times by the community, demonstrating strong engagement and interest.

To build on this success and enhance the effectiveness and coordination of our outreach efforts, the Division of Public Health Services established a dedicated Health Promotion and Partnership Unit. This new unit is responsible for managing all health messaging across platforms, allowing for:

Streamlined and targeted communication designed to reach specific populations in the CNMI more effectively.

Consistent, community-based relevant content that resonates with multifaceted community groups.

Strategic partnerships with local organizations to expand reach beyond digital channels into community events and grassroots outreach.

Enhanced data monitoring and evaluation of campaign performance to continually refine messaging and maximize impact.

With this dedicated unit in place, the CNMI anticipates a significant expansion in both the reach and depth of women's health awareness activities. The Health Promotion and Partnership Unit will support ongoing education, encourage preventive care visits, and strengthen community engagement—ultimately improving health outcomes for women throughout the territory.

Access to preventive medical visits, including well-woman visits, prenatal and postpartum care, and mental health services were identified as top priorities in the 2025 CNMI MICAH Needs Assessment under the Women's Health domain. Health indicators across the CNMI reveal persistent barriers to care for women, including unreliable transportation, limited clinic availability, and interruptions in insurance coverage. These systemic challenges have contributed to a sharp decline in preventive service utilization among women ages 18–44, dropping from 33% in FY2023 to just 21% in FY2024, primarily due to insurance instability and lack of continuous coverage. Additionally, it is estimated that only 56% of women complete a postpartum visit and more than one-third (38%) do not get a mental health screening after birth. Factors such as stigma, shortage of mental health providers, and logistical barriers exacerbate unmet mental health needs. These access barriers have serious implications for women's overall health, undermining early detection and management of chronic and reproductive health conditions such as hypertension, diabetes, cervical cancer, unintended pregnancies, and mental health disorders. Without timely preventive and mental health care, women face increased risks of poor health outcomes that can affect their well-being across the life course.

To address this urgent need, the CHCC MICAH Programs are positioned to lead a coordinated response. Building on strong community partnerships, available services, and existing infrastructure, the program will expand efforts to increase access to preventive care and improve fair health access for women across Saipan, Tinian, and Rota.

Key strategies include:

- Expanding well-woman visits through extended clinic hours and additional service locations
- Promoting understanding of preventive health coverage and benefits
- Standardizing screenings and improving coordination of care
- Engaging with clinical and community partners to ensure culturally responsive outreach
- Grounding activities in the life course framework to promote long-term wellness

Improving access to preventive medical visits for women in the CNMI is closely linked to the MCH Title V National Performance Measure (NPM) focused on postpartum visits. The postpartum period is a vital time for comprehensive health care, including screening for physical and mental health conditions that can significantly impact maternal and infant outcomes. Strengthening maternal mental health screening during postpartum visits addresses a critical priority identified in the CNMI—enhancing access to mental health services for women, which is linked to the national performance measure postpartum mental health screening. Early identification and treatment of postpartum depression and anxiety are essential to support women's overall well-being, reduce the risk of long-term mental health issues, and improve family health. Given the CNMI's persistent barriers such as limited clinic availability, transportation challenges, and insurance instability, improving access to postpartum care ensures that more women receive timely, integrated physical and mental health screenings. By prioritizing these preventive visits and embedding robust mental health screening protocols, the CNMI can improve detection and management of both chronic conditions and maternal mental health needs. This approach aligns with Title V goals by promoting holistic maternal health, reducing preventable complications, and supporting women's health across the life course, ultimately contributing to healthier families and communities in the territory.

Priority Need 1: Access to preventative medical visits.

National Performance Measure: PPV A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components

Objective: By 2030, increase the percentage of women accessing preventive visits, including postpartum visits, by 5% from baseline.

Strategy: Increase access to preventive medical visits, including postpartum, care by expanding mobile clinic and other clinical outreach activities.

Community awareness will remain a cornerstone of the CHCC MICAH Programs' approach to improving access to maternal and child health (MCH) services. In FY 2026, the MCH Program will continue to collaborate with the Public Health Promotion and Partnership Unit (HPPU) to design and deliver impactful public education campaigns. These efforts will focus

on informing the community about available services, clinic locations, and hours of operation, while promoting engagement across all MCH population groups.

Through a combination of traditional outreach and digital engagement, the MICAH Programs and HPPU will create educational materials and culturally relevant social media content to expand their reach. Strategic partnerships will be cultivated with private clinics, insurance providers, faith-based groups, and nonprofit organizations to broaden dissemination and encourage community members to take advantage of services offered.

From October 2025 through September 2026, the CHCC MICAH Programs will implement a strategic community awareness and outreach plan in partnership with the Public Health Promotion and Partnership Unit (HPPU) and other key stakeholders. The effort will begin with gathering community insights through surveys and focus groups, led by the HPPU and the Adolescent & Reproductive Health Program Manager. The data collected will inform the development of targeted campaign materials that effectively address community needs and priorities.

Building on these findings, the MCH Services Coordinator will collaborate closely with the Non-Communicable Disease Health Care Management Unit (NCD-HCMU) to establish and track referrals, ensuring seamless coordination of preventive health services for women. Simultaneously, a comprehensive Women's Health Awareness Campaign will be developed by a dedicated team including representatives from HPPU, the SSDI Project Coordinator, and the MCH Services Coordinator. This campaign will focus on promoting the importance of preventive care and increasing awareness of available services across Saipan, Tinian, and Rota.

From March 2025 to March 2026, educational materials will be updated, printed, and widely disseminated to the community. These materials will be population-based relevant and designed to reach varied population groups. In addition, outreach presentations targeting key stakeholders will be conducted throughout the fiscal year by the HPPU Program Administrator and the MICAH Programs Administrator. These presentations will aim to boost engagement and encourage the use of preventive health services. The impact of these efforts will be evaluated through the number of presentations delivered and participant engagement levels.

Through this coordinated approach, the MICAH Programs aim to enhance community knowledge, strengthen partnerships, and expand access to essential women's health services across the CNMI.

Strategy: Increase access to preventive visits via mobile clinic and other outreach activities.

Community awareness will continue to serve as a cornerstone of the CHCC MICAH Programs' comprehensive strategy to improve access to maternal and child health (MCH) services across the CNMI. To increase preventive visits—including postpartum care—the MCH Program will significantly expand mobile clinic activity and clinical outreach efforts to bring services directly into underserved communities and village settings on Saipan, Tinian, and Rota.

From October 1, 2025 through September 30, 2026, the MICAH Programs will intensify collaboration with the Public Health Promotion and Partnership Unit (HPPU) to design and implement targeted public education campaigns. These campaigns will raise awareness about the availability of preventive services, mobile clinic schedules, clinic locations, and hours of operation, with a focus on engaging all MCH population groups. Outreach efforts will combine traditional methods such as community presentations and printed materials with culturally relevant digital and social media content to maximize reach and resonance.

To inform these campaigns and tailor services to community needs, the HPPU and the Adolescent & Reproductive Health Program Manager will conduct extensive community engagement activities, including surveys and focus groups, during the early part of this timeframe. Insights gathered will guide the development of targeted messaging and outreach strategies that address specific barriers and priorities identified by residents.
Building on community feedback, the MCH Services Coordinator will work closely with the clinical providers to strengthen referral systems that ensure smooth coordination and follow-up of preventive health services for women, including postpartum visits. This integrated referral pathway will be essential for tracking patient care and encouraging continuous

engagement with available services.

A key component of the strategy will be the expansion of mobile clinic services, operating regularly from October 2025 through September 2026, providing preventive care—including postpartum visits, screenings, immunizations, and health education—directly within village and community settings. Mobile clinics will reduce transportation and access barriers for women who might otherwise forgo care. This mobile outreach will be complemented by partnerships with private clinics, insurance providers, faith-based organizations, and nonprofits, creating a network that supports broad dissemination of information and encourages utilization of services.

To promote these efforts, a comprehensive Women's Health Awareness Campaign will be developed by a multidisciplinary team including representatives from HPPU, the SSDI Project Coordinator, and the MCH Services Coordinator. This campaign will focus on emphasizing the importance of preventive health visits, especially postpartum care, and informing women about convenient service options, including mobile clinics.

Between March 2026 and September 2026, educational materials will be updated to reflect current services and community priorities, printed in multiple formats, and disseminated widely across all islands. Outreach presentations conducted throughout the fiscal year by the HPPU Program Administrator and MICAH Programs Administrator will engage key stakeholders—community leaders, healthcare providers, and residents—to encourage increased participation in preventive health services.

The impact of these coordinated efforts will be monitored continuously through metrics such as the number and locations of mobile clinic visits, referral follow-up rates, attendance at postpartum visits, and levels of community engagement during outreach activities. This data will inform ongoing improvements, ensuring sustainable increases in access to essential women's health services across the CNMI.
Through this multifaceted, community-informed approach, the MICAH Programs aim to reduce access barriers, increase preventive visit utilization—including postpartum care—and ultimately improve maternal and child health outcomes throughout the Commonwealth.

Evidence Based Strategy Measure (ESM): Number of women that are accessing well woman visits, prenatal care visits, and postpartum visits via mobile clinic and other clinical outreach.
Data to inform this ESM will be gathered through query of the CHCC's electronic health record system. The program will assess the number and percentage increase in service utilization on a monthly basis among women/maternal population seen.
The CHCC's MCH Program is uniquely positioned to scale up preventive services for women in the CNMI through a combination of targeted outreach, strategic communication, and mobile clinical access. Support for this initiative will directly address health disparities, improve reproductive and preventive care access, and advance the CNMI's long-term health access goals.

Priority Need 2: Access to mental health services

National Performance Measure: MHS- Percent of women who were screened for depression or anxiety following a recent live birth.

Objective: By 2030, increase the percentage of postpartum women who are screened for depression and referred to services by 5% from baseline.

Strategy: Conduct an assessment among clinic providers to identify whether standardized depression screening tools are being utilized.

From October 1, 2025 through September 30, 2026, the CHCC MICAH Programs will implement a comprehensive provider assessment initiative aimed at understanding the extent to which standardized depression screening tools—such as the

Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire-9 (PHQ-9), or others—are being routinely utilized during preventive and postpartum visits. This initiative will provide critical baseline data to guide training, resource allocation, and policy development to enhance maternal mental health screening.

From October through November 2025, the CHCC MICAH Programs will convene a multidisciplinary working group comprised of MCH program leaders, mental health specialists, clinic managers, and frontline healthcare providers to guide the assessment process. This team will define the scope of the assessment, develop data collection tools—including structured surveys and interview guides—and identify all relevant clinics and providers delivering maternal and child health services across Saipan, Tinian, and Rota. Between November and December 2025, a structured provider survey will be designed to capture critical information on awareness and knowledge of depression screening guidelines, current screening practices, perceived barriers and facilitators, and training needs. Additionally, a brief key informant interview guide will be developed to gather qualitative insights from clinic supervisors and mental health coordinators. During January and February 2026, these surveys will be distributed electronically and in paper form to maternal and child health providers in both public and private clinics, complemented by interviews or focus groups with selected clinic supervisors and mental health specialists. Follow-up reminders and incentives will be used to maximize participation. From March through April 2026, collected data will be analyzed to quantify the proportion of providers using standardized depression screening tools, identify trends across clinic locations and provider types, and synthesize qualitative findings to illuminate contextual challenges and opportunities. A comprehensive assessment report will be prepared, highlighting key findings and actionable recommendations. In May 2026, findings will be disseminated to CHCC leadership, MCH partners, and other stakeholders through meetings and webinars, inviting feedback to inform priorities for intervention, training, and policy enhancement. Finally, from June through September 2026, the MICAH Programs will collaborate to develop targeted strategies addressing identified gaps, plan provider training focused on standardized depression screening tools and referral protocols, and integrate these efforts into broader maternal mental health initiatives within the CNMI Title V framework.

The following evaluation metrics will be considered in assessing the impact of the year 1 strategy:

Evaluation Metrics:

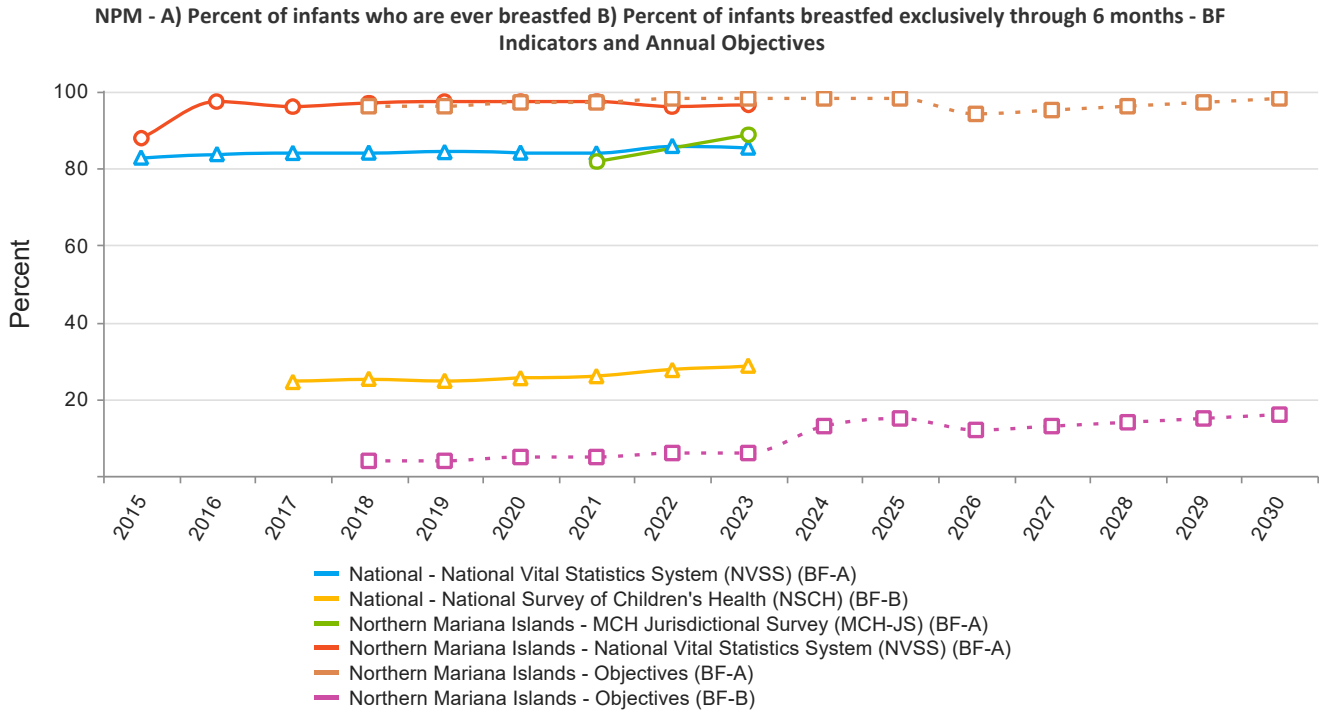
- Percentage of MCH providers responding to the assessment survey.
- Proportion of providers currently utilizing standardized depression screening tools.
- Identification of key barriers and training needs reported by providers.
- Number of clinics represented in the assessment.
- Completion and dissemination of the assessment report by April 2026.

Evidence Based Strategy Measure (ESM): Number of maternal health clinics that participated in the assessment and survey regarding depression screenings.

This measure tracks the number of maternal health clinics across the CNMI that actively participate in the assessment and complete the survey regarding their use of standardized depression screening tools. Participation reflects clinic engagement in evaluating current depression screening practices, identifying gaps, and informing targeted interventions to improve maternal mental health care within the community.

Perinatal/Infant Health

National Performance Measures



NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data	
Data Source: MCH Jurisdictional Survey (MCH-JS)	
	2024
Annual Objective	98
Annual Indicator	88.7
Numerator	4,494
Denominator	5,067
Data Source	MCH-JS
Data Source Year	2021_2023

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	98	98
Annual Indicator	95.7	96.5
Numerator	440	557
Denominator	460	577
Data Source	NVSS	NVSS
Data Source Year	2022	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		97	98	98	98
Annual Indicator	93.3	93.7	94.9	93.1	93.5
Numerator	610	539	449	541	522
Denominator	654	575	473	581	558
Data Source	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	94.0	95.0	96.0	97.0	98.0

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

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

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		5	6	6	13
Annual Indicator	0.4	0	0.5	11.1	11.6
Numerator	2	0	2	47	52
Denominator	544	419	411	424	448
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	12.0	13.0	14.0	15.0	16.0

Evidence-Based or –Informed Strategy Measures

ESM BF.1 - Percent of women enrolled in group prenatal care who exclusively breastfeed at 6 weeks postpartum.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	57.4	57.6	57.8
Annual Indicator		44.6	39.9	43.2	44.6
Numerator		187	164	183	200
Denominator		419	411	424	448
Data Source		WIC Program	WIC Program	WIC Program	WIC Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Final	Final	Provisional

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	46.0	47.0	48.0	49.0	50.0

State Performance Measures

SPM 1 - Percent of CNMI resident women with live births who receive prenatal care beginning in the first trimester.

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective	51	53	70	72	65
Annual Indicator	55.6	67	61.7	61.1	67.6
Numerator	351	383	290	333	338
Denominator	631	572	470	545	500
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	69.0	70.0	71.0	72.0	73.0

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Perinatal/Infant Health - Entry 1	
Priority Need	
Education and support to help with breastfeeding	
NPM	
NPM - Breastfeeding	
Five-Year Objectives	
By 2030, increase the percentage of infants who were breastfed exclusively through 6 months by 5% from baseline.	
Strategies	
Promote breastfeeding initiation and exclusivity by implementing group prenatal care models that incorporate structured breastfeeding education and peer support	
ESMs	Status
ESM BF.1 - Percent of women enrolled in group prenatal care who exclusively breastfeed at 6 weeks postpartum.	Active
NOMs	
Infant Mortality	
Postneonatal Mortality	
SUID Mortality	

State Action Plan Table (Northern Mariana Islands) - Perinatal/Infant Health - Entry 2

Priority Need

Education and services to help prevent premature births and low birthweight.

SPM

SPM 1 - Percent of CNMI resident women with live births who receive prenatal care beginning in the first trimester.

Five-Year Objectives

By 2030, increase the percentage of women receiving first trimester prenatal care by 10% from baseline.

Strategies

Assess and gather data (identifying groups and reasons for delayed care) to inform strategies for reaching women who are not accessing early prenatal care.

ESMs	Status
SPM ESM 1.1 - Assessment to identify groups or reasons for not accessing early prenatal care completed (Y/N).	Active

Based on the MCH Title V Block Grant guidance, the following annual report on infant health describes activities during FY 2024 (October 01, 2023 through September 30, 2024). The CNMI MCH priorities around perinatal/infant health focus on improving breastfeeding rates and early prenatal care among pregnant women. Both breastfeeding and prenatal care were identified as priorities in the 2015 CNMI MCH Needs Assessment and selected again as priorities on the 2020 Needs Assessment.

The Public Health Emergency ended more than mid-way into FY2023, enabling MICAH Programs to transition back to pre-pandemic levels of activities. Strategies identified for FY2023 for improving infant health and addressing breastfeeding and prenatal care priorities included implementing workplace breastfeeding policies and support and providing service navigation for pregnant women.

The following report gives an overview and details on the NPMs and SPMs along with information on the activities completed in FY2024 to address the priorities of breastfeeding and early prenatal care as part of the infant health domain.

Priority: Education and Support for Breastfeeding
NPM 4A: Percent of infants ever breastfed.

Breastfeeding	2019	2020	2021	2022	2023	2024
Percent of Infants	97.5	93.3	93.7	94.9	93.1	93.5
Numerator	887	610	539	449	541	522
Denominator	909	654	575	473	581	558

Source: CNMI HVSO, Birth Registry

The MCH Program gathers breastfeeding data to inform NPM 4A: Percent of Infants Ever Breastfed from the live birth registry out of the CNMI Health and Vital Statistics Office (HVSO). In 2024, 93.5 percent of live births in the CNMI were breastfed.

NPM 4B: Percent of infants breastfed exclusively through 6 months.

Exclusive Breastfeeding	2019	2020	2021	2022	2023	2024
Percent of Infants	1.1	.4	0	.5	11.1	11.6
Numerator	5	2	0	2	47	52
Denominator	470	544	419	411	424	448

Source: CNMI WIC Program

For NPM 4B: Percent of infants breastfed exclusively through 6 months, the MCH program utilizes WIC breastfeeding data to report on this measure. In 2024, 11.6 percent of infants met the criteria for breastfeeding exclusively through 6 months of age, a .5 percent increase in this measure. Activities that took place in FY2023 that contributed to these improvements included the hiring of a WIC Breastfeeding Peer Specialist and the development and implementation of a monthly quality assurance and performance improvement (QAPI) plan that enabled a more frequent and consistent review of breastfeeding status among WIC enrolled infants. The reviews provide the MICAH programs team an opportunity to evaluate monthly

breastfeeding rates, identify potential strategies to implement for improving those rates, and evaluating impact of change strategies timely.

While breastfeeding initiation rates in the CNMI of 95.6 percent is higher than US national rate of 83.2 percent[i], the 6 months breastfeeding rate (44.2 percent) trails behind the US rate of 55.8 percent. However, it is important to note that the CNMI did experience improvements in both the ever breastfed and exclusive breastfeeding rates among 6-month-old infants in 2023 and 2024.

Strategy: Develop or strengthen prenatal clinic policies on breastfeeding education and counseling.
In FY 2024, MCH funds were used to procure breastfeeding supplies and breast pumps to enable direct support for postpartum women encountering challenges with breastfeeding. Lactation visits are offered through the CHCC Children's Clinic with medical provider, Dr. Heather Brook, IBCLC.

Other efforts in the prenatal clinic space that have been undertaken is the development of breastfeeding posters by MICAH programs promoting breastfeeding and including tips on latching along with contact information for accessing breastfeeding support in the CNMI.

In August of 2024, various Public Health Programs, including programs within the MICAH section partnered with the WIC program to coordinate community activities to promote breastfeeding as part of World Breastfeeding Week. Food demonstrations to support lactation, informational booths to promote the breast pump loaner program, as well as a road side waving to highlight the importance of breastfeeding were conducted.

The MCH program continues its partnership with the hospital nursery, NICU, and pediatrics units in supporting the breastfeeding needs of babies and their families who access hospital services. Breast pumps and breast pump kits available in these units continue to be supported by Title V funds. Additionally, access to donor breastmilk is made possible through Title V funds and made available as indicated to infants in the NICU.

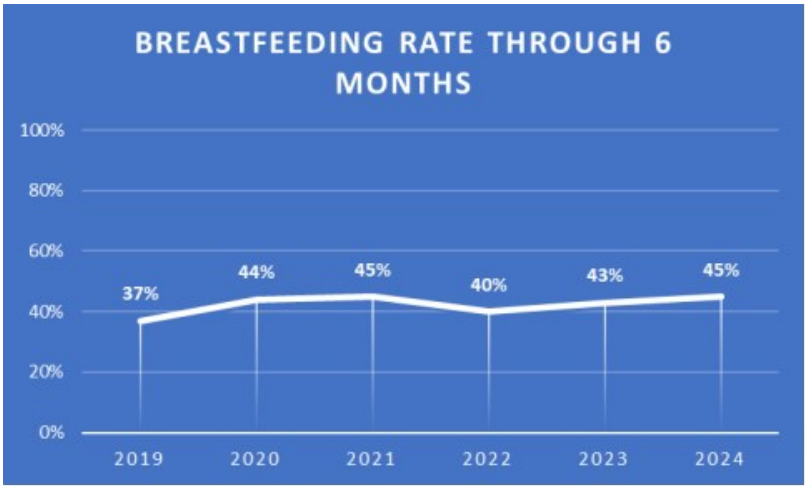
The Commonwealth of the Northern Mariana Islands (CNMI) has selected the percentage of WIC infants breastfed through 6 months of age as an evidence-based/informed strategy measure (ESM) for the perinatal/infant health domain. The CNMI WIC Program plays a critical role in supporting and educating eligible families on breastfeeding and has a broad reach among the territory's infant population.

All breastfeeding-related strategies and initiatives in the CNMI are implemented in close partnership with the WIC Program. Given WIC's significant presence in the perinatal/infant health space, MCH Title V efforts to improve breastfeeding rates are coordinated in collaboration with WIC.

The goal for this ESM is to increase the percentage of WIC infants breastfed through 6 months to 58% by 2025.

Evidence Based Strategy Measure 4.1: Percentage of WIC infants breastfed through 6 months.

Figure 1. Breastfeeding Rates among CNMI WC infants, 2019 through 2024



Source: CNMI WIC Program

High breastfeeding initiation rates indicate that a vast majority of moms in the CNMI want to breastfeed and start out doing so. However, despite the recommendations for exclusive breastfeeding through 6 months, less than half (45 percent) of all 6-month-old WIC infants in the CNMI are being breastfed.

Many factors contribute to success in continued breastfeeding, and support to breastfeeding moms is critical.

Strategy: Implement workplace breastfeeding policies/support

Another strategy identified by the CNMI for improving breastfeeding rates is focused on workplace policies and support. This strategy was placed on hold for the duration of the COVID-19 public health emergency and project implementation was projected in FY2024. Unfortunately, due to staff turnover and other factors limiting human resource capacity, the CNMI was not able to implement this project in FY2024 and carried as an action item into FY 2025.

Priority: Prevention of adverse infant outcomes through Prenatal Care

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

Prenatal Care	2019	2020	2021	2022	2023	2024
Percent	47.9	55	67	62	61	68
Numerator	334	347	382	290	327	338
Denominator	697	631	572	470	537	500

Data Source: CNMI HVSO

In 2024, 68 percent of non-tourist live births were to women who initiated prenatal care (PNC) visit within the first trimester of pregnancy, a 7-percentage point increase compared to the prior year and still significantly higher than the 48 percent reported in 2019. The CNMI experienced noticeable improvements in 2024 with preterm birth rates decreasing by 3 percentage points from 10.5 in 2023 to 7.5%, and Low Birth weight rates also declining by 3.2 percentage points from 10.5 to 7.3, reflecting a successful public health effort in maternal and infant health outcomes.

Strategy: Provide service navigation for pregnant women.

In FY 2024, the MCH Title V funds were leveraged to recruit a Community Health Worker (CHW) as part of efforts to expand

access to service navigation for pregnant women and infants seen through the CHCC Women's and Children's clinics. Service navigation includes assistance with completing Medicaid applications and expedited processing made possible through the memorandum of understanding between MCH Title V and the CNMI Medicaid program. Additionally, through service navigation, pregnant women are referred for prenatal dental cleaning at the CHCC Oral Health Program, enrollment into the CNMI MIECHV HOME Visiting Program, WIC, provided assistance with transportation to complete prenatal appointments, or connected to other community programs. To maximize client engagement and minimize loss to follow-up, the CHW was strategically placed within the CHCC outpatient clinics to allow for a seamless transition between clinical care and MICAH services for prenatal patients needing support.

[i] Centers for Disease Control & Prevention. (2022). Breastfeeding Report Card, United States 2022. Retrieved on July 20, 2023 from https://www.cdc.gov/breastfeeding/pdf/2022-Breastfeeding-Report-Card-H.pdf

Perinatal/Infant Health - Application Year

The CNMI MCH Title V Program has identified two critical priorities for the Perinatal/Infant Health domain based on data trends, stakeholder input, and alignment with national and local maternal and child health goals:

- Education and services to help prevent premature births and low birthweight (LBW), and
- Education and support to help with breastfeeding.

In recent years, the CNMI has seen a concerning increase in both premature births and low birthweight infants, reversing earlier gains and signaling the need for urgent intervention. According to CNMI HVSO data, the premature birth rate increased from 8% in 2019 to 11% in 2023, while the rate of low birthweight infants doubled—from 6% to 11%—over the same period. These negative trends are directly linked to increased risks of infant mortality, developmental delays, and long-term health complications.

Addressing this priority allows the CNMI MCH Program to respond proactively to these emerging issues. By investing in prenatal education, early engagement in prenatal care, and support services, the program aims to:

- Increase the early and consistent use of prenatal care services;
- Decrease the incidence of both fetal and infant mortality;
- Reduce the rates of preterm births and low or very low birthweight infants;
- Promote healthier pregnancies and better birth outcomes.

Community partners and stakeholders at the recent CNMI Health Priorities Setting Meeting emphasized that education is a powerful tool for prevention and also strengthens inter-agency collaboration. Recommended actions include expanding access to care through transportation assistance (e.g., Commonwealth Office of Transit Authority [COTA] vouchers and gas cards), and increasing community outreach through mobile clinics and educational campaigns. This community-informed approach ensures that services reach the most at-risk populations, including women in remote or underserved areas of Saipan, Tinian, and Rota.

While there has been steady improvement in breastfeeding initiation in the CNMI, with 96% of infants having been breastfed in 2023, exclusive breastfeeding through six months remains low. According to WIC data, the rate of exclusive breastfeeding through six months (BF-B) improved from just 1% in 2019 to 11% in 2023.

Prioritizing breastfeeding education and support allows the CNMI MCH Program to build upon this positive trend and further improve both maternal and infant health outcomes. Breastfeeding has been proven to:

- Enhance immune protection and reduce the risk of infections and chronic diseases in infants;
- Lower the risk of postpartum depression, breast cancer, and other conditions in mothers;
- Strengthen maternal-infant bonding;
- Contribute to long-term health cost savings for families and health systems.

Stakeholders agreed that providing consistent breastfeeding education and support—especially through trusted programs like the HOME Visiting Program and WIC—is key to helping mothers overcome barriers and sustain breastfeeding longer. The MCH Program will continue to support capacity building among providers, integrate lactation support into prenatal and postpartum services, and deliver culturally relevant, community-based education that aligns with local practices and values.

The selection of these two priorities reflects clear and measurable health needs, and both are areas where the CNMI MCH Program has existing infrastructure, cross-sector partnerships, and community trust. These priorities are not only realistic and achievable but also aligned with national MCH priorities and the CNMI's long-term health goals. They represent opportunities for high-impact interventions that can be integrated into ongoing programs through enhanced outreach, coordinated referral pathways, and improved health education delivery.

By grounding these efforts in community-identified needs and evidence-based strategies, the CNMI MCH Title V Program is well-positioned to improve health outcomes for mothers, infants, and families. These priorities will guide resource allocation, program planning, and evaluation efforts from FY2026 onward, ensuring a data-driven and community-informed approach to maternal and child health improvement across the Commonwealth.

Priority Need 3: Education and services to help prevent premature births and low birth weight.

State Performance Measure - Percent of CNMI resident women with live births who receive prenatal care beginning in the first trimester.

Objective: By 2030, increase the percentage of women receiving first trimester prenatal care by 10% from baseline.

Strategy: Assess and gather data (identifying groups and reasons for delayed care) to inform strategies for reaching women who are not accessing early prenatal care.

To improve early access to prenatal care across the Commonwealth, the CNMI MCH Title V Program will implement a targeted assessment strategy aimed at identifying the specific populations experiencing delays in care, as well as the underlying reasons contributing to late entry into prenatal services. This data-driven approach will serve as the foundation for designing and implementing effective outreach, education, and service delivery strategies tailored to the unique needs of women in the CNMI.
The FY2026 will be utilized as a planning year to allow the CNMI to systematically collect and analyze quantitative and qualitative data that identifies:

- Which populations are initiating prenatal care late (after the first trimester),
- Where geographic or service-related gaps exist,
- Why women are not accessing early prenatal care, and
- What barriers—structural, cultural, logistical, financial, or informational—are most commonly reported.

The CNMI MCH Title V program will utilize the following planning timeline as part of this planning year's strategy:

1. Planning and Stakeholder Engagement (Oct–Nov 2025):

- Convene an internal working group led by the MCH Program in coordination with the Reproductive Health Program, Women's Clinic, Public Health Promotion and Partnership Unit (HPPU), WIC and Home Visiting teams.
- Develop a workplan and identify key data sources (e.g., electronic health records, MCH program intake forms, community-based programs).
- Engage external partners such as Medicaid, insurance providers, and nonprofit service organizations to support data collection and dissemination.

2. Data Collection and Analysis (Dec 2025 – Mar 2026):

- Gather data from HVSO, CHCC Women's Clinic and MCH service records to determine the percentage of women initiating prenatal care after 13 weeks gestation, disaggregated by age, island (Saipan, Tinian, Rota), ethnicity, insurance status, and other demographics.
- Develop and administer a brief structured survey and/or conduct focus groups with postpartum women, community health workers, and home visiting staff to gather qualitative insights into barriers to early care.
- Key areas of inquiry will include:
    - Awareness of prenatal care recommendations
    - Access to transportation and clinic availability
    - Language and cultural considerations
    - Insurance and financial constraints
    - Perceptions of care quality or relevance

- Role of family or social influences

3. Synthesis and Reporting (Apr–May 2026):

- Analyze findings to identify high-risk or underserved subpopulations.
- Map common barriers by geographic area to identify gaps in coverage or access.
- Prepare a detailed assessment report with actionable recommendations for improving outreach, removing barriers, and tailoring prenatal care messaging and delivery.

4. Strategy Development and Implementation Planning (Jun–Sep 2026):

- Collaborate with HPPU and community partners to design targeted outreach strategies based on assessment findings.
- Develop culturally relevant educational materials and service navigation tools.
- Incorporate assessment results into program planning for FY2027, including mobile clinic scheduling, early pregnancy outreach, and referral system improvements.

Evidence Based Strategy Measure (ESM): Groups and reasons for delayed care identified (Y/N).

Implementing this strategy will result in a clearer understanding of which populations in the CNMI are least likely to access early prenatal care and the underlying reasons behind these delays. By collecting and analyzing both quantitative and qualitative data, the MCH Program will be equipped to develop targeted, data-informed outreach strategies that respond directly to community-identified barriers. These insights will also guide the design of more effective prenatal care programs and enhance collaboration across public health, clinical, and community-based sectors to support earlier engagement in services. In addition, the data gathered will serve as a critical baseline to monitor changes in early prenatal care utilization in future years. Over the long term, this strategy aligns with and advances the CNMI MCH Program's broader goals to improve maternal and infant health outcomes, reduce the incidence of preterm birth and low birthweight, increase early identification and management of high-risk pregnancies, and ensure that all women—regardless of their geographic location or socioeconomic status—have equitable access to timely, high-quality prenatal care.

Priority Need 4: Education and support to help with breastfeeding.

National Performance Measure: BF A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objective: By 2030, increase the percentage of infants who were breastfed exclusively through 6 months by 5% from baseline.

Strategy: Promote breastfeeding initiation and exclusivity by implementing group prenatal care models that incorporate structured breastfeeding education and peer support.

To address persistently low exclusive breastfeeding rates and to build upon recent progress in breastfeeding initiation, the CNMI MCH Title V Program will implement group prenatal care models that integrate structured breastfeeding education and facilitated peer support. This evidence-based approach is designed to improve both the quality and consistency of breastfeeding education delivered to expectant mothers while fostering a supportive environment that encourages sustained breastfeeding behaviors after delivery.

Beginning in FY2026, the CNMI MCH Program will pilot and scale group prenatal care sessions—modeled after evidence-based frameworks such as CenteringPregnancy®—that bring together small cohorts of pregnant women for routine prenatal visits combined with health education and facilitated group discussions. These sessions will incorporate dedicated breastfeeding education components, including:

- Physiological benefits of breastfeeding for mother and infant;
- Proper latch and positioning techniques;
- Milk supply management and signs of effective feeding;
- Common breastfeeding challenges and troubleshooting tips;

- Information on local breastfeeding resources and support services;
- Peer sharing of breastfeeding experiences and culturally relevant practices.

Each session will be co-facilitated by trained health professionals, such as nurse midwives, WIC nutritionists, or lactation counselors, alongside peer educators or mothers with successful breastfeeding experience. Integrating peer support into the model is critical in normalizing breastfeeding, addressing cultural barriers, and creating lasting social support networks for new mothers.

To reduce barriers to participation, the program will coordinate with the CNMI Office of Transit Authority (COTA) and other partners to provide transportation assistance where needed.

Expected Outcomes:

- Increased breastfeeding knowledge and confidence among pregnant women.
- Higher rates of breastfeeding initiation immediately after birth.
- Improved rates of exclusive breastfeeding through six months.
- Stronger social support networks for breastfeeding mothers.
- Improved maternal satisfaction with prenatal care services.

By embedding breastfeeding education and peer support into the prenatal period, the CNMI MCH Program aims to shift community norms, reduce disparities in breastfeeding outcomes, and empower women with the knowledge and support necessary to make informed infant feeding decisions. This strategy supports broader maternal and infant health goals by reducing risks of infant infections, chronic diseases, and postpartum depression, and contributes to stronger mother-infant bonding and long-term public health benefits.

The group prenatal care model also supports health system strengthening, as it allows for more efficient use of clinical time while fostering deeper engagement between women and their healthcare providers. Through continued evaluation and stakeholder collaboration, this model has the potential to be scaled and sustained across the Commonwealth as a core maternal health intervention.

Evidence Based Strategy Measure (ESM): Percent of women enrolled in group prenatal care who exclusively breastfeed at 6 weeks postpartum.

This measure tracks the percentage of women who participated in group prenatal care and reported exclusively breastfeeding their infants at 6 weeks postpartum. Exclusive breastfeeding is defined as feeding the infant only breast milk (no formula, water, or solid food) since birth, in accordance with WHO and AAP guidelines.

This measure is a key indicator of the early effectiveness of the CNMI MCH Program's group prenatal care strategy in promoting and supporting exclusive breastfeeding. The 6-week postpartum mark is a critical milestone, as many mothers return to work or face breastfeeding challenges during this period, often leading to early supplementation or weaning.

By focusing specifically on women who attended group prenatal care sessions that integrated structured breastfeeding education and peer support, this measure helps:

- Assess whether the group care model positively influences early breastfeeding behaviors;
- Identify trends in exclusive breastfeeding among program participants;
- Guide improvements in breastfeeding education and postpartum support services;
- Contribute to the CNMI's broader goal of increasing exclusive breastfeeding through 6 months.

Data for this measure will be collected through:

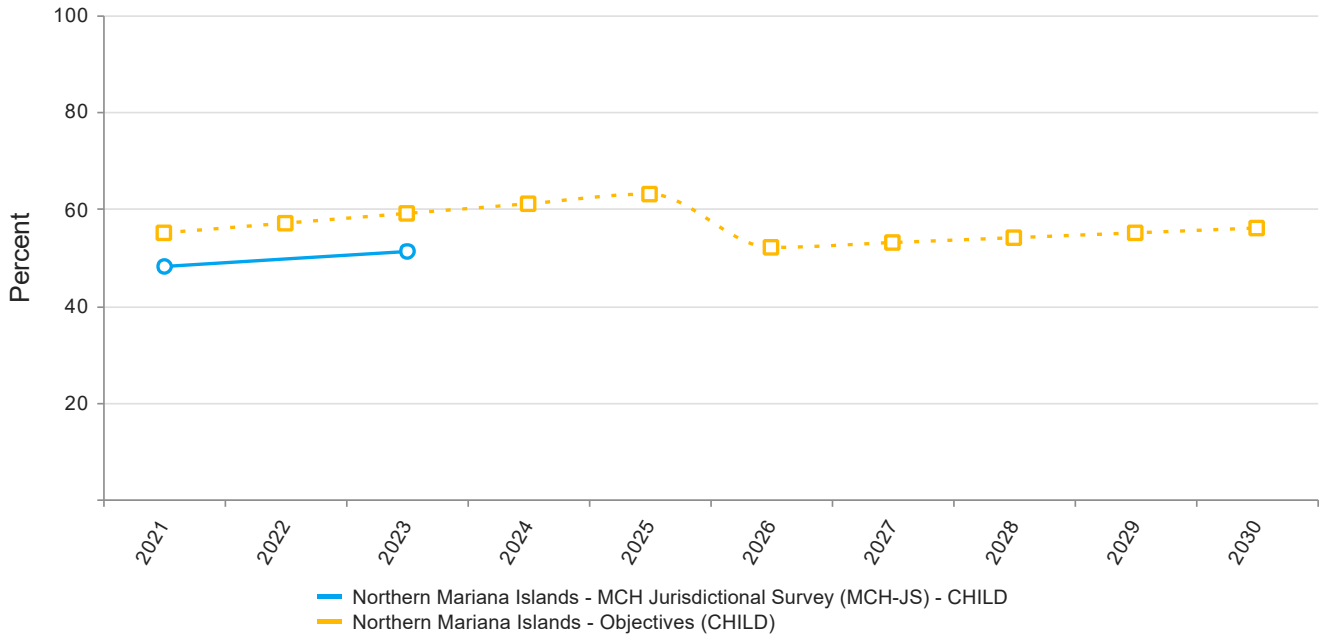
- Postpartum follow-up surveys or interviews conducted at 6 weeks postpartum (either in person, by phone, or electronically);

- Documentation in electronic health records or case management systems for women enrolled in group prenatal care;
- Self-reported feeding practices, verified where possible through WIC or Home Visiting follow-up.
- Women will be asked whether their infant has received only breast milk since birth, and whether any supplementation with formula, water, or solids has occurred.

Child Health

National Performance Measures

NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child Indicators and Annual Objectives



Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		55	57	59	61
Annual Indicator	52.7	43.5	43.5	60.7	51.3
Numerator	2,769	2,393	2,393	2,775	2,584
Denominator	5,253	5,498	5,498	4,572	5,035
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2021	2021	2024	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	52.0	53.0	54.0	55.0	56.0

Evidence-Based or –Informed Strategy Measures

ESM PA-Child.1 - PA-Child.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum.

Measure Status:	Inactive - Replaced

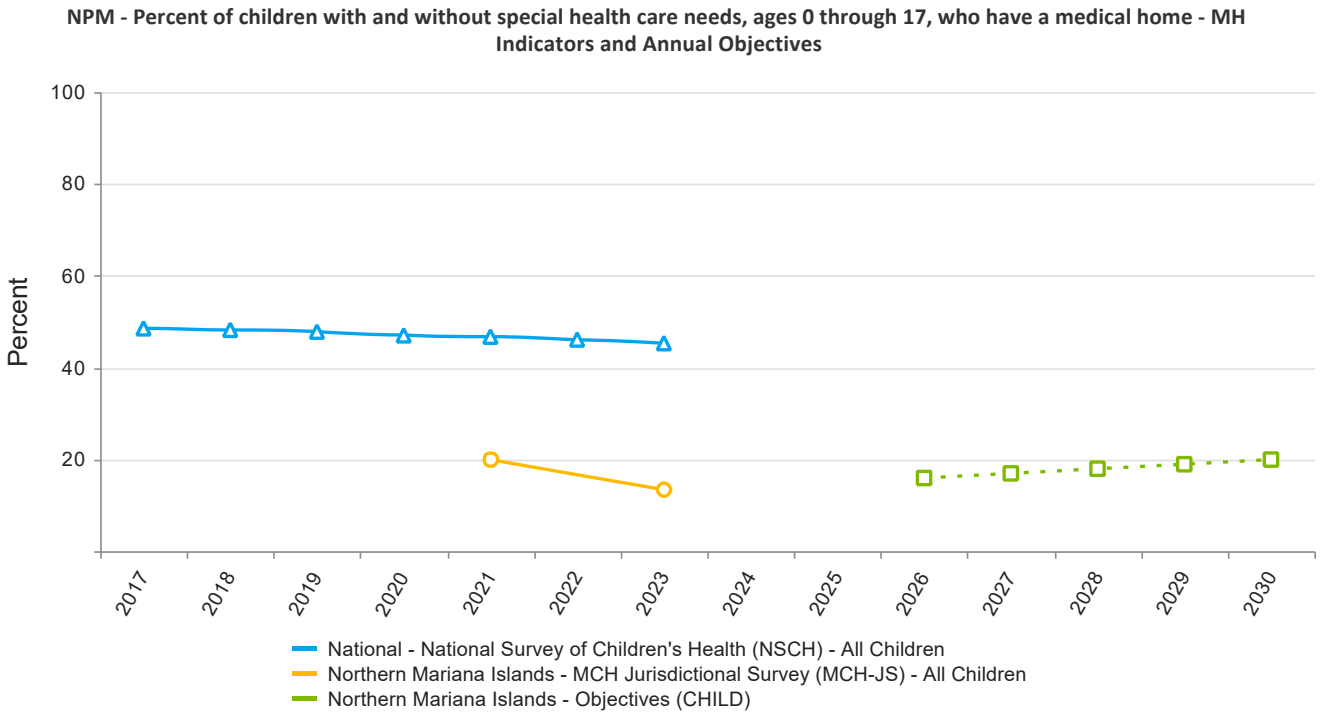
State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		10	15	20	25
Annual Indicator		0	0	25	0
Numerator		0	0	2	0
Denominator		3	8	8	1
Data Source		MCH referral log and EFNEP enrollment record	MCH referral log and EFNEP enrollment record	MCH referral log and EFNEP enrollment record	MCH referral log
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

ESM PA-Child.2 - Number of children ages 6-11 years who enroll in after school sports or other group activities.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5.0	10.0	15.0	20.0	25.0



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	8.9	13.4
Numerator	1,208	2,060
Denominator	13,620	15,385
Data Source	MCH-JS-All Children	MCH-JS-All Children
Data Source Year	2024	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	16.0	17.0	18.0	19.0	20.0

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	20	30	55
Annual Indicator		81	81	52.3	40.5
Numerator		51	51	45	45
Denominator		63	63	86	111
Data Source		F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	45.0	50.0	55.0	60.0	65.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Child Health - Entry 1	
Priority Need	
Access to healthy physical activity	
NPM	
NPM - Physical Activity - Child	
Five-Year Objectives	
By 2030, increase the percentage of children ages 6-11 who are physically active by 5% from baseline.	
Strategies	
Partner with the Public School System and Non-Communicable Disease Programs to increase access to after school sports programs	
ESMs	**Status**
ESM PA-Child.1 - PA-Child.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP programcurriculum.	Inactive
ESM PA-Child.2 - Number of children ages 6-11 years who enroll in after school sports or other group activities.	Active
NOMs	
Children's Health Status	
Child Obesity	

State Action Plan Table (Northern Mariana Islands) - Child Health - Entry 2

Priority Need

Access to care coordination and navigation of healthcare and community programs

NPM

NPM - Medical Home

Five-Year Objectives

By 2030, increase the percentage of CNMI children ages 6-11 who report having a medical home by 5%.

Strategies

Strengthen access to a medical home for children and youth, including children with special healthcare needs by providing training and technical assistance to pediatric primary care clinics and providers on implementing medical home principles and related policies.

ESMs	Status
ESM MH.1 - Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).	Active

NOMs

Children's Health Status
CSHCN Systems of Care
Flourishing - Young Child
Flourishing - Child Adolescent - CSHCN
Flourishing - Child Adolescent - All

Priority Need 4 under the Child Health domain is focused on obesity related issues including nutrition and physical activity. National performance measure 8, percent of children ages 6 through 11 years who are physical active at least 60 minutes per day is linked to priority need 4 and is being utilized by the CNMI Title V MCH program to measure progress or change in activities and outcomes for children in the CNMI. The data source for NPM 8 is the MCH Jurisdictional Survey, which was administered in the CNMI in 2019, 2021 and 2023.

Strategies identified to promote physical activity and overall health among children are focused on increasing the number of families who enroll in an evidence-based nutrition and physical activity program and increasing community awareness on the importance of physical activity among children.

In FY2024, improvements in staff capacity to address nutrition related priorities were made with the hiring of a Registered Dietitian, who serves as a Nutritionist and a lead for nutrition focused initiatives under the Division of Public Health Services.

Priority Need 4: Obesity related issues including nutrition and physical activity

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

Year	2020	2021	2022	2023	2024
Percent	52.7*	43.5*	43.5*	60.7*	51.3
Numerator	2769	2393	2393	2775	2584
Denominator	5253	5498	5498	4572	5035

Data Source: 2019, 2021 & 2023 MCH Jurisdictional Survey
*Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

The data source for NPM 8 – the percent of children ages 6 through 11 years who are physically active at least 60 minutes per day – is the MCH Jurisdictional Survey. For the 2020 reporting year, based on data collected in the 2019 survey, an estimated 52.7% of children in this age group met the recommended physical activity level. The same data source was used for the 2021 and 2022 reporting years, based on the 2021 survey, which estimated that 43.5% of children were physically active for at least 60 minutes per day. This estimate remained unchanged between 2021 and 2022.

In 2023, using data from the 2023 MCH Jurisdictional Survey, the estimated percentage increased significantly to 60.7%. This represents a 17.2 percentage point increase compared to the previous year. However, in 2024, the estimate declined to 51.3%.

It is important to note that the estimates for 2020 through 2023 are marked with an asterisk, indicating that the confidence intervals for these estimates are either greater than 20 percentage points, more than 1.2 times the estimate, or inestimable. These data should therefore be interpreted with caution.

Strategy: Increase the number of families who enroll in an evidence-based nutrition and physical activity program.

In FY2024, the Public Health Dietitian Nutritionist engaged in a range of initiatives serving both adults and children. Key activities included collaboration with the Nutrition Council to improve in-store signage and food placement strategies promoting healthier food choices. The dietitian also contributed to planning activities and providing input for several health awareness campaigns, including National Nutrition Month, Kidney Health Awareness Month, and Child and Adolescent Health Month.

A major highlight of the year was the launch of the CNMI's first Produce Prescription Program, piloted at the CHCC Women's Clinic. This 12-week program, concluding on July 17, 2025, aimed to support pregnant women in increasing their fruit and vegetable intake. Participants attended six educational sessions that included pregnancy nutrition, strategies to boost produce consumption, food demonstrations, sharing recipes, and providing educational handouts. Each participant also received weekly $20 vouchers redeemable for fresh fruits and vegetables (including frozen options without added sugar, salt, or fat).

This pilot program not only supports improved maternal and child health but also encourages long-term, generational shifts in family eating habits.

Strategy: Increase community awareness on physical activity for children.

In FY2023, efforts to increase physical activity among children in the CNMI were led by the Non-Communicable Disease (NCD) Programs under the Division of Public Health. The Healthy Communities Unit organized a series of "Sports Clinics" in villages across the island of Saipan. These clinics introduced youth to a variety of physical activities, including volleyball, basketball, frisbee, and sailing, as a way to promote active lifestyles and reduce sedentary behavior.

The CNMI MCH Title V program supported these efforts by promoting the clinics to MCH clients and the wider community through social media outreach. The NCD Healthy Communities Unit reported a total of 375 youth participants in Sports Clinic events during FY2023. However, due to staffing shortages, the Sports Clinics were placed on hold in FY2024 and remain paused as of the current reporting period.

To continue encouraging physical activity among youth, the CNMI MCH Title V program partnered with Run Saipan, a local nonprofit organization established in 2021 with the mission to promote health and wellness through running. Together, CNMI Title V and Run Saipan coordinated a 5K "Fun Run" on May 4, 2024, themed "May the 4th Be With You" in celebration of Star Wars Day.

The event was held as part of the CNMI's Adolescent Health Awareness Month (AHAM) activities and successfully engaged 128 youth participants, ages 3 to 18 years, in a fun, community-centered fitness activity.

Through ongoing partnerships and creative events, MCH Title V continues to support physical activity initiatives that engage CNMI youth and promote lifelong healthy habits, even in the face of staffing and resource challenges.

Photo: 2024 May the 4th Be with You 5k, CNMI National Adolescent Health Month

Other Child Health Activities

MCH Title V continued to support activities to promote increasing the rate of children completing annual preventive visits and vaccinations. Well-child visits provide children the opportunity to receive preventive screenings and anticipatory guidance on nutrition and physical activity from trusted medical professionals. MICAH Programs staff promoted well-child services available via the CHCC Mobile Clinic. A total of 20 Well-Child outreach clinics were conducted in FY2024 reaching 65 children ages 0-19 years. Additionally, in partnership with the Public School System (PSS) a total of 23 school-based vaccination clinics providing routine pediatric vaccinations to CNMI children in FY2024.

The 2025 CNMI MCH Five-Year Needs Assessment revealed growing concern around increased screen time among children and its impact on physical health, mental well-being, and social development. Excessive use of smartphones, tablets, and televisions has been associated with sedentary lifestyles, contributing to rising rates of childhood obesity, reduced physical activity, and negative behavioral outcomes.

Additionally, results from the 2023 Youth Risk Behavior Survey (YRBS) conducted in the CNMI by the Public School System (PSS), indicated that 69 percent of middle school students and 73 percent of high school students use social media several times a day. Youth who spend more time on screens outside of schoolwork are at increased risk for a range of negative health outcomes. These include lower levels of physical activity and strength training, poor sleep quality and irregular sleep patterns, heightened concerns about weight, symptoms of depression and anxiety, and reduced access to emotional and peer support[i].

In response, the CNMI MCH Steering Committee selected “Reducing Screen Time” as Priority Need 5 under the Child Health domain. This aligns directly with national and local efforts to combat non-communicable diseases (NCDs) and promote healthy behaviors beginning in early childhood. Selecting this priority allows the MCH program to:
• Lower risk of childhood obesity.
• Improve reported physical activity levels.
• Improve mental health and emotional well-being.

Priority Need 5: Access to healthy physical activity.

National Performance Measure: PA-Child: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objective: By 2030, increase the percentage of children ages 6-11 who are physically active by 5% from baseline.

Strategy: Partner with the Public School System and Non-Communicable Disease Programs to increase access to after school sports programs and other group activities.

To address growing concerns around low physical activity levels and increased screen time among children in the Commonwealth, the CNMI MCH Title V Program will implement a strategic partnership-based initiative to expand access to structured after-school physical activity opportunities. This strategy focuses on collaboration with the CNMI Public School System (PSS) and the Non-Communicable Disease (NCD) Programs to deliver equitable, sustainable, and engaging movement-based programs for school-aged children across Saipan, Tinian, and Rota.

The CNMI faces rising rates of childhood obesity, sedentary behaviors, and related health concerns such as early-onset diabetes and cardiovascular risk factors. Many of these issues are exacerbated by limited access to safe recreational spaces, inadequate structured activity programs after school hours, and the growing influence of screen-based entertainment.

Addressing these trends requires a coordinated, community-based approach to increasing children's access to safe, consistent, and developmentally appropriate physical activities. Schools remain one of the most trusted and accessible touchpoints for children and families, making them a critical setting for intervention.

Through this initiative, the CNMI MCH Title V Program will leverage inter-agency partnerships to design, fund, and promote after-school sports and group activity programs that:

- Are free or low-cost to reduce financial barriers for families;
- Take place in safe, school-based or community environments;
- Are inclusive of different skill levels, abilities, and interests;

- Incorporate health education messaging focused on the benefits of physical activity for physical and mental health;
- Offer peer and family engagement components to strengthen social support and long-term habit formation.

The following information provides and outline of the timeline and key milestones and activities for FY 2026 towards achieving objectives around physical activity for children:
Implementation Activities (FY2026):

1. Partnership Development and Planning (Oct–Dec 2025):
   - Formalize a partnership with PSS and the NCD Program to establish shared goals, roles, and resource commitments.
   - Convene a multi-sector planning group including school administrators, physical education (PE) teachers, public health educators, and youth-serving organizations.
   - Identify pilot schools and communities for initial rollout based on need, interest, and infrastructure.

2. Program Design and Capacity Building (Jan–Mar 2026):
   - Develop program models offering a variety of after-school options, including team sports, dance, martial arts, walking clubs, and fitness challenges.
   - Provide mini-grants or in-kind support to schools and community groups to launch or expand programs.
   - Train coaches, PE teachers, and volunteers in trauma-informed, youth-friendly, and inclusive physical activity practices.

3. Program Launch and Promotion (Apr–Sep 2026):
   - Launch programs in at least 3–5 school or community sites across the islands.
   - Conduct outreach campaigns in partnership with the Public Health Promotion and Partnership Unit (HPPU) to raise awareness and encourage participation.
   - Coordinate transportation support or extended supervision for students in need to remove logistical barriers.

This strategy will be aligned with ongoing efforts under the NCD Programs and Health Promotion Programs and integrated into existing youth wellness initiatives supported by Title V. Evaluation will include:
- Tracking program enrollment, attendance, and retention;
- Pre- and post-program physical activity self-assessments;
- Collection of feedback from students, parents, and staff;

Expected Outcomes:
- Increased participation of children in moderate-to-vigorous physical activity for at least 60 minutes per day;
- Reduction in sedentary screen time after school hours;
- Improved physical, emotional, and social health outcomes among participants;
- Strengthened school-community partnerships to promote lifelong wellness.

This strategy supports the CNMI MCH Title V's commitment to fostering environments where all children can grow up healthy, active, and resilient. By investing in school-based physical activity opportunities and supporting families in creating active routines, this initiative contributes to the prevention of chronic disease, improved academic outcomes, and enhanced mental health. Moreover, it reinforces a culture of wellness in schools and communities that can extend across generations.

Priority Need 8: Access to care coordination and navigation of healthcare and community programs.

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

Objective: By 2030, increase the percentage of CNMI children ages 6-11 who report having a medical home by 5%.

Strategy: Strengthen access to a medical home for children and youth, including children with special healthcare needs by providing training and technical assistance to pediatric primary care clinics and providers on implementing medical home principles and related policies.

The CNMI MCH Title V Program is committed to strengthening access to a comprehensive, continuous, and family-centered medical home for all children and youth, including those with special healthcare needs. Recognizing that a well-functioning medical home is critical to improving child health outcomes, the program will focus on providing targeted training and technical assistance to pediatric primary care clinics and healthcare providers across the Commonwealth. This strategy aims to enhance providers' capacity to implement core medical home principles such as coordinated care, accessible services, culturally competent communication, and effective care planning tailored to each child's unique needs. Through a collaborative approach, the MCH Program will work closely with clinics to develop and refine policies and protocols that support medical home standards, ensuring that children receive timely preventive services, management of chronic conditions, and appropriate referrals to specialty care and community resources. The initiative will also emphasize building stronger partnerships between families and providers, empowering caregivers to actively participate in care decisions. By investing in provider education, quality improvement, and system-level supports, this strategy seeks to reduce disparities in healthcare access, improve care coordination for children with complex health needs, and ultimately foster better health, developmental, and psychosocial outcomes for CNMI's children and youth. Through continuous monitoring and feedback, the program will ensure that implementation is responsive to local challenges and opportunities, laying the groundwork for a sustainable medical home model that promotes equity and excellence in child health services across the Commonwealth.

Evidence Based Strategy Measure (ESM): Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).

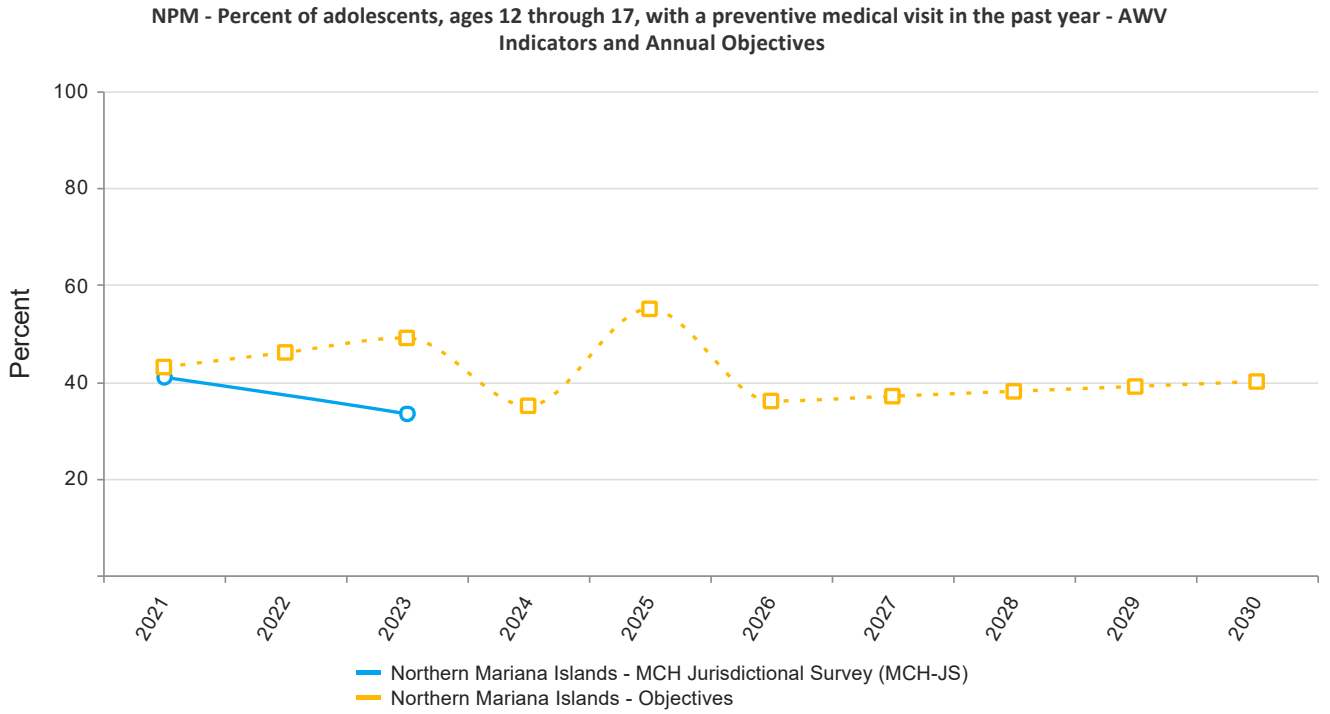
This measure—tracking the number of pediatric providers who have received medical home training and subsequently implemented at least one core component such as care coordination, family engagement, or team-based care—is critical for assessing the effectiveness of efforts to improve access to medical homes for children in the CNMI. The medical home model is widely recognized as a best practice framework for delivering comprehensive, continuous, and family-centered care that addresses the complex needs of children, especially those with special healthcare needs. Training pediatric providers in these principles equips them with the knowledge and skills necessary to transform their practices, improve care quality, and enhance patient and family experiences.

Measuring both the receipt of training and the practical application of medical home components ensures that capacity-building translates into real-world improvements in care delivery. Care coordination helps streamline services and reduce fragmentation, family engagement fosters shared decision-making and empowers caregivers, and team-based care promotes collaboration among healthcare professionals to provide holistic support. By monitoring the number of providers who adopt these practices, the CNMI MCH Program can evaluate progress toward expanding medical home access, identify gaps in implementation, and tailor ongoing technical assistance to meet provider needs.

Ultimately, this measure serves as an important indicator of the program's impact on strengthening healthcare systems that support healthier outcomes for all children and youth in the CNMI, promoting equitable access to high-quality, coordinated care that adapts to each family's unique circumstances.

Adolescent Health

National Performance Measures



Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		43	46	49	35
Annual Indicator	42.4	39.3	39.3	27.3	33.5
Numerator	2,593	2,156	2,156	1,386	1,771
Denominator	6,119	5,493	5,493	5,072	5,282
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2021	2021	2024	2021_2023

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		43	46	49	35
Annual Indicator	8.1	22	12.1	16.6	6.9
Numerator	503	1,378	749	998	390
Denominator	6,215	6,256	6,177	5,994	5,661
Data Source	RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue EHR	CareVue EHR
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	36.0	37.0	38.0	39.0	40.0

Evidence-Based or –Informed Strategy Measures

ESM AWV.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites

Measure Status:	Inactive - Replaced

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		10	1	12.5	17
Annual Indicator		22	12.1	16.6	6.9
Numerator		1,378	749	998	390
Denominator		6,256	6,177	5,994	5,661
Data Source		CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

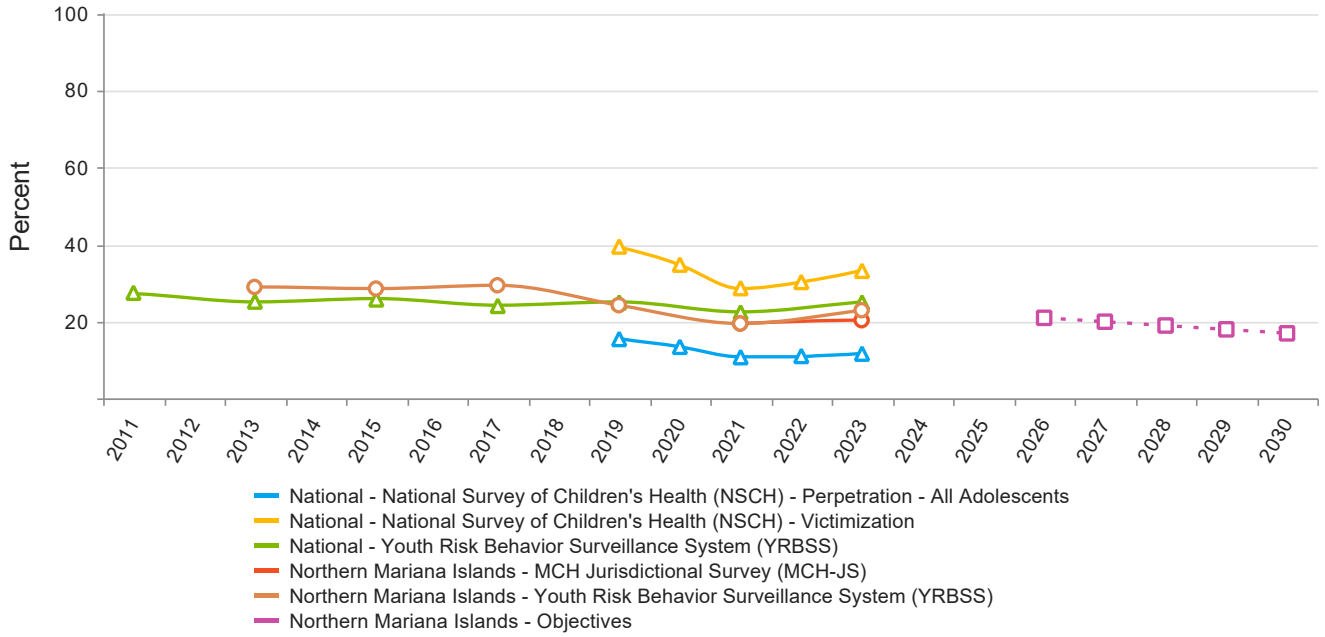
ESM AWV.2 - Percentage of Public School System (PSS) students ages 12-17 years who had an adolescent well-visit in the past year.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5.0	10.0	15.0	20.0	25.0

NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY Indicators and Annual Objectives



NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY - Adolescent Health

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2024
Annual Objective	
Annual Indicator	22.9
Numerator	718
Denominator	3,143
Data Source	YRBSS
Data Source Year	2023

Federally Available Data	
Data Source: MCH Jurisdictional Survey (MCH-JS)	
	2024
Annual Objective	
Annual Indicator	20.5
Numerator	1,084
Denominator	5,282
Data Source	MCH-JS-All Adolescents
Data Source Year	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	21.0	20.0	19.0	18.0	17.0

Evidence-Based or –Informed Strategy Measures

ESM BLY.1 - Percent of schools who have implemented evidence based bullying prevention programs.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	20.0	30.0	40.0	50.0	60.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Adolescent Health - Entry 1	
Priority Need	
Access to teen pregnancy and sexually transmitted infection prevention programs	
NPM	
NPM - Adolescent Well-Visit	
Five-Year Objectives	
By 2030, decrease the rate of sexually transmitted infections (STIs) and teen births among adolescents aged 12 to 17 years by 5% from baseline.	
Strategies	
Partner with the Public School System to expand access to adolescent well- visits and the Family Planning program.	
Increase awareness of adolescent well-visits and confidential services through conducting PATCH for Peer Workshops.	
ESMs	**Status**
ESM AWV.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites	Inactive
ESM AWV.2 - Percentage of Public School System (PSS) students ages 12-17 years who had an adolescent well-visit in the past year.	Active
ESM AWV.3 - Number of teens who completed the PATCH Peer-to-Peer Workshops in the past year.	Active

NOMs

Teen Births
Adolescent Mortality
Adolescent Motor Vehicle Death
Adolescent Suicide
Adolescent Firearm Death
Adolescent Injury Hospitalization
Children's Health Status
Child Obesity
Adolescent Depression/Anxiety
CSHCN Systems of Care
Flourishing - Child Adolescent - CSHCN
Flourishing - Child Adolescent - All

State Action Plan Table (Northern Mariana Islands) - Adolescent Health - Entry 2

Priority Need

Bullying prevention and support

NPM

NPM - Bullying

Five-Year Objectives

By 2030, decrease the rate of high school students who experienced bullying on school property by 5% from baseline.

Strategies

Strengthen partnership with the Public and Private School Systems to adopt and implement evidence based bullying prevention programs.

ESMs	Status
ESM BLY.1 - Percent of schools who have implemented evidence based bullying prevention programs.	Active

NOMs

Adolescent Mortality

Adolescent Suicide

Adolescent Firearm Death

Adolescent Injury Hospitalization

Adolescent Depression/Anxiety

Adverse Childhood Experiences

2021-2025: National Performance Measures

2021-2025: NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC
Indicators and Annual Objectives

2021-2025: 2021-2025: NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Adolescent Health - All Adolescents

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - All Adolescents					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		55	55	55	51
Annual Indicator	48.4	46.3	46.3	39.6	42.4
Numerator	2,788	2,306	2,306	2,006	2,240
Denominator	5,761	4,982	4,982	5,072	5,282
Data Source	MCH-JS-NONCSHCN	MCH-JS-All Adolescents	MCH-JS-All Adolescents	MCH-JS-All Adolescents	MCH-JS-All Adolescents
Data Source Year	2019	2021	2021	2024	2021_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

None

Activities identified in this reporting period for the MCH Title V Block Grant reflect the FY2024 (October 01, 2023–September 30, 2024) timeframe. The MCH Title V project focused on implementing activities that support and educate adolescents, encourage healthy behaviors and transitional care, and increase their engagement with accessing health care services. Similar to other domain areas, the CNMI MCH Title V program leverages its robust partnerships with agencies such as the CNMI Public School System (PSS) to reach a large segment of the population, develop plans for activities, and monitor prevalent factors that impact adolescent health. The MICAH Programs continues to uphold these collaborations while also establishing new partnerships to better address the evolving needs of adolescents.

A priority need identified through the 2020 CNMI MCH comprehensive needs assessment process for the adolescent population was a focus on coping skills and suicide prevention. This priority need was aligned with National Performance Measure (NPM) 10, percent of adolescents ages 12 through 17 years with a preventive medical visit in the past year. To address this need, the MCH program promotes adolescent well visits through a holistic approach that emphasizes the importance of behavioral health screenings and assessments during these wellness checks. This initiative aims to support the development of healthy coping skills and prevent suicide. In addition, priority need 7 has been identified by the MCH needs assessment as an area of focus for adolescents with and without special healthcare needs; which is to support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful. Priority need 7 is aligned with National Performance Measure (NPM) 12, percent of adolescents with and without special healthcare needs, ages 12 through 17 years, who received services necessary to make transitions into adult health care.

During the FY 2024 reporting period, the CNMI Public School System (PSS) resumed full-time, in-person instruction across all public schools in the jurisdiction. This return to in-person learning created renewed opportunities for the Division of Public Health Services to conduct school-based outreach activities, including classroom health education and mobile clinical services.

In collaboration with CNMI PSS, MICAH program leadership-initiated planning meetings and implementation assessments to support coordinated outreach efforts on school campuses. As part of this partnership, multiple programs within the Division of Public Health Services—including MICAH, Non-Communicable Disease (NCD) Programs, and Communicable Disease Programs—collaborated under the Teen Health Initiative to engage students in preventive health services and education.

As part of this initiative, staff developed and delivered teen health presentations and participated in trainings to conduct basic health screenings in schools. These screenings included:

- Blood glucose checks
- Blood pressure monitoring
- Body Mass Index (BMI) measurements
- Interpretation of screening results
- Referrals and assistance in scheduling adolescent well-visits

In addition to screenings, high school outreach events also offered access to Sexual and Reproductive Health (SRH) services through the CHCC Mobile Clinic, including:

- Pregnancy testing
- Contraceptive counseling and methods
- STI (Sexually Transmitted Infection) testing
- Vaccinations

This collaborative, school-based approach has strengthened adolescent health promotion efforts and ensured

broader access to essential services for students throughout the CNMI.

Priority Need 5: Coping Skills and Suicide Prevention

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

Adolescent Well-visits	2020	2021	2022	2023	2024
Percent	42.4	39.3	39.3	27.3	33.5
Numerator	2,593	2,156	2,156	1,386	1,771
Denominator	6,119	5,493	5,493	5,072	5,282

Data Source: CNMI MCH Jurisdictional Survey

The data source for NPM 10 – the percent of adolescents ages 12 through 17 years who had a preventive medical visit in the past year – is the CNMI MCH Jurisdictional Survey. In 2020, an estimated 42.4% of adolescents had a preventive visit. This percentage declined slightly to 39.3% in both 2021 and 2022, based on identical estimates for those years.

A more significant decline occurred in 2023, when the percentage dropped to 27.3%. This represents a 12 percentage point decrease from the previous estimate of 39.3%. In 2024, the percentage increased slightly to 33.5%, though it remains below the levels observed from 2020 to 2022.

These trends suggest a notable decrease in adolescent access to preventive health care over the five-year period, particularly between 2022 and 2023.

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

Efforts to increase the number of adolescents accessing wellness visits is to enhance the early identification of behavioral health concerns through screening and to connect youth with appropriate services that support the development of coping skills and suicide prevention. During the reporting period, the Public Health Programs, including the MICAH Programs, conducted a series of classroom presentations at local middle and high schools in Saipan. These sessions addressed the importance of seeking regular adolescent wellness visits and their various components. Additionally, students received information on confidential teen health services available through the Title X (Family Planning) Program. Presentations are facilitated through workshops hosted by our Providers and Teens Communicating for Health (PATCH) Teen Educator Program. PATCH Teen Educators are trained at the beginning of every program year to present and promote teen wellness visits to their peers. In FY2024, the PATCH Program conducted (6) PATCH for Peer Workshops, reaching 90 peers from youth-serving partner organizations.

High school students also participated in school-based clinic outreach events held during the School Year 2023-2024, where they were provided with access to basic preventive screening services, including screenings for diabetes and hypertension. These outreach activities further offered students information about available adolescent health services and partner organizations operating within the CNMI. This strategy supports the Maternal and Child Health (MCH) Program's efforts in the early detection of youth at risk for chronic conditions and facilitates timely referrals to appropriate health care services.

Evidence Based Strategy Measure 10.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites

Year	2021	2022	2023	2024
Percentage	22.0	12.1	16.6	9.7
Numerator	1378	749	998	550
Denominator	6256	6177	5994	5661

Data Source: CHCC EHR

The ESM used to track progress toward CNMI's adolescent health goals is the percentage of teens (ages 12–17) accessing preventive services at CHCC sites. According to U.S. Census International Database estimates, there were approximately 5,661 adolescents in this age group in the CNMI in 2024. Of these, only 550 received preventive care at CHCC—about 9.7%. This reflects a 6.9 percentage point decline from 2023 and remains significantly below the 2021 rate of 22%.

Several factors likely contributed to the decrease in this measure. The expiration of Medicaid presumptive eligibility reduced immediate access to coverage, creating delays or barriers for families attempting to schedule well visits. In addition, limited availability of pediatric and adolescent care providers, especially for non-urgent visits, contributed to appointment backlogs. Families also continue to face logistical challenges, including transportation barriers and difficulty navigating the appointment scheduling process. These issues, compounded by ongoing health literacy gaps, have further limited access to timely adolescent preventive services in the CNMI.

In FY2024, the MICAH Programs—through a continued partnership between the CNMI Public School System (PSS) and the Division of Public Health Services—provided school-based screening services and preventive health education at 3 out of 5 public high school campuses in the CNMI, reaching 60% of public high schools.

As part of these outreach efforts:

- 266 high school students completed preventive health screenings focused on diabetes, hypertension, and obesity.
- 1,328 students participated in presentations and workshops led by a team of Public Health professionals. Topics included chronic disease prevention, sexually transmitted infection (STI) prevention, and teen pregnancy prevention.

Students identified with elevated glucose or blood pressure levels during screenings were referred for follow-up care. Depending on need, they were either encouraged to contact their primary care provider or were assisted in securing appointments with a pediatrician at the CHCC Children's Clinic.

To support timely follow-up care, the Children's Clinic team reserved appointment slots specifically for students referred through outreach. These reserved slots ensured that any student requiring urgent evaluation could be seen promptly.

During the reporting period, a total of 37 referrals were made to the Children's Clinic. The MCH team provided service coordination to help ensure that each referred student was supported in scheduling and completing a follow-up visit with a pediatrician.

These efforts reflect a strong commitment to early intervention, preventive care, and improving long-term health outcomes for adolescents in the CNMI.

Moreover, the CNMI has noted increases in the number of teens within the age group (12 through 17 years old) accessing Family Planning services and increases in male teens being served. In the reporting year (2024), there were 120 teens (12-17 years old) who reported to have accessed family planning services, which is significantly higher compared to years prior to the COVID-19 pandemic (2019, 82 teens accessed family planning). The number of male teens accessing family planning services have also been on the rise. In 2024, there were 7 male teens (12-17 years old) who reported to have accessed family planning services, compared to 2019 when there were no male teen participants. The MICAH programs have been working diligently to ensure access to confidential adolescent

health services is sustained.

Priority Need 7: Support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful.

NPM 12-B: Transition- Percent of adolescents without special healthcare needs, ages 12 through 17 years, whose families report that they received services necessary to make transitions into adult health care.

Transition (Non-CSHCN)	2020	2021	2022	2023	2024
Percent	50.1	41.7	41.7	39.6	42.4
Numerator	2,971	1,886	1,886	2,006	2,240
Denominator	5,927	4,518	4,518	5,072	5,282

Data Source: CNMI MCH Jurisdictional Survey

Based on data from the CNMI MCH Jurisdictional Survey, 42.4% of adolescents without special healthcare needs, ages 12 through 17 years, received the necessary services to support their transition into adult healthcare in 2024. This reflects a slight increase from 39.6% in 2023.

Over the five-year period from 2020 to 2024, the percentage has fluctuated, starting at 50.1% in 2020 and declining to a low of 39.6% in 2023 before the modest rebound in 2024. These data indicate a general downward trend in the provision of transitional services for adolescents without special healthcare needs, though there has been some improvement in the most recent year.

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

Similar to strategy 1 in the adolescent health domain, strategies to increase the percentage of teens ages 12 through 17 years that receive transition services focuses on leveraging the existing partnerships the CHCC and MICAH programs has with the Public School System. During the reporting period, the partnership worked on the development of plans and strategies to address the priority need. Since school instruction has resumed mostly in-person and is set in classrooms, and with the start of a new partnership between MICAH Programs and the Providers and Teens Communicating for Health (PATCH) Program; the activities related to this strategy were carried into FY2024 plans.

Other Adolescent Health Activities

In FY 2023-2024, the MICAH programs worked closely with the CHCC Children's Clinic department on tracking the number of teens that complete preventive well-visits as referred by the CNMI PSS outreach activities. As part of monthly quality improvement efforts within the Division of Public Health Services, MICAH Programs monitor the number of teens visits to support data-driven decision making, and to inform interventions for improving teen well-visit rates.

Additionally, the MICAH Programs was awarded funds by the Association of Maternal & Child Health Programs (AMCHP) to replicate the PATCH Program in the CNMI. The PATCH Program is an evidence-based program that aims to improve adolescent health and wellbeing by working with youth to advocate for adolescent health care rights, responsibilities, and healthy relationships. In anticipation of implementing the PATCH Program, MCH developed partnership with the CNMI Division of Youth Services (DYS) and formalized partnership through a Memorandum of Understanding. Following the PATCH Coordinators training, the MICAH team recruited (10) Teens as Teen Educators in the PATCH Program. The Teen Educators completed a 20-hour training to introduce the PATCH model and prepare the youth to conduct workshops. PATCH Teen Educators completed 9- PATCH for Provider Workshops, 2-PATCH for Parents Workshops, and 6- PATCH for Peers Workshops. Through the workshops; 76% of providers who attended said they are more likely to change the way they interact with and care for teens; 93% of parents who attended said they would help their child become responsible managers of their own health; and 81% of teens said

they plan to learn more about how they can manage their own health care.

Adolescent Health - Application Year

Improving adolescent health continues to be a priority across Public Health programs and its partners. The MICAH Programs maintains its essential partnership with the CNMI Public School System (PSS) in collaborating to address adolescent health issues. Together, MCH and PSS will continue to work together on developing plans and implementing activities to most effectively address the needs of adolescent populations in the CNMI.

The CNMI Public School System has direct contact with a vast majority of the adolescent population in the CNMI with no established school-based health centers on campuses. Therefore, utilizing a school-based approach to providing preventive programs outreach and information is an ideal strategy. As a public health focus, preventing risky behaviors in childhood and adolescence is less challenging when compared to trying to change unhealthy behaviors in adulthood. MCH will continue its efforts towards improving adolescent health by focusing on the priorities of providing access to teen pregnancy and Sexually Transmitted Infections (STI) prevention services, and addressing bullying prevention and support, as identified in the CNMI 2025 MCH Title V comprehensive needs assessment.

Promoting annual teen well visits by educating adolescents and conducting outreaches will support addressing the priority needs identified for the adolescent population. Preventive health well visits for adolescents, which are fully covered under public insurance (i.e. Medicaid), assesses overall physical health (healthy eating, physical activity, sexual health), as well as social-emotional health (relationships, coping skills, managing stress). Social-emotional health can also be strengthened by trained adults and mentors helping adolescents navigate life skills and set goals (high school completion, employment, healthy relationships). Given that adolescents have a natural desire to become active agents in society and community, this priority can be promoted through community partnerships and engagement and can reinforce protective factors and promote prevention of risky behaviors.

Based on the MCH Needs Assessment, Priority Need 6 is identified as a primary focus on adolescents accessing teen pregnancy and STI prevention services, linked to National Performance Measure AMW: the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. The objective for the CNMI MCH is to decrease the rate of sexually transmitted infections (STI) and teen births among adolescents, ages 12 through 17, by 5% from baseline. Increasing the percentage of teens accessing well-visits will also increase the number of teens who are accessing preventive healthcare as well as screenings, information, and access to Sexual and Reproductive Health services for prevention and wellness needs.

Priority Need 6: Access to teen pregnancy and Sexually Transmitted Infection (STI) prevention services.

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

Objective: By 2030, decrease the rate of sexually transmitted infections (STIs) and teen births among adolescents aged 12 to 17 years by 5% from baseline.

Strategy: Partner with the Public School System to expand access to adolescent well- visits and the Family Planning program.

The MICAH Programs will continue to collaborate with the CNMI PSS to conduct on-campus health screenings focused on engaging teens in the local high schools on preventive care visits. In partnership with CNMI PSS, Public Health staff will conduct classroom presentations educating students on the importance of preventive checks, chronic disease prevention, and sexual and reproductive health. In addition to the classroom presentations, the CHCC Mobile Clinic will be utilized to provide preventive care services and screenings at the high schools on Saipan. Services will be mirrored on Tinian and Rota through coordination with school administration and offered through utilization of designated campus rooms.

Students will have the opportunity to receive screening services such as glucose screening, blood pressure screening, and family planning services (pregnancy testing, STI testing, contraceptive administration). Screening results will be interpreted and trained screeners will educate students on healthy practices. Students identified with potential health risks based on their screening results will be referred for follow-up care through the CHCC Children's Clinic or Family Planning services. The MCH Services Manager provides service coordination working with pediatric providers to ensure that students needing follow-up care are seen by a Physician.

Conducting outreach through this mechanism increases students' awareness of accessible health care services and provides information to share with their parents regarding adolescent well visits and support for accessing them. This project aims to reach approximately 40% of the targeted high school population to provide information and education regarding healthy lifestyle behaviors. The MICAH programs will work to expand the activities to all public high schools in the CNMI in FY2026.

The CNMI Title X Family Planning Program is a critical resource for STI screening and pregnancy prevention resources for teens and will be vital partner in addressing this adolescent health priority. As a federally funded initiative dedicated to providing confidential, accessible, and comprehensive reproductive health services, this program is an essential resource in addressing the unique needs and challenges faced by adolescents in the CNMI. One of the program's defining strengths is its commitment to confidentiality and creating a safe, non-judgmental environment for teens. Many adolescents hesitate to seek care due to concerns about privacy or fear of stigma. Title X services are designed to be teen-friendly, culturally sensitive, and linguistically appropriate, ensuring that young people feel respected and supported when accessing care.

For FY 2026, October 2025 through September 2026, the following activities provide an outline of the strategy in partnering with the school system to identify and refer adolescents to well-visits:

School Partnership to Identify and Refer for adolescent well-visits:

- Partner with the CNMI PSS to develop an outreach schedule for school-based presentations, screenings, and referrals for accessing adolescent well visits and Family Planning services.
- Expand outreach and screenings to include more public high schools.
- Procure needed screening and outreach supplies.
- Utilize survey data gathered from previous outreach to improve and update outreach presentation materials.
- Complete all scheduled outreach events.
- Evaluate the outreach and referral process.
- Complete a report and present outreach outcomes and evaluation results to key stakeholders.

Evidence Based Strategy Measure (ESM): Percentage of Public School System (PSS) students ages 12-17 years who had an adolescent well-visit in the past year.

To measure the impact of the strategy on the priority area and objective, the MCH program will report on the percentage of students referred to adolescent well visits during high school outreach events. Additionally, the MICAH programs will work with the CHCC Children's Clinic to monitor the number of teens completing well visits at the clinic and identify trend changes in the number and percentage of adolescent well visits being conducted each month.

Strategy: Increase awareness of adolescent well-visits and confidential services through conducting PATCH for Peer Workshops.

In 2023, the CNMI MCH Title V Program successfully implemented the Providers and Teens Communicating for Health (PATCH) Teen Educator program. The project aims to promote access to care for adolescents and contributes to the strategies identified in the MCH work plan for adolescent health.

The PATCH program toolkit is composed of two workshops: PATCH for Teens and PATCH for Providers. PATCH for Teens aims to improve the way adolescents' access, receive, and experience health care by teaching teens their health care rights, responsibility to manage their own health, and the importance of developing a trusting relationship with their health care provider. PATCH for Providers aims to inform adolescent serving health care staff and providers how to develop a trusting relationship with their adolescent patients, as well as how to teach adolescents the importance of health care rights and responsibilities.

For FY 2026, October 2025 through September 2026, the following activities provide an outline of the strategy in increasing awareness and sharing information with adolescents in the CNMI:

Adolescent Health Workshops by PATCH

- Develop presentations utilizing information available through the PATCH program toolkit.
- Partner with the Public School System and Private Schools to recruit Teen Educators and connect PATCH with their youth groups.
- Conduct presentations with youth agencies and organizations, high school students, and peer groups.
- Gather feedback/ input on presentations to evaluate effectiveness of information delivery and identify areas of improvement.

Evidence Based Strategy Measure (ESM): Number of teens who completed the PATCH Peer-to-Peer Workshops in the past year.

To measure the impact of the strategy on the priority area and objective, the MCH program will report on the number of teens who participate and complete a PATCH for Peers Workshop at outreach events. Additionally, the MICAH programs will work with the PATCH Evaluation team to monitor measurements and impact of PATCH workshops with teens through evaluations completed after each workshop is conducted.

Priority Need 7: Support adolescents in bullying prevention.

National Performance Measure: Percent of adolescents, with and without special healthcare needs, ages 12 through 17, who are bullied or who bully others.

Objective: By 2030, decrease the rate of high school students who experienced bullying on school property to 5% from the baseline.

Strategy: Strengthen partnership with the Public and Private School Systems to adopt and implement evidence based bullying prevention programs.

The MICAH Programs, in partnership with the CNMI Public School System (PSS) and private schools, will continue to advance bullying prevention through collaborative policy development, staff training, and student education. Recognizing that schools play a vital role in shaping safe and respectful environments, the MCH Program will support efforts to adopt and implement policies that are both evidence-based and culturally responsive to each school community.

By enhancing existing programs and aligning strategies across public and private educational settings, this initiative seeks to ensure that educators are equipped to recognize signs of bullying, intervene appropriately, and support students affected by it. The initiative also encourages schools to identify gaps, share resources, and advocate for the specific needs of their students.

Key Activities Include:

- Engage School Leadership: Collaborate with school administrators and key stakeholders to develop tailored training and outreach plans that reflect the needs of each school community.
- Develop a Unified Framework: Work with CNMI PSS and private schools to establish a framework for bullying prevention programs and inform policy development grounded in local priorities.
- Deliver Staff Trainings: Conduct targeted presentations and trainings for teachers, counselors, and administrators focused on understanding the harmful impacts of bullying, recognizing warning signs, and utilizing proper referral pathways.
- Promote Policy Implementation: Support schools in integrating key policy strategies into daily practice and provide updates on program outcomes to reinforce the value of these efforts.
- Monitor and Improve: Gather feedback and measure progress to continually refine program approaches and ensure meaningful impact.

Through strong inter-agency collaboration, the MCH Program is committed to creating safer, more inclusive learning environments across CNMI schools—ensuring that all students have the opportunity to thrive socially, emotionally, and academically.

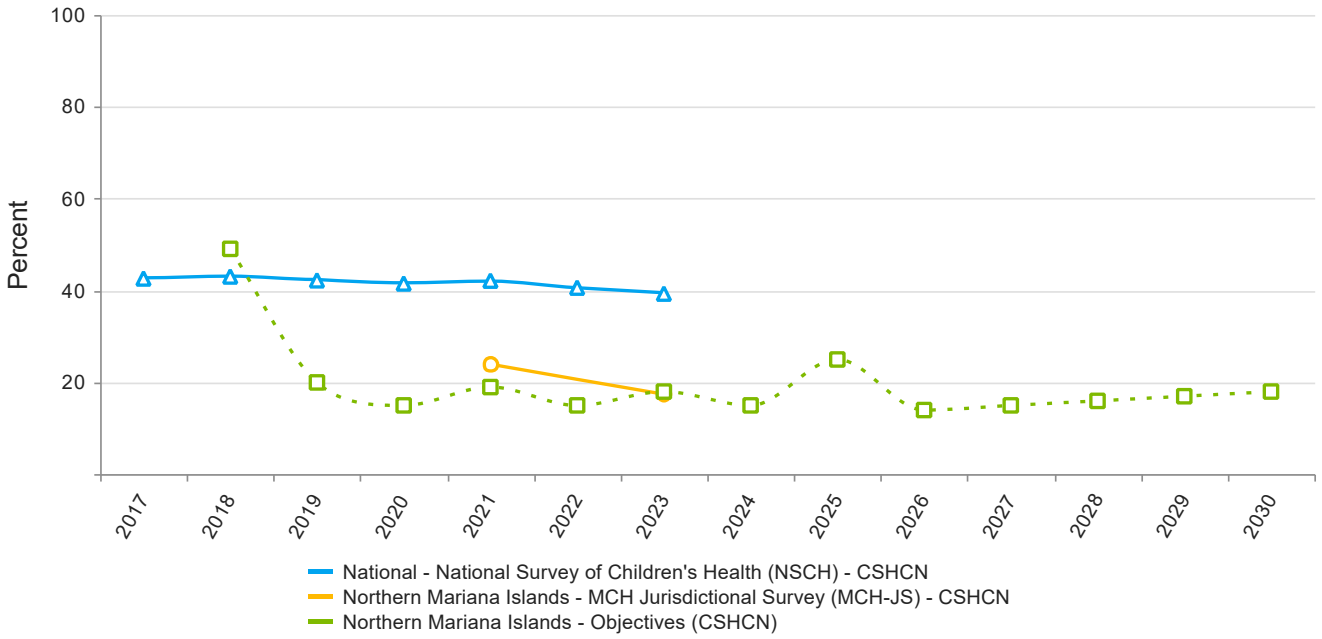
Evidence Based Strategy Measure (ESM): Percent of schools who have implemented evidence based bullying prevention programs.

To measure the impact of the strategy on the priority area and objective, the MCH program will report on the percentage of schools, public and private, who implemented bullying prevention policies or programs in their schools. Additionally, the MCH programs will work with their partners to monitor measurements and impact of Bullying Prevention and Support trainings with schools through identified evaluation methods.

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH Indicators and Annual Objectives



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	15	19	15	18	15
Annual Indicator	13.3	14.1	14.1	12.5	17.4
Numerator	141	176	176	138	290
Denominator	1,059	1,252	1,252	1,101	1,666
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2021	2021	2024	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	14.0	15.0	16.0	17.0	18.0

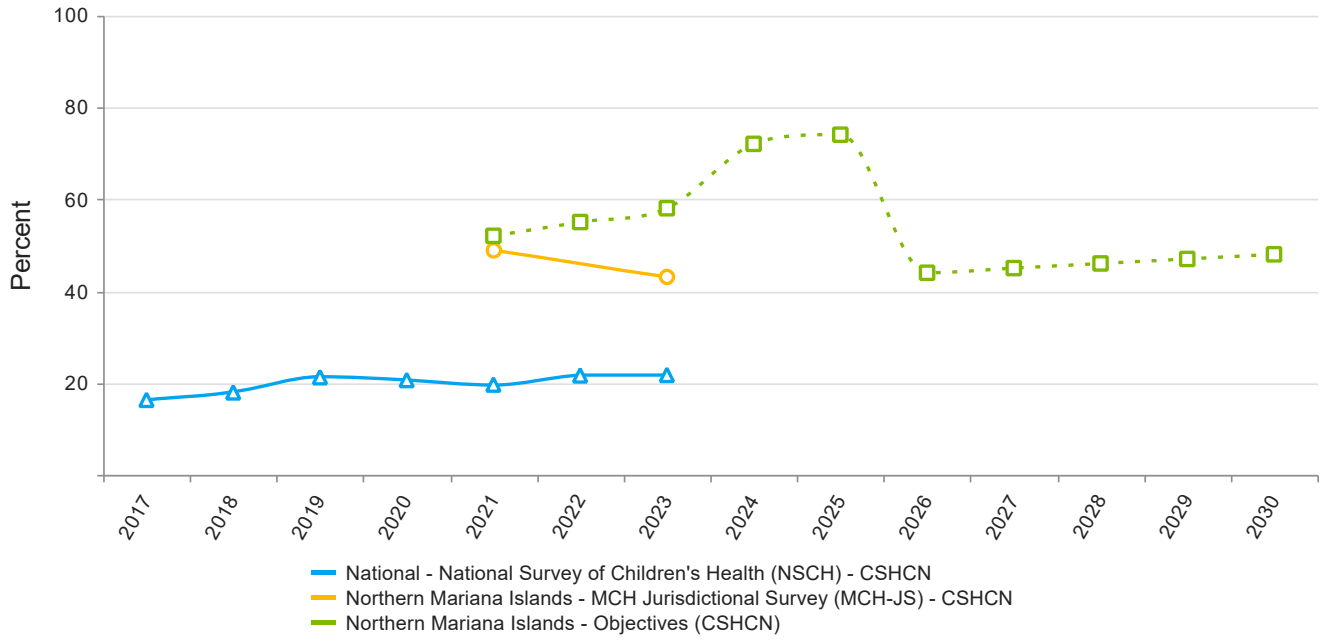
Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	20	30	55
Annual Indicator		81	81	52.3	40.5
Numerator		51	51	45	45
Denominator		63	63	86	111
Data Source		F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	45.0	50.0	55.0	60.0	65.0

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



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

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		52	55	58	72
Annual Indicator	51.0	32.8	32.8	70.7	43.0
Numerator	183	167	167	322	299
Denominator	358	511	511	455	695
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2021	2021	2024	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	44.0	45.0	46.0	47.0	48.0

Evidence-Based or –Informed Strategy Measures

ESM TAHC.1 - Percentage of high school students served by SPED who received information on transition

Measure Status:	Inactive - Replaced

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		10	15	20	35
Annual Indicator		0	4.9	34.4	78.5
Numerator		0	16	115	205
Denominator		322	329	334	261
Data Source		Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED	Program Administrative Records
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Final	Provisional

ESM TAHC.2 - Number of parents who complete transition training.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10.0	15.0	20.0	25.0	30.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Access to care coordination and navigation of healthcare and community programs	
NPM	
NPM - Medical Home	
Five-Year Objectives	
By 2030, increase the percentage of CNMI CSHCN ages who report having a medical home by 5%.	
Strategies	
Strengthen access to a medical home for children and youth, including children with special healthcare needs by providing training and technical assistance to pediatric primary care clinics and providers on implementing medical home principles and related policies.	
ESMs	Status
ESM MH.1 - Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).	Active
NOMs	
Children's Health Status	
CSHCN Systems of Care	
Flourishing - Young Child	
Flourishing - Child Adolescent - CSHCN	
Flourishing - Child Adolescent - All	

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

Priority Need

Parent training to support Transition from pediatric to adult healthcare

NPM

NPM - Transition To Adult Health Care

Five-Year Objectives

By 2030, increase the percent of parents of CSHCN who receive training on transition into adult care by 10% from baseline.

Strategies

Provide training on transition planning to help families prepare for the shift from pediatric to adult systems.

ESMs	Status
ESM TAHC.1 - Percentage of high school students served by SPED who received information on transition	Inactive
ESM TAHC.2 - Number of parents who complete transition training.	Active

NOMs

CSHCN Systems of Care

Based on the MCH Title V Block Grant guidance, the following annual report is based on activities during FY 2024 (October 01, 2023 through September 30, 2024). The CNMI MCH priorities for Children with Special Healthcare Needs (CSHCN) focus on providing support to parents and caregivers in navigating systems and supporting CSHCN and their families with transition into adult care, priority needs 6 and 7 identified through the 2020 CNMI MCH comprehensive needs assessment. Priorities 6 and 7 align with NPM 11- Percent of children with and without special health care needs, ages 0 through 17, who have a medical home and NPM 12- Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.

Data to inform NPM 11 and NPM 12 is gathered from the CNMI MCH Jurisdictional Survey (MCH-JS), which was conducted in 2019, 2021 and 2023. Based on the CNMI MCH-JS, is estimated that 8.1 percent of children in the CNMI have a special healthcare need.

Following the end of the Public Health Emergency, most CSHCN services in CNMI returned to regular operations. Key activities—such as screenings, early identification, and service coordination for infants enrolled in Early Intervention—continued without interruption. Outreach clinics, including those conducted in partnership with Shriners Hospitals, were also resumed.

Training sessions for parents, caregivers, and professionals were delivered using a hybrid model, offering both virtual and in-person options throughout the reporting year. Additionally, support groups for families of children with Down syndrome, autism, and those who are deaf or hard of hearing (DHH) successfully transitioned from virtual to in-person meetings during the 2023–2024 project year.

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

NPM 11A: Percent of children with special health care needs, ages 0 through 17, who have a medical home

Year	2019	2020	2021	2022	2023	2024
Percentage	13.3*	13.3*	14.1*	14.1*	12.5*	17.4*
Numerator	141	141	176	176	138	290
Denominator	1059	1059	1252	1252	1101	1666

Data Source: CNMI MCH-JS

* Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

According to data from the CNMI MCH Jurisdictional Survey (MCH-JS), an estimated 17.4% of children with special health care needs (CSHCN), ages 0 through 17, had a medical home in 2024. This represents a notable increase of 4.9 percentage points from the previous year (12.5% in 2023).

Over the six-year period from 2019 to 2024, the percentage has remained relatively low, ranging from 12.5% to 17.4%, with minimal fluctuation until the most recent year. It is important to note that all estimates are marked with an asterisk, indicating wide confidence intervals or other limitations, and should be interpreted with caution.

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

The CNMI MCH Title V strategy for outreach and peer support to families of Children with Special Health Care Needs (CSHCN) is led by the Family-to-Family Health Information Center (F2F). Supported by Title V, the F2F is staffed by a Family Support Specialist and registered parent leaders who assist with outreach and peer support activities. Support is provided both one-on-one and through group-based formats.

The F2F coordinates four CSHCN support groups for families and caregivers of children diagnosed with autism, Down syndrome, deaf and hard of hearing (DHH), and attention deficit hyperactivity disorder (ADHD). In FY 2024, 15 support group meetings were held, with 11 parents or caregivers actively participating. The F2F currently has 9 parent leaders on Saipan, 1 on Tinian, and 1 on Rota.

In addition, the F2F conducted six outreach exhibits in FY 2024, reaching 947 community members. Many of these events were held in partnership with the Disability Network Partners (DNP), of which the CSHCN program is an active member. Through its involvement, the program contributes to community planning and coordination of activities focused on disability and special health needs.

Table 1: CNMI CSHCN Outreach Activities October 2023 – September 2024

DATE	COMMUNITY OUTREACH EVENTS	FACILITATORS	Community Members Reached
October 2023	National Disabilities Employment Awareness Month	Disability Network Partners	158
December 2023	Family Fun Day for International Day of Persons with Disabilities	Disability Network Partners	100
March 2024	Developmental Disability Awareness Month	Disability Network Partners	158
April 2024	Autism Awareness Month: Family Fun Day	S.A.F.E. Jamboree	253
June 2024	CNMI Child Matter Month	Evergreen Learning	193
July 2024	Disability Sports Fest	Disability Network Partners	85

Source: CNMI F2F HIC Data & Disability Network Partners

The CNMI MCH is utilizing evidence informed/based measure 11.1 - Percentage of families served by the Family-to-Family Health Information Center who reported having a medical home as a measure on progress on strategies towards making impact on the objectives identified for the priority on medical home.

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

Table 2: Percentage of CNMI F2F Families reporting a Medical Home, 2021-2024

Year	2021	2023	2024
Percentage	81	52	41
Numerator	51	45	45
Denominator	63	86	111

Data Source: CNMI F2F Health Information Center

In June 2024, the CNMI Family-to-Family Health Information Center (F2F) conducted a brief phone survey to assess medical home access among enrolled families (Figure 1). Of 192 families, 111 completed the survey, resulting in a 57.8% response rate. The remaining 81 were unreachable due to non-responses, disconnected numbers, or time constraints. Among F2F clients that responded to the survey, 45, or 41%, reported that their child's provider made them feel like a partner in their child's care, receive services from multiple agencies, and receive care in a well-functioning system.

Overall, most families reported having access to a medical home and receiving coordinated care. Key findings include:

- 72.1% reported their child had completed a preventive visit.
- 86.2% felt they were treated as partners in their child's care.
- 72.5% said their child with special health care needs (CSHCN) received care in a well-functioning system.

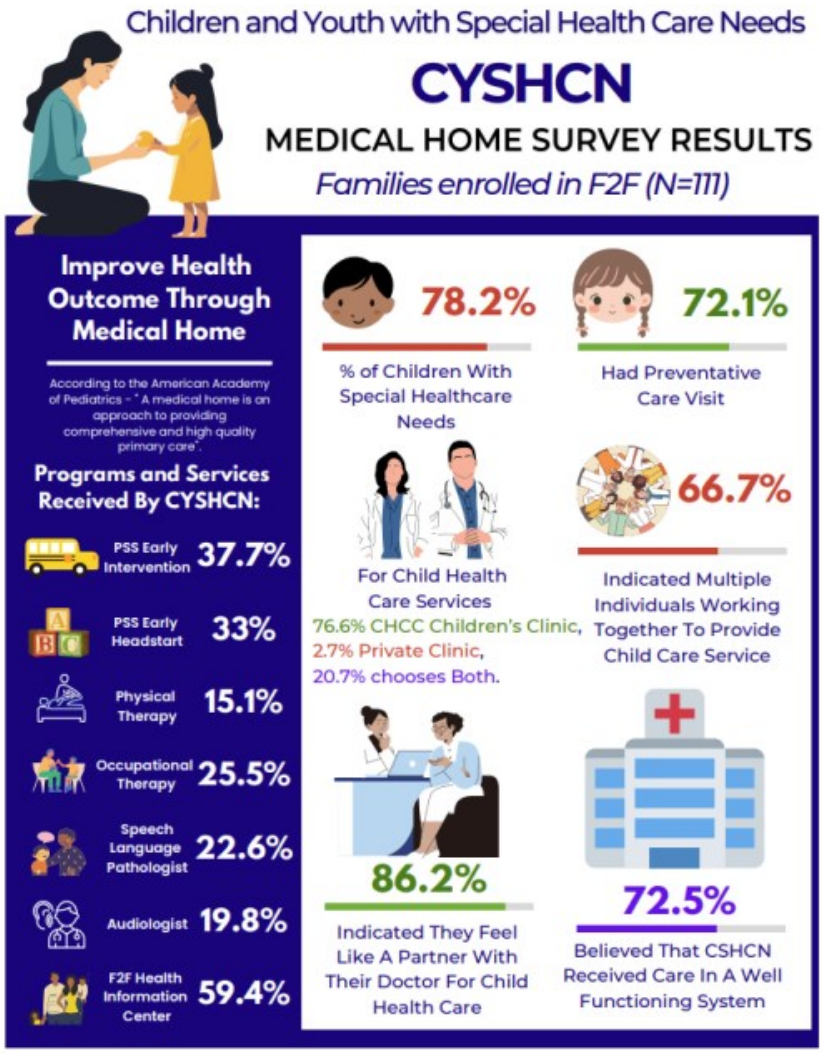
The survey also identified the top programs accessed by families:

- CNMI F2F Health Information Center – 59.4%
- CNMI Public School System Early Intervention Program – 37.7%
- CNMI Early Head Start/Head Start Program – 33%

When asked where they access care, 76.6% reported using the CHCC Children's Clinic, 2.7% used private clinics, and 20.7% used both.

These results provide valuable insight into service use and care coordination experiences among families of CSHCN in CNMI.

Figure 1: CNMI F2F Medical Home Survey Infographic



Source: 2024 CNMI F2F HIC Medical Home Survey

In addition to outreach and peer support, the CNMI F2F Health Information Center (F2F HIC) continues to empower families

and caregivers of CSHCN through targeted learning sessions. These sessions are designed to build their knowledge and confidence to effectively partner with medical providers and other professionals involved in their child's care.

From October 2023 to September 2024, the F2F HIC hosted eight virtual learning sessions, reaching a total of 229 parents, caregivers, and professionals (see Table 3). The program actively leverages partnerships across the Division of Public Health and with external agencies to deliver both virtual and in-person educational opportunities, expanding its reach and strengthening family engagement across the Commonwealth.

Table 3. Learning Sessions October 2023 – September 2024

Month	Topics	Facilitators	Participants
10/2023	Down Syndrome Awareness 101	Chrislaine Manibusan, CNMI F2F HIC Family Support Specialist Dr. Patrick Castillon, CNMI F2F HIC Parent Leader	20
11/2023	Medicaid and Other Healthcare Payment Options	Antonio Yarobwemal, MICAH Services Program Manager	11
12/2023	Mental Health 101	Kimberly Tudela, Youth & Young Adult Coordinator	25
01/2024	Immunization Program	Emman Parian, Immunization Program Manager	41
06/2024	Legal Guardianship for Children & Youth with Special Healthcare Needs	Elsie R. Tilipao, NMPASI Program Manager	29
07/2024	Understanding the Importance of Child Wellness Check	Dr. Jacob Wingerter, MD	41
08/2024	Back to School: Integrating Augmentative and Alternative Communication	Kathy Ruszala, PSS Speech-Language Pathologist	55
09/2024	Northern Marianas Technical Institute	Leiana Ogumoro, NMITECH Enrollment Specialist	7

Source: CNMI F2F Health Information Data

To strengthen understanding of the link between child health and programs serving Children with Special Health Care Needs (CSHCHN), the MCH Title V Program collaborated with partner agencies to deliver professional development and in-service training. These efforts have enhanced coordination among programs and healthcare providers, leading to improved family engagement across systems of care.

One key family engagement initiative supported by MCH Title V was the Deaf & Hard of Hearing (DHH) Family Engagement Workshop, hosted by the Division of Public Health Services – MICAH Programs in partnership with the CNMI Public School System (PSS) Special Education Program. The event brought together DHH children, their families, and professionals who support them in a collaborative and inclusive setting.

The MICAH team presented information on a range of CHCC programs that support CSHCN, including:

- Newborn Hearing and Metabolic Screening
- Ages & Stages Developmental Screening
- Service Coordination
- Newborn Screening Programs
- Family-to-Family Health Information Center (peer support and parent leadership training)

Workshop activities were led by Dr. Angie Mister, PSS Audiologist, and Ms. Tricia Taitano, DHH Instructor, who facilitated family-centered team-building using American Sign Language (ASL), including an interactive ASL Family Bingo. To ensure accessibility, Ms. Mystica Kaipat provided sign language interpretation for children who are deaf or have severe to profound hearing loss.

The workshop aimed to build and sustain family engagement and leadership capacity among families of DHH children supported by CHCC and PSS services. Feedback was overwhelmingly positive. One parent shared, “My family and I are so happy to be here. I’m so happy to see other children who have the same type of hearing loss as my child.”

This initiative highlights the power of cross-agency collaboration and culturally responsive engagement to empower families and strengthen the support system for CSHCN in the CNMI.

Photo: CNMI DHH Family Engagement Workshop March 2024

Building on the success of the DHH Family Engagement Workshop, the CNMI CSHCN Program partnered with the PSS Special Education Program to deliver a parent training focused on Understanding the Individualized Education Plan (IEP).

This workshop was designed specifically for parents new to the Special Education system, offering practical guidance and tools to help them confidently navigate the IEP process. The session aimed to demystify special education procedures, empower parents to be active participants in their child’s educational journey, and strengthen collaboration between families and school staff from the very beginning.

By equipping families with knowledge early in their Special Education experience, the training helped lay the foundation for strong, informed advocacy and meaningful engagement throughout their child’s academic path.

Photo: CNMI F2F HIC Family Engagement: Understanding IEP

During the 2023–2024 project year, the CNMI Family-to-Family Health Information Center (F2F HIC) continued to successfully organize in-person family and parent engagement activities. A key partnership this year was with the Division of Youth Services (DYS) – Family & Youth Enhancement Program (F&YEP), which focuses on providing preventive and supportive programs that help youth and families develop essential life skills, reduce at-risk behaviors, and promote self-sufficiency.

Through this collaboration, a cohort of F2F HIC Parent Leaders participated in a specialized training series hosted at the F2F Center. The training was part of DYS's Common Sense Parenting program, which is structured into six sessions and aligned with F&YEP's broader mission. The sessions were designed to be practical and empowering, covering key topics such as:

- Parents as Teachers & Encouraging Positive Behavior
- Preventing and Correcting Problem Behaviors
- Teaching Self-Control
- Applying Parenting Skills in Daily Life

Each session included hands-on activities and real-life applications, allowing participants to reflect on their own family dynamics and strengthen their parenting approach. The interactive format fostered meaningful discussions, peer support, and skill-building that parents could apply immediately at home.

This partnership highlights the value of cross-agency collaboration in building family capacity and delivering programs that are not only educational, but also deeply relevant and impactful for families of children with special health care needs.

Photo: CNMI F2F HIC Family Engagement: Division of Youth Services-Common Sense Parenting

As part of ongoing efforts to strengthen collaboration and promote available services, the MICAH Program facilitated a targeted presentation for pediatricians and medical providers at CHCC. The session aimed to build stronger connections between healthcare providers, the CNMI CSHCN Program, and families—emphasizing the importance of coordinated care.

The presentation focused on how providers can refer families to the CNMI Family-to-Family Health Information Center (F2F HIC), which offers support in navigating health insurance, Early Intervention (Part C), educational services (Part B), and access to community-based resources. Providers were introduced to a range of supports available to families, including advocacy services, peer networks, and government assistance programs. The goal was to equip pediatric providers with referral tools and foster collaboration that enhances care coordination, strengthens the support network, and improves health outcomes for CSHCN in the CNMI. A total of 10 pediatricians and mid-level providers attended.

CHCC pediatric clinical staff play a critical role in identifying and referring children for needed services. They ensure that children receive developmental and health screenings, diagnostic assessments, and referrals to the CSHCN program for early intervention, peer support, transportation assistance, and other vital resources.

In addition to clinic-based screenings, MICAH's Community Health Workers (CHWs) expanded outreach efforts to the islands of Rota and Tinian in partnership with the Early Intervention team. These visits included Ages & Stages Questionnaire (ASQ-3) developmental screenings, follow-up hearing screenings at local health centers, house-to-house outreach, and participation in parent café sessions. Children identified through these screenings were promptly referred to appropriate services, ensuring early support and intervention.

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

NPM 12: Percent of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Year	2019*	2020*	2021*	2022*	2023*	2024*
Percentage	51.1	51.1	32.8	32.8	70.7	39.6
Numerator	183	183	167	167	322	299
Denominator	358	358	511	511	455	695

Data Source: MCH-JS

*Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

Data for NPM 12, which measures the percent of children with special health care needs (ages 12 through 17) who received services necessary to make transitions to adult health care, is collected through the CNMI MCH Jurisdictional Survey (MCH-JS), conducted biennially since 2019.

In both 2019 and 2020, an estimated 51.1% of CSHCN received the necessary transition services. This percentage declined significantly to 32.8% in 2021 and remained the same in 2022. In 2023, the estimate rose sharply to 70.7%, but then declined again in 2024 to 39.6%.

These fluctuations suggest variability in service delivery or reporting over time. All data points are marked with an asterisk, indicating that they have wide confidence intervals or other limitations and should be interpreted with caution.

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

The CNMI Title V CSHCN Programs continue to strengthen vital partnerships across internal and external agencies to better serve children and families. A key collaboration exists between the CNMI Public School System's Early Head Start and Head Start Programs and the Family-to-Family Health Information Center (F2F HIC). Together, they focus on enhancing services that provide families—especially those with young children who have special health care needs or developmental risks—with critical information on preventive healthcare and healthcare transitions.

Funded federally, the CNMI Early Head Start and Head Start Programs promote early childhood education, health, nutrition, and parent involvement, targeting improved school readiness for children from low-income families. Complementing these efforts, the CNMI F2F HIC offers families of children with special health care needs essential resources, advocacy support, and guidance to ensure their children receive the right services and care.

This strong partnership guarantees families access to advocacy and assistance, helping parents navigate the complex intersection of early education and health challenges. By combining their expertise and resources, these programs create a comprehensive support network that empowers children and families to thrive academically, socially, and medically.

Table 4. Early Headstart & Headstart Centers

CNMI PSS Early Headstart & Headstart Centers	Number of participants reached
San Antonio Early Headstart/Headstart	18
Dan-Dan Early Headstart/Headstart	30
Kagman Early Headstart/Headstart	10

Source: CNMI F2F Health Information Data

The CSHCN Programs partnered with the PATCH Program, which operates under the Adolescent and Reproductive Health Program. PATCH is a youth-driven initiative focused on promoting adolescent health by empowering young people and placing their voices at the center of public health efforts. It creates meaningful opportunities for professionals to engage directly with youth in open dialogue. As part of this collaboration, the CSHCN Program delivered a presentation highlighting

the importance of healthcare transition for adolescents.

Evidence Based Strategy Measure 12.1 - Percentage of high school students served by SPED who received information on transition

Year	2021	2022	2023	2024
Percentage	0	4.9	34.4	78.5
Numerator	0	16	115	205
Denominator	322	329	334	261

Data Source: CNMI PSS Special Education Program

The CNMI MCH Title V uses ESM 12.1—the percentage of high school students served by Special Education (SPED) who receive information on transition—as a key indicator to measure progress in improving access to transition services. In 2024, 78.5% of high school students enrolled in SPED received transition information, marking a significant increase from previous years, largely due to the resumption of full-time, in-person schooling.

The program continues to collaborate closely with the Special Education Program to advance healthcare transition for youth with special needs. Team members have already begun planning to integrate Public Health Services into students' Individualized Education Program (IEP) meetings. These efforts aim to strengthen the partnership between education and health systems, ensuring that students approaching adulthood receive the support and resources necessary for a seamless transition from pediatric to adult healthcare.

Together, both programs are exploring strategies to improve communication, align goals, and promote continuity of care during this critical stage of development.

Other CSHCN Activities

MCH Title V funds are used to support developmental screening activities in the CNMI as part of efforts to identify CSHCN. In 2024, a total of 1,536 developmental screenings were conducted at the Children's Clinic during well-child visits. Children who are identified with developmental risk and who need further assessment are referred to the Early Intervention Program or the Special Education Program. In 2024, 630 (41%) children were identified as requiring additional monitoring or referral to Early Intervention Program (Part C) or Early Childhood Program (Part B).

Table 5: Number of children screened with ASQ and identified as needing monitoring or below developmental cut-off, 2022 – 2024.

Year	Total Number Screened	Number Identified for monitoring or at below cut-off
2022	1,094	216
2023	1,122	473
2024	1,536	630

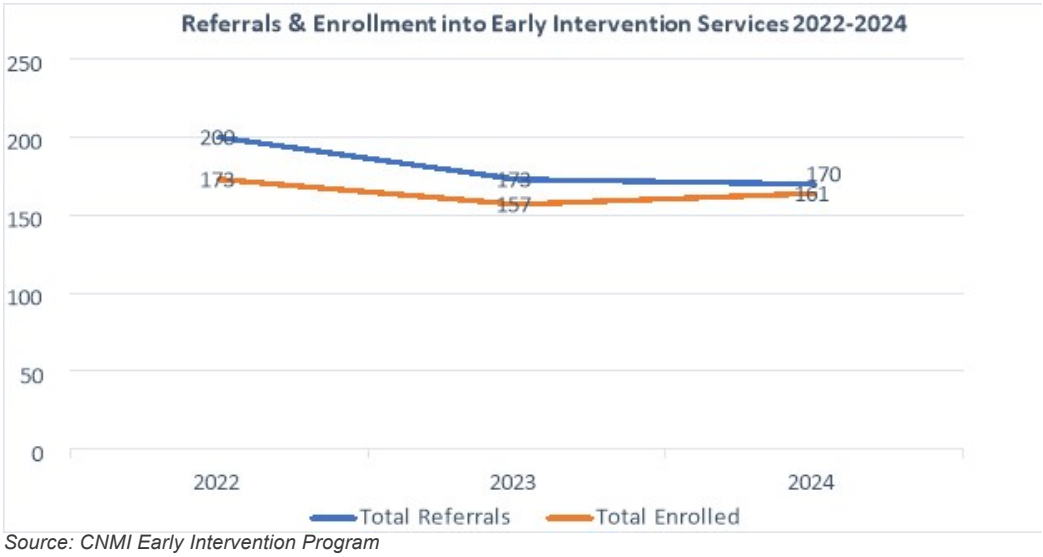
Source: MICAH Program

Early Intervention (EI) referral data remained steady in both the number of referrals and families served compared to the previous year (see Graph 1). During the 2023-2024 school year, the EI Program served 161 families. Of these, 41 infants and toddlers (ages 0 to 3) were eligible due to an established condition, while 120 were identified with developmental delays.

Additionally, 75 infants and toddlers exited the program, primarily due to transitioning to Early Childhood (Part B), families relocating to the US mainland, or meeting developmental milestones and goals.

In 2024, 71% of EI referrals originated from CHCC units such as Nursery, Pediatrics, and the Neonatal Intensive Care Unit (NICU). Other referrals came from private clinics, daycares, the Early Head Start Program, public health programs like MIECHV and WIC, as well as concerned parents.

Graph 1: Total Referrals to CNMI Early Intervention Services, 2022 - 2024



Source: CNMI Early Intervention Program

Newborn screenings play a vital role in identifying potentially life-threatening or disabling conditions as early as possible. The CNMI MCH Title V Program supports both newborn hearing and metabolic (bloodspot) screenings to ensure timely identification and intervention, which can significantly reduce or prevent the effects of these conditions.

At CNMI CHCC, every baby receives newborn screenings before discharge. Hearing screenings are conducted by hospital nursery nurses, while bloodspot samples are collected and sent to the Oregon Department of Public Health laboratory for analysis.

The CHCC Early Hearing Detection & Intervention (EHDI) Program continues to meet national standards set by the Joint Committee on Infant Hearing (JCIH). In 2024, data shows that 99% of babies born in the CNMI received hearing screening before one month of age. Among those not screened on time, four infants passed away shortly after birth, one was urgently transferred off-island due to critical condition, and one infant, born to a tourist mother at a local hotel, had all screenings declined by the parent.

Of the 155 infants requiring follow-up hearing screening by three months, six were lost to follow-up (LTFU). These infants were born to visiting mothers from China, who opted to complete follow-up screenings in their home country. The program documented all communication attempts and parental preferences in the infants' electronic health records.

The program remains committed to closely tracking newborn screenings to minimize loss to follow-up and ensure every child receives the care they need for a healthy start.

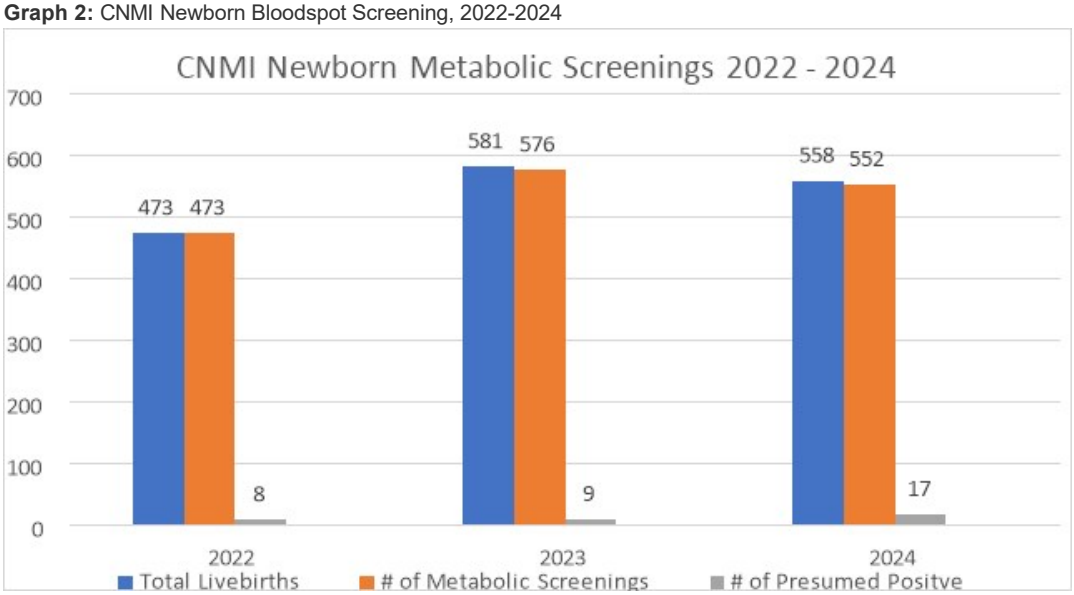
Table 6: CNMI EHDI Data

	2022	2023	2024
Births	575	473	558
Screened	569	472	552
Inpatient Pass	469	336	397
Inpatient Refer	100	133	155
Outpatient Pass	90	130	149
Loss to Follow-Up	5	3	6
Refer to DAE	5	3	0
DAE with Pass Results	4	0	0
Confirmed Hearing Loss	1	2	0
Referral to EI	1	2	0

Source: CNMI EHDI-IS

The MICAH unit works closely with the pediatrics and CHCC laboratory to ensure that newborn bloodspot services remain uninterrupted, identifying children who are identified as needing a secondary screening or diagnostic testing, and assist in contacting families to prevent lost to follow up, graph 2.

Graph 2: CNMI Newborn Bloodspot Screening, 2022-2024



Source: CHCC Carevue & CNMI EHDI-IS

In 2024, of the 558 live births in the CNMI, 99% completed newborn bloodspot screening (NBS). When an abnormal result is detected, the Oregon Public Health Laboratory promptly alerts Children's Clinic providers and the Program Coordinator. This triggers follow-up actions, including repeat screenings for confirmatory diagnosis or ongoing monitoring every six months with blood tests. Of the 17 infants who initially tested positive, 10 received confirmed diagnoses and are actively followed by primary care providers. The remaining seven infants, born to visiting mothers, returned to China and continue care there. MCH Title V funds support the expedited shipping of NBS kits via FedEx to Oregon to maintain sample viability.

During project year 2023-2024, Shriner's Hospital Honolulu sustained its outreach efforts in the CNMI, serving 180 children with orthopedic concerns. The program also facilitated critical medical interventions, including surgeries, by assisting nine CNMI children to receive surgery at Shriners Honolulu. Additionally, telehealth services provided by Shriners have been crucial in supporting post-surgery recovery, preventing complications, and promoting overall well-being.

However, plans to expand local orthopedic services by Shriners are currently on hold due to provider shortages at Shriners Hospital for Children-Honolulu. Despite this, Shriners continues to conduct biannual outreach visits to the CNMI, maintaining vital support for the community.

Table 7: Shiners Outreach Clinic

Outreach Date:	Total Patients Served:	
December 2023	108	84 established patients / 24 new referrals
April 2024	72	57 established patients / 15 new referrals

The CNMI MICAH-CSHCN Program was honored to participate as a panelist at the 2024 Association of Maternal & Child Health Programs (AMCHP) Annual Conference. This opportunity allowed the program to showcase the coordinated systems of care for Children with Special Health Care Needs (CSHCN) in the CNMI, highlighting the Pacific Islands' strong commitment to advancing care and promoting the well-being of children and youth with special health needs.

Building on this success, the CNMI Early Hearing Detection and Intervention (EHDI) Program was invited to present at the 2024 Hands & Voices Conference in Spokane, Washington—a nationally recognized event dedicated to supporting families of children who are deaf or hard of hearing. The invitation underscores the program's dedication to early identification, timely intervention, and family-centered care. At the conference, the CNMI EHDI team shared program updates, best practices, and collaborative strategies aimed at improving outcomes for children and families, while also engaging in valuable dialogue and networking with professionals and families nationwide.

Family engagement remains a cornerstone of the CNMI CSHCN Program's success. Parent leaders have grown significantly in knowledge and skills, becoming well-informed advocates who actively connect families with local services and resources. Many parents now lead community outreach efforts—delivering group presentations, facilitating focus groups, participating in panel discussions, and courageously sharing their family journeys through social media—amplifying the voices of CSHCN families across the island.

Source: CHCC-DPHS Social Media Page

The MICAH Program will focus its efforts on improving access and establishing a medical home model for the CNMI CSHCN unit. A medical home model will Integrate care across all elements of the healthcare system and including other social services such as education and vocational services. According to data from the CNMI MCH-JS conducted in 2023, it is estimated that 12.5 percent of children with special healthcare needs in the CNMI report have a medical home. There is a slight decrease by 1.6 percentage points on this indicator in 2023 compared to the prior reporting year, 2022. However, this measure remains consistent from 2019-2023. The program has made efforts for improving collaboration with the medical providers, early intervention services team, and other partnering agencies by providing professional development and in-service trainings to help understand and provide coordinated services to the CSHCN population.

Priorities specific to the needs of children and youth with special health care needs will address all children in the way that CHCC MICAH Programs strives; comprehensively and inclusively. One of the main goals of the CSHCN program that was identified through the Needs Assessment is access to care coordination and navigation of healthcare and community programs. During the 2025 needs assessment process, it became apparent that family support was still emerging as a high need and that those supports include understanding available resources. Navigation of services still poses a challenge for many CSHCN families. Other priorities identified were parent training and access to specialty healthcare.

Understanding the resources and how to navigate them can reduce caregiver stress. This priority exemplifies the collaboration and partnership building principles that CHCC MICAH programs promote and is willing to sustain so that all children with health care needs are children first. To help address this need, the MICAH CSHCN program staff has attended various trainings and workshops that focused on communicating with CSHCN families. The CSHCN unit has four (4) Community Health Outreach Workers serving CSHCN families and a full time Family Support Specialist focused on family engagement and building capacity with parents and families of CSHCNs to be able to more effectively partner with medical providers and advocate for their needs.

The priority need for the CSHCN domain is access to care coordination and navigation of healthcare and community programs which aligns with the Universal National Performance Measure of Medical Home. The program aims to increase the percentage of CSHCN who report having a medical home to 5% from baseline by 2030 by continuing to work with internal and external partners to leverage resources to promote medical home.

Priority Need 8: Access to care coordination and navigation of healthcare and community programs.

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

Objective: By 2030, increase the percentage of CSHCN who report having a medical home by 5% from the baseline.

Strategies Strengthen access to a medical home for children and youth, including children with special healthcare needs by providing training and technical assistance to pediatric primary care clinics and providers on implementing medical home principles and related policies.

The CNMI MCH Title V program is committed to advancing health equity and improving health outcomes for all children and youth, particularly those with special healthcare needs (CSHCN). To achieve this goal, the FY2026 strategy focuses on strengthening access to a medical home by equipping pediatric primary care clinics and providers with the knowledge, skills, and resources necessary to fully implement medical home principles and supportive policies.

A medical home is a model of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. It ensures that every child and youth has a consistent source of care that actively supports their physical, emotional, and developmental health. For children with special healthcare needs, a medical home is essential in managing complex health issues, navigating multiple services, and ensuring seamless care coordination

across providers and systems.
Central to this strategy is the delivery of targeted training and technical assistance (TA) tailored to the unique context of CNMI pediatric primary care settings. This includes:

- Training Pediatric Providers and Clinic Staff: Interactive workshops, webinars, and on-site training sessions will be conducted to enhance providers' understanding of medical home principles, such as family-centered care, cultural competency, care coordination, and health information technology use. Training content will emphasize practical application, including developing individualized care plans, facilitating referrals, and engaging families as active partners in care.

- Policy Implementation Support: CNMI MCH will assist clinics in adopting and operationalizing policies that support medical home practices. This includes guidance on appointment scheduling practices to improve access, implementing care coordination protocols, utilizing electronic health records effectively, and addressing barriers related to language, culture, and transportation.

- Ongoing Technical Assistance: Through regular follow-up consultations, site visits, and peer learning opportunities, the program will provide continuous support to clinics as they integrate medical home concepts into daily workflows. This TA will also help clinics troubleshoot challenges, monitor progress, and share best practices across the network.

Recognizing the heightened complexity of care for CSHCN, the strategy prioritizes strengthening providers' capacity to address this population's unique requirements. Training modules will cover topics such as comprehensive care planning, transition to adult care, mental health integration, and collaboration with specialty providers and community-based services. The goal is to ensure CSHCN receive timely, coordinated, and family-centered care that improves health outcomes and quality of life.

To monitor implementation and impact, the program will establish clear performance indicators such as the number of clinics and providers trained, adoption of medical home policies, improvements in care coordination activities, and family satisfaction measures. Data collected will guide iterative improvements and demonstrate progress toward ensuring all children and youth in CNMI have a reliable medical home.

The success of this strategy depends on strong partnerships with healthcare providers, families, advocacy groups, and community organizations. CNMI MCH will engage these stakeholders throughout the implementation process to ensure training and policies reflect community priorities, cultural values, and lived experiences.

By focusing on building provider capacity and supporting policy implementation in pediatric primary care settings, the FY2026 strategy aims to strengthen the foundation of the medical home model in CNMI. This approach promises to enhance access to high-quality, coordinated care for all children and youth—especially those with special healthcare needs—ultimately fostering healthier families and communities across the islands.

Evidence Based Strategy Measure (ESM) 5.3: Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).

This performance measure tracks the count of pediatric healthcare providers who have participated in medical home training sessions and subsequently integrated at least one key medical home component into their clinical practice. These components may include, but are not limited to:

Care Coordination: Activities that ensure seamless management of a child's healthcare across multiple providers and

services, such as facilitating referrals, follow-ups, and communication among specialists, schools, and community resources.

Family Engagement: Strategies that actively involve families in decision-making processes, respect family preferences and cultural contexts, and foster collaborative partnerships between providers and caregivers.

Team-Based Care: Adoption of a multidisciplinary approach where healthcare providers, nurses, social workers, and other team members collaborate to address the comprehensive needs of the child and family.

Tracking this measure provides critical insight into both the reach and practical impact of the training initiative. It reflects not only the number of providers exposed to medical home principles but also the extent to which these principles translate into real-world changes in care delivery.

By focusing on actual implementation, this measure emphasizes meaningful behavior change rather than training attendance alone. It helps identify successes, barriers, and opportunities for additional support, ensuring that training investments lead to improved care experiences and outcomes for children and youth, including those with special healthcare needs.

Priority Need 9: Parent Trainings

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

Objective: By 2030, increase the percent of parents of CSHCN who receive training on transition into adult care by 10% from baseline.

Strategy: Provide training on transition planning to help families prepare for the shift from pediatric to adult systems.

For FY 2026, October 2025 through September 2026, the following activities provide an outline of the strategy for providing parent training sessions, presentations, and support for families with children with special healthcare in transitioning from pediatric care into adult healthcare:

Transition Presentations and Services

- Host professional development workshops for CNMI Family-to-Family Health Information Center (F2F HIC) support group members to strengthen their capacity in healthcare transition support.
- Collaborate with the CNMI Disability Network Partners (DNP) to integrate healthcare transition topics into annual transition conferences, ensuring broad stakeholder engagement.
- Continue joint efforts with partner agencies to offer virtual and in-person learning sessions for families on healthcare transition, led by CNMI F2F HIC.
- Strengthen collaboration with the CNMI Public School System to participate in Individualized Education Plan (IEP) meetings for Children and Youth with Special Health Care Needs (CYSHCN) with complex medical conditions.
- Evaluate the current transition protocol at the CHCC Children's Clinic for teens and work with pediatric leadership to identify improvement strategies, leveraging tools from Got Transition and the PATCH Program.

Evidence Based Strategy Measure (ESM): Number of parents who complete transition training.
The CNMI will report on the number of parents of CSHCN that complete training on transition.

Cross-Cutting/Systems Building

State Performance Measures

SPM 2 - Percent of progress milestones completed toward the development and implementation of a centralized, user-friendly digital platform.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10.0	15.0	20.0	25.0	30.0

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Cross-Cutting/Systems Building - Entry 1	
Priority Need	
Clear communication about health services and supports available for MCH populations	
SPM	
SPM 2 - Percent of progress milestones completed toward the development and implementation of a centralized, user-friendly digital platform.	
Five-Year Objectives	
By 2030, develop and implement a centralized, user friendly digital platform that serves as a resource hub for health and wellness resources for all MCH population health domains.	
Strategies	
Conduct user experience (UX) research with MCH populations (e.g., surveys, focus groups) to guide the design and content structure of the digital platform.	
ESMs	Status
SPM ESM 2.1 - User research (i.e. surveys and focus groups) completed.	Active

2021-2025: State Performance Measures

2021-2025: SPM 2 - Percentage of CHCC Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	15	20	50
Annual Indicator		2.1	34	49.2	91.7
Numerator		2	32	61	100
Denominator		94	94	124	109
Data Source		CHCC HUMAN RESOURCES	CHCC HUMAN RESOURCES	CHCC Training Spreadsheet	CHCC Public Health Training Logs
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

A key finding in the 2020 CNMI MCH 5 - year needs assessment suggested a need for professionals who work with the MCH populations to have the knowledge and skills necessary to address their needs. To improve the delivery of quality health and public health services, and enhance skills, abilities, and performances of MCH serving professionals, it is critical to provide capacity building and training opportunities to ensure a competent workforce, but also support retention, morale and productivity.

To address this need, a State Cross-cutting/system building Priority Need 8, and State Performance measure 2 (SPM-2) was established.

Priority Need 8: **Professionals have the knowledge and skills to address the needs of maternal and child health populations**

State Performance Measure 2- Percentage of CHCC staff and other professionals who serve MCH populations that receive training on MCH priorities and/or related strategies was developed to be able to report on progress and impact of the strategies implemented to address priority need 8.

After a careful review of SPM-2, an update to the original version was initiated to reflect a realistic approach for addressing Priority Need 8. The updated version of SPM – 2 reads as follows:

State Performance Measure 2- Percentage of CHCC Public Health staff who receive training on MCH priorities and/or related topics.

Strategy: Provide training to public health professionals on MCH priorities and/or strategies that support improvements in national outcome and performance measures.
In 2024, MICAH Programs collaborated with other sections within the Division of Public Health Services to coordinate an annual Division-wide professional development training event. There were an estimated 109 Division personnel with 100 (92%) staff who participated in the event. Training topics included focus on mental health, chronic diseases, along with staff engagement and retention topics such as team building and stress management.

In FY2024, the CNMI Division of Public Health Services (DPHS) made significant strides in strengthening its public health workforce through comprehensive planning and capacity-building efforts. These activities laid the foundation for long-term infrastructure and workforce development, aligned with the goals of the Maternal and Child Health (MCH) Title V Block Grant and broader public health modernization initiatives.

A major focus of the year was preparation for the implementation of the Public Health Workforce Interests and Needs Survey (PH WINS). Recognizing PH WINS as a critical tool for understanding workforce capacity, satisfaction, and development needs, the DPHS formed a core planning team to oversee pre-survey readiness. This included identifying key staff contacts, coordinating with ASTHO, the De Beaumont foundation and other national partners, and conducting internal briefings to raise awareness and encourage participation. The planning process ensured that CNMI would be well-positioned to maximize survey response rates and leverage PH WINS data to guide future workforce strategies.

In parallel, the Division initiated the foundational planning process for the development of its comprehensive Workforce Development Plan (WDP). A cross-program Workforce Development Planning Committee was established to guide this effort, bringing together representatives from key public health programs, human resources, and leadership to ensure broad input and alignment with agency goals. To strengthen the planning process, technical assistance from the Association of

State and Territorial Health Officials (ASTHO) secured, providing the team with access to national best practices, planning tools, and subject matter expertise. In addition, the Division began identifying and mobilizing the internal resources needed to support the plan's development, including staff time, data sources, and administrative support. These early investments set the stage for a structured, inclusive, and actionable workforce development plan that will guide capacity-building and training efforts across CNMI's public health system in the years to come.

Another key milestone in FY2024 was the initiation of procurement planning for a Learning Management System (LMS). In response to the need for centralized, accessible, and culturally relevant training, DPHS worked with procurement and IT staff to outline system requirements, explore available platforms, and secure funding to support the acquisition and future implementation of an LMS. The system will be critical for delivering both required and elective training to public health staff across islands and programs, while also supporting ongoing performance evaluation and credentialing efforts.

Together, these efforts represent CNMI's commitment to investing in its public health workforce as a cornerstone of maternal and child health advancement. By laying this groundwork in FY2024, the Division of Public Health Services has positioned itself to build a more resilient, skilled, and adaptable workforce to meet current and future MCH challenges.

Cross-Cutting/Systems Building - Application Year

Based on the findings from the 2025 comprehensive Maternal and Child Health (MCH) five-year needs assessment, clear and effective communication about available health services and supports in each community across the CNMI has emerged as a critical new priority. This priority reflects the ongoing challenges faced by families and providers in navigating the healthcare system, often resulting in underutilization of essential services, missed appointments, and delays in receiving timely care. Many community members report difficulties understanding where and how to access the range of MCH resources available, compounded by language barriers, limited health literacy, and inconsistent dissemination of information across the islands of Saipan, Tinian, and Rota.

By addressing this priority, the CNMI MCH Program aims to significantly increase awareness and utilization of preventive, primary, and specialty health services critical to improving maternal and child health outcomes. Enhancing communication strategies will empower families with clearer, culturally and linguistically appropriate information, fostering better health literacy that enables individuals to make informed decisions about their care. Improved communication will also facilitate stronger engagement between healthcare providers and the community, reduce no-show rates, and promote earlier intervention for health issues, ultimately decreasing disparities and supporting healthier pregnancies, births, and childhood development. By prioritizing clear communication, the MCH Program positions itself to strengthen the overall healthcare delivery system, ensuring that vital health supports reach all populations equitably throughout the CNMI.

Priority Need 10: Clear communication about health services and supports available for MCH populations.

State Performance Measure 2: Percent of progress milestones completed toward the development and implementation of a centralized, user-friendly digital platform.

Objective: By 2030, develop and implement a centralized, user-friendly digital platform that serves as a resource hub for health and wellness resources for all MCH population health domains.

Strategy: Conduct user experience (UX) research with MCH populations (e.g., surveys, focus groups) to guide the design and content structure of the digital platform.

To fulfill the objective of creating a comprehensive and accessible digital platform by 2030, the CNMI MCH Title V Program will undertake a phased, collaborative, and community-centered approach to design, develop, and sustain a centralized online hub that consolidates health and wellness resources across all maternal and child health (MCH) domains. This platform will serve as a trusted, one-stop resource for families, healthcare providers, community organizations, and stakeholders throughout the Commonwealth.
The FY2026 will be utilized as a planning year with information gathering and design and development as a focus. These first couple of phases will allow the CNMI team to gather the necessary input from stakeholders and community members to inform the design of the system.
Outlined below is the phased approach that the CNMI will undergo as part of the project design, development, and implementation phases:

Phase 1: Needs Assessment and Stakeholder Engagement (October 2025- February 2026)

- Conduct community needs assessments including surveys, focus groups, and interviews with MCH populations and providers to identify key information gaps, preferred communication channels, and usability requirements.
- Establish a multidisciplinary advisory committee comprising public health experts, IT specialists, healthcare providers, cultural and linguistic representatives, and family advocates to guide platform development.
- Map existing digital resources and services to identify redundancies, gaps, and opportunities for integration.

Phase 2: Platform Design and Development (March 2026- September 2026)

- Use findings from user experience (UX) research to inform the platform's architecture, ensuring it is intuitive, accessible, and culturally responsive.
- Develop core features such as searchable service directories, eligibility criteria, appointment scheduling, educational materials, and interactive tools tailored for diverse MCH domains including prenatal care, breastfeeding, immunizations, developmental screenings, mental health, nutrition, and more.
- Incorporate multilingual support and ADA-compliant design to maximize accessibility for all users.
- Pilot the platform with select user groups to gather feedback and make iterative improvements.

Phase 3: Implementation, Training, and Outreach (October 2026 – September 2027)

- Launch the platform across all islands with coordinated outreach campaigns through schools, clinics, community centers, and media outlets to raise awareness and encourage use.
- Provide training and technical assistance to healthcare providers, social service agencies, and community leaders on leveraging the platform to enhance care coordination and family engagement.

Phase 4: Evaluation and Continuous Improvement (October 2027- September 2030 and Beyond)

- Establish ongoing monitoring and evaluation protocols to assess platform usage, user satisfaction, and impact on access to MCH services.
- Gather regular user feedback and update content, features, and technology to keep the platform relevant and responsive to evolving community needs.
- Secure sustainable funding and partnerships to maintain and expand the platform as a vital MCH resource hub well into the future.

The expected outcomes of this strategy include enhanced access for both community members and healthcare providers to timely, accurate, and culturally relevant maternal and child health (MCH) information. It aims to improve care coordination and service navigation for families across all MCH domains, fostering increased engagement and empowerment of MCH populations in managing their own health. Additionally, the strategy seeks to establish a sustainable, centralized digital infrastructure that aligns with and supports the CNMI's broader public health goals. Through this strategic, phased approach, the CNMI's centralized digital resource hub will be thoughtfully designed, widely accessible, and continually optimized to meet the diverse and evolving needs of maternal and child health populations, ultimately advancing health equity and improving outcomes throughout the CNMI.

Evidence Based Strategy Measure (ESM): Detailed platform design and specifications informed by UX research findings completed.

By monitoring the completion of Phase 1 activities such as surveys, focus groups, and advisory committee formation, the project demonstrates its commitment to grounding platform development in real community needs and input. This reduces the risk of developing solutions that are irrelevant or inaccessible to the target population, ultimately improving the chances of adoption and sustained use.

The measure tracks whether user research findings are effectively translated into platform design decisions in Phase 2. This ensures the technology developed is intuitive, culturally responsive, and user-friendly—factors critical to maximizing engagement among diverse MCH populations.

III.F. Public Input

The CHCC MICAH Program fosters robust public input and stakeholder collaboration through varied, represented channels —critical components for grant alignment and community accountability.

1. Multi-Channel Public Input Approach

- Digital Outreach: Program priorities and MCH updates are published on the CHCC website, with linked executive summaries to facilitate public access.

- Direct Outreach: MICAH staff distribute email invitations to community partners and agency stakeholders soliciting feedback and input year-round.

- Advisory Engagement: MICAH team members actively participate in advisory committees, technical workgroups, and cross-agency meetings, ensuring varied perspectives inform priority selection and strategy development.

2. Community Events & Awareness

- Annual Presence: The team attends high-visibility events like the Red Cross Walk-a-Thon and Safe Jamboree. These events—attended by hundreds—offer an opportunity to promote program services, objectives, and community impact.

- Adolescent Health Awareness Month in May: A signature event platform where MCH Title V shares goals, strategies, and outcomes with partner agencies and the public through targeted outreach activities.

3. Clinical & Agency Partnerships

- Regular Coordination: MICAH Coordinators meet frequently with clinical providers (pediatricians, OB/GYNs, family practice, internal medicine staff) to review health indicators, reinforce program initiatives, and gather feedback.

- Partnership Integration: Team meetings include both internal CHCC programs and external agencies. This cross-sector collaboration directly influences the selection of strategic priorities and enhances program responsiveness to service gaps.

4. Accessibility and Transparency

Given the nearly 300-page length of the Annual Title V report, MICAH publishes a concise executive summary online, with contact information for the Project Director for public comments and input.

The full grant report is shared electronically with community partners and made publicly available. Feedback is encouraged year-round, supporting ongoing community-informed planning.

The CNMI’s approach to public input is guided by the following principles:

- Consistent Engagement: Actively involves the public and professional stakeholders, meeting a key requirement for competitive funding opportunities.

- Community-Driven Strategies: Bases planning on community needs and provider insights to improve effectiveness and long-term sustainability.

- Transparent Communication: Prioritizes openness and responsiveness to build trust and demonstrate accountability.

III.G. Technical Assistance

The CNMI relies primarily on national technical assistance to develop leadership and build public health capacity within the health department and in MCH population serving agencies. Our efforts to explore opportunities were largely delayed in 2021 due to the COVID-19 pandemic.

In 2024, the CNMI continued to utilize technical assistance available through the HRSA Maternal and Child Health Bureau (MCHB) and the Association of Maternal and Child Health Programs (AMCHP). Training and presentation events were attended virtually and included Title V Learning Labs, consultation with project officers and AMCHP regional representatives, the AMCHP national conference, and recurring region IX calls.

In 2024, As part of efforts towards Public Health accreditation, and with support through the CDC, the Division of Public Health engaged with the De Beaumont foundation in the planning for the implementation of the Public Health Workforce Interest and Needs Survey (PHWINS) in the CNMI. Survey collection was scheduled for the spring of 2025 with results available by the fall of 2025. The survey is intended to identify workforce needs and capacity strengths and gaps and provide the programs within Public Health with the data needed to drive workforce development needs, including informing technical assistance priorities.

The CNMI MICAH Programs has received technical assistance and continues to engage with the following national and regional partners for supporting MCH efforts:

- Association of Maternal and Child Health Programs (AMCHP)
- Reproductive National Health Training Center (RHNTC)
- Association of State and Territorial Health Officials (ASTHO)
- Public Health Accreditation Board (PHAB)
- National Network of Public Health Institutes (NNPHI)
- Children's Safety Network (CSN)
- Communities and Hospitals Advancing Maternity Practices (CHAMPS), a CDC-funded initiative led by the Center for Health Equity, Education, and Research at Boston Medical Center
- Centers for Disease Control and Prevention (CDC)
- Hands & Voices
- Family Voices
- The Beacon Center & NCHAM

For FY 2026, the CNMI MCH Title V team seeks to request additional technical assistance on the following topics(s) for improving staff capacity and program implementation and improvement efforts:

Technical Assistance Center	Linkage to CNMI activities
Bullying Prevention & Support	Priority Need 8: Bullying Prevention and Support; BLY - Bullying-Victimization - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MP_MOU_FY25.pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - ORGANIZATIONAL CHARTS (2).pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Northern Mariana Islands

	FY 26 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 489,000	
A. Preventive and Primary Care for Children	$ 147,100	(30%)
B. Children with Special Health Care Needs	$ 158,353	(32.3%)
C. Title V Administrative Costs	$ 43,818	(9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 349,271	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 414,218	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 414,218	
A. Your State's FY 1989 Maintenance of Effort Amount $ 395,500		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 903,218	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 8,086,638	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 8,989,856	

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 295,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN	$ 47,282
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,458,860
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 200,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 5,750,496

	FY 24 Annual Report Budgeted		FY 24 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 474,000 (FY 24 Federal Award: $ 488,206)		$ 488,206	
A. Preventive and Primary Care for Children	$ 153,474	(32.4%)	$ 146,861	(30%)
B. Children with Special Health Care Needs	$ 146,544	(30.9%)	$ 148,458	(30.4%)
C. Title V Administrative Costs	$ 42,117	(8.9%)	$ 43,473	(9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 342,135		$ 338,792	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0		$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 459,410		$ 450,506	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 459,410		$ 450,506	
A. Your State's FY 1989 Maintenance of Effort Amount $ 395,500				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 933,410		$ 938,712	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 7,401,082		$ 6,641,768	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 8,334,492		$ 7,580,480	

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs		$ 172,943
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees		$ 51,303
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > MCH Data Systems Linkage and Training Initiative	$ 100,000	$ 116,102
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening	$ 235,000	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant & Early Childhood Homevisiting Grant Program	$ 1,123,516	$ 1,136,508
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Family Planning Program	$ 200,000	$ 120,722
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN	$ 89,140	$ 65,123
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PRAMS	$ 175,000	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Immunization and Vaccines for Children Grants	$ 1,266,906	$ 0
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants, Children	$ 4,211,520	$ 4,979,067

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: The CNMI no longer receives this grant. The CNMI receives the Early Hearing Detection and Intervention Program Grant.	
2.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PRAMS**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: The Division of Public Health continues to receive this federal grant, however, it is no longer managed under the MICAH Unit. It is now managed under the Public Health Data Surveillance and Performance Management Unit under the Division of Public Health which the MICAH Unit no longer has spending authority over.	
3.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Immunization and Vaccines for Children Grants**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: The Division of Public Health continues to receive this federal grant, however, it is no longer managed under the MICAH Unit. It is now managed under the Communicable Disease Unit under the Division of Public Health which the MICAH Unit no longer has spending authority over.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Northern Mariana Islands

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 59,364	$ 51,498
2. Infants < 1 year	$ 59,365	$ 51,499
3. Children 1 through 21 Years	$ 147,100	$ 146,861
4. CSHCN	$ 158,353	$ 148,458
5. All Others	$ 21,000	$ 46,417
Federal Total of Individuals Served	$ 445,182	$ 444,733

IB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 69,245	$ 86,976
2. Infants < 1 year	$ 69,246	$ 86,976
3. Children 1 through 21 Years	$ 158,372	$ 158,281
4. CSHCN	$ 117,355	$ 118,273
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 414,218	$ 450,506
Federal State MCH Block Grant Partnership Total	$ 859,400	$ 895,239

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Northern Mariana Islands

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 215,401	$ 190,426
3. Public Health Services and Systems	$ 273,599	$ 297,780
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 489,000	$ 488,206

IIB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 392,326	$ 417,655
3. Public Health Services and Systems	$ 21,893	$ 32,841
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 414,219	$ 450,496

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: 558 **Data Source Year: 2024**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	552 (98.9%)	17	10	10 (100.0%)

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

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn Hearing Screening	552 (98.9%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

When an infant received a confirmed diagnosis, the infant will receive continuous follow-up care at CHCC Children's Clinic. In addition to that, the infant and their families will be referred to other healthcare related social services such as Early Intervention. Families will also be connected to other families for peer-to-peer support and to access other services such Medicaid and Social Security to name a few.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Northern Mariana Islands

Annual Report Year 2024

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	556	68.0	0.0	12.0	20.0	0.0
2. Infants < 1 Year of Age	558	68.0	0.0	12.0	20.0	0.0
3. Children 1 through 21 Years of Age	6,012	57.0	0.0	16.0	27.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,188	0.0	0.0	0.0	0.0	100.0
4. Others	5,679	40.0	0.0	30.0	30.0	0.0
Total	12,805					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	579	Yes	579	100.0	579	556
2. Infants < 1 Year of Age	579	Yes	579	100.0	579	558
3. Children 1 through 21 Years of Age	17,536	Yes	17,536	100.0	17,536	6,012
3a. Children with Special Health Care Needs 0 through 21 years of age^	2,034	Yes	2,034	100.0	2,034	1,188
4. Others	32,973	Yes	32,973	100.0	32,973	5,679

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2024**
	Field Note: Number of pregnant women with live births in year 2024.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2024**
	Field Note: Total number of live births year 2024	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note: Number of unduplicated children ages 1 through 21 years who visited CHCC in 2024. Data source: CareVue Electronic Health Record	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note: Number of children enrolled in Special Education (SPED) and Early Intervention (EI) Programs (Data source: SPED & EI datasets)	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2024**
	Field Note: Number of unduplicated males and females > 21 years old, who visited Family Care Clinic, Family Planning Mobile Clinic and Women's Clinic in year 2024. The CNMI MCH Title V agency supports direct and enabling services through these sites. Data source: CareVue Electronic Health Record	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2024**
	Field Note: Number of individuals served by Title V (Enabling and Direct services)	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2024**

Field Note:
The CNMI Title V MCH Program supports direct, enabling, and public health services and systems and estimates of all pregnant women. Case management for high risk prenatal patients are provided by MCH funded personnel and trainings and other capacity building needs of the nursing staff at the Labor & Delivery and Obstetrics departments. The CNMI has a single birthing facility and no home births are recorded for the reporting period. Additionally, communications and other messaging campaigns on topics such as early prenatal care, vaccinations, as well as patient handout and educational materials are provided through a variety of mechanisms (i.e Social Media, Radio, posters, flyers, brochures, etc).

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2024**

Field Note:
The CNMI MCH Title V supports direct, enabling, and public health services and systems which is estimated to reach all infants less than 1 years old in the CNMI. The CNMI MCH Title V supports training for nurses, child care providers, home visitors, and other public health program staff who serve infants or their families. Additionally, communications materials on infant health topics such as breastfeeding, developmental screening and milestones, and vaccinations are disseminated through patients/family handout or educational materials, and advertisements on radio, social media, newspaper or during exhibits at community events.

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**

Field Note:
The CNMI MCH Title V supports direct, enabling, and public health services and systems for children ages 1 through 21 years by providing training and capacity building for hospital and clinic nurses and providers, public health staff, public school system staff members, and parents. Additionally, community awareness and educational information on topics relating to child health are also supported by Title V and disseminated through a variety of mechanisms, including social media, radio ads, newspaper, and others.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**

Field Note:
The CNMI MCH Title V supports direct, enabling, and public health services and systems for children with special health care needs by providing case management and service navigation for infants and children up to 3 years, training for parents and service providers of children with special healthcare needs, assistance with transportation to healthcare facility and related appointments, and community awareness and health promotion activities. Additionally, MCH Title V supports screening and early identification activities.

5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2024**

Field Note:
The CNMI MCH Title V supports direct, enabling, and public health services and systems for other populations including family planning services for women and men of reproductive age, educational outreach during community events to promote primary and preventive health services, support for primary care and preventive services through the CHCC mobile clinic, and community awareness activities via social media, radio and newspapers.

Data Alerts:

1.	Pregnant Women, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
2.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
3.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

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

State: Northern Mariana Islands

Annual Report Year 2024

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	556	4	0	0	0	233	201	114	4
Title V Served	556	4	0	0	0	233	201	114	4
Eligible for Title XIX	378	2	0	0	0	104	176	94	2
2. Total Infants in State	558	4	0	0	0	235	201	114	4
Title V Served	558	4	0	0	0	235	201	114	4
Eligible for Title XIX	379	2	0	0	0	105	176	94	2

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Unduplicated count of deliveries by race/ethnicity to pregnant women served by Title V in 2024. Data Source: HVSO	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or postpartum services through the Title V program during the reporting period. Data source: Health and Vital Statistics Office (HVSO)	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Total number of unduplicated individuals who were eligible for State's Title XIX (Medicaid) program by race/ethnicity in year 2024 Data source: Health and Vital Statistics Office (HVSO)	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Unduplicated count of infants who received services by the State’s Title V program during the reporting period. Data source: HVSO	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2024**

	Column Name:	**Total**
	Field Note: Unduplicated count of infants who were provided delivery, prenatal care, including well-child exams and newborn screenings through the State’s Title V program during the reporting period. Data source: HVSO	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Unduplicated number of newborns who were eligible for State's Title XIX (Medicaid) program. Data source: HVSO	

Form 7
Title V Program Workforce

State: Northern Mariana Islands

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	6.59
1a. Total Number of FTEs (State Level)	6.59
1b. Total Number of FTEs (Local Level)	0
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	0
3. Total Number of FTEs eliminated in the past 12 months	0.25
4. Total Number of Current Vacant FTEs	0.67
4a. Total Number of Vacant MCH Epidemiology FTEs	0
5. Total Number of FTEs onboarded in the past 12 months	0.30

B. Training Needs (Optional)	
1	Training on analytical skills to effectively analyze data and use it to implement strategies and evaluate impacts on MCH population.
2	Training on health program evaluation to build evaluation capacity to effectively assess program effectiveness
3	
4	

Form Notes for Form 7:

None

Field Level Notes for Form 7:

Form 7 Field Level Notes Table

1.	**Field Name:**	**Total Number of FTEs (State Level)**
	Field Note: 6.59% FTEs including current vacancies	
2.	**Field Name:**	**Total Number of FTEs eliminated in the past 12 months**
	Field Note: Health Promotions Intern position has been eliminated at 25% FTE.	
3.	**Field Name:**	**Total Number of Current Vacant FTEs**
	Field Note: Vacant: Community Health Outreach Worker I at 50% FTE Vacant: FP Clinical Coordinator at 17% FTE	
4.	**Field Name:**	**Total Number of FTEs onboarded in the past 12 months**
	Field Note: MICAH Administrative Specialist at 30% FTE on boarded on November 2024.	
5.	**Field Name:**	**Training Needs Line 1**
	Field Note: Advance Data analytics using SAS or other various statistical analysis tools and methods, to perform descriptive and inferential statistics to communicate findings and enhance evidence-based decision-making.	
6.	**Field Name:**	**Training Needs Line 2**
	Field Note: Need to increase health evaluation capacity to ensure quality of care, better patient/client outcomes, and accountability for optimizing resource allocations.	

Form 8
State MCH and CSHCN Directors Contact Information

State: Northern Mariana Islands

1. Title V Maternal and Child Health (MCH) Director	
Name	Heather Pangelinan
Title	Director Public Health Services/MCH Title V Director
Address 1	1178 Hinemlu' St. Garapan
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 234-8950
Extension	2003
Email	heather.pangelinan@chcc.health

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Shiella Deray
Title	CYSHCN Program Manager
Address 1	1178 Hinemlu' St. Garapan
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 783-1613
Extension	
Email	shiella.deray@chcc.health

3. State Family Leader (Optional)	
Name	Chrislaine Lely
Title	Family Peer Support Specialist
Address 1	1178 Hinemlu St
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 234-8950
Extension	
Email	chrislaine.manibusan@chcc.health

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

5. SSDI Project Director	
Name	Heather Pangelinan
Title	Director of Public Health Services
Address 1	1178 Hinemlu' St. Garapan
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 234-8950
Extension	2003
Email	heather.pangelinan@chcc.health

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(670) 287-7718

Form Notes for Form 8:

None

Form 9
List of Priority Needs – Needs Assessment Year

State: Northern Mariana Islands

Application Year 2026

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Access to preventative medical visits	Revised
2.	Access to Mental Health Services	Revised
3.	Education and services to help prevent premature births and low birthweight.	Revised
4.	Education and support to help with breastfeeding	Continued
5.	Access to healthy physical activity	New
6.	Access to teen pregnancy and sexually transmitted infection prevention programs	New
7.	Bullying prevention and support	New
8.	Access to care coordination and navigation of healthcare and community programs	Revised
9.	Parent training to support Transition from pediatric to adult healthcare	New
10.	Clear communication about health services and supports available for MCH populations	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 1

Field Note:
Revised - change focus to type of healthcare services specifically Preventive medical visits, which remained to be the most critical health needs and issues for the Women/Maternal Health domain

Field Name:

Priority Need 2

Field Note:
REVISED - Increased focus on Postpartum visits and treatment of mother's emotional, mental well-being and physical recovery from childbirth.

Field Name:

Priority Need 3

Field Note:
REVISED - Focused on increasing awareness of risk associated with Preterm births and Low birth weight through education and outreach services.

Field Name:

Priority Need 4

Field Note:
CONTINUING - Same description and focus identified

Field Name:

Priority Need 5

Field Note:
New - Aim to decrease excessive screen time and sedentary lifestyle to increase physical activity and improve mental health among children.

Field Name:

Priority Need 6

Field Note:
New priority: focused on reducing the rate of teen pregnancy and STI

Field Name:

Priority Need 7

Field Note:
New priority: focused on bullying prevention on school property.

Field Name:

Priority Need 8

Field Note:
Access to care coordination and navigation of healthcare and community programs *Required NPM Medical Home.
(To increase access to Medical Home for CSHCN population)

Field Name:

Priority Need 9

Field Note:
New Priority: focused on increasing support for the CSHCN population through Parent training

Field Name:

Priority Need 10

Field Note:
New Priority - Provide clear communication about healthcare services and available support to patients, healthcare providers, and community.

Form 10
National Outcome Measures (NOMs)

State: Northern Mariana Islands

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

No FAD available and the CNMI MCH Title V is working to establish mechanisms for tracking the following NOMs:
- NAS
- FL-YC
- FL- CA
- FL- Child Adolescent
- ACE

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

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

State Provided Data	
	2024
Annual Indicator	215.1
Numerator	12
Denominator	558
Data Source	Health and Vital Statistics
Data Source Year	2024

NOM SMM - Notes:

Severe Maternal Morbidity included:
1. Maternal transfusion
2. Hypertension Eclampsia
3. Unplanned hysterectomy
4. Admission to ICU
5. Ruptured Uterus
6. Unplanned OR procedure.

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019_2023	NR	NR	NR	NR
2018_2022	NR	NR	NR	NR
2017_2021	NR	NR	NR	NR
2016_2020	NR	NR	NR	NR
2015_2019	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2024
Annual Indicator	0.0
Numerator	0
Denominator	558
Data Source	CHCC Health and Vital Statistics
Data Source Year	2024

NOM MM - Notes:

There were zero (0) maternal mortality cases in the CNMI for year 2024
Data source: CHCC Health and Vital Statistics

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	16.9	2.7	39	2,304
2022	9.4	2.1	21	2,224
2021	14.0	2.6	30	2,147
2020	17.9	2.9	38	2,126
2019	20.6	3.1	43	2,091
2018	28.3	3.7	58	2,048
2017	16.1	2.8	33	2,052
2016	27.4	3.7	56	2,047
2015	28.2	3.8	56	1,988
2014	29.6	3.9	59	1,992
2013	35.6	4.2	71	1,996
2012	33.1	4.1	66	1,996
2011	46.3	4.9	90	1,944
2010	57.0	5.4	112	1,965
2009	49.8	4.9	103	2,069

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2024
Annual Indicator	11.7
Numerator	27
Denominator	2,308
Data Source	CHCC Health and Vital Statistics and US census IDB
Data Source Year	2024

NOM TB - Notes:

Numerator - # of births to teens (ages 15-19 years) - Data Source: Health and Vital Statistics

Denominator - Data source: U.S. Census International Database (IDB)

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	10.5 %	1.3 %	61	579
2022	10.9 %	1.4 %	51	467
2021	8.1 %	1.1 %	46	570
2020	10.7 %	1.2 %	67	628
2019	7.1 %	1.0 %	48	679
2018	10.9 %	1.3 %	61	561
2017	7.6 %	1.4 %	27	356
2016	7.8 %	1.3 %	32	411
2015	7.8 %	1.3 %	33	424
2014	7.6 %	1.2 %	39	516
2013	7.8 %	1.0 %	53	677
2012	6.4 %	0.8 %	54	847
2011	7.3 %	0.8 %	75	1,032
2010	7.2 %	1.1 %	42	580
2009	8.6 %	0.8 %	95	1,107

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	12.7 %	1.7 %	1,946	15,385
2019_2021	12.0 %	1.6 %	2,066	17,149

Legends:

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

State Provided Data	
	2024
Annual Indicator	7.3
Numerator	41
Denominator	558
Data Source	CHCC Health and Vital Statistics
Data Source Year	2024

NOM LBW - Notes:

NUMERATOR
Number of live births weighing less than 2,500 grams

DENOMINATOR
Number of live births

Data source: HVSO

Data Alerts: None

NOM - Percent of preterm births (<37 weeks gestation) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2023	10.4 %	1.3 %	60	578
2022	12.0 %	1.5 %	56	466
2021	9.0 %	1.2 %	51	568
2020	10.7 %	1.2 %	67	628
2019	8.7 %	1.1 %	59	682
2018	10.4 %	1.3 %	59	565
2017	7.8 %	1.4 %	28	359
2016	12.1 %	1.6 %	50	412
2015	9.7 %	1.4 %	41	424
2014	9.3 %	1.3 %	48	517
2013	9.8 %	1.2 %	65	665
2012	7.6 %	0.9 %	62	813
2011	6.8 %	0.8 %	70	1,028
2010	7.6 %	0.8 %	78	1,023
2009	8.2 %	0.8 %	90	1,100

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021_2023	16.2 %	1.8 %	2,487	15,385
2019_2021	14.9 %	1.9 %	2,548	17,149

Legends:

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

State Provided Data	
	2024
Annual Indicator	7.5
Numerator	42
Denominator	558
Data Source	Health and Vital Statistics
Data Source Year	2024

NOM PTB - Notes:

NUMERATOR:
Number of live births before 37 weeks of complete gestation

DENOMINATOR
Number of live births

Data source: HVSO

Data Alerts: None

NOM - Stillbirth rate per 1,000 live births plus fetal deaths - SB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	NR	NR	NR	NR
2018	17.4	5.5	10	576
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	9.6	3.1	10	1,043
2010	NR	NR	NR	NR
2009	8.9	2.8	10	1,119

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM SB - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

⚑ Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2024
Annual Indicator	21.5
Numerator	12
Denominator	558
Data Source	Health and Vital Statistics
Data Source Year	2024

NOM PNM - Notes:

Numerator
Number of fetal deaths 28 weeks or more gestation plus early neonatal deaths occurring under 7 days

Denominator
Number of live births plus fetal deaths at 28 weeks or more gestation

Data source: HVSO

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2020	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2024
Annual Indicator	7.2
Numerator	4
Denominator	558
Data Source	Health and Vital Statistics
Data Source Year	2024

NOM IM - Notes:

Numerator: Number of deaths to infants from birth through 364 days of age

Denominator: Number of Live births

Data source: HVSO

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2019				
2018				
2018				
2017				
2016				
2015				
2014				
2013				
2012				
2011				
2010				
2009				

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2024
Annual Indicator	0.0
Numerator	0
Denominator	558
Data Source	Health and Vital Statistics
Data Source Year	2024

NOM IM-Neonatal - Notes:

NUMERATOR: Number of deaths to infants under 28 days

DENOMINATOR: Number of live births

Data source: HVSO

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2024
Annual Indicator	0.0
Numerator	0
Denominator	558
Data Source	Health and Vital Statistics
Data Source Year	2024

NOM IM-Postneonatal - Notes:

Numerator: Number of deaths to infants from 28 through 364 days of age.

Denominator: Number of live births

Data source: HVSO

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births - IM-Preterm Related

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

State Provided Data	
	2024
Annual Indicator	537.6
Numerator	3
Denominator	558
Data Source	Health and Vital Statistics
Data Source Year	2024

NOM IM-Preterm Related - Notes:

Numerator - Number of death due to preterm-related causes (<37 completed weeks of gestation) with the underlying cause of death

Denominator - Number of live births

Data source: HVSO

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM IM-SUID - Notes:

None

Data Alerts: None

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

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

NOM NAS - Notes:

No FAD available and the CNMI MCH Title V is working to establish mechanisms for tracking this measure.

Data Alerts:

1.	Data has not been entered for NOM NAS. This outcome measure is linked to the selected NPM(s): PPV,MHS. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM - Percent of children meeting the criteria developed for school readiness - SR

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

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year - TDC

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	20.7 %	2.1 %	3,027	14,628
2019_2021	15.0 %	2.1 %	2,433	16,242

Legends:

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

NOM TDC - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	NR	NR	NR	NR
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2020	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2024
Annual Indicator	77.0
Numerator	5
Denominator	6,493
Data Source	Health and Vital Statistics
Data Source Year	2024

NOM CM - Notes:

Numerator Number of deaths among children ages 1 through 9 years - HVSO
Denominator Number of children ages 1 through 9 years - US Census IDB

Data source: Numerator: Health and Vital Statistics
Denominator: U.S. Census IDB

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	NR	NR	NR	NR
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2020	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2024
Annual Indicator	55.2
Numerator	5
Denominator	9,066
Data Source	Health and Vital Statistics and US census IDB
Data Source Year	2024

NOM AM - Notes:

Numerator:
Number of deaths among adolescents ages 10 through 19 years (HVSO)

Denominator
Number of adolescents ages 10 through 19 years (US census IDB)

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021-2023	NR	NR	NR	NR
2020_2022	NR	NR	NR	NR
2019_2021	NR	NR	NR	NR
2015_2017	NR	NR	NR	NR
2014_2016	NR	NR	NR	NR
2013_2015	NR	NR	NR	NR
2012_2014	NR	NR	NR	NR
2011_2013	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR
2008_2010	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 10 through 19 per 100,000 - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021_2023	NR	NR	NR	NR
2020_2022	NR	NR	NR	NR
2019_2021	NR	NR	NR	NR
2018_2020	NR	NR	NR	NR
2017_2019	NR	NR	NR	NR
2016_2018	NR	NR	NR	NR
2015_2017	NR	NR	NR	NR
2014_2016	NR	NR	NR	NR
2013_2015	NR	NR	NR	NR
2012_2014	NR	NR	NR	NR
2011_2013	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2024
Annual Indicator	11.0
Numerator	1
Denominator	9,066
Data Source	Health and Vital Statistics
Data Source Year	2024

NOM AM-Suicide - Notes:

Numerator Number of deaths attributed to suicide among youths ages 15 through 19 years - HVSO

Denominator Number of adolescents ages 15 through 19 years

Data source: (US Census IDB)

Data Alerts: None

NOM - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	NR	NR	NR	NR
2020_2022	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM AM-Firearm - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child

Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	6.8	1.9	555	8,178
2019_2021	3.3 ϟ	1.1 ϟ	313 ϟ	9,440 ϟ

Legends:

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

NOM IH-Child - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

Data Source: MCH Jurisdictional Survey (MCH-JS) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	4.3	1.3	312	7,207
2019_2021	4.7	2.0	180	3,855

Legends:

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

NOM IH-Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	48.8 %	3.0 %	5,598	11,483
2019_2021	48.9 %	3.1 %	6,021	12,303

Legends:

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

NOM WHS - Notes:

None

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	74.4 %	2.3 %	11,451	15,385
2019_2021	76.6 %	2.2 %	13,130	17,149

Legends:

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

NOM CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 6 through 17, who are obese (BMI at or above the 95th percentile) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	9.3 %	0.9 %	102	1,095
2018	8.7 %	0.7 %	136	1,569
2016	7.8 %	0.7 %	111	1,418
2014	9.0 %	0.7 %	162	1,808
2012	11.3 %	0.7 %	253	2,239
2010	14.1 %	0.8 %	304	2,157

Legends:

Indicator has a denominator <20 and is not reportable

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

Data Source: MCH Jurisdictional Survey (MCH-JS) - Age 10-17

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	21.6 %	2.8 %	1,555	7,207
2019_2021	20.8 %	3.0 %	1,602	7,709

Legends:

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

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	23.1 %	1.4 %	126	547

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	36.9 %	9.1 %	471	1,277
2019_2021	44.0 %	8.3 %	798	1,817

Legends:

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

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum anxiety symptoms - PPA

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	25.1 %	1.5 %	138	548

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPA - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	0.9 %	0.5 %	43	5,035
2019_2021	2.9 %	1.2 %	154	5,376

Legends:

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

NOM BCD - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	2.1 %	0.8 %	111	5,282
2019_2021	1.2 %	0.6 %	67	5,806

Legends:

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

NOM ADA - Notes:

None

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	0 %	0	0	1,666
2019_2021	0.8 %	0.8 %	14	1,811

Legends:

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

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 5, who are flourishing - FL-YC

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

NOM FL-YC - Notes:

No FAD available and the CNMI MCH Title V is working to establish mechanisms for tracking this measure.

Data Alerts:

1.	Data has not been entered for NOM FL-YC. This outcome measure is linked to the selected NPM(s): MH. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA

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

NOM FL-CA - Notes:

No FAD available and the CNMI MCH Title V is working to establish mechanisms for tracking this measure.

Data Alerts:

1.	Data has not been entered for NOM FL-CA. This outcome measure is linked to the selected NPM(s): MH,AWV. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent

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

NOM FL-Child Adolescent - Notes:

No FAD available and the CNMI MCH Title V is working to establish mechanisms for tracking this measure.

Data Alerts:

1.	Data has not been entered for NOM FL-Child Adolescent. This outcome measure is linked to the selected NPM(s): MH,AWV. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE

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

NOM ACE - Notes:

No FAD available and the CNMI MCH Title V is working to establish mechanisms for tracking this measure.

Data Alerts:

1.	Data has not been entered for NOM ACE. This outcome measure is linked to the selected NPM(s): BLY. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

Form 10
National Performance Measures (NPMs)

State: Northern Mariana Islands

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	56.0	56.0
Numerator	250	308
Denominator	447	550
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2023	**2024**
Annual Objective		
Annual Indicator	75.1	82.4
Numerator	411	1,007
Denominator	548	1,222
Data Source	MCH-JS	MCH-JS
Data Source Year	2024	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	57.0	58.0	59.0	60.0	61.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2026**

	Column Name:	**Annual Objective**
	Field Note: PRAMS DATA SOURCE The baseline data value for PPV - (A) = 56%. With a 5 percentage points increase to (61%) by year 2030, The 2026 annual objective for PPV-(A) is set at 57%	
2.	**Field Name:**	**2027**
	Column Name:	**Annual Objective**
	Field Note: PRAMS DATA SOURCE The baseline data value for PPV - (A) is at 56%. With a 5% points increase to (61%) by year 2030, The 2027 annual objective for PPV-(A) is set at 58%	
3.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**
	Field Note: PRAMS DATA SOURCE The baseline data value for PPV - (A) is at 56%. With a 5% points increase to (61%) by year 2030, The 2028 annual objective for PPV-(A) is set at 59%	
4.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**
	Field Note: PRAMS DATA SOURCE The baseline data value for PPV - (A) is at 56%. With a 5% points increase to (61%) by year 2030, The 2029 annual objective for PPV-(A) is set at 60%	
5.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**
	Field Note: PRAMS DATA SOURCE The baseline data value for PPV - (A) is at 56%. With a 5 percentage points increase to (61%) by year 2030, The 2030 annual objective for PPV-(A) is set at 61%	

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	67.0	63.3
Numerator	167	188
Denominator	249	296
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	66.0	67.0	68.0	69.0	70.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: PRAMS - NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV The baseline PPV - (B) = 65%. With a 1 percentage point increase annually to 70% by year 2030, The 2026 annual objective for PPV-(B) is set at 66%	
2.	**Field Name:**	**2027**
	Column Name:	**Annual Objective**
	Field Note: PRAMS - NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV The baseline PPV - (B) = 65%. With a 1 percentage points increase annually to 70% by year 2030, The 2027 annual objective for PPV-(B) is set at 67%	

3.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**

Field Note:
PRAMS - NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

The baseline PPV - (B) = 65%.
With a 1 percentage points increase annually to 70% by year 2030,

The 2028 annual objective for PPV-(B) is set at 68%

4.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**

Field Note:
PRAMS - NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

The baseline PPV - (B) = 65%.
With a 1 percentage points increase annually to 70% by year 2030,

The 2029 annual objective for PPV-(B) is set at 69%

5.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**

Field Note:
PRAMS - NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

The baseline PPV - (B) = 65%.
With a 1 percentage points increase annually to 70% by year 2030,

The 2030 annual objective for PPV-(B) is set at 70%

NPM - Percent of women who were screened for depression or anxiety following a recent live birth - MHS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	62.6
Numerator	340
Denominator	544
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective					

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data	
Data Source: MCH Jurisdictional Survey (MCH-JS)	
	2024
Annual Objective	98
Annual Indicator	88.7
Numerator	4,494
Denominator	5,067
Data Source	MCH-JS
Data Source Year	2021_2023

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	98	98
Annual Indicator	95.7	96.5
Numerator	440	557
Denominator	460	577
Data Source	NVSS	NVSS
Data Source Year	2022	2023

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		97	98	98	98
Annual Indicator	93.3	93.7	94.9	93.1	93.5
Numerator	610	539	449	541	522
Denominator	654	575	473	581	558
Data Source	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	94.0	95.0	96.0	97.0	98.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of infants who were reported by their parents to have been breastfed after birth or prior to discharge at CHCC. Denominator: 2021 HVSO Live birth dataset	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of infants who were reported by their parents to have been breastfed after birth or prior to discharge at CHCC. Denominator: 2022 HVSO Live birth dataset	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

	Field Note: Numerator: Number of infants who were reported by their parents to have been breastfed after birth or prior to discharge at CHCC. Denominator: 2023 HVSO Live birth dataset	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of infants who were reported by their parents to have been breastfed after birth or prior to discharge at CHCC. Denominator: 2024 HVSO Live birth dataset	
5.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: CNMI Health and Vital Statistics For NPM - A) Percent of infants who are ever breastfed - BF, Baseline = 94%, with a .1 percentage point increase to 94.4% by 2030 Annual object for year 2026 is 94%	
6.	**Field Name:**	**2027**
	Column Name:	**Annual Objective**
	Field Note: For NPM - A) Percent of infants who are ever breastfed - BF, Baseline = 94%, with a .1 percentage point increase to 94.4% by 2030 Annual object for year 2027 is 94.1%	
7.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**
	Field Note: For NPM - A) Percent of infants who are ever breastfed - BF, Baseline = 94%, with a .1 percentage point increase to 94.4% by 2030 Annual object for year 2028 is 94.2%	
8.	**Field Name:**	**2029**

	Column Name:	**Annual Objective**

Field Note:
For NPM - A) Percent of infants who are ever breastfed - BF,
Baseline = 94%, with a .1 percentage point increase to 94.4% by 2030

Annual object for year 2029 is 94.3%

9.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**

Field Note:
For NPM - A) Percent of infants who are ever breastfed - BF,
Baseline = 94%, with a .1 percentage point increase to 94.4% by 2030

Annual object for year 2030 is 94.4%

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

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

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		5	6	6	13
Annual Indicator	0.4	0	0.5	11.1	11.6
Numerator	2	0	2	47	52
Denominator	544	419	411	424	448
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	12.0	13.0	14.0	15.0	16.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of 6 month old infants enrolled in the WIC program who were breastfed exclusively for 6 months. Denominator: Number of 6 month old infants enrolled in the WIC program.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of 6 month old infants enrolled in the WIC program who were breastfed exclusively for 6 months. Denominator: Number of 6 month old infants enrolled in the WIC program.	
3.	**Field Name:**	**2023**

	Column Name:	**State Provided Data**
	Field Note: Percent of infants currently enrolled in the WIC program who were breastfed exclusively for 6 months.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: For NPM - B) Percent of infants breastfed exclusively through 6 months - BF Baseline data is set at 11%, with a 3 percentage points increase to 14% by 2030.	
5.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: CNMI WIC Program For NPM - B) Percent of infants breastfed exclusively through 6 months - BF Baseline data = 10% --- increased to 5 percentage points (14%) by 2030. Annual objective for year 2026 is 10%	
6.	**Field Name:**	**2027**
	Column Name:	**Annual Objective**
	Field Note: CNMI WIC Program For NPM - B) Percent of infants breastfed exclusively through 6 months - BF Baseline data = 10% --- increased to 5 percentage points (14%) by 2030. Annual objective for year 2027 is 11%	
7.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**
	Field Note: CNMI WIC Program For NPM - B) Percent of infants breastfed exclusively through 6 months - BF Baseline data = 10% --- increased to 5 percentage points (14%) by 2030. Annual objective for year 2028 is 12%	
8.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**

	Field Note: CNMI WIC Program For NPM - B) Percent of infants breastfed exclusively through 6 months - BF Baseline data = 10% --- increased to 5 percentage points (14%) by 2030. Annual objective for year 2029 is 13%	
9.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**
	Field Note: CNMI WIC Program For NPM - B) Percent of infants breastfed exclusively through 6 months - BF Baseline data = 10% --- increased to 5 percentage points (14%) by 2030. Annual objective for year 2030 is 14%	

NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		55	57	59	61
Annual Indicator	52.7	43.5	43.5	60.7	51.3
Numerator	2,769	2,393	2,393	2,775	2,584
Denominator	5,253	5,498	5,498	4,572	5,035
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2021	2021	2024	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	52.0	53.0	54.0	55.0	56.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2026**

   Column Name: **Annual Objective**

   Field Note:
   MCH-JS -- Child
   For NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

   3 rounds average of the MCH-JS - Baseline of 51% with a .5 percentage points increased annually to 53.5% by 2030

   Annual Objective for year 2026 is set at 51.5%

2. **Field Name:** **2027**

   Column Name: **Annual Objective**

   Field Note:
   MCH-JS -- Child
   For NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

   3 rounds average of the MCH-JS - Baseline of 51% with a .5 percentage points increased annually to 53.5% by 2030

   Annual Objective for year 2027 is set at 52%

3.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**

Field Note:
MCH-JS -- Child
For NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

3 rounds average of the MCH-JS - Baseline of 51% with a .5 percentage points increased annually to 53.5% by 2030

Annual Objective for year 2028 is set at 52.5%

4.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**

Field Note:
MCH-JS -- Child
For NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

3 rounds average of the MCH-JS - Baseline of 51% with a .5 percentage points increased annually to 53.5% by 2030

Annual Objective for year 2029 is set at 53%

5.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**

Field Note:
MCH-JS -- Child
For NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

3 rounds average of the MCH-JS - Baseline of 51% with a .5 percentage points increased annually to 53.5% by 2030

Annual Objective for year 2030 is set at 53.5%

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		43	46	49	35
Annual Indicator	42.4	39.3	39.3	27.3	33.5
Numerator	2,593	2,156	2,156	1,386	1,771
Denominator	6,119	5,493	5,493	5,072	5,282
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2021	2021	2024	2021_2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		43	46	49	35
Annual Indicator	8.1	22	12.1	16.6	6.9
Numerator	503	1,378	749	998	390
Denominator	6,215	6,256	6,177	5,994	5,661
Data Source	RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue EHR	CareVue EHR
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	36.0	37.0	38.0	39.0	40.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2020**

	Column Name:	**State Provided Data**
	Field Note: Numerator: 2020 CHCC RPMS query of Preventive Visit using ICD-10, CPT codes and provider's narratives. Denominator: US International Census estimates of the number of individuals ages 12 to 17 years for 2020	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of adolescents, ages 12 through 17, with a preventive medical visit in the past year. Data Source: RPMS and New CareVue EHR Denominator Number of adolescents, ages 12 through 17 Data source: International Database Estimate, US CENSUS	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of adolescents, ages 12 through 17, with a preventive medical visit in the past year at the CHCC. Data Source: New CareVue EHR Denominator Number of adolescents, ages 12 through 17 Data source: International Database Estimate, US CENSUS	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of adolescents, ages 12 through 17, with a preventive medical visit in the past year at the CHCC. Data Source: New CareVue EHR Denominator Number of adolescents, ages 12 through 17 Data source: U.S. Census International Database (IDB)	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of adolescents, ages 12 through 17, with a preventive medical visit in the past year at the CHCC. Data Source: New CareVue EHR Denominator Number of adolescents, ages 12 through 17 Data source: U.S. Census International Database (IDB)	

6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
CareVue EHR
For - NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Baseline data = 13% - with a 1 percentage point increased annually to 18% by 2030

Annual objective for 2026 is 14%

7.	**Field Name:**	**2027**
	Column Name:	**Annual Objective**

Field Note:
CareVue EHR
For - NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Baseline data = 13% - with a 1 percentage point increased annually to 18% by 2030

Annual objective for 2027 is 15%

8.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**

Field Note:
CareVue EHR
For - NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Baseline data = 13% - with a 1 percentage point increased annually to 18% by 2030

Annual objective for 2028 is 16%

9.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**

Field Note:
CareVue EHR
For - NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Baseline data = 13% - with a 1 percentage point increased annually to 18% by 2030

Annual objective for 2029 is 17%

10.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**

Field Note:
CareVue EHR
For - NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Baseline data = 13% - with a 1 percentage point increased annually to 18% by 2030

Annual objective for 2030 is 18%

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	15	19	15	18	15
Annual Indicator	13.3	14.1	14.1	12.5	17.4
Numerator	141	176	176	138	290
Denominator	1,059	1,252	1,252	1,101	1,666
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2021	2021	2024	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	14.0	15.0	16.0	17.0	18.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2026**

   Column Name: **Annual Objective**

   Field Note:
   MCH-JS--CSHCN
   For - NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - CSHCN

   Baseline 13% with an increase of 1 percentage points annually to 18% by 2030

   Annual Objective for year 2026 is 14%

2. **Field Name:** **2027**

   Column Name: **Annual Objective**

   Field Note:
   MCH-JS--CSHCN
   For - NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - CSHCN

   Baseline = 13%, with an increase of 1 percentage points annually to 18% by 2030

   Annual Objective for year 2027 is 15%

3.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**
	Field Note: MCH-JS--CSHCN For - NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - CSHCN Baseline = 13%, with an increase of 1 percentage points annually to 18% by 2030 Annual Objective for year 2028 is 16%	
4.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**
	Field Note: MCH-JS--CSHCN For - NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - CSHCN Baseline = 13%, with an increase of 1 percentage points annually to 18% by 2030 Annual Objective for year 2029 is 17%	
5.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**
	Field Note: MCH-JS--CSHCN For - NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - CSHCN Baseline = 13%, with an increase of 1 percentage points annually to 18% by 2030 Annual Objective for year 2030 is 18%	

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	8.9	13.4
Numerator	1,208	2,060
Denominator	13,620	15,385
Data Source	MCH-JS-All Children	MCH-JS-All Children
Data Source Year	2024	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	16.0	17.0	18.0	19.0	20.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2026**

   Column Name: **Annual Objective**

   Field Note:
   MCH-JS - ALL
   For - NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - ALL

   Baseline = 15% with an increase of 1 percentage point annually to 20% by 2030

   Annual Objective for year 2026 is 16%

2. **Field Name:** **2027**

   Column Name: **Annual Objective**

   Field Note:
   MCH-JS - ALL
   For - NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - ALL

   Baseline = 15% with an increase of 1 percentage point annually to 20% by 2030

   Annual Objective for year 2027 is 17%

3.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**

Field Note:
MCH-JS - ALL
For - NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - ALL

Baseline = 15% with an increase of 1 percentage point annually to 20% by 2030

Annual Objective for year 2028 is 18%

4.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**

Field Note:
MCH-JS - ALL
For - NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - ALL

Baseline = 15% with an increase of 1 percentage point annually to 20% by 2030

Annual Objective for year 2029 is 19%

5.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**

Field Note:
MCH-JS - ALL
For - NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - ALL

Baseline = 15% with an increase of 1 percentage point annually to 20% by 2030

Annual Objective for year 2030 is 20%

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

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		52	55	58	72
Annual Indicator	51.0	32.8	32.8	70.7	43.0
Numerator	183	167	167	322	299
Denominator	358	511	511	455	695
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2021	2021	2024	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	44.0	45.0	46.0	47.0	48.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2026**

   Column Name: **Annual Objective**

   Field Note:
   MCH-JS -- CSHCN
   For - NPM - Percent of adolescents with special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

   Baseline : 51% with a 1 percentage point increased to 56% by 2030

   Annual Objective for year 2026 is 52%

2. **Field Name:** **2027**

   Column Name: **Annual Objective**

   Field Note:
   MCH-JS -- CSHCN
   For - NPM - Percent of adolescents with special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

   Baseline : 51% with a 1 percentage point increased to 56% by 2030

   Annual Objective for year 2027 is 53%

3.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**

Field Note:
MCH-JS -- CSHCN
For - NPM - Percent of adolescents with special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

Baseline : 51% with a 1 percentage point increased to 56% by 2030

Annual Objective for year 2028 is 54%

4.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**

Field Note:
MCH-JS -- CSHCN
For - NPM - Percent of adolescents with special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

Baseline : 51% with a 1 percentage point increased to 56% by 2030

Annual Objective for year 2029 is 55%

5.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**

Field Note:
MCH-JS -- CSHCN
For - NPM - Percent of adolescents with special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

Baseline : 51% with a 1 percentage point increased to 56% by 2030

Annual Objective for year 2030 is 56%

NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY - Adolescent Health

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2024
Annual Objective	
Annual Indicator	22.9
Numerator	718
Denominator	3,143
Data Source	YRBSS
Data Source Year	2023

Federally Available Data	
Data Source: MCH Jurisdictional Survey (MCH-JS)	
	2024
Annual Objective	
Annual Indicator	20.5
Numerator	1,084
Denominator	5,282
Data Source	MCH-JS-All Adolescents
Data Source Year	2021_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	21.0	20.0	19.0	18.0	17.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

State: Northern Mariana Islands

2021-2025: NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Adolescent Health - All Adolescents

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - All Adolescents					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		55	55	55	51
Annual Indicator	48.4	46.3	46.3	39.6	42.4
Numerator	2,788	2,306	2,306	2,006	2,240
Denominator	5,761	4,982	4,982	5,072	5,282
Data Source	MCH-JS-NONCSHCN	MCH-JS-All Adolescents	MCH-JS-All Adolescents	MCH-JS-All Adolescents	MCH-JS-All Adolescents
Data Source Year	2019	2021	2021	2024	2021_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	56	57	59	61	63
Annual Indicator	55.5	57.1	57.1	54.5	56.0
Numerator	6,544	7,415	7,415	5,531	6,473
Denominator	11,784	12,993	12,993	10,143	11,568
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2021	2021	2024	2021_2023

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		57	59	61	63
Annual Indicator	25.4	65.4	53.1		
Numerator	1,959	5,047	4,057		
Denominator	7,721	7,717	7,641		
Data Source	CHCC Preventive Visits and US international census	CHCC EHR/RPMS Preventive visits	CHCC CareVue EHR Preventive Visits		
Data Source Year	2020	2021	2022		
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator: RPMS query; using ICD-10 and CPT codes plus provider's narrative on preventive visits that include physical and annual exams counseling, screening, well women visits, immunizations and tuberculin skin test, employment health, diabetes and blood pressure check, gynecological exam pap and mammograms of females ages 18-44 who visited CHCC. Denominator: 2020 U.S. International Census Estimates	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Preventive visits included: adult annual and well-women exams, as well as gynecological, and vision or hearing exams; encounters for preventive screening of STDs, mammogram, cancer A1C, body mass index, diabetes, counseling, dental and immunization.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Number of women, ages 18 through 44, who had a preventive medical visit in the past year. (Excluding Emergency Room, and Radiology Department)	

Form 10
State Performance Measures (SPMs)

State: Northern Mariana Islands

SPM 1 - Percent of CNMI resident women with live births who receive prenatal care beginning in the first trimester.

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective	51	53	70	72	65
Annual Indicator	55.6	67	61.7	61.1	67.6
Numerator	351	383	290	333	338
Denominator	631	572	470	545	500
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	69.0	70.0	71.0	72.0	73.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator value based on the number of resident live births with prenatal care beginning in the first trimester. Denominator value based on the total number of resident live births.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

	Field Note: Numerator: Number of deliveries to resident women receiving prenatal care beginning in the first trimester of pregnancy. Denominator: Number of deliveries to resident women in year 2021.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of deliveries to resident women receiving prenatal care beginning in the first trimester of pregnancy. Denominator: Number of deliveries to resident women in year 2022.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Percent of live births to resident or Non-Tourist women with first trimester prenatal care.	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: SPM 2 - Percent of live births to resident women with first trimester prenatal care. Annual objective of 65% achieved.	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: HVSO Percent of live births to resident women with first trimester prenatal care. Baseline = 63%, with a 1.0 percentage point increased annually to 68% by 2030 Annual objective for 2026 is set at 64%	
7.	**Field Name:**	**2027**
	Column Name:	**Annual Objective**

	Field Note: HVSO Percent of live births to resident women with first trimester prenatal care. Baseline = 63%, with a 1.0 percentage point increased annually to 68% by 2030 Annual objective for 2027 is set at 65%	
8.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**
	Field Note: HVSO Percent of live births to resident women with first trimester prenatal care. Baseline = 63%, with a 1.0 percentage point increased annually to 68% by 2030 Annual objective for 2028 is set at 66%	
9.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**
	Field Note: HVSO Percent of live births to resident women with first trimester prenatal care. Baseline = 63%, with a 1.0 percentage point increased annually to 68% by 2030 Annual objective for 2029 is set at 67%	
10.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**
	Field Note: HVSO Percent of live births to resident women with first trimester prenatal care. Baseline = 63%, with a 1.0 percentage point increased annually to 68% by 2030 Annual objective for 2030 is set at 68%	

SPM 2 - Percent of progress milestones completed toward the development and implementation of a centralized, user-friendly digital platform.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10.0	15.0	20.0	25.0	30.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 2 - Percentage of CHCC Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	15	20	50
Annual Indicator		2.1	34	49.2	91.7
Numerator		2	32	61	100
Denominator		94	94	124	109
Data Source		CHCC HUMAN RESOURCES	CHCC HUMAN RESOURCES	CHCC Training Spreadsheet	CHCC Public Health Training Logs
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Numerator: 2 MICAH employees received training on using / entering data into the new electronic health record (CareVue) revenue cycle management (RCM) that was conducted in year 2021, however, due to the challenges presented by COVID-19 pandemic, development of instructional methods to administer training across CHCC PHS staff and MCH serving professionals was postponed to a later date.

Denominator: Number of PHS and MICAH employees

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Numerator: 3 individuals from PHS and 1 person from MCH attended SAS analytic training conducted by CHCC Epidemiologist; 1 employee attended Power BI training in year 2022; 6 attended one key question training; 21 attended breastfeeding bootcamp. Total 32 training participants in 2022.

Other training opportunities were interrupted due to COVID-19 pandemic.

Discussion for providing standardized curriculum for online training to Population Health Staffs including MCH Professionals are ongoing.

Denominator: Number of CHCC PHS and MCH staff and employees.

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Denominator reflects the total number of Public Health staff in 2023. The numerator value indicates the unduplicated number of Public Health staff members who completed at least one training related to MCH priorities or activities.

4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
The denominator reflects the total number of staff under the Division of Public Health in 2024. The numerator value indicates the number of staff under the Division of Public Health that participated in capacity building/training workshops focused on MCH related topics.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Northern Mariana Islands

ESM PPV.1 - Number of women that are accessing well woman visits, prenatal care visits, and postpartum visits via mobile clinic and other clinical outreach.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5.0	10.0	15.0	20.0	25.0

Field Level Notes for Form 10 ESMs:

None

ESM BF.1 - Percent of women enrolled in group prenatal care who exclusively breastfeed at 6 weeks postpartum.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	57.4	57.6	57.8
Annual Indicator		44.6	39.9	43.2	44.6
Numerator		187	164	183	200
Denominator		419	411	424	448
Data Source		WIC Program	WIC Program	WIC Program	WIC Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Final	Final	Provisional

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	46.0	47.0	48.0	49.0	50.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of WIC enrolled infants who were breastfed at 6 months. Denominator: Total number of 6 month old infants in the WIC Program	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of WIC enrolled infants who were breastfed at 6 months. Denominator: Total number of 6 month old infants in the WIC Program	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of WIC enrolled infants who were breastfed at 6 months. Denominator: Total number of 6 month old infants in the WIC Program	
4.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Baseline percentage for this measure is 45%. The CNMI seeks to increase this percentage by 5% in 2030.	

ESM PA-Child.1 - PA-Child.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum.

Measure Status:	Inactive - Replaced

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		10	15	20	25
Annual Indicator		0	0	25	0
Numerator		0	0	2	0
Denominator		3	8	8	1
Data Source		MCH referral log and EFNEP enrollment record	MCH referral log and EFNEP enrollment record	MCH referral log and EFNEP enrollment record	MCH referral log
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of referrals who reported completing at least 75% of the EFNEP program curriculum. Denominator: Number of referrals to the EFNEP program	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of referrals who reported completing at least 75% of the EFNEP program curriculum. Denominator: Number of referrals to the EFNEP program	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Due to challenges around staff capacity, strategies around partnerships with community agencies focused on physical activity were paused in 2024. There were no referrals made to the EFNEP program.	

ESM PA-Child.2 - Number of children ages 6-11 years who enroll in after school sports or other group activities.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5.0	10.0	15.0	20.0	25.0

Field Level Notes for Form 10 ESMs:

None

ESM AWV.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	1	12.5	17
Annual Indicator		22	12.1	16.6	6.9
Numerator		1,378	749	998	390
Denominator		6,256	6,177	5,994	5,661
Data Source		CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator- Number of teens ages 12 through 17 years who accessed preventive care at CHCC sites. Denominator- Number of teens ages 12 through 17 years (US Census International Database Estimate)	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator- Number of teens ages 12 through 17 years who accessed preventive care at CHCC sites. Denominator- Number of teens ages 12 through 17 years (US Census International Database Estimate)	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator- Number of teens ages 12 through 17 years who accessed preventive care at CHCC sites. Denominator- Number of teens ages 12 through 17 years (US Census International Database Estimate)	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: CHCC CareVue EHR/US Census IDB Numerator- Number of teens ages 12 through 17 years who accessed preventive care at CHCC sites. Denominator- Number of teens ages 12 through 17 years (US Census International Database Estimate)	

ESM AWV.2 - Percentage of Public School System (PSS) students ages 12-17 years who had an adolescent well-visit in the past year.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5.0	10.0	15.0	20.0	25.0

Field Level Notes for Form 10 ESMs:

None

ESM MH.1 - Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	20	30	55
Annual Indicator		81	81	52.3	40.5
Numerator		51	51	45	45
Denominator		63	63	86	111
Data Source		F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	45.0	50.0	55.0	60.0	65.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of families served by the Family to Family Health Information Center who reported having a medical home. Denominator: Number of families served by Family to Family Health Information Center.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data Source Year: 2021	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of families served by the Family to Family Health Information Center who reported having a medical home. Denominator: Number of families served by Family to Family Health Information Center.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of families served by the Family to Family Health Information Center who reported having a medical home. Denominator: Number of families served by Family to Family Health Information Center.	

ESM TAHC.1 - Percentage of high school students served by SPED who received information on transition

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	15	20	35
Annual Indicator		0	4.9	34.4	78.5
Numerator		0	16	115	205
Denominator		322	329	334	261
Data Source		Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED	Program Administrative Records
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Provisional	Provisional	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Due to the unforeseen challenges arising from the COVID-19 pandemic, activities surrounding ESM 12.1 is postponed to a later date. Numerator: Number of high school teens in special education services who received information on transition services. Denominator: Number of high school teens in special education services.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of high school teens in special education services who received information on transition services. Denominator: Number of high school teens in special education services.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of high school teens in special education services who received information on transition services. Denominator: Number of high school teens in special education services.	

ESM TAHC.2 - Number of parents who complete transition training.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10.0	15.0	20.0	25.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM BLY.1 - Percent of schools who have implemented evidence based bullying prevention programs.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	20.0	30.0	40.0	50.0	60.0

Field Level Notes for Form 10 ESMs:

None

Form 10

Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM WWV.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at all CHCC health service sites.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		5	49	53	35
Annual Indicator		65.4	53.1	28.6	21.5
Numerator		5,047	4,057	2,170	1,647
Denominator		7,717	7,641	7,595	7,648
Data Source		CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of females ages 18-44 who received preventive care services at CHCC sites Denominator: Number of women ages 18-44 years (International Database Estimates; U.S. Census)	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of females ages 18-44 who received preventive care services at CHCC sites Denominator: Number of women ages 18-44 years (International Database Estimates; U.S. Census)	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of females ages 18-44 who received preventive care services at CHCC sites Denominator: Number of women ages 18-44 years (International Database Estimates; U.S. Census)	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of females ages 18-44 who received preventive care services at CHCC sites Denominator: Number of women ages 18-44 years (International Database Estimates; U.S. Census)	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Northern Mariana Islands

SPM 1 - Percent of CNMI resident women with live births who receive prenatal care beginning in the first trimester.
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the number of pregnant women with first trimester prenatal Care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of live births by resident women with first trimester prenatal care. **Denominator:** Total number of live births by resident women.
Healthy People 2030 Objective:	Increase the proportion of pregnant women who receive early and adequate prenatal care — MICH-08
Data Sources and Data Issues:	CNMI Hospital records, CNMI HVSO data
Significance:	Early and adequate prenatal care is vital to ensuring a healthy pregnancy. Receiving inadequate prenatal care increases the risk for complications and other adverse outcomes for both mother and baby. Early and adequate prenatal care provides the opportunity for early detection and management of complications which reduces the risk for pre-term labor and babies being born with low birth weight. According to the 2015 CNMI MCH Needs Assessment, almost 70% of deliveries in 2013 received inadequate prenatal care and 6% received no prenatal care at all.

SPM 2 - Percent of progress milestones completed toward the development and implementation of a centralized, user-friendly digital platform.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To improve access to comprehensive, culturally appropriate, and equitable health and wellness information for all MCH populations in the CNMI through a centralized and accessible digital platform.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of project milestones completed according to the implementation plan timeline (e.g., planning, design, stakeholder engagement, content development, testing, launch, promotion, evaluation). **Denominator:** Total number of project milestones outlined in the 2030 implementation plan.
Healthy People 2030 Objective:	Increase the health literacy of the population --HC/HIT-R01
Data Sources and Data Issues:	Internal administrative project management documentation
Significance:	The development and implementation of a centralized, user-friendly digital platform for health and wellness resources is significant because it directly addresses critical barriers to health equity and access for maternal and child health (MCH) populations in the CNMI. Given the islands' geographic isolation, limited health infrastructure, and diverse linguistic and cultural landscape, many individuals and families struggle to find reliable, timely, and culturally appropriate health information. This platform will serve as a vital tool to bridge that gap by offering easily accessible, centralized resources for all MCH domains—women, infants, children, adolescents, and children with special health care needs. It supports Title V's systems-building goals by fostering cross-agency collaboration, enhancing care coordination, and modernizing public health communication. By empowering families with the tools to make informed decisions, increasing awareness of available services, and ensuring equitable access—especially for underserved and rural populations—this initiative promotes long-term improvements in health outcomes. It also aligns with national priorities, including Healthy People 2030, by leveraging technology to improve public health infrastructure and readiness across CNMI.

Form 10
State Performance Measure (SPM) Detail Sheets (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 2 - Percentage of CHCC Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	By 2025, increase the number of CHCC Public Health staff (PHS) and MCH serving professionals who complete training on MCH priorities and topics by 25% from baseline.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CHCC PHS staff and MCH serving professionals who completed training on MCH priorities and related topics. **Denominator:** Number of CHCC PHS staff and MCH serving professionals
Healthy People 2030 Objective:	This measure is linked to the Public Health Infrastructure topic area and objective PHI-1 related to ensuring competent public and personal health care workforce.
Data Sources and Data Issues:	Health Department/CHCC Administrative Records.
Significance:	A skilled workforce is critical for rapidly changing and emerging public health issues. It is important for health department employees, especially those serving MCH populations, to posses the knowledge and skills to effectively work towards improving the health outcomes and life trajectories of the women and children we serve.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Northern Mariana Islands

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Northern Mariana Islands

ESM PPV.1 - Number of women that are accessing well woman visits, prenatal care visits, and postpartum visits via mobile clinic and other clinical outreach.
NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Measure Status:	Active
Goal:	To increase the number of women accessing preventive visits, including well-woman, prenatal, and postpartum visits.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of unduplicated women receiving well-woman, prenatal, or postpartum visits through outreach. **Denominator:** Number of Women Who Received Well-Woman, Prenatal, or Postpartum Care at CHCC.
Data Sources and Data Issues:	CHCC EHR System
Evidence-based/informed strategy:	The strategy this ESM measures is to increase access to preventive medical visits, including postpartum, care by expanding mobile clinic and other clinical outreach activities. Evidence reviewed to support the strategy includes: 1. Miami-Dade Mobile Prenatal Care Study Source: Dugger, R., et al. (2009). Impact of a mobile van on prenatal care utilization and birth outcomes in Miami-Dade County. 2. Dyadic Mobile Postpartum Care Program (Boston) Source: Mendelsohn, A., et al. (2023). The Dyadic Care Mobile Unit: A model for improving postpartum and newborn care. In geographically dispersed settings like CNMI, many women—especially in rural or outer island communities—face challenges getting to health centers after childbirth. Mobile clinics bring care closer to the community, eliminating long travel times and reducing the burden of finding transportation while recovering from birth or caring for a newborn. Mobile or outreach clinics can offer flexible hours, visit locations near the woman's home, or even home visits, which are particularly important during the postpartum period when mobility is limited. This convenience improves the likelihood that new mothers will follow through on recommended postpartum visits, especially within the critical 6-week window. When mobile units are staffed by providers who are culturally competent, community-based, and known to the population, women are more likely to feel comfortable and safe accessing postpartum care. This can be particularly important in communities where there may be stigma, fear, or discomfort with clinical care after delivery.

	Outreach services often integrate maternal, infant, and family services into a single encounter. A woman may receive postpartum check-ups, mental health screenings, breastfeeding support, family planning counseling, and infant immunizations during the same mobile visit—reducing the number of separate appointments she needs to attend and improving comprehensive care.
Significance:	Expanding women's health services through mobile clinics and outreach has been shown to be an effective strategy for improving access, utilization, and health behaviors, particularly among underserved and hard-to-reach populations. A growing body of evidence from both high-income countries and low- and middle-income settings demonstrates that mobile and outreach services can significantly increase the number of women accessing critical services such as prenatal care, well-woman visits, family planning, and postpartum care. For example, a study in Miami-Dade County found that women who used a mobile van for prenatal care began care earlier and had better visit adherence compared to those using traditional clinics. Mobile clinics help reduce well-documented barriers to care, including transportation challenges, lack of nearby facilities, long wait times, and stigma. They are particularly effective when paired with culturally appropriate services and when staff are trained to work in a youth- and family-friendly manner. In Boston, for instance, a mobile postpartum and newborn care program achieved 97% visit attendance, compared to about 60% for standard in-clinic follow-up care. Similarly, mobile mammography and cervical cancer screening programs have increased uptake in rural or low-income communities across several countries. For the CNMI, where geographic dispersion and limited access to fixed health facilities can be major barriers to care, expanding services through mobile clinics and outreach is especially relevant. These strategies can help bring high-quality, culturally tailored care directly into communities, improve timely access to prenatal and postpartum care, and support preventive services such as screenings and health education. When thoughtfully implemented and aligned with local needs and infrastructure, mobile and outreach services offer a powerful tool for improving women's health outcomes and advancing health equity across the islands.

ESM MHS.1 - Number of maternal health clinics that participated in the assessment and survey regarding depression screenings.
NPM – Percent of women who were screened for depression or anxiety following a recent live birth - MHS

Measure Status:	Active
Goal:	To increase the percent of women who were screened for depression or anxiety following a recent live birth.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of maternal health clinics that participated in an assessment or survey on practice use of standardized depression screening tools. **Denominator:**
Data Sources and Data Issues:	Survey results and assessment interview transcripts.
Evidence-based/informed strategy:	The strategy measured by the ESM is routine depression screening using validated tools (such as the PHQ-9 or PHQ-2) in clinical settings where systems are in place for accurate diagnosis, effective treatment, and appropriate follow-up care. This approach is designed to identify individuals with undiagnosed depression, initiate timely intervention, and ultimately improve mental health outcomes. The strategy emphasizes that screening should not occur in isolation, but must be embedded within a broader system of mental health care delivery. The evidence for this strategy was accessed from several high-quality, authoritative sources: *U.S. Preventive Services Task Force (USPSTF) recommendations: Depression Screening in Adults (2023) Depression Screening in Adolescents (2016) These guidelines are based on rigorous, systematic reviews of clinical trials and observational studies. *Cochrane Systematic Reviews, such as the 2017 review on depression screening in primary care, which assesses the clinical impact of screening interventions. *Peer-reviewed validation studies of tools like the PHQ-9 and PHQ-2 (e.g., Kroenke et al., 2001), which provide evidence of their reliability and accuracy. *National Institute of Mental Health (NIMH) and CDC for epidemiological data on depression prevalence. This strategy directly supports the performance measure by increasing the rate of depression screening and identification among the target population (e.g., women, postpartum women). When implemented effectively, the strategy leads to more individuals being accurately screened and subsequently referred for diagnosis and treatment. This enhances the overall performance on key metrics such as: *Percentage of patients screened for depression using a validated tool within a specified timeframe. *Proportion of positive screens that receive follow-up care or a mental health referral.
Significance:	Depression screening is supported by strong evidence when implemented within systems that ensure appropriate follow-up care. Depression is common—affecting around 7% of adults and up to 20% of adolescents each year—and often goes unrecognized, particularly

in primary care settings. Validated tools like the PHQ-9 and PHQ-2 are effective at identifying individuals who may be experiencing depression, especially when symptoms aren't obvious. The U.S. Preventive Services Task Force (USPSTF) recommends routine screening for adults, including pregnant and postpartum women, and for adolescents aged 12 to 18, but only in settings where accurate diagnosis, treatment, and follow-up are available. Studies show that screening in these contexts can lead to earlier identification, improved access to care, and better clinical outcomes.

ESM BF.1 - Percent of women enrolled in group prenatal care who exclusively breastfeed at 6 weeks postpartum.
NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase of the number of infants breastfed exclusively.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of women enrolled in group prenatal care who breastfed exclusively at 6 week post partum.</td></tr>
<tr><td>Denominator:</td><td>Number of women who enrolled in group prenatal care.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CHCC EHR System, Participant survey</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The strategy that this ESM measures is to Promote breastfeeding initiation and exclusivity by implementing group prenatal care models that incorporate structured breastfeeding education and peer support.

The strategy of using group prenatal care (GPC)—most commonly implemented through models like CenteringPregnancy—has growing evidence showing its effectiveness in improving infant breastfeeding rates, among other maternal and infant health outcomes.

Evidence for this strategy was accessed from several high-quality sources, including:
Peer-Reviewed Studies and Systematic Reviews

1. Grady & Bloom (2020) – Maternal and Child Health Journal: Meta-analysis showing that participants in GPC were more likely to initiate and sustain breastfeeding compared to those receiving traditional prenatal care.

2. Carter et al. (2016) – Obstetrics & Gynecology: A randomized controlled trial showing higher breastfeeding initiation and continuation rates among women in CenteringPregnancy groups.

3. Novick et al. (2013) – Journal of Midwifery & Women's Health: Qualitative synthesis demonstrating that GPC fosters increased knowledge and confidence around breastfeeding.</td></tr>
<tr><td>Significance:</td><td>This ESM—“Percent of women enrolled in group prenatal care who exclusively breastfeed at 6 weeks postpartum”—measures the effectiveness of the group prenatal care (GPC) strategy in influencing sustained breastfeeding behavior after birth. Specifically, it captures an early outcome of the strategy: whether participants continue exclusive breastfeeding beyond the immediate postpartum period (6 weeks is a meaningful milestone). This reflects how well the breastfeeding education, peer support, and continuity of care provided in GPC translate into real-world infant feeding practices.
Measuring this outcome is important because it:
*Demonstrates the impact of GPC on behavior change: Exclusive breastfeeding at 6 weeks postpartum is a strong indicator that the prenatal education and support were effective and empowering.
*Tracks alignment with national goals: Exclusive breastfeeding is a key target in initiatives like Healthy People 2030 and the MCH National Performance Measure for breastfeeding. Measuring it within the GPC context shows how this strategy contributes to those broader objectives.</td></tr>
</table>

ESM PA-Child.1 - PA-Child.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum.
NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Inactive - Replaced
Goal:	Increase enrollment in an evidence-based nutrition and physical activity program.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of referrals who reported completing at least 75% of the EFNEP program curriculum **Denominator:** Number of referrals to the EFNEP program
Data Sources and Data Issues:	Data source: MCH referral log and EFNEP program
Evidence-based/informed strategy:	Referrals to an evidence-based nutrition and physical activity program (EFNEP) can be made during Well child visits at CHCC outpatient clinics (Children's Clinic, Mobile Clinic, RHC, THC) which supports an evidence-based Eating Smart Being Active curriculum that teaches children healthy lifestyle choices, nutrition, physical activity including food preparation.
Significance:	Medical providers play a critical role in obesity prevention through communicating early body mass index screening results to parents and helping them to adopt key behavioral changes in diet and physical activity. The well-child visit and evidence-based program on healthy eating and physical activities are essential at addressing obesity prevention,

ESM PA-Child.2 - Number of children ages 6-11 years who enroll in after school sports or other group activities.
NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Active
Goal:	To increase the percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children in the CNMI who participate in after school sports or group activities. **Denominator:** Number of children in the CNMI.
Data Sources and Data Issues:	Enrollment data from sports and other community partner organizations.
Evidence-based/informed strategy:	This ESM measures the following strategy: Partner with the Public School System and Non-Communicable Disease Programs to increase access to after school sports programs and other group activities. The evidence supporting this strategy was accessed from a combination of peer-reviewed literature, federal public health agencies, and program evaluations from community-based and school-based initiatives. Key sources include: * Centers for Disease Control and Prevention (CDC) – The CDC's Whole School, Whole Community, Whole Child (WSCC) model emphasizes the importance of physical activity and school-community partnerships to improve health outcomes and prevent non-communicable diseases. *Community Preventive Services Task Force (The Community Guide) – Recommends school-based and after-school physical activity programs to increase physical activity among youth, citing improvements in weight status, cardiovascular health, and mental well-being. *Peer-reviewed studies – Research shows that structured after-school physical activity programs are associated with increased physical activity levels, improved mental health, better academic performance, and lower risk factors for chronic diseases. -Beets et al. (2016) in Preventive Medicine found that evidence-based after-school programs can significantly increase moderate-to-vigorous physical activity among children. *World Health Organization (WHO) – Endorses multisectoral collaboration to prevent NCDs through increased physical activity, including school-based interventions.
Significance:	Partnering with the public school system and non-communicable disease (NCD) programs to increase access to after-school sports and group activities is a significant strategy for improving child and adolescent health. It plays a critical role in preventing chronic conditions such as obesity, type 2 diabetes, and cardiovascular disease by increasing opportunities for regular physical activity—helping youth meet the CDC's recommendation of at least 60 minutes per day. Beyond physical health, participation in structured group activities supports mental and emotional well-being by reducing symptoms of anxiety and depression,

enhancing self-esteem, and fostering social connection. This strategy also promotes health equity by embedding programs within schools, ensuring that students from underserved or low-income communities have access to the same opportunities for physical activity as their peers. By aligning efforts across education and public health sectors, the strategy encourages sustainable, systems-level change and supports measurable outcomes such as increased physical activity rates, reduced obesity prevalence, and improved academic engagement.

ESM AWV.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Measure Status:	Inactive - Replaced
Goal:	The goal is to reduce youth suicide rate among adolescent by working with Providers to increase preventive care visits that provides behavioral health screenings and assessments.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number adolescent ages 12 through 17 who receive prevent care visit at CHCC sites **Denominator:** Total number adolescent ages 12-17 years.
Data Sources and Data Issues:	Numerator: CareVue EHR Denominator: International Database U.S. Census
Evidence-based/informed strategy:	The ESM measures the the number of adolescent ages 12 through 17 years who access preventive care visits and allow providers to conduct behavioral/mental health screening, and assessment focused on improving the patient's health and well-being holistically.
Significance:	The adolescent well-visit is an opportunity for adolescents to receive healthcare, counseling, and guidance to help teens identify and adopt or modify behaviors to avoid damage to health, effectively manage chronic conditions, or to prevent disease. Adolescent healthcare is critical for establishing lifelong healthy behaviors and prepares adolescents for transition into adult healthcare.

ESM AWV.2 - Percentage of Public School System (PSS) students ages 12-17 years who had an adolescent well-visit in the past year.
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Measure Status:	Active
Goal:	Increase the percentage of CNMI teens accessing well visits through partnership referrals mechanisms with the CNMI Public School System.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents enrolled in PSS high schools who are seen during school based clinic outreach. **Denominator:** Number of adolescents enrolled in PSS high schools.
Data Sources and Data Issues:	Administrative logs
Evidence-based/informed strategy:	1. The ESM will measure the impact of school based preventive services on increasing the rates of adolescent well visits. 2. There is substantial evidence around school based health services and its impact on student health outcomes. A source of evidence is cited in: Clayton S, Chin T, Blackburn S, Echeverria C. Different setting, different care: integrating prevention and clinical care in school-based health centers. Am J Public Health. 2010 Sep;100(9):1592-6. doi: 10.2105/AJPH.2009.186668. Epub 2010 Jul 15. PMID: 20634447; PMCID: PMC2920951. 2. Providing access to preventive services/care through school located clinics will increase the percentage of CNMI youth accessing well visits.
Significance:	School-based preventive health services play a critical role in supporting the overall well-being of children and adolescents by addressing health needs directly within the school environment—where young people spend a significant portion of their time. Their significance includes: 1. Improved Access to Care Schools eliminate many barriers to care (e.g., transportation, cost, scheduling) by providing convenient, on-site services. Students from underserved or low-income backgrounds are especially likely to benefit from equitable access to primary and preventive care. 2. Early Identification and Intervention Routine screenings, health education, and behavioral observations by school staff enable early detection of physical, mental, and developmental health concerns. Timely interventions can prevent escalation and reduce the need for costly, crisis-driven care. 3. Integration of Prevention and Clinical Services Comprehensive services—from vaccinations and asthma management to mental health counseling and nutrition education.

4. Support for Academic Success
Healthy students are better learners. Preventive services help reduce chronic absenteeism, manage chronic conditions (like asthma or diabetes), and support mental health, all of which are linked to improved academic performance.

5. Promotion of Lifelong Healthy Habits
Schools offer repeated, age-appropriate opportunities to educate students on topics like physical activity, sexual health, nutrition, and substance use.

Early exposure to health education in a trusted setting helps establish long-term health literacy and behaviors.

6. Whole-Child and Community-Centered Approach
Preventive health in schools is part of a holistic model that engages families, educators, and communities to support youth development.

ESM AWV.3 - Number of teens who completed the PATCH Peer-to-Peer Workshops in the past year.
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Measure Status:	Active
Goal:	To increase the number of teen who complete adolescent well-visits and confidential services.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of teens who completed the PATCH Peer-to-Peer Workshops in the past year. **Denominator:**
Data Sources and Data Issues:	PATCH Peer Workshop sign in logs.
Evidence-based/informed strategy:	This ESM measures the following strategy: Increase awareness of adolescent well-visits and confidential services through conducting PATCH for Peer Workshops. The PATCH program has been evaluated, especially for its curriculum to improve clinician-adolescent communication. One study from Wisconsin (Hughes et al., Stud Fam Plann. 1998) showed that after implementing PATCH workshops for clinicians and peer/teen educators, there were improvements in clinician and adolescent knowledge, intentions, and reported communication behaviors. Another evaluation, “Enhancing Youth Engagement in Health Promotion: Evaluating the Impact and Strategies of a Teen Consultant Program,” analyzes PATCH’s “teen consultant” model, focusing on youth engagement in health promotion, The strategy of implementing the PATCH (Providers and Teens Communicating for Health) program can influence the Maternal and Child Health (MCH) National Performance Measure (NPM) for adolescent well visit rates by targeting key behavioral and systemic factors that affect whether adolescents seek and receive routine preventive care. PATCH focuses on training both healthcare providers and teens to improve the quality and comfort of conversations around adolescent health. Better communication can: *Increase adolescents’ willingness to engage in visits. *Reduce fear, embarrassment, or mistrust that often discourage adolescents from attending preventive appointments. *Encourage return visits by making the clinical experience more adolescent-friendly. Impact on MCH Measure: When teens feel heard, respected, and safe during a visit, they are more likely to attend their annual well visit, directly improving the NPM.
Significance:	This ESM measures the reach and implementation of the youth education component of the PATCH program—specifically, how many adolescents are engaged through the Peer-to-Peer Workshops. These workshops are designed to increase teen participants’ awareness,

	knowledge, and confidence in navigating healthcare, understanding their rights, and utilizing preventive services like annual well visits. By tracking the number of teens who complete the workshops, this measure captures how effectively the strategy is being delivered and how many adolescents are being exposed to its intended health-promoting messages.

ESM MH.1 - Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The goal is to increase the percentage of CNMI children with or without special healthcare needs who report having a medical home by 5%.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).</td></tr>
<tr><td>Denominator:</td><td>n/a</td></tr>
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</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be obtained through program administrative records (training participant logs) and clinic surveys.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>This ESM measures the strategy of: Strengthen access to a medical home for children and youth, including children with special healthcare needs by providing training and technical assistance to pediatric primary care clinics and providers on implementing medical home principles and related policies.

Key Evidence & Resources

-“Improved Outcomes Associated With Medical Home Implementation in Pediatric Primary Care” (Cooley et al., Pediatrics, 2009)
Study of 43 primary care practices across 5 states that measured “medical homeness” (using the Medical Home Index) and found associations with reduced hospitalizations and emergency department visits among children with chronic conditions.
PubMed

This supports that transforming primary care practices toward a medical home model can lead to improved utilization and cost outcomes.

-Medical Home Transformation in Pediatric Primary Care — What Drives Change?
A study of high-performing pediatric practices several years after they’d participated in a learning collaborative for medical home transformation. Key drivers identified: culture of quality improvement, family-centered care, team-based care, and care coordination.

Shows that training, facilitation, and technical assistance (e.g. via collaboratives) are important to implementation.

The strategy of providing training and technical assistance (TA) to pediatric primary care clinics and providers on implementing medical home principles and related policies directly influences the performance measure of increasing medical homes by enabling clinics to transform their practices in ways that meet the core components of a patient-centered medical home (PCMH).</td></tr>
<tr><td>Significance:</td><td>This ESM measures the reach and initial implementation impact of the training and technical</td></tr>
</table>

assistance strategy. Specifically, it tracks how many pediatric providers not only received medical home training but also applied what they learned by integrating at least one key medical home component into their practice. This reflects both the engagement of providers in capacity-building activities and their translation of knowledge into practice change, which are critical early steps in transforming clinics into medical homes.

Measuring this ESM is important because it captures tangible evidence that the training strategy is effective in prompting real changes in clinical practice, beyond just participation. Without providers implementing components of the medical home model, the strategy cannot advance broader goals of improving care coordination, family engagement, and team-based care. Tracking this measure helps identify progress toward systemic practice transformation, guides program improvements, and demonstrates accountability by showing how many providers are adopting practices that enhance care quality and access for children and youth.

ESM TAHC.1 - Percentage of high school students served by SPED who received information on transition
NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

Measure Status:	Inactive - Replaced
Goal:	The goal is to utilize school based presentations to increase awareness and knowledge regarding the importance of and process of transition into adult healthcare.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of high school students served by SPED who received information on transition **Denominator:** Number of high school students served by SPED
Data Sources and Data Issues:	CSHCN presentation dataset
Evidence-based/informed strategy:	Number of adolescents and families who attended healthcare transition presentation that aims to enhance awareness to the importance of transition/referral to another provider, managing medical needs, and knowledge about health continuity.
Significance:	Healthcare transition is defined by the American National Alliance to advance adolescents healthcare as the process of changing from a pediatric to an adult model of health care. This is critical for ensuring continuity of care and prioritization of key factors for health improvement. The benefits of transition include preparing the adolescent early for taking responsibility for his care by knowing his own condition, progress, medications and possible disease outcome.

ESM TAHC.2 - Number of parents who complete transition training.
NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

Measure Status:	Active
Goal:	To increase the number of parents/caregivers of children with special healthcare needs who receive information and training on healthcare transition in the CNMI.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of parents with children with special healthcare needs who complete training focused on planning for and transfer assistance. **Denominator:** Number of parents with children with special healthcare needs
Data Sources and Data Issues:	Training logs and Program Administrative records
Evidence-based/informed strategy:	1. This ESM will measure the number of families that are receiving information and support for planning for healthcare transition. 2. Evidence was reviewed in the evidence library at the mchevidence.org online. 3. Providing support and building parent capacity to plan for healthcare transition will increase the likelihood of successful transition from pediatric care to adult clinics.
Significance:	This ESM measures the reach and delivery of transition planning training provided to families. Specifically, it captures how many families are being equipped with the knowledge, skills, and resources needed to navigate the complex process of moving from pediatric to adult healthcare systems. This reflects the strategy's focus on family engagement and education as a critical component of successful healthcare transitions. Measuring this ESM is important because providing families with effective transition training is essential to ensure continuity of care and reduce gaps in health services as youth age out of pediatric care. Without tracking training delivery, it is difficult to know whether families are being adequately prepared for this shift, which can impact health outcomes and self-management. Monitoring this measure helps programs assess their outreach success, identify barriers to training access, and demonstrate progress in supporting youth and families during a critical developmental milestone.

ESM BLY.1 - Percent of schools who have implemented evidence based bullying prevention programs.
NPM – Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY

Measure Status:	Active
Goal:	Decrease the percentage of high school students who experienced bullying on school property by 5% from baseline.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CNMI high schools that have implemented an evidence based bullying prevention programs. **Denominator:** Total number of CNMI high schools
Data Sources and Data Issues:	Youth Risk Behavior Survey
Evidence-based/informed strategy:	1. This ESM measures the strategy: Strengthen partnership with the Public and Private School Systems to adopt and implement evidence based bullying prevention programs. 2. Evidence on this strategy was reviewed on the MCH evidence center online via mchevidence.org. 3. School-based violence prevention programs aim to reduce disruptive and antisocial behavior by promoting self-awareness, emotional regulation, self-esteem, social skills, problem-solving, conflict resolution, and teamwork. These programs target both general violence and specific forms, such as bullying and dating violence. Bullying prevention initiatives within schools may focus on individuals who bully, their victims, bystanders, teachers, or the broader school environment. Most of these programs are designed to reduce both the incidence of bullying and the experience of victimization.
Significance:	This ESM measures the extent of adoption and implementation of evidence-based bullying prevention programs within schools. It reflects how widely and effectively schools are incorporating structured, research-backed interventions aimed at reducing bullying behaviors and creating safer, more supportive school environments. This indicator focuses on the programmatic reach and fidelity to prevention strategies recommended by the evidence base. Measuring this ESM is crucial because the implementation of evidence-based bullying prevention programs is a key step toward reducing bullying incidents and improving student well-being. Without tracking how many schools have adopted these programs, it's impossible to assess whether prevention efforts are reaching the population at risk or to evaluate the potential impact on bullying-related outcomes. Monitoring this measure allows stakeholders to identify gaps in implementation, allocate resources effectively, and demonstrate accountability for progress in creating safe and inclusive school environments.

ESM 1.1 - Assessment to identify groups or reasons for not accessing early prenatal care completed (Y/N).
SPM 1 – Percent of CNMI resident women with live births who receive prenatal care beginning in the first trimester.

Measure Status:	Active
Goal:	To increase the number of women accessing preventive health services by expanding access to services through outreach and mobile clinics.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Assessment to identify groups or reasons for not accessing early prenatal care completed (Y/N). **Denominator:**
Data Sources and Data Issues:	Data will be gathered from surveys and focus group transcripts/reports.
Evidence-based/informed strategy:	The CNMI will use the first year of this new 5-year cycle to conduct and assessment to identify the reasons and populations who are not accessing early prenatal care. A evidence based strategy to address early prenatal care rates will be identified/determined after this initial work.
Significance:	Conducting an assessment to determine the reasons and groups who are not accessing early prenatal care is critically significant because it lays the foundation for designing effective, targeted interventions. Early prenatal care is essential for monitoring maternal and fetal health, managing risks, and improving pregnancy outcomes. However, not all pregnant individuals access care early, and the barriers can vary widely across populations. By performing this assessment, programs can: Identify Specific Barriers: Understand whether obstacles are related to structural issues (e.g., lack of transportation, clinic hours), cultural or linguistic barriers, socioeconomic factors, misinformation, fear or mistrust of the healthcare system, or other challenges. Recognize Disparities Among Groups: Pinpoint which populations—such as racial/ethnic minorities, adolescents, low-income individuals, or specific island residents—are less likely to receive early prenatal care, enabling a focus on health equity. Inform Tailored Strategies: With detailed knowledge about who is underserved and why, interventions can be customized to address the unique needs and preferences of those groups, increasing the likelihood of success. Optimize Resource Allocation: Avoid generic or one-size-fits-all approaches that might waste resources, instead directing efforts where they are most needed and effective. Establish a Baseline for Monitoring: The assessment provides baseline data against which the impact of subsequent strategies can be measured.

ESM 2.1 - User research (i.e. surveys and focus groups) completed.
SPM 2 – Percent of progress milestones completed toward the development and implementation of a centralized, user-friendly digital platform.

Measure Status:	Active
Goal:	To develop and implement a centralized, user friendly digital platform that serves as a resource hub for health and wellness resources for all MCH population health domains.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** User research (i.e. surveys and focus groups) completed (Y/N). **Denominator:**
Data Sources and Data Issues:	Data will be gathered through programmatic administrative records.
Evidence-based/informed strategy:	The CNMI will utilize year 1 of this new 5-year cycle to conduct assessments, user surveys and gather stakeholder input to inform the design and implementation of the digital platform/resource hub.
Significance:	It's important to conduct assessments, user surveys, and gather stakeholder input when designing and implementing a digital platform or resource hub because these steps ensure the platform truly meets the needs of its users and achieves its intended goals. Here's why: Understand User Needs and Preferences: Assessments and surveys reveal what users actually want and need from the platform—such as the types of resources, ease of navigation, language preferences, and accessibility features—ensuring the platform is user-friendly and relevant. Identify Barriers and Challenges: Direct input helps uncover potential obstacles users might face in accessing or using the platform, such as technology limitations, literacy levels, or cultural considerations, so these can be addressed upfront. Enhance Engagement and Adoption: When stakeholders and end-users are involved early, they're more likely to feel ownership and trust in the platform, increasing its acceptance, usage, and sustainability. Ensure Alignment with Organizational and Community Goals: Stakeholder feedback ensures the platform supports broader programmatic objectives and integrates well with existing systems and resources. Inform Content and Feature Prioritization: Gathering diverse perspectives helps prioritize which features or resources are most valuable, making the platform more efficient and impactful. Support Continuous Improvement: Ongoing input establishes a foundation for iterative enhancements based on real-world feedback, rather than assumptions.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM WWV.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at all CHCC health service sites.
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	The goal is to increase the number of women ages 18-44 accessing preventive medical services at CHCC sites.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women ages 18-44 years accessing preventive health services at CHCC service sites. **Denominator:** Number of women ages 18-44 years
Data Sources and Data Issues:	CHCC Electronic Health Record System
Evidence-based/informed strategy:	1. The strategy that ESM WWV-2 measures is expanding access to women's preventive health services via outreach or mobile clinics. 2. Information supporting evidence on this strategy was accessed via the citation: Coaston A, Lee SJ, Johnson JK, Weiss S, Hoffmann T, Stephens C. Factors associated with mobile medical clinic use: a retrospective cohort study. Int J Equity Health. 2023 Sep 26;22(1):195. doi: 10.1186/s12939-023-02004-3. PMID: 37749529; PMCID: PMC10521435. 3. There is growing evidence that mobile clinics are an effective method of delivering healthcare, particularly to underserved communities, including both insured and uninsured individuals and those with unmanaged chronic conditions. Bringing mobile clinics into neighborhoods where people live, work, and gather increases access and utilization of services. Their presence supports improved access to high-quality, cost-effective care for populations with limited healthcare options. By increasing outreach in various CNMI villages it is projected that there will be an increase in the number of women accessing preventive health services.
Significance:	Evidence suggests that expanded hours increases access and provides opportunities for working women and others with schedule challenges to access care.

Form 11
Other State Data

State: Northern Mariana Islands

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: Northern Mariana Islands

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	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	1		
2) Vital Records Death	Yes	Yes	Monthly	1	Yes	
3) Medicaid	Yes	Yes	Annually	3	No	
4) WIC	Yes	Yes	Monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	Monthly	1	Yes	
6) Newborn Hearing Screening	Yes	Yes	Monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Annually	2	No	
8) PRAMS or PRAMS-like	Yes	Yes	Monthly	1	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Maternal, Infant, and Early Childhood Home Visiting (MIECHV)	Yes	Yes	More often than monthly	1	No	
10) CHCC Dental/Oral Health Program	Yes	Yes	Monthly	1	No	
11) Immunization Weblz	Yes	Yes	More often than monthly	1	No	
12) Family Planning Program	Yes	Yes	Monthly	1	No	
13) Developmental Screening program	Yes	Yes	More often than monthly	1	No	
14) Breast and Cervical Cancer Screening Program	Yes	Yes	Annually	1	No	
15) CNMI Cancer Registry	Yes	Yes	Annually	1	No	
16) Early Intervention Program	Yes	Yes	Annually	1	No	
17) Special Education Program	Yes	Yes	Annually	1	No	
18) Public School System	Yes	Yes	Annually	1	No	
19) Maternal and Child Health Jurisdictional Survey	Yes	Yes	Less Often than Annually	4	No	
20) CNMI Non-communicable Disease Hybrid Survey	Yes	Yes	Less Often than Annually	3	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Northern Mariana Islands

Annual Report Year 2024

Products and Publications information has not been provided by the State.