Maternal and Child Health Services Title V Block Grant

Northern Mariana Islands

FY 2027 Application/ FY 2025 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-L26-598

June 23, 2026

Eliza Heppner
Acting 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-27-001 / Tracking No. 245919

Dear Ms. Heppner,

On behalf of the Commonwealth of the Northern Mariana Islands'(CNMI) Commonwealth Healthcare Corporation (CHCC), I am pleased to submit the FY 2027 MCH Title V Block Grant Application and FY 2025 Annual Report. This submission reflects our continued commitment to improving the health and well-being of mothers, infants, children, and families across the CNMI.

The FY 2027 application builds upon the priorities identified through the recently completed comprehensive MCH Needs Assessment. Conducted in collaboration with key stakeholders, the assessment provided valuable insight into the strengths, challenges, and needs within the CNMI maternal and child health system. These findings continue to guide our priorities and strategies to ensure that our efforts are data-driven and responsive to the needs of our islands.

The CNMI is grateful for the opportunity to report on the projects and activities undertaken to improve the health and well-being of mothers, infants, children, throughout the Northern Mariana Islands. Through continued support from the Title V MCH Block Grant, the CNMI remains committed to providing preventive, primary health care, and population-based services that promote access to quality care and improve health outcomes for families.

We thank you for your continued leadership and support of the CNMI MCH Title V Program and look forward to our ongoing partnership in advancing maternal and child health.

Sincerely,

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

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

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

This executive summary provides a comprehensive overview of the Commonwealth of the Northern Mariana Islands (CNMI) Maternal and Child Health (MCH) Title V Block Grant, covering the accomplishments and data from the FY 2025 Annual Report and the strategic objectives for the FY 2027 Application.

I. Program Overview and Mission

The mission of the CNMI MCH Title V Program is to promote and improve the health and wellness of women, infants, children (including those with special healthcare needs), adolescents, and their families through quality prevention programs and effective partnerships. Situated within the Division of Public Health Services of the Commonwealth Healthcare Corporation (CHCC), the program leverages its position within an integrated health system to adapt to community needs across Saipan, Tinian, and Rota.

Federal Title V funds are primarily used to support Enabling Services and Public Health Services and Systems. Key efforts include care coordination for pregnant women and CSHCN, newborn screening supplies, health education, and workforce development. Notably, the program does not utilize these funds for direct clinical services, focusing instead on infrastructure and access.

II. Women/Maternal Health

FY 2025 Progress:

- **Preventive Access:** The program prioritized increasing access to timely preventive care for women of reproductive age.
- **Mobile Clinic Outreach:** A key success was the use of the CHCC Mobile Clinic, which conducted **46 outreach events** serving 206 adult women before a mechanical issue halted operations in May 2025. Additionally, MCH supported **monthly women's health outreach clinics to the islands of Tinian and Rota** enabling access to well woman visits, prenatal care, family planning and other women's preventive health services. Outreach providers saw 174 patients in Rota and 188 in Tinian in FY2025.
- **Data Trends:** In FY 2025, 31.1% of women reported accessing preventive health services at CHCC, an increase from 21.5% in 2024.
- **Postpartum Care:** CNMI data showed that **68% of mothers** received a checkup 12 weeks after giving birth.

FY 2027 Plans:

- **Expanded Outreach:** The program will scale up mobile clinic services and clinical outreach to reduce transportation barriers for women, particularly in outer islands.
- **Maternal Depression Screening:** A major new focus is strengthening universal maternal depression screening and referral systems across all prenatal and postpartum settings.
- **Standardization:** Plans include standardizing screening tools and improving coordination between maternal health providers and behavioral health services.

III. Perinatal and Infant Health

FY 2025 Progress:

- **Breastfeeding Initiation:** Breastfeeding initiation remains consistently high, with **90.0% of infants** ever breastfed in 2025.
- **Exclusive Breastfeeding:** The exclusive breastfeeding rate at six months (for WIC-enrolled infants) reached **10.1%**, which, while slightly lower than the 2024 peak, is nearly double the long-term baseline of 4.9%.
- **Early Prenatal Care:** Utilization of first-trimester prenatal care reached **75.0%**, its highest level in the

reporting period and for the first time, comparable to US national rates.

FY 2027 Plans:

- **Standardized Referral Pathways:** To improve early prenatal care entry, the program will establish a multidisciplinary workgroup to create standardized referral protocols and designate "prenatal care navigators".
- **Enhancing breastfeeding support:** Strengthen coordinated breastfeeding education, referral, and early postpartum support through existing maternal and child health programs.
- **Community Support:** The program will continue to procure breastfeeding supplies and promote breastfeeding-friendly workplaces.

IV. Child Health

FY 2025 Progress:

- **Physical Activity:** 59.6% of children aged 6–11 were reported to be physically active for at least 60 minutes daily, exceeding the 51.3% reported in 2023.
- **Nutrition and Obesity:** The program partnered with community organization Run Saipan to promote physical activity among CNMI and supported community nutrition workshops, healthy recipes demonstrations, and information sharing in partnership with the Public Health Registered Dietician.
- **Clinical Access:** 12 well-child outreach clinics were conducted via the mobile clinic, and **22 school-based vaccination clinics** were held in partnership with the Public School System (PSS).

FY 2027 Plans:

- **Physical Activity Council:** The MCH program will take an active leadership role in the CNMI Physical Activity Council to coordinate community events and advocate for active lifestyles.
- **Medical Home Training:** A primary objective is strengthening the "Medical Home" model. The program will provide training and technical assistance to pediatric clinics to improve care coordination and family engagement.
- **Vaccination and well child visits:** Efforts will continue to ensure that children have timely access to recommended well-child visits and routine immunizations in accordance with evidence-based guidelines.

V. Adolescent Health

FY 2025 Progress:

- **Well-Visit Decline:** A concerning trend was noted as annual adolescent well-visit rates declined to **28.9%** from a previous baseline of nearly 41%.
- **PATCH Success:** The "Providers and Teens Communicating for Health" (PATCH) program conducted **four peer workshops**, reaching 83 adolescents with health education and navigation skills.
- **School Outreach: A total of 910 CNMI high school youth** participated in preventive health workshops and 257 received Health screenings (BMI, blood pressure, etc.) and referral services.

FY 2027 Plans:

- **Teen Pregnancy and STI Prevention:** The program will prioritize decreasing STI rates and teen births by expanding access to confidential services and family planning via school partnerships.
- **Expansion of PATCH:** The program aims to recruit more Teen Educators and expand workshops to all public high schools to reach 40% of the student population.
- **Bullying Prevention:** A new priority for FY 2027 is collaborating with schools to assess bullying needs and implement evidence-based prevention programs to improve student safety.

VI. Children with Special Health Care Needs (CSHCN)

FY 2025 Progress:

- **System Navigation:** The Family-to-Family Health Information Center (F2F HIC) hosted **seven virtual learning sessions**, reaching 289 participants on topics such as Down Syndrome and early literacy.
- **Parent Leadership:** The program supports a network of **11 trained parent leaders** who serve as trusted peer mentors and community advocates, providing outreach, education, and support to families across the Commonwealth. During FY2025, these efforts reached **610 community members** through education, outreach, and peer support activities.
- **Specialty Outreach:** Partnerships with providers like **Shriners Children's** continued to facilitate access to subspecialty care providing **232** clinic visits in FY2025.
- **Transition Planning:** Collaborative efforts with the Disability Network Partners (DNP) focused on preparing youth for the shift to adult healthcare.

FY 2027 Plans:

- **Medical Home Implementation:** Similar to the child health domain, the program will emphasize the Medical Home model for CSHCN, focusing on comprehensive care planning and mental health integration.
- **IEP Collaboration:** Title V staff will strengthen collaboration with the school system to participate directly in **Individualized Education Program (IEP) meetings** for children with complex medical conditions.
- **Parent Transition Training:** A new five-year objective aims to increase the percentage of parents of CSHCN receiving formal training on transitioning to adult care.

VII. Cross-Cutting and Systems Building

FY 2025 Progress:

- **Workforce Development:** The CNMI participated in the Public Health Workforce Interests and Needs Survey (PH WINS) for the first time, marking its inclusion in this national workforce assessment. The survey established baseline data on workforce capacity, training needs, and organizational strengths to inform future workforce development and planning.
- **Data Capacity Building:** Increased data capacity with the publishing of the first CNMI Pregnancy Risk Assessment Monitoring System (PRAMS) Report and the planning for implementation of the CNMI Behavioral Risk Factor Surveillance System (BRFSS).

FY 2027 Plans:

- **Centralized Digital Platform:** A new priority is the development of a user-friendly digital platform (website) to serve as a resource hub for all MCH domains.
- **Digital Integration:** FY 2027 activities include expanding multilingual content, ensuring ADA accessibility, and exploring integration with clinical health information systems (e.g., Meditech Expanse) to improve referral tracking.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 with 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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

Title V Success Story: Once Supported, Now Supporting Others



Through the CNMI Maternal and Child Health (MCH) Title V Program, families have access to evidence-based home visiting services that strengthen parenting skills, promote healthy child development, and improve maternal and child health outcomes. One such initiative, the H.O.M.E. Visiting Program, demonstrates the lasting impact of these investments by empowering parents with the knowledge, skills, and confidence to help their children thrive.

Pressel Indalecio enrolled in the H.O.M.E. Visiting Program during her first pregnancy as a first-time mother. When her son, Elijah, was born prematurely, she faced uncertainty about his health and development. Through regular home visits, parenting education, developmental guidance, and ongoing encouragement, Pressel gained the confidence and practical skills to care for her son and create a safe, nurturing home environment. Over the next five years, she watched Elijah reach important developmental milestones and successfully graduate from the program.

When Pressel's second son was also born prematurely, she approached the experience with greater confidence and resilience. The knowledge and parenting skills she gained through the program enabled her to advocate for her child's needs and navigate the challenges of caring for a premature infant.

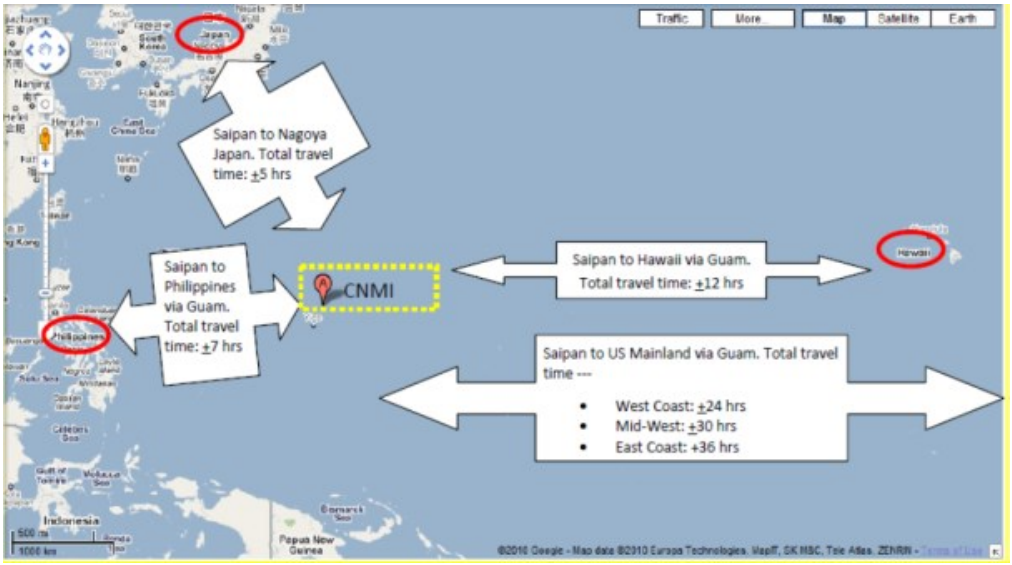
Inspired by the support she received, Pressel was determined to give back. After applying five times, she was hired as a home visitor with the very program that had supported her family. Today, she combines her lived experience with professional training to help expectant parents and families across the Commonwealth build strong foundations for their children's health and development.

Pressel's journey is a powerful example of the long-term impact of Title V and MIECHV-supported home visiting services. Her story demonstrates that investing in families not only improves child and family outcomes but also cultivates future community leaders who are committed to supporting the next generation.

III.B. Overview of the State

III.B.1. State Description (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

The Commonwealth of the Northern Mariana Islands (CNMI) remains committed to developing and strengthening a comprehensive, community-based system of services that support 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 family education and advocacy training that is responsive to family needs is needed to strengthen empowerment and engagement.

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 (Part C), 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 Fund (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 Title V Program signed a Memorandum of Agreement (MOA) with the CNMI Public School System (PSS). This agreement allows CNMI Title V representatives to participate in Individualized Education Program (IEP) transition meetings, strengthening collaboration between health and education partners. Through attendance at these meetings, Title V staff can provide families with information, resources, and support to help ensure a smooth transition process and improve access to needed services for children and youth with special health care needs.

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 CSHCN.

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 population-specific 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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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	FY25
CNMI	7	63	62	64	66	93	68
Total	**$7**	**$63**	**$62**	**$64**	**$66**	**$93**	**68**

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).
- 2025-2026 Key Programmatic updates:
  Expanded access to telemedicine and telehealth and coverage for podiatry services, alongside a new waiver

exempting the territory from specific federal reporting requirements.

Medicaid Enrollment Increase in FY 2024–2025

Medicaid enrollment increased from 13,075 in FY 2023–2024 to 15,479 in FY 2024–2025, representing an 18.4% increase across all three islands—Saipan, Tinian, and Rota. The 18.4% increase in enrollment is partly due to the CNMI's current economic challenges. The government implemented austerity measures, including reduced working hours, which led some government employees to lose or drop their government health insurance and apply for Medicaid coverage instead. In FY 2024-2025, CNMI Medicaid enrolled 15,479 inclusive of male participants, children (ages 1–17) and 6,589 women of reproductive age (15–44), including qualified non-U.S. citizens. By the end of the fiscal year, total enrollment reached 15,479, including children, women of reproductive age, and eligible non-citizens such as Freely Associated State (FAS) migrants and pregnant women with legal status.

The CNMI Title V MCH Program 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).

The 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 the CNMI MCH, 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—including lack of insurance, transportation, and low health literacy—the CNMI Title V Program continues to provide individualized care coordination for maternal and child health clients. A Title V-funded Community Health Worker (CHW) assists eligible individuals with Medicaid enrollment, coordinates health and social service referrals, and conducts follow-up to ensure timely access to care. These services have strengthened care navigation for prenatal and postpartum women, infants, children, and Children with Special Health Care Needs (CSHCN).

To further improve access, Title V maintains a standing Memorandum of Understanding (MOU) with the CNMI Medicaid Office. Consistent with Section 509(a)(2) of Title V and Section 1902(a)(11) of Title XIX of the Social Security Act, the MOU strengthens coordination between the Title V and Medicaid programs. Under the agreement, MCH staff may visit the Medicaid Office up to three times per week to submit and track applications on behalf of clients, expediting eligibility determinations and reducing delays in access to prenatal, specialty, and other essential health services.

Supporting Families of CSHCN

The CNMI Family-to-Family Health Information Center (F2F), housed within the MICAH Unit, improves access to healthcare coverage and care coordination for children with special health care needs and their families. F2F staff assist families with Medicaid applications, required documentation, and coordination with the Medicaid Office, reducing administrative barriers to specialty care and early intervention services.

F2F also educates families about Medicaid benefits, including automatic annual Medicaid renewal for children receiving Supplemental Security Income (SSI), and assists eligible families with SSI enrollment to help maintain uninterrupted healthcare coverage.

To promote early enrollment and linkage to services, MICAH distributes newborn care packets each month to families in the CHCC Obstetrics Ward before hospital discharge. Packets include Medicaid applications, Title V and community resource information, PRAMS materials, and MICAH contact information, supporting timely access to well-child care, immunizations, developmental screening, and other preventive services.

III.B.4. MCH Emergency Planning and Preparedness (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 FY2026-2027.

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 helped develop standard operating procedures for COVID-19 mass vaccination operations and vaccine points of dispensing (PODs). In collaboration with the CHCC AOC Communications Team, the Director also supported development of registration systems, reporting metrics, staff training, and establishment of the CNMI COVID-19 vaccination call center to improve public access to information and vaccination services.

Throughout the pandemic, Title V programs developed policies and procedures aligned with CDC and CHCC guidance, federal and local requirements, and executive orders. Adaptations to programs had to be implemented for the health and safety of staff, families, and the community.

The following information describes ongoing efforts that demonstrate the extent to which the CNMI MCH Title V Program participates in developing and coordinating plans that strengthen CNMI-wide preparedness and resilience in addressing disasters, public health emergencies, and other threats impacting maternal and child health (MCH) populations.

Newborn Metabolic Screening – Staff continue to work closely with the CNMI hospital nursery department, pediatricians, and the CHCC laboratory to ensure timely specimen collection for newborn metabolic screening prior to hospital discharge. Screening results are routinely monitored to ensure appropriate follow-up services are initiated and to minimize the risk of loss to follow-up. Lessons learned from prior emergency response efforts led to the implementation of a seven-day specimen collection schedule, replacing the former limited weekly collection window. This enhancement has improved program accessibility and continuity of services, particularly during periods of operational disruption.

Newborn Hearing Screening – Staff continue to ensure that newborns receive hearing screening services prior to discharge. The EHDI Program Coordinator works closely with hospital nursing staff and providers to ensure infants requiring follow-up or diagnostic audiological services receive timely care and are not lost to follow-up. Challenges encountered during the COVID-19 pandemic highlighted the importance of contingency planning for equipment maintenance and calibration. As a result, the program strengthened vendor relationships and continuity procedures to support uninterrupted screening services. Routine on-site calibration and maintenance activities have since resumed and continue to support

program readiness.

Home Visiting Services – During the COVID-19 public health emergency, home visiting services successfully transitioned to virtual service delivery using telephone and videoconferencing platforms. To reduce barriers to participation, families were provided with prepaid cellular cards and mobile devices when needed. Emergency supplies, including diapers, wipes, cleaning supplies, and food vouchers, were also distributed to participating families. These experiences informed the development of flexible service delivery models that continue to enhance program resilience and ensure continuity of services during emergencies. Home visiting services have since returned to primarily face-to-face delivery while retaining the capacity to utilize virtual approaches when circumstances require.

WIC Services – Emergency waivers issued during the pandemic allowed the CNMI WIC Program to successfully implement remote certification and service delivery processes. The CNMI's early adoption of eWIC in 2018 positioned the program to maintain uninterrupted access to food benefits during periods of restricted movement and emergency response operations. Innovations such as WIC-to-Go services, developed in collaboration with authorized vendors, demonstrated the value of alternative service delivery methods and strengthened the program's ability to support participants during future emergencies and disasters.

Immunization Services – Routine immunization activities continued throughout the COVID-19 response and reinforced the importance of maintaining essential public health services during emergencies. The CNMI Immunization Program strengthened partnerships with public and private schools, expanded outreach activities, and coordinated mobile vaccination events to improve vaccine access and coverage. These efforts continue to support preparedness by maintaining protection against vaccine-preventable diseases among children and adolescents.

Early Intervention Program – As the CNMI's IDEA Part C program, Early Intervention successfully adapted services during the pandemic through telephone and videoconferencing platforms before returning to face-to-face services. Virtual service delivery strengthened continuity of care during disruptions and expanded options for reaching families in geographically isolated communities.

Children with Special Health Care Needs (CSHCN) Program – The CSHCN Program utilized telephone and virtual platforms to continue parent support, peer networking, training, and educational activities during the pandemic. These experiences demonstrated the value of multiple service delivery modalities and informed future planning for maintaining support services during emergencies. The successful continuation of specialty outreach clinics, including Shriners outreach services, further highlighted the importance of collaboration and contingency planning to ensure access to specialized care for children with complex health needs.

Group Prenatal Care – Group prenatal care services were suspended during the COVID-19 pandemic due to public health restrictions and challenges associated with delivering comprehensive prenatal assessments virtually. Participants were successfully transitioned to individual prenatal care services through the CHCC Women's Clinic to ensure continuity of care. Lessons learned from this experience highlighted the importance of maintaining flexible care models and contingency plans to ensure uninterrupted access to prenatal services during emergencies.

Emergency Preparedness and Risk Communication Lessons – The COVID-19 pandemic underscored the importance of preparedness planning, continuity of operations, and effective risk communication for MCH populations. One key lesson was the need for timely, accurate, and culturally appropriate information to address misinformation and support informed decision-making. Title V staff collaborated with healthcare providers and public health partners to develop multilingual public awareness campaigns using social media, video messaging, local television, and community outreach. Messaging focused on vaccination, maternal health, infant health, and preventive care. The establishment of a centralized call center, (670) 682-SHOT (7468), provided residents with direct access to trusted information and demonstrated the value of coordinated

communication during public health emergencies. These experiences continue to inform emergency preparedness planning and communication strategies across MCH programs.

PRAMS and Public Health Emergency Preparedness – The CNMI Pregnancy Risk Assessment Monitoring System (PRAMS) was implemented in 2021, with data collection beginning for 2022 births following IRB approval. The CNMI PRAMS surveys 100 percent of resident births and includes questions on prenatal care, delivery experiences, postpartum care, infant care, vaccination, and public health emergency impacts. Initial data became available in 2024 and has provided valuable insights into the experiences of mothers and infants during and following the COVID-19 pandemic. Findings from PRAMS emergency preparedness and COVID-19-related questions continue to inform MCH program planning, emergency preparedness activities, risk communication strategies, and efforts to strengthen resilience among CNMI families.

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[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 for Needs Assessment Update (Last Modified: FY 2027 Application/FY 2025 Annual Report)

Process Description for Needs Assessment Update

The CNMI Title V Maternal and Child Health (MCH) Program conducts an annual review of the state's maternal and child health needs to ensure that priorities, strategies, and performance measures remain responsive to emerging issues and changing population needs. The annual update builds upon the 2025 Comprehensive Five-Year Needs Assessment and incorporates new quantitative and qualitative information collected throughout the reporting period.

The annual review included analysis of available surveillance and program data from the Commonwealth Healthcare Corporation (CHCC), Vital Statistics, Medicaid, WIC, Immunization Program, PRAMS, newborn screening, and other Title V programs. Additional information was obtained from hospital utilization data, program performance reports, quality improvement activities, and emerging public health surveillance. National data sources, when applicable, were also reviewed to compare local trends with national benchmarks.

Input from families, healthcare providers, community organizations, and interagency partners was incorporated through existing advisory committees, coalition meetings, stakeholder workgroups, and routine partner engagement activities. Families of Children with Special Health Care Needs (CSHCN) continued to provide feedback through the Family-to-Family Health Information Center, while maternal and child health partners representing clinical care, behavioral health, education, early childhood, social services, and community organizations shared emerging concerns and recommendations during regular program meetings and collaborative initiatives.

The Title V team reviewed progress toward National Performance Measures (NPMs), National Outcome Measures (NOMs), Evidence-based Strategy Measures (ESMs), and state performance measures to assess whether current priorities continue to address identified needs. Existing priorities remained appropriate for the reporting period, although implementation strategies were refined to strengthen access to care, improve care coordination, enhance family engagement, and support disaster recovery efforts.

The annual update informed ongoing program planning, resource allocation, quality improvement activities, and cross-program collaboration. Findings continue to guide implementation of evidence-based and evidence-informed strategies while ensuring that Title V investments remain aligned with the evolving needs of women, children, adolescents, children with special health care needs, and families throughout the Commonwealth of the Northern Mariana Islands.

III.C.1.b. Findings

III.C.1.b.i. MCH Population Health and Wellbeing (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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

Maternal and women's health indicators in the CNMI demonstrate meaningful progress in access to maternity care while highlighting persistent challenges in maternal health outcomes. Timely prenatal care has improved substantially, with 75% of women receiving care during the first trimester, reflecting significant gains in early engagement with prenatal services, although the CNMI remains slightly below the Healthy People 2030 target of 80.5%. Attendance at postpartum visits also increased markedly, rising from 52.9% in 2021 to 67.9% in 2025, indicating stronger continuity of maternal care after delivery. Healthy behaviors during pregnancy remain encouraging, with alcohol use reported at just 1% and smoking during pregnancy declining from 4% to 1%, though increasing e-cigarette use warrants continued monitoring. Maternal mortality has remained low, with no reported deaths from 2022–2025 following one maternal death in 2021. Despite these positive trends, significant concerns remain. Severe maternal morbidity has increased dramatically from 122 to 394.4 cases per 10,000 deliveries between 2020 and 2025, far exceeding the Healthy People target and signaling the need for enhanced clinical and public health interventions. Additionally, approximately 23.1% of women reported postpartum depressive symptoms, preventive medical visits among women aged 18–44 have remained relatively stagnant at 55–59%, and preventive dental care during pregnancy remains underutilized despite modest improvement, underscoring ongoing opportunities to strengthen comprehensive maternal health services across the Commonwealth.

Prenatal and Postpartum Care

- First Trimester Prenatal Care: The percentage of women receiving prenatal care during the first trimester increased substantially to 75%, representing a significant improvement in timely access to prenatal care. This progress reflects ongoing efforts to promote early engagement in prenatal services and improve maternal health outcomes across the Commonwealth. While this marks meaningful advancement, the CNMI remains slightly below the Healthy People 2030 target of 80.5%, underscoring the importance of continuing efforts to ensure all pregnant women receive early

and comprehensive prenatal care.
- Postpartum Visits: The percentage of women attending a postpartum visit has shown substantial improvement over the past five years, increasing from 52.9% in 2021 to 67.9% in 2025.

Maternal Health Outcomes
- Severe Maternal Morbidity: Rates fluctuated significantly, rising from 122 per 10,000 deliveries in 2020 to 394.4 in 2025, signaling a worsening trend and greatly surpassing the Healthy People 2020 target of 64.4 per 10,000.
- Maternal Mortality: There was 1 reported maternal death (174 per 100,000) in 2021, but no deaths in other years from 2019-2025.

Healthy Behaviors During Pregnancy
- Alcohol Use During Pregnancy: Alcohol use was reported at 1% in the CNMI PRAMS data.
- Smoking During Pregnancy: Smoking rates showed significant improvement, dropping from 4% to 1% 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: Reports of depressive symptoms, approximately 23.1%, according to CNMI PRAMS.
- Preventive Medical Visits: Slight variation in rates, with 55-59% of women aged 18-44 having a preventive medical visit annually. Efforts remain below the optimal levels.
- Preventive Dental Visits During Pregnancy: These visits remained relatively low but showed a slight improvement from 29% in 2020 to 32% in 2025, according to the MCH-JS.

Perinatal/Infant Health Domain

Infant health indicators in the CNMI demonstrate strong progress in infant nutrition and selected safe sleep practices, while several birth and mortality outcomes have worsened. Breastfeeding remains a major strength, with 96% of infants ever breastfed in 2023. Exclusive breastfeeding through six months reached a record high of 11% in 2023, a substantial improvement from 0% in 2021, and remained relatively stable at 10.1% in 2025. Among WIC participants, the percentage of infants breastfed at six months increased gradually from 40% in 2022 to 43.2% in 2023, although it remains below the target of 60.6%. Safe sleep practices have also improved, with 92.1% of mothers reporting that they place their infants on their backs to sleep; however, only one-third (33.4%) reported consistently following all recommended safe sleep practices by having their infants sleep alone in a safe sleep environment. Despite these encouraging trends, several infant health outcomes are of increasing concern. The percentage of low birthweight infants rose from 6.0% in 2019 to 8.8% in 2023, while preterm births remained elevated at 11.2% in 2025, exceeding the Healthy People target of 9.4%. Most concerning, infant mortality increased substantially from 4.4 deaths per 1,000 live births in 2019 to 14.0 per 1,000 in 2025, with post-neonatal mortality also rising sharply over the same period. These trends underscore the need to strengthen maternal, newborn, and infant health interventions to improve birth outcomes and reduce preventable infant deaths across the Commonwealth.

Positive Trends:
- Breastfeeding rates are notably high, with 96% of infants ever breastfed in 2023.
- 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. This rate is maintained at 10.1% in 2025.
- 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. Data from the CNMI PRAMS indicate that in 2023, 92.1% of mothers reported placing their babies on their backs to sleep. However, only 33.4% 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 8.8% in 2023.
- Similarly, the preterm birth (PTB) rate reached 12% in 2022 and remained at 11.2% in 2025, exceeding the HP 2020 target of 9.4%.
- Infant mortality (IM) rates have worsened, increasing from 4.4 per 1,000 in 2019 to 14 per 1,000 in 2025, well above the Healthy People 2030 target of 5.0 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, slightly dropped to 7 per 1,000 in 2023 and the increased to 14.4 per 1,000 in 2025.

Child Health Domain

Child health indicators in the CNMI show encouraging improvements in immunization, access to care, and physical activity, while chronic disease risk factors and access to comprehensive primary care remain significant concerns. Completion of the recommended 7-vaccine series by age two increased from 58.3% in 2020 to 63.0% in 2025, although coverage remains below the Healthy People 2030 target of 80%. Access to healthcare has improved, with the percentage of children unable to obtain needed care declining from 6.0% to 3.5% between 2020 and 2025, while uninsured rates have remained relatively stable at approximately 14%. Child mortality among children aged 1–9 years declined following fluctuations in earlier years, with no reported deaths in 2024 and 2025. Physical activity also improved, with nearly 60% of children aged 6–11 achieving at least 60 minutes of daily activity in 2025, although these findings should be interpreted cautiously. Despite these positive trends, several indicators point to ongoing health challenges. The prevalence of dental caries increased substantially from 15.0% in 2020 to 23.8% in 2025, obesity continues to rise among both children and adolescents, and access to a medical home remains critically low, with only 7.9% of children reporting having one—far below the Healthy People 2030 target of 53.5%. Although parent-reported child health status improved modestly in 2025, it remains well below the U.S. national average, underscoring the need for continued investments in preventive care, oral health, healthy lifestyles, and coordinated systems of care for children across the Commonwealth.

Areas of Improvement

- **Vaccination Rates**
  - Completion of the 7-vaccine series by age 2 increased from 58.3% in 2020 to 63% in 2025, however still below the HP 2030 target (80%).
- **Access to Health Care**
  - Children unable to obtain needed care decreased from 6% in 2020 to 3.5% in 2025.
  - The percentage of uninsured children is maintained from 13.9% in 2020, slightly decreasing to 12.2% in 2022 and then slightly returned to baseline levels at 13.8% for 2025.
- **Child Mortality Rates**
  - 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 and then dropped to 0.0 per 100,000 for both the 2024 and 2025 reporting years.
- **Physical Activity**
  - The share of children aged 6-11 active for 60+ minutes daily increased to 59.6% in 2025, up from 48% in 2020 *(* - data should be interpreted with caution)*.

Areas of Concern

- **Dental Health**
  - The percentage of children with decayed teeth or cavities increased from 15% in 2020 to 23.8% in 2025, indicating worsening oral health.

- **Obesity**
  - Obesity rates among adolescents (ages 10-17) were high at 24% in 2025, increasing from 20.8% reported in 2020.
  - Among high school students (grades 9-12), rates were even higher, with 22% reported as obese, according to the CNMI Youth Risk Behaviors Survey (YRBS).
- **Medical Home Access**
  - Only 7.9% of children in the CNMI report having a medical home, far below the HP 2030 objective of 53.5%
- **General Health Status**
  - The percentage of children reported in excellent or very good health fell from 76.6% in 2019 to 74.4% in 2023, then modestly rebounded to 78.1% in 2025, but still below the US national average of 89.9%.

Adolescent Health Domain

Adolescent health outcomes in the CNMI reflect several encouraging gains alongside emerging challenges that require continued attention. Youth mental health has improved, with the percentage of high school students reporting that their mental health was "most of the time" or "always" not good declining from 31.9% in 2021 to 25.2%. Immunization coverage remains a significant strength, with HPV, Tdap, and meningococcal vaccination rates consistently exceeding 95% since 2019. The CNMI has also achieved the WHO 2030 target for HPV vaccination series completion, reaching 91.8% among adolescent girls aged 13–17. Additional positive trends include fewer adolescents reporting they have never visited a dentist and a sustained reduction in the teen birth rate compared with 2019 levels. However, several indicators point to growing concerns. Annual adolescent preventive wellness visits have declined substantially from 40.9% in 2020 to 28.9% in 2025, while access to a medical home has dropped sharply from 20.1% to 7.9% over the same period. Obesity among high school students has also continued to rise, increasing from 16.0% in 2015 to 22.1% in 2023, highlighting the need for strengthened efforts to improve access to preventive care and promote healthy lifestyles among CNMI youth.

Positive Trends

Mental Health

- 25.2% of high school youth reported that their mental health was most of the time or always not good, a decrease from 31.9% in 2021 as reported by the YRBS.

High Vaccination Rates

- 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, a rate that is maintained in 2025.

Dental Care

- 4.4% of high school teens reported that they never saw a dentist, a decrease from 5.5% in 2021 and 7.9% in 2015.

Areas of Concern

- Preventive Medical Visits: Adolescent wellness visits declined from 40.9% in 2020 to 28.9% in 2025 of CNMI adolescents completed annual wellness visits.
- Medical Home Access: Declining rates of medical home access among CNMI youth, with 20.1% reporting having a medical home in 2020 decreasing to 7.9% in 2025.
- Obesity: CNMI YRBS data indicates an upward trend in the percent of high school teens reporting having obesity, from 16.0% in 2015 to 22.1% in 2023.

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

- According to the CNMI MCH-JS, there is an estimated 11.4% of Children with Special Healthcare Needs (CSHCN) in the CNMI, with 2.2% identified with autism and 2.4% with ADD or ADHD.
- Among CNMI CSHCN, more than half (53.5%) report receiving care coordination and 52.7% report receiving care that was family centered.
- Only 7.9% of families report having access to a medical home
- The percentage of CNMI CSHCN that received services to transition into adult care declined from 48.9% in 2020 to 39.7% in 2025.

Challenges Identified

- Limited access to a medical home: Only 7.9% of families report having a medical home, indicating that most CSHCN lack access to coordinated, continuous, and comprehensive primary care, increasing the risk of fragmented services and unmet healthcare needs.
- Gaps in coordinated, family-centered care: While just over half of families report receiving care coordination (53.5%) and family-centered care (52.7%), many continue to face challenges navigating multiple providers and services, highlighting the need for stronger care integration.
- Declining transition to adult healthcare: The percentage of CSHCN receiving transition services decreased from 48.9% in 2020 to 39.7% in 2025, increasing the risk of disruptions in care and poorer health outcomes as youth move into adult healthcare systems.
- Growing demand for developmental and behavioral health services: An estimated 11.4% of children have special health care needs, including autism (2.2%) and ADD/ADHD (2.4%), placing increasing demand on limited pediatric specialty, behavioral health, and therapy services.
- Workforce and geographic barriers: Limited pediatric specialty providers, coupled with transportation and geographic challenges across the islands, continue to restrict timely access to diagnostic, treatment, and support services for CSHCN and their families.

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

III.C.1.b.ii.a. Impact of Organizational Structure (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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) unite, under the Public 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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

Agency Capacity

The Commonwealth Healthcare Corporation (CHCC), through its various divisions—including the Division of Public Health Services (DPHS), Women's Clinic, Children's Clinic, Community Guidance Center, and other programs—provides a comprehensive system of primary, preventive, and specialty health services to the CNMI community. Services include medical, dental, behavioral health, substance use treatment, women's health, nutrition services, family planning, and health promotion activities.

Through strong internal collaboration and partnerships with community organizations, CHCC expands access to care beyond traditional clinical settings through outreach activities, mobile clinic services, case management, health education, and other enabling services. Together, these efforts support a coordinated system of care for women, children, adolescents, children and youth with special health care needs, and their families. The following sections describe agency capacity across key maternal and child health domains.

Women/Maternal Health

Prenatal care services are provided through the CHCC Women's Clinic and the Rota and Tinian Health Centers. Care is delivered in accordance with nationally recognized standards, including guidelines established by the American College of Obstetricians and Gynecologists (ACOG).

Women also have access to a broad range of preventive and gynecological health services through these clinical sites. In addition, DPHS conducts community-based screening activities that provide blood pressure, blood sugar, BMI checks, and other preventive health assessments to improve access to care and support the early identification and management of chronic diseases.

The Breast and Cervical Cancer Screening Program (BCCSP) further supports women's health by providing eligible women with no-cost breast and cervical cancer screening services. The program assists clients with eligibility determination, transportation, and referrals for follow-up care. Transportation assistance includes airfare for eligible residents of Rota and Tinian who require mammography services on Saipan. The program also conducts community outreach and education activities focused on cancer prevention, early detection, and risk reduction, including collaborative awareness campaigns conducted throughout the year.

Perinatal/Infant Health and Child Health

CHCC provides a continuum of preventive health services for infants and children designed to promote healthy growth, development, and early identification of health concerns. Services are aligned with recommendations from the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP).

Well-baby and well-child services are provided through the Children's Clinic and include immunizations, developmental surveillance, physical examinations, nutrition counseling, injury prevention education, breastfeeding support, and routine health screenings. Children identified as needing additional services are referred to specialty care, dental services, hearing screening, early intervention, home visiting, and other support programs as appropriate.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) plays a critical role in supporting

maternal and child health by providing nutritious foods, nutrition education, breastfeeding support, and referrals to health and social services for eligible women, infants, and children under five years of age. WIC collaborates closely with MICAH and other DPHS programs to promote healthy pregnancies, breastfeeding, and early childhood development.

Newborn Hearing Screening is provided for all infants born at CHCC prior to hospital discharge. Follow-up screening and diagnostic audiology services are available through the Children's Clinic to ensure timely identification and intervention for hearing-related conditions.

Immunization services are available through both public and private providers across the CNMI. The Public Health Immunization Clinic offers walk-in services and Saturday clinic hours to improve accessibility for working families. MICAH and partner programs support immunization efforts through education and outreach activities that promote vaccine confidence and adherence to recommended immunization schedules.

The Immunization Program also administers and monitors compliance with CNMI school health requirements. Children entering the school system must complete a physical examination, vision and hearing screening, and receive age-appropriate vaccinations consistent with CDC recommendations. Annual school health certification requirements help ensure students remain healthy and ready to learn.

Oral health services are provided through the CHCC Dental Clinic and School Dental Program. Through partnerships with Head Start and public schools, children receive preventive services including oral health assessments, fluoride varnish applications, dental sealants, and oral health education. Students identified as needing additional treatment receive referrals and report cards that inform parents of recommended follow-up care.

Beyond school-based services, the CHCC Dental Clinic provides comprehensive dental care including preventive services, restorative treatment, community outreach, and oral health education. Medicaid-enrolled children may also receive services through participating private dental providers, helping expand access to care throughout the CNMI.

Adolescent Health

Adolescents have access to preventive and primary health care services through the Women's Clinic, Children's Clinic, Mobile Clinic Program, and community outreach activities. Behavioral health and social services are available through the Community Guidance Center (CGC), providing a coordinated approach to adolescent health and well-being.

Adolescent health initiatives emphasize prevention and the promotion of healthy behaviors. Programs focus on reducing substance use, preventing unintended pregnancy, promoting mental wellness, and supporting positive youth development. MICAH programs collaborate closely with the Family Planning Program, Public School System, and Community Guidance Center to deliver education, outreach, and support services tailored to adolescents and young adults.

The Community Guidance Center leads many of the CNMI's prevention efforts related to underage drinking, suicide prevention, violence prevention, and behavioral health promotion. Through strong partnerships with local, federal, and community organizations, CGC helps coordinate comprehensive strategies aimed at reducing risk factors and strengthening protective factors among youth.

Children and Youth with Special Health Care Needs (CYSHCN)

CHCC is committed to promoting a coordinated and family-centered system of care for children and youth with special health care needs (CYSHCN) from birth through 21 years of age. Services are designed to address the medical, developmental, educational, social, and emotional needs of children and their families through strong interagency collaboration and care coordination.

The CYSHCN Program, administered through MICAH, works closely with the hospital, the Early Intervention Services Program, the Public School System's Special Education Program, healthcare providers, and community partners to ensure children receive appropriate services and supports. Community Health Workers serve as care coordinators and assist families with navigating complex systems of care, coordinating specialty appointments, securing referrals, and accessing needed resources.

To reduce barriers to care, the program provides transportation assistance, eligibility support, family education, parent engagement activities, health forums, and training opportunities. Contracted specialty providers, including audiology services, supplement local capacity and help ensure access to services that may not otherwise be available within the CNMI.

Because specialty healthcare services are limited within the CNMI, partnerships with off-island providers remain critical. Specialty outreach teams from Shriners Children's Hawai‘i visit the CNMI multiple times each year to provide evaluations and treatment planning for children with complex medical conditions. In addition, the CNMI partners with Rady Children's Hospital San Diego through the Health Network Program (HNP) to provide access to specialized pediatric services, including cardiology, neurology, gastroenterology, orthopedics, and select surgical specialties. These partnerships help ensure that children and families have access to comprehensive care and specialty expertise when services are not available locally.

Cross-Cutting Systems and Partnerships

A strong network of partnerships and enabling services supports access to care across all maternal and child health populations. Programs throughout CHCC work collaboratively to connect individuals and families to healthcare, insurance coverage, preventive services, and community resources.

The CHCC Dental Clinic serves all MCH populations and provides preventive, restorative, and educational services that support lifelong oral health. Dental services are integrated into broader public health and clinical initiatives to improve access and promote overall health and well-being.

MICAH maintains a close partnership with the CNMI Medicaid Program to promote healthcare coverage and reduce barriers to care. Dedicated staff assist individuals and families with Medicaid applications, eligibility determination, translation services, and enrollment support. MICAH receives referrals from numerous CHCC programs, including the Women's Clinic, Children's Clinic, Early Intervention Services, Home Visiting Program, and Family Planning Program, among others. Insurance screening and enrollment assistance are also incorporated into Mobile Clinic outreach activities to ensure community members are connected to available coverage options.

The partnership between MICAH and Medicaid extends beyond enrollment assistance and includes data sharing, staff training, referral coordination, and reimbursement for eligible services. Medicaid staff provide regular eligibility and enrollment information and collaborate with MICAH to streamline application processing and improve access to care for eligible families. MICAH also supports enrollment in the CHCC income-based sliding fee program to assist uninsured and underinsured individuals who qualify for discounted healthcare services.

Together, these partnerships strengthen care coordination, improve access to services, and support a more integrated system of care for women, children, adolescents, and families throughout the CNMI.

Data Capacity and Systems Development

CHCC continues to strengthen its public health data infrastructure to support data-driven decision-making and improve health outcomes across the CNMI. The Maternal and Child Health State Systems Development Initiative (SSDI) serves as a

key component of these efforts by enhancing the CNMI's ability to collect, analyze, share, and utilize reliable maternal and child health data.

The SSDI Project supports data collection and analysis for the Title V Maternal and Child Health Block Grant, including National Outcome Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs), and Evidence-based or Informed Strategy Measures (ESMs). Through these activities, SSDI helps inform program planning, resource allocation, policy development, and performance improvement efforts.

A primary focus of SSDI is strengthening data integration and reducing information silos across programs and systems. Efforts include the development of data governance structures, standardized operating procedures, and processes that promote data quality, interoperability, security, and responsible data sharing. These activities support timely access to information and strengthen the ability of CHCC programs to respond to emerging health priorities.

To support ongoing monitoring of maternal and child health outcomes, SSDI maintains an MCH Trend Analysis Dataset that tracks healthcare encounters and performance indicators related to Title V priorities. These surveillance activities help identify emerging trends, monitor health disparities, and inform strategies to improve population health outcomes.

The SSDI Project also works closely with CHCC's Health Information Technology (HIT) Department to maximize the use of the CareVue Electronic Health Record (EHR) and Revenue Cycle Management (RCM) systems. CareVue serves as the centralized EHR platform across CHCC, including facilities on Saipan, Rota, and Tinian, and provides valuable clinical and utilization data to support program planning and evaluation.

Recent system enhancements have included electronic prescribing (eRx), improved patient data displays, enhanced clinical decision support functions, and strengthened cybersecurity protections. These improvements support more efficient clinical workflows, improve access to health information, and enhance data quality. CHCC continues to explore additional capabilities, including Electronic Case Reporting (eCR), to further strengthen public health surveillance and reporting functions.

In 2022, the CNMI successfully secured continued SSDI funding through 2027 to advance these efforts. Key priorities include strengthening data collection and analysis capacity, improving interoperability among MCH data systems, enhancing the integration of social and community health factors into program planning, and expanding timely data reporting and visualization capabilities to support rapid public health response and informed decision-making.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 Services, 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 2025, the CNMI Title V program includes 18 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 pathway 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 Services, 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) (Last Modified: FY 2027 Application/FY 2025 Annual Report)

Commonwealth of the Northern Mariana Islands

State Systems Development Initiative (SSDI) Performance Narrative Report

Budget Period: FY 2027 Application | **Reporting Period:** FY 2025 Annual Report

1. Executive Summary & Foundational Data Capacity

In FY 2025, the Commonwealth of the Northern Mariana Islands (CNMI) State Systems Development Initiative (SSDI) program successfully advanced foundational Maternal and Child Health (MCH) data capacity, directly supporting the Title V MCH Block Grant assessment, monitoring, and evaluation lifecycle.

A primary milestone for the reporting year was the SSDI Program Coordinator's integration into the newly developed Data Surveillance and Performance Management (DSPM) Unit. This centralized data hub structurally unites dedicated data analysts across core public health sectors—including Immunization, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, Non-Communicable Diseases (NCDs), Early Hearing Detection and Intervention (EHDI), and the CNMI Cancer Registry. This structural alignment fosters an environment of cross-programmatic efficiency and shared technical skillsets. Under this integrated unit, the SSDI program has expanded its centralized analytical capacity to deliver critical epidemiological and methodological support to the newly integrated Bullying Prevention, ERASE MM, and BRFSS programs within the Maternal and Child Health program

portfolio.

To improve data infrastructure and support data-driven decision-making, the jurisdiction is currently in a transition phase from Medsphere CareVue to the MEDITECH Electronic Health Record (EHR) system. The core system cutover is targeted for late November 2026, with full system optimization anticipated in early 2027. Despite preparing for this transition, we successfully maintained critical linkages between the current EHR and birth and vital records, enabling wide-ranging analysis of maternal health outcomes, including the timeliness of prenatal, postpartum, and preventive care visits.

Additionally, the SSDI program developed an analytical MCH-Trend Analysis Table (MCH-TAT), linking National Outcome Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs), and Evidence-Based or -Informed Strategy Measures (ESMs) from 2019 to 2025, which provides a valuable cross-sectional view of MCH measures over time.

Needs Assessment and Program Management

The CNMI Comprehensive MCH 5-year Needs Assessment was completed in 2025 and incorporated both advanced quantitative and deep qualitative community findings. This included NORC at the University of Chicago's large-scale survey deployment and Insight for Action's Community Health Needs Assessment (CHNA), which provided rich qualitative community indicators.

The SSDI Program Coordinator served as a strategic member of the CNMI Needs Assessment Steering Committee, helping translate survey results into clearly defined priority needs. These findings directly informed the development of the State Action Plan and the selection of Evidence-Based Strategy Measures (ESMs), all aligned with the Plan-Do-Study-Act (PDSA) cycle to support continuous quality improvement.

In addition to its role in the Needs Assessment, the SSDI program contributes to system-level data governance and modernization. The program serves as an active member of the CHCC Data Governance Committee and the Data Modernization Initiative Council, where it supports improvements in data quality, standardization, interoperability, and analytic readiness across the Maternal and Child Health portfolio.

2. Progress in Core MCH Data Linkages (FY 2025 Report)

The SSDI program, in partnership with the Data Surveillance and Performance Management Unit, maintains a comprehensive portfolio of electronic datasets that form the backbone of the CNMI's Maternal and Child Health (MCH) surveillance system. These datasets—ranging from Vital Statistics and EHR data to newborn screening, immunization, WIC, BRFSS, and ERASE MM—support continuous monitoring of maternal, infant, and child health outcomes across the jurisdiction.

Table 1 below summarizes each dataset's electronic form, reporting periodicity, linkage status with Vital Records, and programmatic utility. This structured inventory reflects the SSDI program's ongoing work to standardize data sources, improve interoperability, and ensure that each dataset contributes meaningfully to MCH performance measurement and quality improvement.

Through this portfolio, the SSDI program enables the jurisdiction to track key indicators such as birth outcomes, maternal risk factors, immunization coverage, chronic disease comorbidities, and behavioral health trends. The linkage of Vital Statistics with the Medsphere CareVue EHR system represents a major advancement, creating a unified analytic environment that supports longitudinal tracking and more accurate evaluation of service delivery.

By maintaining and modernizing these datasets, the SSDI program can generate timely, high-quality data for Title V reporting, program planning, and evidence-based decision-making. This integrated surveillance infrastructure also positions CNMI to expand future linkages—such as newborn screening, WIC, and ERASE MM—further enhancing the MCH data ecosystem.

Table 1: CNMI MCH Surveillance System Dataset Inventory

Data Sources	Title V Access	Electronic Form	Periodicity	Lag Length in # of Months	Vital Birth Records Linkage	Programmatic Utility
Vital Statistics Birth	Yes	Yes	Monthly	1	Not applicable	Core MCH indicators, birth outcomes surveillance
Vital Statistics Death	Yes	Yes	Quarterly	1	Yes	Core MCH indicators, birth outcomes, mortality surveillance
Hospital Discharge	Yes	Yes	Daily	1	Yes	Provides comprehensive, ICD-coded clinical information that strengthens surveillance across maternal and child health, chronic disease, injury prevention, and emergency care.
Medicaid / Medicare	Yes	No	Annually	3	No	Health Insurance Eligibility
New Hearing Screening	Yes	Yes	Monthly	1	Yes	Strengthens early identification, referral pathways, data quality, and long-term developmental outcomes
New Blood spot Screening	Yes	Yes	Monthly	1	Yes	Early identification of metabolic disorders; infant follow-up
Immunization Registry	Yes	Yes	Daily	1	No	WebIZ strengthens surveillance, quality improvement, care coordination, including preventive care delivery. It enhances capacity to integrate, analyze, and visualize population-level health data.
WIC Program	Yes	Yes	Monthly	1	No	Provides nutrition risk assessment, Body Mass Index (BMI), and breastfeeding indicators
Home Visiting Program	Yes	Yes	Monthly	1	No	Enhances early childhood development surveillance, supports Title V priorities, and serves as a critical linkage point across MCH programs including WIC, EHDI, WebIZ, and Early Intervention.
CSHCN / SPED	Yes	Yes	Annually	3	No	Provides early identification, cross-system coordination, and equity-focused analytics. It improves the ability to monitor developmental outcomes, support Title V priorities, and align educational and health services across early childhood and school-age programs.
NCD Bureau	Yes	Yes	Quarterly	1	No	Provides surveillance data on chronic disease management, early detection, cross-program linkage, and population-level prevention—making it a cornerstone of Title V's maternal health priorities.
PRAMS	Yes	Yes	Annual	6	Yes	Provides high-quality, population-level data on maternal behaviors, experiences, and social determinants before, during, and after pregnancy.
BRFSS	Yes	Yes	Annual	6	Not applicable	Provides surveillance, case review, prevention strategy development, cross-system linkage, and Title V maternal health priorities.
ERASE MM	Yes	Maternal mortality review system	Annual	6	Planned linkage FY 2028	Maternal mortality contributing factors surveillance, case review, prevention strategy development, cross-system linkage, and Title V maternal health improvement.

3. Data Integration, Visualization, and Health Equity Analysis

Longitudinal Performance Monitoring & Trend Analysis

To systematically inform the Title V MCH Block Grant annual reporting cycles, the SSDI program developed a centralized MCH-Trend Analysis Table that supports a longitudinal data matrix, compiling and tracking key MCH performance indicators across all NOMs, NPMs, SPMs, and ESMs spanning from 2019 to the present. The MCH-TAT functioned as the engine to drive strategic Title V programs and Quality Improvement (QI) Plan-Do-Study-Act

(PDSA) cycles that update monthly or as data becomes available. This tool empowers the SSDI program and DSPM unit to evaluate the effectiveness of program strategies, spot critical gaps, and test targeted changes. Ultimately, these insights provide program managers, partners, and key stakeholders with the clear data needed to track performance improvements across reporting cycles. These findings are regularly shared through annual reports, interactive dashboards, and collaborative meetings to ensure data-driven decision-making across all levels of leadership.

2020 – 2025: National and State Performance Measure (SPM) Summaries

1. Metrics Exceeding Baseline Averages

- **SPM 2: PNC (Prenatal Care visit):** Hit 75.0% in 2025 compared to a historical baseline average of 62.6%, indicating substantial improvements in early Prenatal Care rates
- **PPV-A (Postpartum Visit Attendance):** Climbed to 67.8% in 2025, significantly outperforming its historical baseline average of 50.3%.
- **PPV-B (Recommended Components Complete):** Hit 81.96% in 2025 compared to a historical baseline average of 70.2%, indicating substantial improvements in postpartum clinical quality control.
- **MHS (Postpartum Mental Health Screening):** Increased slightly to 2.5% from its single historical data point in 2024 (2.16%), remaining above that limited baseline though still low overall.
- **BF-B (Exclusive Breastfeeding - WIC):** Reached 10.15% in 2025. Although this dipped slightly from the 2024 peak of 11.61%, it remains nearly double the long-term baseline average of 4.9%.
- **Safe Sleep Compliance (HVP Program):** Every measured safe sleep metric reached peak levels in 2025, exceeding long-term historical norms:
  - **SS-A (Back Placement):** Reached 100.00% compliance in 2025 (Historical Average: 91.4%).
  - **SS-B (Approved Surface):** Climbed to 89.36% in 2025 (Historical Average: 82.02%).
  - **SS-C (No Loose Bedding):** Climbed to 89.36% in 2025 (Historical Average: 78.5%).
- **PA-Child (Physical Activity-Child):** Hit 59.6% and is 16.9% higher than the multi-year historical average (51.0%). The physical activity rate recorded for 2025 is factually reliable and is an accurate reflection of the community; however, prior years' data recorded low statistical reliability due to small sample sizes.

2. Stabilized Performance Plateaus

These indicators matched their recent 2024 performance exactly but remain shifted relative to their wider historical baselines.

- **NPM 4A - ESM 4.1 (Breastfed at 6 months - WIC):** Breastfeeding rates have remained remarkably stable, hovering between roughly 40% and 45%. Both the numerator (infants breastfed) and the denominator (total infants tracked) have steadily grown since 2022. The program tracked its highest number of infants in 2025 (473 infants), maintaining a strong baseline success rate of 41.6%.
- **MHT (Mental Health Treatment Access):** Maintained 100.00% complete access for the second consecutive year, staying significantly above its historical baseline average of 65.2%.
- **MH (Medical Home All Children - Care Coordination):** Maintained its improved rate of 49.70% from 2024, tracking above its historical norm of 43.6%.
- **BF-A (Breastfeeding Ever - WIC):** Remained stable at 96.00% in 2025, essentially flat against its reliable historical baseline average of 96.3%.
- **MH (Medical Home CSHCN Subgroup):** Remained stuck at a low 8.20% in 2025, well below its already modest historical average of 17.5%.
- **Bullying Exposure Metrics:** Both tracking cohorts remained flat at elevated 2024 risk levels, tracking above historical averages and showing increased risk exposure:
  - **BLY (Adolescents):** Safe at 25.0% in 2025 (Historical Average: 21.4%).

- **BLY (CSHCN Subgroup):** Safe at 47.0% in 2025 (Historical Average: 31.9%).

3. Performance Regressions & Drop-offs

These indicators performed significantly below their historical baseline averages, signaling systemic bottlenecks, or measurement errors.

- **NPM 1 - ESM 1.1 (Preventive visit):** Access plummeted by 43.9 percentage points between 2021 and 2024. However, 2025 broke the multi-year downward trend, recovering by 4.0 percentage points up to 25.5%. This establishes a clear turnaround point for ongoing quality improvement strategies.
- **SPM 1: WWV (Well Woman Visit):** Dropped back down to 31.1% in 2025, representing a significant decline from 2024 (38.8%); it tracks below the historical baseline average of 39.5%.
- **TAHC (Transition to Adult Health Care - CSHCN - MCHJ Survey):** The 2025 rate (39.7%) sits 12.5% below the historical average of 45.4%. The decrease signifies that fewer adolescents with special health care needs are actively receiving services to build independent health-management skills, navigate health insurance changes, or plan transitions to adult providers by age 18. A data reliability flag indicates a small sample size; this data is statistically unstable and should be interpreted with caution.
- **DS (Developmental Screening):** Dropped back down to 36.9% in 2025, representing a significant decline from the 65.9% spike observed in 2024 and falling well below the historical baseline average of 42.6%.
- **AWV (Adolescent Well-Visit):** Logged a low of 7.95% in 2025. While this represents a minor increase from 2024 (6.89%), it tracks far below the historical baseline average of 13.2%.
- **VAX (Childhood Vaccination - WebIZ):** Although the total tracked population of children decreased significantly between 2019 and 2025, the program successfully increased its vaccine completion rate from a low of 49.3% to a peak of 63.0%, demonstrating improved coverage efficiency over time.

4. Quality Improvement (QI) Workflows & Local Programmatic Impact

Translating Needs Assessment Data to Action via PDSA Frameworks

The integration of findings from NORC's Round 4 data and Insight for Action's community health assessment allowed the Steering Committee to build an actionable, data-driven framework. By isolating increasing postpartum visit attendance as a paramount jurisdictional priority, the committee successfully mapped operational targets directly into the State Action Plan across designated NPMs, SPMs, and ESMs.

Execution of this postpartum care initiative is structurally driven by the Plan-Do-Study-Act (PDSA) quality improvement cycle methodology:

- **Formative Evaluation:** The SSDI program, with the support of the Data Surveillance Performance Management Unit, tracks real-time clinic scheduling, provider tool utilization, and patient outreach efforts to identify drop-offs in postpartum attendance shortly after discharge.
- **Summative Evaluation:** Multi-disciplinary data analysts cross-reference monthly longitudinal data from PRAMS and vital records to determine if localized PDSA adjustments are yielding statistically meaningful increases in postpartum compliance over time.

6. Operational Challenges & Data Performance Limitations

Historical Structural Hurdles (FY 2020–2025)

While the SSDI program made substantial infrastructure gains in FY 2025, the program continues to navigate trailing operational limitations inherited from the FY 2020–2025 block grant cycle:

- **Federal PRAMS Data Disruptions:** The reporting and availability of PRAMS (Pregnancy Risk Assessment Monitoring System) data for the 2023 and 2024 birth cohorts have experienced significant disruptions at the federal level due to structural changes and technical modernizations at the CDC. This external delay directly affects the timeline for receiving finalized, weighted maternal behavioral datasets, compounding local analysis hurdles.

- **Performance Measure Postponement and Inactivation:** Due to historical operational gaps and a systemic lack of quorum among key state stakeholder committees, several designated State Performance Measures (SPMs) and Evidence-based Strategy Measures (ESMs) spanning the 2020–2025 cycle were either postponed or formally inactivated. The inability to gather data for informed decision making and convene consistent voting bodies disrupted the continuous execution and monitoring of these specific state-level measures.
- **Longitudinal Data Gaps:** The temporary inactivation of these measures created localized data collection gaps within historical tracking systems. This directly impacted the data unit's ability to maintain an uninterrupted longitudinal dataset for every single state-specific metric in our 2019–present trend table.

7. Plan for the Upcoming Cycle (FY 2027 Application)

Building upon the successes of FY 2025 and directly addressing our historical limitations, the CNMI SSDI program will prioritize the following data capacity objectives for the upcoming application cycle:

- **Migrate and Optimize Vital Records Linkage to MEDITECH:** The commonwealth is currently transitioning its core Electronic Health Record system, replacing the legacy Medsphere CareVue platform with MEDITECH. The core system cutover is targeted for late November 2026, with full system optimization anticipated in early 2027. A priority objective is the seamless migration of our established Health and Vital Statistics birth/death data linkage architecture over to the new MEDITECH environment. To protect longitudinal patient tracking and ensure continuous data integrity during the system transition, the SSDI program and DSPM unit will implement a strict pre-cutover audit alongside a post-go-live Plan-Do-Study-Act (PDSA) cycle. This dual-phase approach eliminates data fracture risks and guarantees that multi-year performance metrics and health equity indicators remain fully unbroken across platforms.
- **Collaborative Upgrades to Inferential Statistics and Impact Evaluation:** The SSDI Program Coordinator is working closely with the MCH Administrator to systematically investigate options for improving data capacity beyond basic descriptive statistics. This joint initiative focuses on transitioning the data unit into performing inferential statistics and advanced program evaluations (such as regression modeling and quasi-experimental designs) linked to the State Action Plan's Impact Evaluation framework.
- **Re-Calibrating Postponed Measures for the 2026–2030 Cycle:** In tandem with the MCH Administrator, the SSDI program will systematically review the postponed 2020–2025 SPMs and ESMs. Utilizing our newly stabilized, electronic data portfolio, the team will determine which measures can be safely reactivated, updating their evaluation frameworks to utilize automated data streams that do not rely on manual committee quorums to drive data capture.

III.C.1.b.ii.e. Other Data Capacity (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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

January 2026- Release of 2022-2023 Report

- Finalization and dissemination of the first CNMI Pregnancy Risk Assessment Monitoring System (PRAMS) Report

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.

Non-Communicable Disease & Risk Factor Adult Hybrid Survey

The CNMI NCD & Risk Factor Adult Hybrid Survey is a comprehensive population-based health assessment conducted by the Commonwealth Healthcare Corporation (CHCC) to measure the prevalence of non-communicable diseases (NCDs)—including diabetes, hypertension, cardiovascular disease, and other chronic conditions—and the behavioral and biological risk factors that contribute to them in the Commonwealth of the Northern Mariana Islands (CNMI).

The survey is considered a "hybrid" because it combines standardized questionnaires from internationally recognized surveillance systems, including the U.S. Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS) and the World Health Organization's (WHO) STEPwise Approach to NCD Risk Factor Surveillance (STEPS), with objective clinical and laboratory measurements.

Key components of the survey include:

- Health Behaviors: Assesses dietary habits, physical activity, tobacco and betel nut use, alcohol consumption, mental health, and other lifestyle factors associated with chronic disease.
- Clinical Assessments: Includes physical measurements such as blood pressure, height, weight, and body mass index (BMI), as well as laboratory testing for hemoglobin A1C, blood glucose, and cholesterol to provide objective health data beyond self-reported information.
- Public Health Purpose: Provides reliable local data to monitor chronic disease trends, identify priority health needs, guide resource allocation, evaluate programs, and inform evidence-based policies and interventions aimed at improving the health of CNMI residents.

Findings from the 2023 CNMI NCD & Risk Factor Adult Hybrid Survey have been used to inform community health improvement planning, strengthen chronic disease prevention and control efforts, and support strategic public health decision-making across the Commonwealth.

Behavioral Risk Factor Surveillance System (BRFSS)
The CNMI was awarded funding through the US Centers for Disease Control and Prevention (CDC) to implement the BRFSS in the CNMI. The Behavioral Risk Factor Surveillance System (BRFSS) is the CDC's largest continuously conducted health survey and the primary source of state- and territorial-level data on adult health behaviors, chronic diseases, preventive health practices, and access to healthcare in the United States. The CNMI will partner with the CDC on the planning and implementation of the BRFSS in the CNMI and is scheduled to launch in FY2026.
Although the Behavioral Risk Factor Surveillance System (BRFSS) is not a maternal health survey, it contributes significantly to maternal health by providing population-level information on the health, behaviors, and social conditions of women of reproductive age before, between, and after pregnancies. These data help identify risk factors that influence maternal outcomes and inform prevention strategies.

For maternal health, BRFSS is valuable in several ways:

1. Monitors the Health of Women of Reproductive Age
Many maternal health outcomes are influenced by a woman's health before pregnancy. BRFSS provides data on:
- Obesity
- Hypertension
- Diabetes
- Physical activity
- Nutrition
- Tobacco and e-cigarette use
- Alcohol use
- Mental health
- Sleep health

These indicators help public health programs identify opportunities to improve preconception health and reduce pregnancy-related risks.

2. Measures Access to Healthcare

BRFSS includes questions on:

- Health insurance coverage
- Having a personal healthcare provider
- Cost barriers to receiving care
- Routine medical checkups

These measures help identify barriers that may delay prenatal care or limit access to preventive services before pregnancy.

3. Supports Chronic Disease Prevention
Chronic conditions are major contributors to maternal morbidity and mortality. BRFSS helps monitor the prevalence of conditions such as:

- Hypertension
- Diabetes
- Cardiovascular disease
- Asthma

These data guide interventions aimed at improving women's health before pregnancy and reducing complications during pregnancy.

4. Assesses Mental Health
BRFSS includes measures of:

- Frequent mental distress
- Depression (in some years/modules)
- General health status
- Quality of life

Because maternal mental health begins before pregnancy and extends into the postpartum period, these data support planning for behavioral health services and prevention efforts.

Disability status

This allows public health agencies to identify populations at higher risk and develop targeted maternal health interventions.

5. Informs Policy and Program Planning
State and territorial maternal health programs use BRFSS data to:

- Conduct needs assessments
- Develop strategic plans
- Support Title V Maternal and Child Health Block Grant priorities
- Evaluate chronic disease prevention efforts

- Monitor progress toward Healthy People objectives

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.

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

Table 1. CNMI MCH Data Sources

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination (Last Modified: FY 2027 Application/FY 2025 Annual Report)

The CNMI MICAH Programs have been instrumental in forging strong partnerships to enhance disease prevention and public awareness activities. Other strategies to strengthen the MICAH Programs' 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 CNMI Public School System (PSS). Staff members work with other state agency staff on a nearly daily basis through coalitions, task forces, advisory groups, committees, and through cooperative agreements.

The CNMI 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.

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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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.

6. Interim Review and Updates to Priority Needs

Although the CNMI's maternal and child health (MCH) priority needs were established for the 2025–2030 Title V reporting cycle through a comprehensive needs assessment, the Title V Program recognizes that community needs, health trends, and system capacity may change during the five-year period. Therefore, the selected priorities will be reviewed annually as part of the interim reporting process to ensure they remain responsive to emerging issues and

population needs.

Annual reviews will incorporate updated quantitative and qualitative data, including vital statistics, disease surveillance, program performance measures, hospital and clinic utilization data, PRAMS (when available), the MCH Jurisdictional Survey, community assessments, and stakeholder and family feedback. The Title V MCH team will also consider the impact of public health emergencies, natural disasters, policy changes, healthcare workforce capacity, funding opportunities, and other factors that may influence maternal and child health outcomes across the Commonwealth.

If interim data indicate that a priority need has substantially improved, new evidence identifies a more pressing concern, or significant changes occur within the healthcare or public health system, the Title V Program may refine strategies, modify objectives, or adjust National and State Performance Measure alignment as appropriate. Any proposed changes will be reviewed in collaboration with the CNMI MCH Working Group, family representatives, youth partners, and other key stakeholders to ensure decisions remain data-driven, transparent, and reflective of community priorities.

While the overall priority needs established through the five-year comprehensive needs assessment are expected to remain stable throughout the reporting cycle, this continuous quality improvement process provides the flexibility to adapt implementation strategies and resource allocation to address emerging maternal and child health needs while maintaining accountability to Title V program goals.

III.D. Financial Narrative

	2023		2024	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$466,540	$489,239	$474,000	$488,206
State Funds	$0	$0	$0	$0
Local Funds	$0	$0	$0	$0
Other Funds	$479,204	$463,932	$459,410	$450,506
Program Funds	$0	$0	$0	$0
SubTotal	$945,744	$953,171	$933,410	$938,712
Other Federal Funds	$7,930,007	$8,902,682	$7,401,082	$6,641,768
Total	$8,875,751	$9,855,853	$8,334,492	$7,580,480

	2025		2026	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$490,000	$473,159	$489,000	
State Funds	$0	$0	$0	
Local Funds	$0	$0	$0	
Other Funds	$417,385	$417,381	$414,218	
Program Funds	$0	$0	$0	
SubTotal	$907,385	$890,540	$903,218	
Other Federal Funds	$8,599,630	$6,127,490	$8,086,638	
Total	$9,507,015	$7,018,030	$8,989,856	

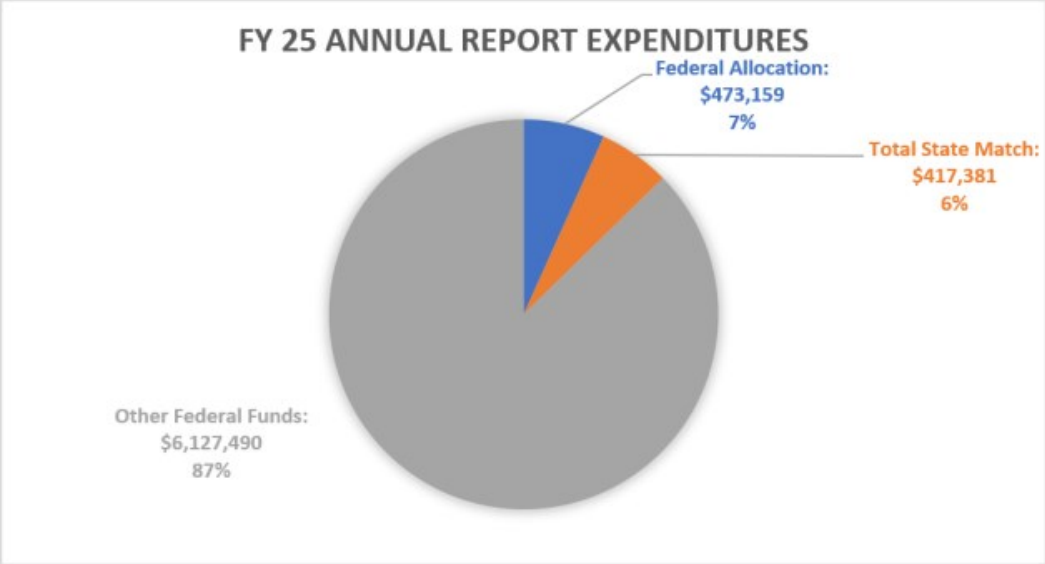
	2027	
	Budgeted	Expended
Federal Allocation	$489,000	
State Funds	$0	
Local Funds	$0	
Other Funds	$411,605	
Program Funds	$0	
SubTotal	$900,605	
Other Federal Funds	$8,368,881	
Total	$9,269,486	

III.D.1. Expenditures (Last Modified: FY 2027 Application/FY 2025 Annual Report)

Overview of Expenditures:

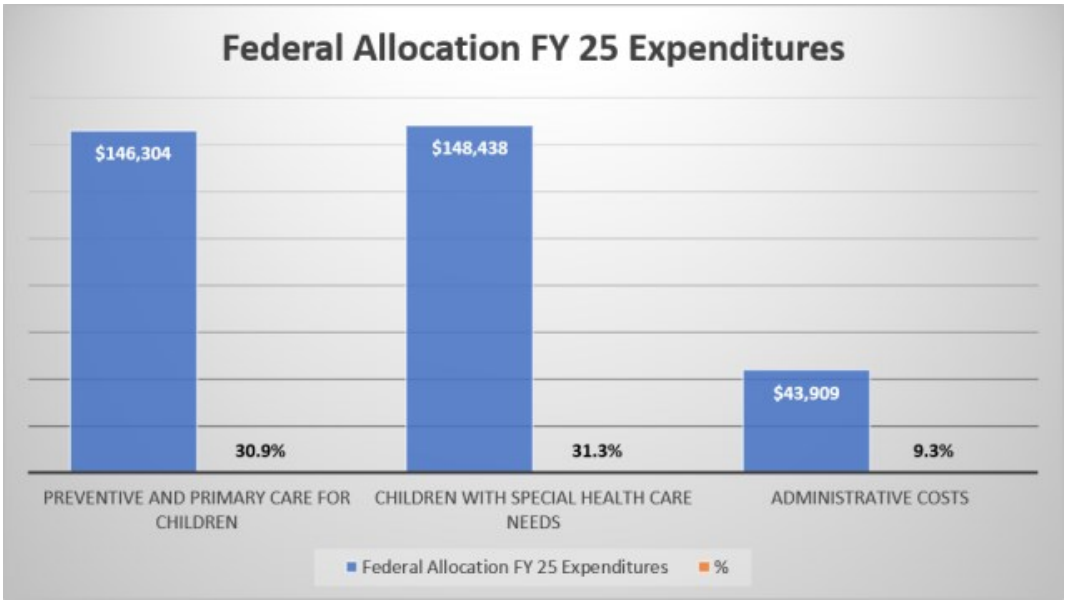
The mission of the CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and 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 25 Expenditures:



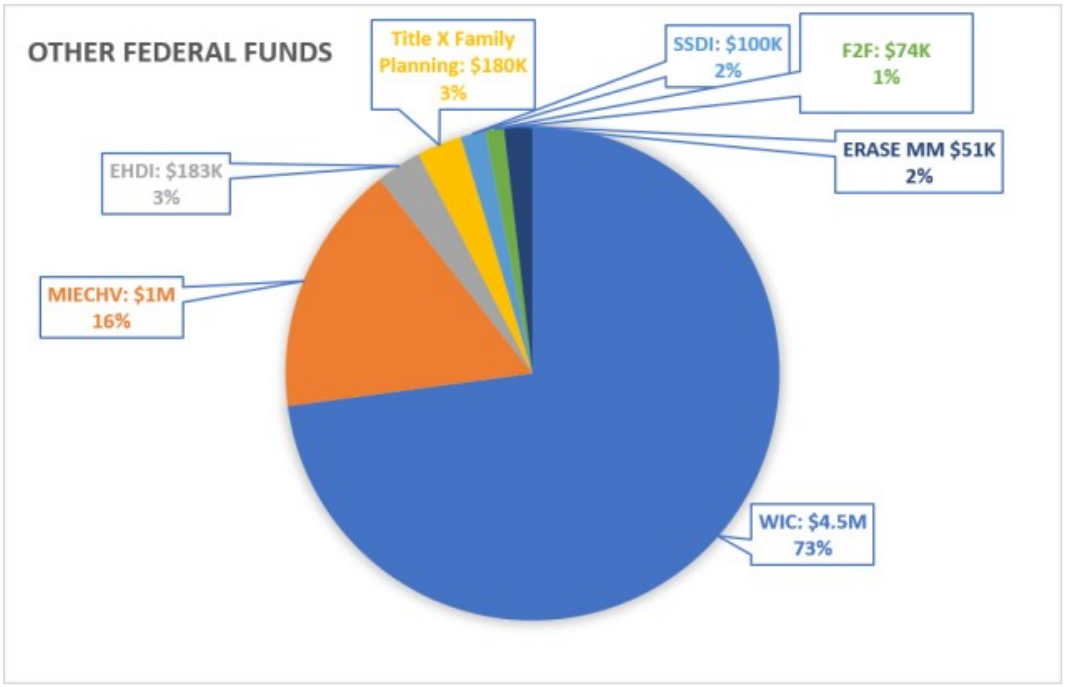
Legislative Requirements Met:

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 25. The chart below provides an overview of the required federal allocation for the FY 25 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, 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 $6,127,490.



Total State Match:

The Total State Matching funds in the amount of $417,381 was expended for FY 2025. 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.

Budget Overview:

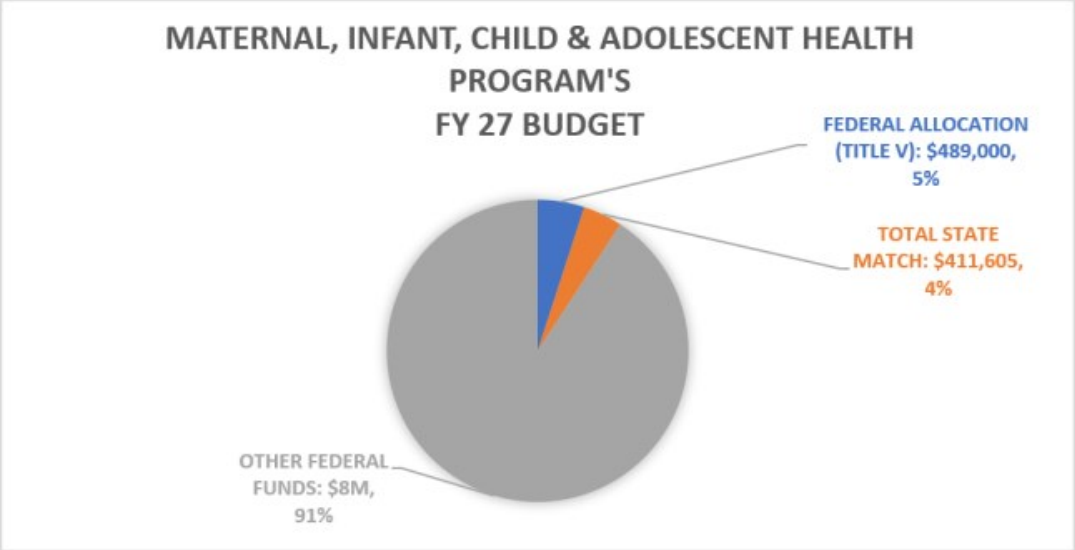
The mission of the CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs under the Commonwealth Healthcare Corporation is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through 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 2027 estimating a total state MICAH Programs budget of $8.9M.

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: Three (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 Programs Administrator, MICAH Program Manager (Service Coordination), Adolescent & Reproductive Health Program Manager, Family Planning Clinical Coordinator, Health Promotion Specialist, one (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 Programs Administrator is funded 75% under the Title V funds and 25% under the Maternal, Infant Early Childhood Home Visiting funds. 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 25% under the Title V funds and 75% under the Family Planning Program funds. The Family Planning Clinical Coordinator is funded 15% under the Title V funds and 85% 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 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

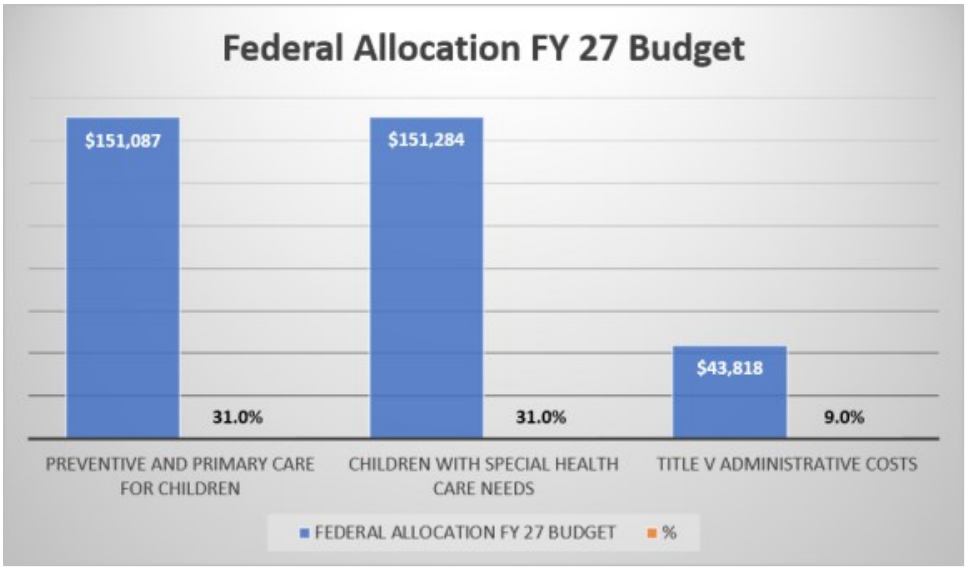
towards other costs such as travel, dues and subscriptions, license and fees, repairs and maintenance, communication services costs, office space rental, and et cetera.

The chart below provides an overview of the CNMI MICAH's FY 2027 Budget as reported on Form 2.



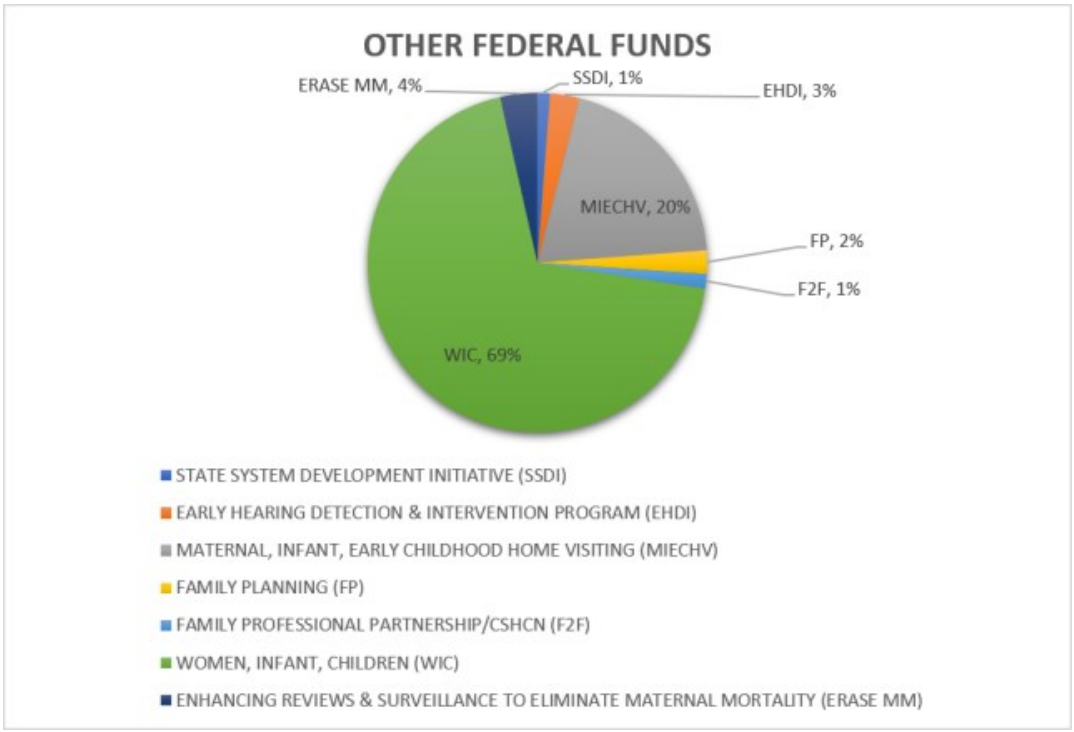
Legislative Requirements Met:

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 2027 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 $115,312 which is at 24% of the total federal award. Preventive and Primary Care for Children was budgeted at $151,087 which is at 31% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Children with Special Health Care Needs was budgeted at $151,284 which is 31% 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 $27,500 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 27 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 $8,368,881.

Total State Match:

The MCH match is budgeted at $411,605 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 $900,605. 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

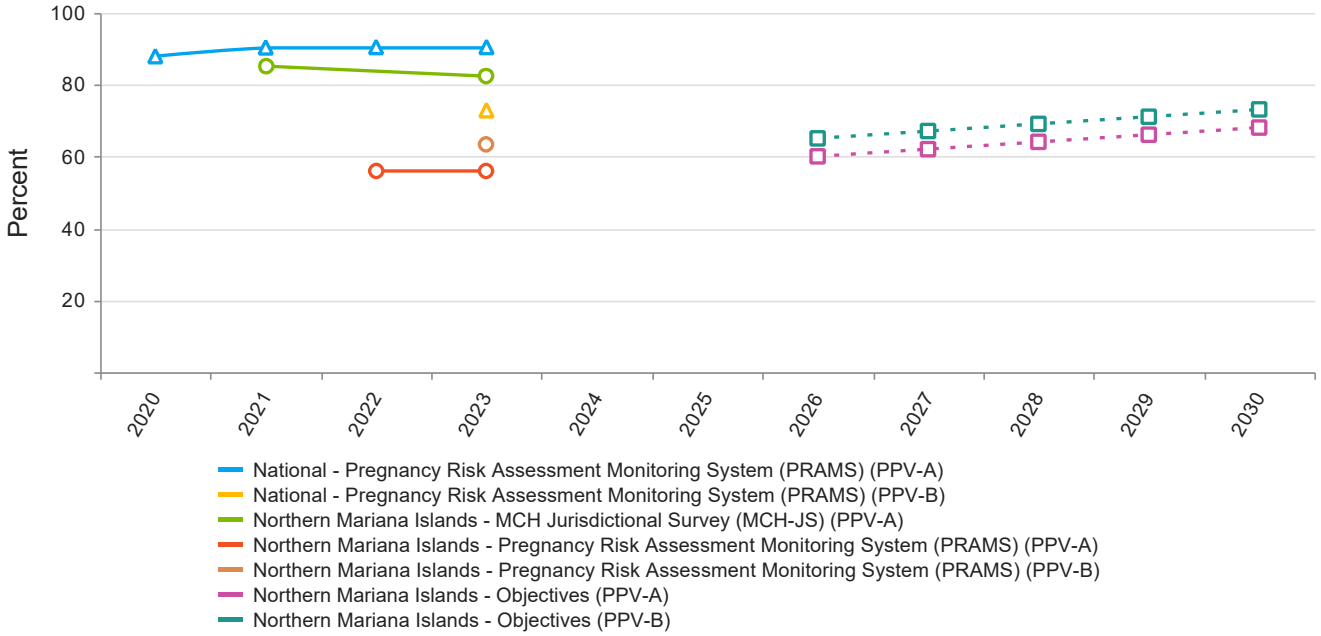
III.E.3 State Action Plan Narrative by Domain

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: MCH Jurisdictional Survey (MCH-JS)			
	2023	**2024**	**2025**
Annual Objective			
Annual Indicator	75.1	82.4	82.4
Numerator	411	1,007	1,007
Denominator	548	1,222	1,222
Data Source	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2024	2021_2023	2021_2023

The measure captures the percent of children aged 0-1 years whose biological mother had a regular checkup 12 weeks after giving birth, which differs from the definition in the Block Grant guidance. See the All FAD Jurisdiction NPM data notes for more details.

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2023	**2024**	**2025**
Annual Objective			
Annual Indicator	56.0	56.0	56.0
Numerator	250	308	308
Denominator	447	550	550
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2022	2023	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	60.0	62.0	64.0	66.0	68.0

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**	**2025**
Annual Objective			
Annual Indicator	67.0	63.3	63.3
Numerator	167	188	188
Denominator	249	296	296
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2022	2023	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	65.0	67.0	69.0	71.0	73.0

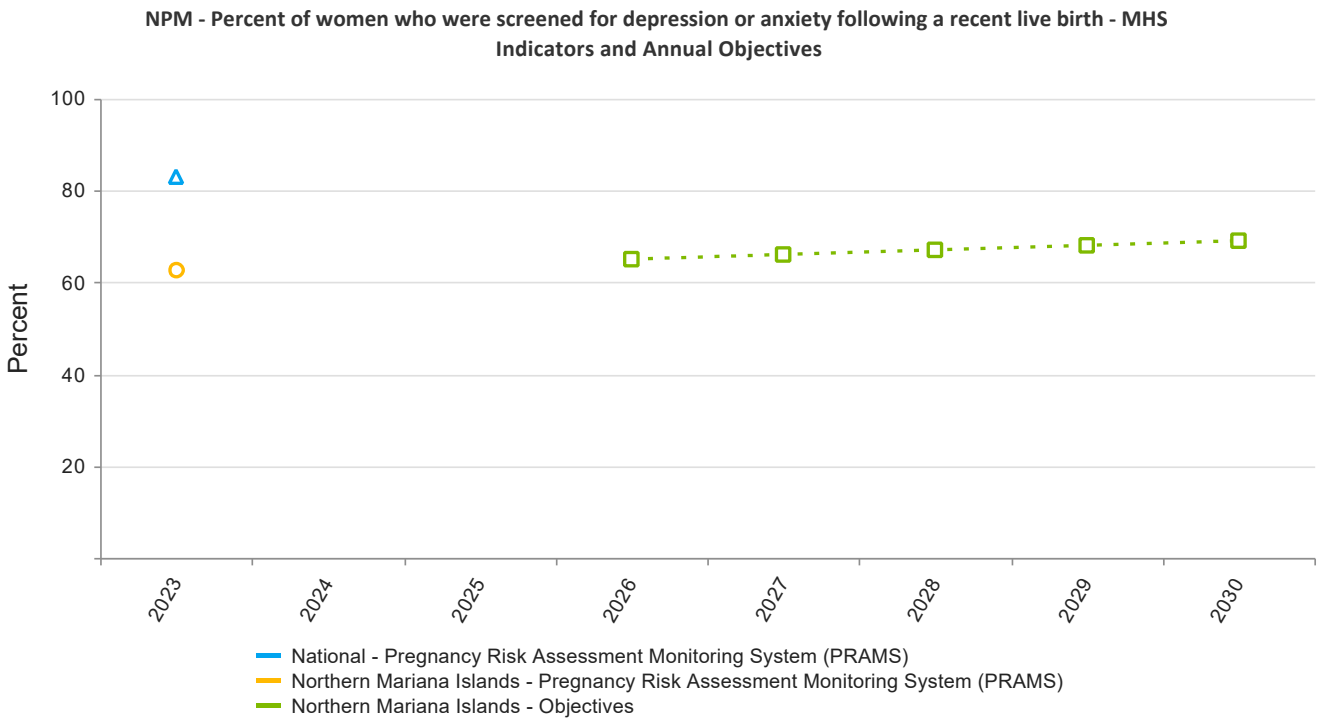
Evidence-Based or –Informed Strategy Measures

ESM PPV.1 - Percentage of women (age 18+) who are accessing well woman visits, prenatal care visits, and postpartum visits via mobile clinic and other clinical outreach.

Measure Status:	Active

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator	2.6	4.4
Numerator	70	132
Denominator	2,698	3,007
Data Source	CareVue EHR	CareVue
Data Source Year	2024	2025
Provisional or Final ?	Provisional	Provisional

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	**2025**
Annual Objective		
Annual Indicator	62.6	62.6
Numerator	340	340
Denominator	544	544
Data Source	PRAMS	PRAMS
Data Source Year	2023	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	65.0	66.0	67.0	68.0	69.0

Evidence-Based or –Informed Strategy Measures

ESM MHS.1 - Number of maternal health clinics that participated in the assessment survey regarding maternal depression screenings.

Measure Status:	Active

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator		0
Numerator		
Denominator		
Data Source		Program Administrative Records/Survey Report
Data Source Year		2025
Provisional or Final ?		Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	6.0	0.0	0.0	0.0	0.0

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 - Percentage of women (age 18+) who 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 5% from baseline.

Strategies

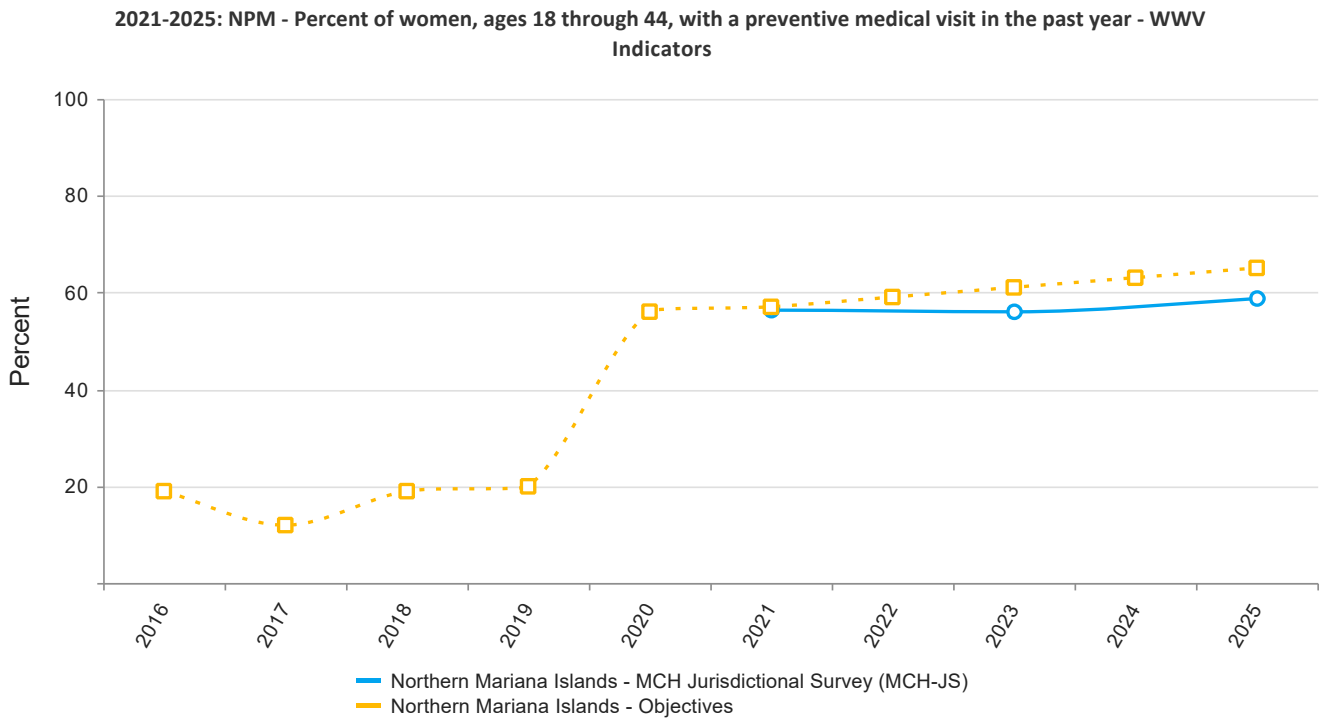
Strengthen universal maternal depression screening, referral, and follow-up systems across prenatal and postpartum care settings.

ESMs	Status
ESM MHS.1 - Number of maternal health clinics that participated in the assessment survey regarding maternal 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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	57	59	61	63	65
Annual Indicator	57.1	57.1	54.5	56.0	58.6
Numerator	7,415	7,415	5,531	6,473	5,846
Denominator	12,993	12,993	10,143	11,568	9,972
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2021	2021	2024	2021_2023	2023_2025

MCH-JS data for this measure are reported by the biological mother, aged 18 through 44 years, of the sampled child. This measure captures the percent of children, aged 0 through 17 years, whose biological mother reported visiting a doctor for a routine checkup in the past year, which differs from the definition in the Block Grant guidance detail sheets. See All FAD - Jurisdication SM Data Notes for more details.

State Provided Data					
	2021	2022	2023	2024	2025
Annual Objective	57	59	61	63	65
Annual Indicator	65.4	53.1			
Numerator	5,047	4,057			
Denominator	7,717	7,641			
Data Source	CHCC EHR/RPMS Preventive visits	CHCC CareVue EHR Preventive Visits			
Data Source Year	2021	2022			
Provisional or Final ?	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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	5	49	53	35	40
Annual Indicator	65.4	53.1	28.6	21.5	31.1
Numerator	5,047	4,057	2,170	1,647	2,405
Denominator	7,717	7,641	7,595	7,648	7,732
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	CHCC CareVue EHR/US Census International Estimate
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Final	Final	Final	Final	Final

Improving access to preventive health services for women remains a priority identified through the CNMI Maternal and Child Health (MCH) Comprehensive Needs Assessment. Specifically, the ability to find and receive timely preventive healthcare continues to be a critical need for women of reproductive age across the Commonwealth. This priority aligns with National Performance Measure (NPM) 1, which measures the percentage of women ages 18 through 44 who receive an annual preventive health visit. Performance for this measure is monitored using data from the CNMI MCH Jurisdictional Survey, which was most recently updated in 2025.

During FY2025, the Maternal, Infant, Child, and Adolescent Health (MICAH) Program continued to strengthen access to preventive health services through coordinated referral systems, strategic partnerships, and patient navigation services. Women and children who were uninsured or underinsured continued to be referred to the MCH Services Coordinator, who assists eligible individuals with enrollment in Medicaid or the CHCC Sliding Fee Program, helping to reduce financial barriers to care.

The MCH Services Office also maintained its co-located presence within the CNMI Women's Clinic throughout the reporting period. This integrated service delivery model supports seamless referrals between clinical and public health programs, facilitates coordinated patient visits, reduces loss to follow-up, and enables providers to address clinical and social risk factors more efficiently.

Building upon the systems established during and following the COVID-19 Public Health Emergency, collaboration among CHCC outpatient providers, nursing staff, and Division of Public Health Services programs remained strong throughout FY2025. These partnerships have supported continuity of preventive health services, strengthened care coordination, and enhanced access to women's health services across the Commonwealth.

The MICAH Program will continue to build upon these collaborative efforts by strengthening referral pathways, expanding outreach to underserved communities, and improving access to preventive healthcare services for women throughout the CNMI, with particular attention to reducing geographic and financial barriers to care.

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	2025
Percent	56.3	56.3	55.9	55.9	58.6	58.6
Numerator	6,979	6,979	6,473	6,473	5,846	5,846
Denominator	12,388	12,388	11,568	11,568	9,973	9,972

Source: MCH Jurisdictional Survey

According to the CNMI MCH Jurisdictional Survey, the percentage of women ages 18 through 44 who reported receiving an annual preventive visit remained relatively stable between 2020 and 2023, fluctuating only slightly between 55.9% and 56.3% and then increasing in 2024 to 58.6%.

Preventive health visit utilization remained relatively stable from 2020 through 2023, followed by an increase in 2024. While multiple factors may influence women's use of preventive healthcare services, the improvement observed during the two most recent reporting years coincides with the MICAH Program's continued efforts to strengthen access through coordinated referral systems, patient navigation, community outreach, and partnerships with clinical providers. These strategies are intended to reduce barriers to care and increase access to annual preventive health services for women of reproductive age throughout the Commonwealth.

Findings from the 2025 CNMI Maternal and Child Health Comprehensive Needs Assessment further support the importance of maintaining access to preventive healthcare services. Across community focus groups conducted on Saipan, Tinian, and Rota, approximately 74% of participating women reported having access to preventive medical services. While this finding suggests that many women perceive preventive healthcare as available, differences between perceived access and actual utilization indicate that barriers such as transportation, scheduling, insurance coverage, awareness of available services, and competing family or work responsibilities may continue to influence whether preventive services are obtained.

Throughout FY2025, the CNMI MCH Title V program continued to implement strategies to reduce these barriers and expand access to preventive healthcare services. One key strategy has been the continued use of the CHCC Mobile Clinic to deliver services directly to communities. During the reporting period, Title V-supported staff collaborated with CHCC Outpatient Clinics to refine operational procedures, coordinate outreach schedules, and support the delivery of preventive health services through mobile clinic events. This community-based approach helps reduce transportation barriers and increases access to care for residents who may otherwise experience difficulty obtaining routine preventive services.

Expanding access for residents of the Commonwealth's outer islands also remained a priority during FY2025. In collaboration with the CNMI Breast and Cervical Cancer Screening Program (BCCSP) and the CHCC Women's Clinic, the MCH Title V program continued to support regular women's health outreach services to Tinian and Rota. These outreach clinics provide well-woman visits, prenatal care, family planning services, cervical cancer screening, and other preventive health services that may otherwise require travel to Saipan. During the reporting period, outreach efforts continued to improve access to essential preventive healthcare for women residing on Tinian and Rota while strengthening coordination between public health and clinical service providers.

Despite the positive trend observed in FY2025, continued efforts are needed to sustain and further improve preventive health service utilization among women of reproductive age. The MCH Program will continue to strengthen partnerships with healthcare providers, expand community outreach and mobile service delivery, enhance patient navigation and referral systems, and implement culturally responsive health education strategies to ensure equitable access to preventive healthcare services throughout the Commonwealth.

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

Year	2021	2022	2023	2024	2025
% Served	65.4	53.1	50	21.5	31.1
Numerator	5047	4057	3862	1647	2405
Denominator	7717	7641	7717	7648	7732

The CNMI MCH Program continues to monitor Evidence-Based/Informed Strategy Measure (ESM) 1.2, which measures the percentage of women ages 18 through 44 who receive preventive health services through the Commonwealth Healthcare Corporation (CHCC). Unlike National Performance Measure (NPM) 1, which is based on population-level survey data, ESM 1.2 measures utilization of preventive health services delivered within the CHCC healthcare system. Together, these measures provide complementary information on women's access to and utilization of preventive healthcare services throughout the Commonwealth.

Preventive health visits are identified using data extracted from CHCC's electronic health record (EHR) system. The measure includes preventive services provided through CHCC outpatient clinics, including the Women's Clinic, Family Planning Clinic, Mobile Clinic, and outreach services on the islands of Tinian and Rota. Encounters are identified using a combination of ICD-10 diagnosis codes, provider documentation, and the purpose of the visit to ensure comprehensive capture of eligible preventive healthcare services. The numerator includes women ages 18 through 44 who received preventive services during the reporting period, while the denominator is based on the estimated population of women in this age group using the U.S. Census International Database for the Commonwealth of the Northern Mariana Islands.

ESM 1.2 data demonstrate fluctuations in preventive healthcare utilization over the past three reporting years. In 2023, 50.0% of women ages 18 through 44 accessed preventive health services through CHCC. Utilization declined to 21.5% in 2024, before increasing to 31.1% in FY2025. Although the FY2025 results represent a 9.6 percentage point improvement over the previous year, utilization remains below pre-2024 levels, indicating that continued efforts are needed to improve access to preventive healthcare services among women of reproductive age.

Several factors may continue to influence preventive healthcare utilization, including insurance coverage, transportation challenges, appointment availability, geographic isolation, competing work and family responsibilities, and awareness of available preventive health services. These findings underscore the importance of maintaining targeted strategies that reduce barriers to care and improve access for women throughout the Commonwealth.

During FY2025, the MCH Program continued implementing evidence-informed strategies to improve preventive healthcare utilization. These efforts included strengthening patient referral and navigation services through the MCH Services Coordinator, maintaining integrated services within the CHCC Women's Clinic, expanding community outreach through the CHCC Mobile Clinic, and supporting monthly preventive health outreach to women residing on the islands of Rota and Tinian. In FY2025, women’s health outreach providers saw 174 patients in Rota and 188 in Tinian, providing access to well women visits, prenatal and postpartum care, family planning and critical preventive screenings like pap smears and breast exams.
In collaboration with CHCC outpatient providers and community partners, the program also continued promoting awareness of preventive health services and encouraging women to establish routine preventive care.

In addition to ESM 1.2, the MICAH Program monitors utilization of preventive health services provided through the CNMI Family Planning Program and other women's health initiatives. Together, these measures provide a comprehensive assessment of women's preventive healthcare access and utilization and help evaluate progress toward improving maternal and women's health outcomes in the CNMI.

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

Year	2019	2020	2021	2022	2023	2024	2025
% Served	16.3	15.1	16.1	13.14	15.4	14.7	13.5
Numerator	1262	1164	1241	1,004	1,169	1,143	1048
Denominator	7742	7721	7717	7641	7,595	7,732	7732

Data Source: CNMI Family Planning Annual Report

The Family Planning Annual Report (FPAR) provides important information on the utilization of family planning and preventive reproductive health services across the Commonwealth and serves as a key data source for monitoring women's access to preventive healthcare. The Family Planning Program plays a vital role in the CNMI's maternal and child health system by providing comprehensive reproductive health services, including annual preventive examinations, contraceptive counseling and services, sexually transmitted infection (STI) screening and treatment, cervical cancer screening, and preconception health counseling.

During FY2025, the Family Planning Program served 1,048 unduplicated women ages 18 through 44, representing 13.5% of the estimated population of women in this age group within the CNMI. Program utilization data are derived from Family Planning encounter records, while the denominator is based on population estimates from the U.S. Census International Database. Although utilization declined slightly from 14.7% in FY2024 to 13.5% in FY2025, the Family Planning Program continues to serve as a critical access point for preventive healthcare services, particularly for women who may otherwise experience financial, geographic, or healthcare access barriers.

The modest decline in utilization highlights the continued need to strengthen outreach efforts, increase awareness of available services, and reduce barriers that may prevent women from seeking routine preventive care. During FY2025, the MCH Program continued collaborating with the CHCC Family Planning Program to promote preventive health services, strengthen referral pathways, and improve coordination of care across clinical and public health programs. These collaborative efforts support the Title V priority of increasing access to preventive healthcare services for women of reproductive age.

In addition to monitoring Family Planning Program utilization, the MCH Title V program tracks cervical cancer screening through the annual number of Papanicolaou (Pap) tests performed for CNMI residents. Pap test specimens collected throughout the Commonwealth are processed by Diagnostic Laboratory Services (DLS) in Honolulu, Hawaii. Annual Pap testing data provide an additional indicator of women's utilization of preventive healthcare services and support ongoing monitoring of cervical cancer screening trends across the CNMI.

Number of Pap Tests Conducted in the CNMI, 2019 – 2025

CNMI PAP Data	2019	2020	2021	2022	2023	2024	2025
Number of Tests	1,516	1,895	2,682	1,879	1,518	947	1,531

Data Source: DLS Hawaii

In Fiscal Year 2025, Diagnostic Laboratory Services (DLS) in Honolulu processed a total of 1,531 Pap tests from the CNMI. This was 584 more screenings than in the previous fiscal year, representing a 62% increase in cervical cancer screening volume across the CNMI.

By timeframe comparison, cervical cancer screening volume showed a declining trend from Fiscal Year 2021 through Fiscal Year 2024, followed by a notable rebound in Fiscal Year 2025. Screening volume decreased from 2,682 Pap tests in FY2021 to 1,879 in FY2022, representing a 30% decline. The downward trend continued with 1,518 screenings in FY2023 and 947 screenings in FY2024. In FY2025, however, screening volume increased substantially to 1,531 Pap tests, an increase of 584 screenings (62%) compared to FY2024. Despite this improvement, the FY2025 screening volume remained below pre-decline levels observed in FY2021.

Several factors may have contributed to the fluctuations in screening volume during this period. The Public Health Emergency (PHE) ended on May 11, 2023, resulting in the termination of Presumptive Eligibility for Medicaid on May 31, 2023, which may have affected access to healthcare services and preventive screenings for some individuals. Additionally, economic challenges and reductions in government employee working hours led some employees to discontinue their government-sponsored health insurance and enroll in Medicaid. Increased Medicaid enrollment and eligibility for the Breast and Cervical Cancer Screening Program may have contributed to the rise in cervical cancer screenings observed in FY2025.

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

Evidence-Based Home Visiting and Maternal Health

In 2025, evidence-based home visiting continued to serve as an important community-based strategy for supporting maternal and family health in the Northern Mariana Islands. The CNMI implemented the Healthy Families America (HFA) model through one local agency, providing 3,475 home visits to 201 families and 204 children, including 290 virtual visits.

Among participating CNMI families, 57% of children were identified as Asian and 39% as Native Hawaiian/Pacific Islander, while 57% of households reported a primary language other than English. Additionally, 94% of children had public insurance, and 15% of caregivers reported having no high school diploma. Most children served were between one and two years of age (48%), with 26% under one year and 25% ages three to five.

Home visiting provides an important opportunity to address maternal health needs within the context of the family and

community. Through regular contact with families, home visitors can provide education and support related to prenatal and postpartum health, breastfeeding, parenting, maternal well-being, and healthy child development, while also identifying needs and connecting families to appropriate healthcare and social services. This approach can help reduce barriers related to transportation, language, socioeconomic circumstances, and access to care and strengthens continuity between families, healthcare providers, and community resources.

Home visiting therefore complements the CNMI's broader maternal and women's health strategies by supporting timely access to preventive and postpartum care, strengthening referral and care coordination, and helping families navigate available services. Continued community outreach, patient education, mobile clinic services, and coordinated referral pathways can further strengthen the connection between home visiting and the CNMI's efforts to improve maternal health outcomes and reduce health disparities.

Strategy: Expand preventive healthcare- increase clinic hours or service sites

In FY2025, the MCH Programs partnered with the Health Promotions team on expanding women's preventive health services through the CHCC Mobile Clinic. Overall, there were 46 mobile clinic outreach events serving 386 individuals with 206 patients being adult women of reproductive age. There were 21 well women and 4 Family Planning mobile clinics. The mobile clinics ran from October 2024 until May 2025 when the mobile unit encountered a mechanical issue that remained unresolved for the remainder of FY2025. Additionally, MICAH programs supported monthly women's health outreach providers to the islands of Tinian and Rota, enabling and expanding access to well women visits, prenatal and postpartum care, family planning and critical preventive screenings such as pap smears and breast exams. In Rota, these outreach providers provided care to 174 women in FY2025.

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

During Fiscal Year 2024–2025, Division of Public Health Services and Maternal, Infant, Child, and Adolescent Health (MICAH) Program, in collaboration with the Health Promotion and Partnership Unit (HPPU), continued its efforts to strengthen health messaging and increase awareness of women's preventive health services among the target population. Social media remained an effective platform for community outreach and health education.

Throughout the reporting period, a total of 27 social media posts were disseminated, reaching 19,554 individuals. These posts generated 488 likes and a combined total of 124 reactions and shares, demonstrating community engagement with preventive health messaging. The continued use of social media has enhanced the program's ability to disseminate health information, promote preventive care services, and increase public awareness of women's health issues across the CNMI.

In 2025, community awareness efforts for women's health in the CNMI primarily centered on social media campaigns and activities during CNMI Women's Health Month, celebrated every May. Each year, the Division of Public Health Services, through MICAH, commemorates Women's Health Month with various activities and events. In 2025, the focus shifted to adolescent health, with programs and initiatives dedicated to promoting the health and well-being of adolescents throughout the month.

Throughout May, a total of 14 social media posts were shared, reaching 7,948 individuals. These posts received 284

likes and reactions and were shared 91 times by the community, demonstrating strong engagement and interest.

Building on previous outreach successes, the CNMI MCH Title V program will continue its collaboration with the Health Promotion and Partnership Unit (HPPU) to further strengthen the coordination and effectiveness of health communication efforts. HPPU will continue to take the lead in managing and disseminating health messaging across various platforms, supporting a streamlined and data-driven approach to engaging priority populations and improving the reach of public health information throughout the CNMI. This collaborative effort will ensure the delivery of consistent, community-based, and meaningful content that resonates with the CNMI's diverse population groups.

Strategic partnerships with local organizations will expand outreach beyond digital channels through community events and grassroots engagement. Enhanced data monitoring and evaluation of campaign performance will allow for continuous refinement of messaging and help maximize the impact of health promotion efforts.

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 health services—including well-woman visits, prenatal and postpartum care, and mental health services—was identified as a priority in the 2025 CNMI Maternal and Child Health (MCH) Title V Comprehensive Needs Assessment under the Women's Health domain. Although more than half of women ages 18–44 receive an annual preventive visit, the assessment identified persistent barriers that continue to limit equitable access to timely and comprehensive healthcare. These barriers include transportation challenges, limited clinic availability, workforce shortages, geographic isolation, and instability in health insurance coverage.

Access to annual preventive medical visits among women ages 18–44 has remained relatively stable over the past six years, ranging from 55.9% to 58.6%. In 2025, 58.6% of women in this age group received an annual preventive visit, maintaining the improvement observed in 2024 after rates of 55.9% in both 2022 and 2023. Although the overall percentage has remained consistent, changes in the number of women included in the measure suggest shifts in the eligible population over time. Despite these encouraging trends, approximately four in ten women of reproductive age still do not receive an annual preventive visit, underscoring the need to continue expanding access to routine preventive healthcare and reducing barriers that limit timely use of these essential services.

The needs assessment also identified significant gaps in access to behavioral health services for women. Mental health stigma, shortages of behavioral health providers, transportation barriers, and limited service availability continue to delay access to screening and treatment. These barriers reduce opportunities for early detection and management of chronic diseases, reproductive health conditions, and maternal mental health concerns, ultimately affecting women's health across the life course.

To address these challenges, the Commonwealth Healthcare Corporation (CHCC) Maternal, Infant, Child, and Adolescent Health (MICAH) Programs will continue leading a coordinated, territory-wide approach to improve access to preventive healthcare services for women across Saipan, Tinian, and Rota. Building upon existing partnerships with healthcare providers, community organizations, and public health programs, MICAH will strengthen systems that promote timely, equitable, and comprehensive preventive care.

Key strategies include:

- Expanding access to well-woman visits through extended clinic hours and additional service delivery locations.
- Increasing awareness of preventive health benefits and available insurance coverage.
- Standardizing preventive screenings and strengthening care coordination across healthcare providers.

Improving access to annual preventive visits directly supports MCH Title V National Performance Measure 1, which aims to increase the proportion of women receiving routine preventive healthcare. Annual preventive visits provide important opportunities to deliver recommended screenings, assess behavioral and mental health, identify risk factors, manage chronic conditions, and provide reproductive health counseling. Strengthening access to these services supports early intervention, improves continuity of care, and promotes healthier outcomes for women throughout the life course. Continued investment in preventive care infrastructure and coordinated service delivery will help the CNMI advance maternal health, reduce health disparities, and improve the overall well-being of women, children, and families.

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.

The CHCC Maternal, Infant, Child, and Adolescent Health (MICAH) Programs will implement a coordinated, community-based approach to increase access to preventive medical services for women across Saipan, Tinian, and Rota. Recognizing that transportation, geographic isolation, limited clinic availability, and insurance challenges continue to affect healthcare access, the program will expand mobile clinic services and strengthen community outreach to bring preventive care directly to underserved populations.

From October 1, 2026, through September 30, 2027, the MICAH Programs will partner with the Public Health Promotion and Partnership Unit (HPPU) to implement culturally responsive education and outreach activities that increase awareness of available preventive health services. Outreach efforts will promote well-woman visits, postpartum care, preventive screenings, and other women's health services while informing residents of clinic locations, mobile clinic schedules, and available resources. Communication strategies will include community presentations, printed educational materials, radio announcements, social media, and other digital platforms to maximize community reach.

To ensure outreach efforts are responsive to community needs, the HPPU and the Adolescent and Reproductive Health Program will conduct community engagement activities, including surveys and focus groups, to better understand barriers to preventive care and identify opportunities to improve service delivery. Findings will be used to refine outreach messaging and inform future program planning.
The MCH Services Coordinator will collaborate with clinical providers and community partners to strengthen referral and follow-up systems that improve continuity of care for women receiving preventive services. Enhanced care coordination will support timely referrals, facilitate postpartum follow-up, and improve linkages between community outreach activities and clinical services.

A central component of this strategy will be the expansion of mobile clinic services throughout the project period. Mobile clinics will provide preventive health services—including well-woman visits, postpartum care, health screenings, immunizations, family planning services, and health education—in community settings across the CNMI. Delivering services directly within villages will reduce transportation and geographic barriers while improving access for women who may otherwise delay or forgo preventive care.

The MICAH Programs will also collaborate with private healthcare providers, insurance partners, community organizations, and faith-based organizations to expand referral networks, increase community awareness, and promote utilization of preventive health services.

To further support these efforts, a comprehensive Women's Health Awareness Campaign will be developed to encourage women to seek routine preventive care and postpartum services. Educational materials will be updated to reflect available services and community priorities and distributed widely through healthcare facilities, community events, schools, partner organizations, and digital communication platforms.

Progress will be monitored throughout the project period using process and outcome measures, including the number of mobile clinic events conducted, women served through outreach activities, referral completion rates, postpartum visit utilization, and community participation in health education events. Evaluation findings will be used to guide continuous quality improvement and strengthen service delivery.

Evidence Based Strategy Measure (ESM): Percentage 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 mobile clinic 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: Strengthen universal maternal depression screening, referral, and follow-up systems across prenatal and postpartum care settings.

From October 1, 2026, through September 30, 2027, the CHCC Maternal, Infant, Child, and Adolescent Health (MICAH) Programs will strengthen maternal depression screening, referral, and follow-up practices across prenatal and postpartum care settings by implementing recommendations identified through the provider assessment of depression screening tools and clinical practices. The strategy will focus on standardizing screening processes, strengthening provider capacity, and improving coordination between maternal healthcare providers and behavioral health services to ensure women experiencing perinatal depression or anxiety receive timely identification, referral, and treatment.

During the first quarter of the project period, the MICAH Programs will convene a multidisciplinary workgroup consisting of representatives from the Maternal and Child Health Program, Behavioral Health Services, Women's Health Clinic, Family Medicine, Pediatrics, nursing leadership, and private healthcare providers. The workgroup will review assessment findings and develop standardized clinical protocols for routine maternal depression screening during prenatal and postpartum visits. These protocols will establish guidance on the recommended screening instrument, screening intervals, documentation procedures, referral criteria, and follow-up expectations across participating clinics.

Between January and March 2027, the MICAH Programs will provide training and technical assistance to healthcare providers on the use of standardized depression screening tools, interpretation of screening results, trauma-informed communication, and evidence-based referral practices. Training will also reinforce culturally responsive approaches to discussing maternal mental health and reducing stigma associated with seeking behavioral health services.

To improve continuity of care, the MICAH Programs will work with clinical and behavioral health partners to establish standardized referral pathways and follow-up procedures for women who screen positive for depression or other perinatal mental health concerns. Referral protocols will include communication processes between referring providers and behavioral health services, mechanisms for tracking referral completion, and procedures for ensuring women receive appropriate follow-up care.

Throughout the project period, the MICAH Programs will collaborate with clinic leadership to integrate standardized screening tools and referral workflows into routine prenatal and postpartum care. Where feasible, electronic health record documentation and reminder systems will be utilized to support consistent screening and follow-up practices.

Progress will be monitored through routine quality improvement activities and ongoing collaboration with participating clinics. Findings will be used to identify implementation challenges, provide targeted technical assistance, and strengthen maternal mental health services across the Commonwealth.

Evaluation Metrics

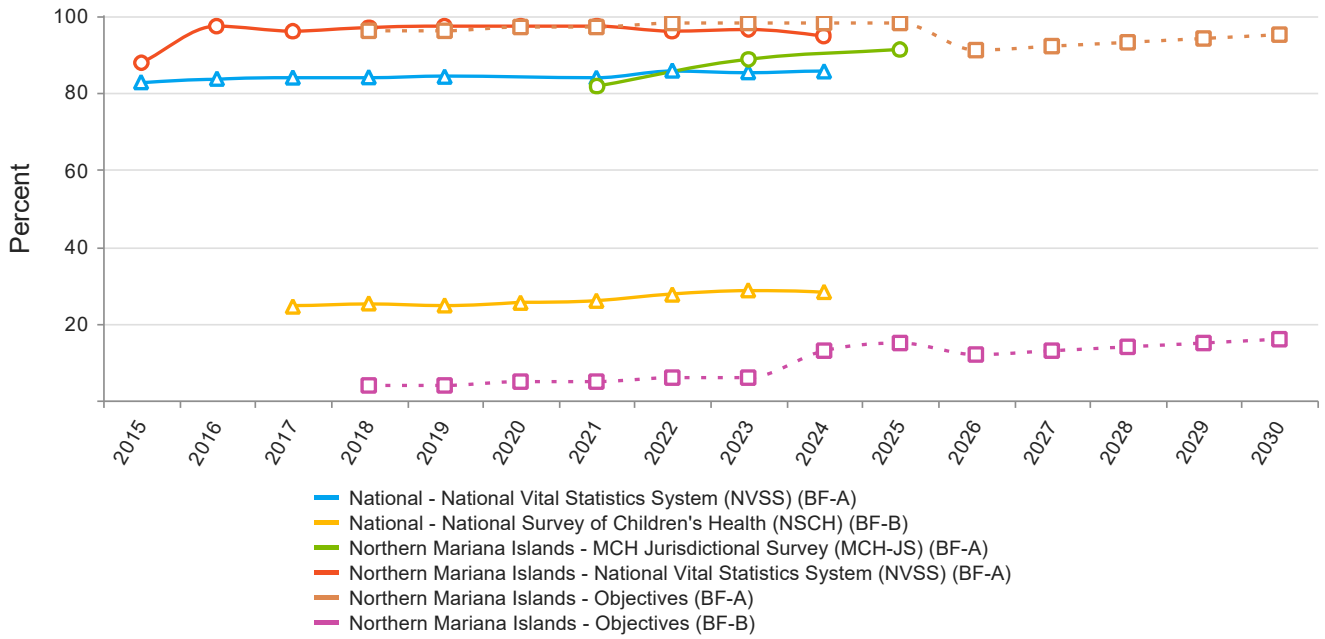
- Percentage of prenatal and postpartum care providers implementing a standardized maternal depression screening tool.
- Number and percentage of women receiving depression screening during prenatal and postpartum visits.
- Number and percentage of women with positive screening results who receive a behavioral health referral.
- Percentage of referred women who complete an initial behavioral health appointment.
- Number of healthcare providers trained on standardized maternal depression screening and referral protocols.
- Number of participating clinics implementing standardized screening and referral procedures.

Evidence Based Strategy Measure (ESM): Percentage of women receiving a standardized depression screening during prenatal and postpartum visits.

Perinatal/Infant Health

National Performance Measures

NPM - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF Indicators and Annual Objectives



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

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	97	98	98	98	98
Annual Indicator	88.2	88.2	89.4	88.7	91.0
Numerator	5,434	5,434	3,555	4,494	3,574
Denominator	6,158	6,158	3,976	5,067	3,930
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2021	2021	2024	2021_2023	2023_2025

This measure captures the percent of children, aged 0 through 5 years, who are reported to have ever been breastfed or received breast milk, which differs from the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdiction NPM Data Notes for more details.

Federally Available Data			
Data Source: National Vital Statistics System (NVSS)			
	2023	**2024**	**2025**
Annual Objective	98	98	98
Annual Indicator	95.7	96.5	94.8
Numerator	440	557	527
Denominator	460	577	556
Data Source	NVSS	NVSS	NVSS
Data Source Year	2022	2023	2024

State Provided Data					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	97	98	98	98	98
Annual Indicator	93.7	94.9	93.1	93.5	90.3
Numerator	539	449	541	522	501
Denominator	575	473	581	558	555
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	2021	2022	2023	2024	2025
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	91.0	92.0	93.0	94.0	95.0

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					
	2021	2022	2023	2024	2025
Annual Objective	5	6	6	13	15
Annual Indicator	0	0.5	11.1	11.6	10.1
Numerator	0	2	47	52	48
Denominator	419	411	424	448	473
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2021	2022	2023	2024	2025
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 postpartum women who receive breastfeeding education, assessment, or referral during a postpartum or infant healthcare encounter within two weeks of delivery.

Measure Status:	Inactive - This measure is captured incorrectly. The CNMI will inactivate this ESM and recreate another one to accurately capture the measure that was intended.

State Provided Data					
	2021	2022	2023	2024	2025
Annual Objective	10	57.4	57.6	57.8	58
Annual Indicator	44.6	39.9	43.2	44.6	41.6
Numerator	187	164	183	200	197
Denominator	419	411	424	448	473
Data Source	WIC Program	WIC Program	WIC Program	WIC Program	WIC Program
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Provisional	Final	Final	Provisional	Provisional

ESM BF.2 - Percent of postpartum women who receive breastfeeding education, assessment or a referral during a postpartum or infant healthcare encounter within 2 weeks of delivery.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	40.0	45.0	50.0	55.0	60.0

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					
	2021	2022	2023	2024	2025
Annual Objective	53	70	72	65	75
Annual Indicator	67	61.7	61.1	67.6	75
Numerator	383	290	333	338	382
Denominator	572	470	545	500	509
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	76.0	77.0	78.0	79.0	80.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective					

SPM 3 - Percent of CNMI WIC infants breastfed at 6 months.

Measure Status:	Active

State Provided Data	
	2025
Annual Objective	
Annual Indicator	41.6
Numerator	197
Denominator	473
Data Source	CNMI WIC PROGRAM
Data Source Year	2025
Provisional or Final ?	Provisional

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

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

Strengthen coordinated breastfeeding education, referral, and early postpartum support through existing maternal and child health programs.

ESMs	Status
ESM BF.1 - Percent of postpartum women who receive breastfeeding education, assessment, or referral during a postpartum or infant healthcare encounter within two weeks of delivery.	Inactive
ESM BF.2 - Percent of postpartum women who receive breastfeeding education, assessment or a referral during a postpartum or infant healthcare encounter within 2 weeks of delivery.	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

Implement a coordinated prenatal care navigation and referral system to ensure pregnant women are connected to prenatal care as early as possible.

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

State Action Plan Table (Northern Mariana Islands) - Perinatal/Infant Health - Entry 3

Priority Need

Education and support to help with breastfeeding

SPM

SPM 3 - Percent of CNMI WIC infants breastfed at 6 months.

Five-Year Objectives

By September 2030, increase the proportion of WIC-enrolled infants who are breastfed through 6 months by 10 percentage points from the CNMI baseline, through strengthened postpartum breastfeeding support, lactation referral, and peer counseling.

Strategies

Strengthen coordinated breastfeeding education, referral, and early postpartum support through existing maternal and child health programs.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

Improving infant health remains a priority for the CNMI MCH Title V. Guided by findings from the CNMI Comprehensive Maternal and Child Health Needs Assessment, the program continued to prioritize education and support for breastfeeding and early access to prenatal care as evidence-based strategies to improve infant health outcomes. These priorities recognize the critical role that optimal maternal health, timely prenatal care, and breastfeeding play in reducing infant morbidity and mortality, promoting healthy growth and development, and establishing a strong foundation for lifelong health.

During FY2025, CNMI MICAH Programs continued implementing a coordinated, systems-based approach to improve maternal and infant health through partnerships with the CHCC Women's Clinic, Women, Infants, and Children (WIC) Program, MIECHV Home Visiting Program, Medicaid, the Hospital Nursery, Neonatal Intensive Care Unit (NICU), Pediatrics, and other community partners. Together, these collaborations support families across the continuum of care—from early pregnancy through infancy—by improving access to prenatal care, breastfeeding education, lactation support, postpartum services, and community-based resources.

Overall, FY2025 data demonstrate continued progress in several areas of infant health while also identifying opportunities for improvement. Early prenatal care reached its highest level in the reporting period, with 75.0% of resident women initiating prenatal care during the first trimester, reflecting continued improvements in access to maternal healthcare and service navigation. Exclusive breastfeeding through six months has also remained substantially higher than pre-2023 levels, suggesting that strengthened breastfeeding support services and WIC interventions are contributing to improved breastfeeding continuation among participating families.

At the same time, the data highlight emerging challenges that warrant continued attention. Although the CNMI continues to exceed national averages for breastfeeding initiation, the percentage of infants ever breastfed declined to 90.3% in FY2025, the lowest rate observed during the reporting period. Additionally, while more infants are being enrolled in breastfeeding support services, sustaining breastfeeding through six months remains challenging for many families because of barriers such as limited postpartum support, workplace constraints, transportation challenges, and competing family and employment responsibilities.

The following section summarizes progress on the Infant Health priority through National Performance Measures (NPMs) 4A and 4B, State Performance Measure (SPM) 1, and Evidence-Based Strategy Measure (ESM) 4.1. It also describes the strategies implemented during FY2025 to strengthen breastfeeding education and support, improve access to early prenatal care, enhance service navigation for pregnant women, and expand community partnerships that support healthy pregnancies and optimal infant health outcomes throughout the Commonwealth.

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

Breastfeeding	2019	2020	2021	2022	2023	2024	2025
Percent of Infants	96.5	93.3	93.7	94.7	93.1	93.5	90.3
Numerator	887	610	539	448	541	522	501
Denominator	909	654	575	473	581	558	555

Source: CNMI HVSO, Birth Registry

Breastfeeding continues to be a priority identified through the CNMI Maternal and Child Health (MCH) Comprehensive Needs Assessment due to its well-established benefits for infant nutrition, immune protection, healthy growth and development, and maternal health. Increasing breastfeeding initiation and duration remains a key strategy for improving infant health outcomes and aligns with National Performance Measure (NPM) 4A, which measures the percentage of infants who were ever breastfed.

According to the CNMI Health and Vital Statistics Office (HVSO) Birth Registry, breastfeeding initiation has remained consistently high throughout the reporting period. Between 2019 and 2025, the percentage of infants ever breastfed ranged from 90.3% to 96.5%, with a seven-year average of 93.6%. Although breastfeeding initiation remained above 90% each year, the rate declined from 96.5% in 2019 to 90.3% in 2025, representing the lowest level observed during the reporting period.

Interpretation of these findings should consider the substantial demographic changes occurring within the Commonwealth. Between 2019 and 2025, the annual number of live births declined by approximately 39%, from 909 births to 555 births. During the same period, the number of infants who initiated breastfeeding decreased from 887 to 501. While much of this decline reflects a smaller birth cohort, the reduction in breastfeeding initiation as a percentage of all live births suggests that fewer families are choosing to initiate breastfeeding than in previous years. These findings indicate the importance of continuing efforts to strengthen breastfeeding education, counseling, and support for expectant and new parents.

Despite the downward trend, breastfeeding initiation in the CNMI continues to exceed national performance. Throughout the reporting period, the CNMI consistently reported breastfeeding initiation rates above 90%, compared with recent U.S. national estimates of approximately 85%. This continued performance reflects the strong cultural acceptance of breastfeeding, longstanding support provided through the CNMI Women, Infants, and Children (WIC) Program, Baby-Friendly maternity practices, and collaborative efforts among healthcare providers and public health programs.

While these strengths provide a solid foundation, the decline observed in FY2025 highlights the need to sustain and strengthen breastfeeding promotion efforts. Continued investment in prenatal breastfeeding education, postpartum lactation support, community outreach, provider training, and family-centered breastfeeding services will be important to maintain high breastfeeding initiation rates and prevent further declines. The MICAH Program will continue working closely with the WIC Program, CHCC Women's Clinic, Hospital Nursery, Neonatal Intensive Care Unit (NICU), Pediatrics, and other community partners to ensure that families receive timely education, counseling, and support from pregnancy through the postpartum period.

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

Exclusive Breastfeeding	2019	2020	2021	2022	2023	2024	2025
Percent of Infants	1.1	.4	0	.5	11.1	11.6	10.1
Numerator	5	2	0	2	47	52	48
Denominator	470	544	419	411	424	448	473

Source: CNMI WIC Program

Exclusive breastfeeding during the first six months of life provides optimal nutrition for infants and is associated with reduced risk of infectious diseases, obesity, and chronic health conditions while promoting healthy growth and development. Increasing the percentage of infants who are exclusively breastfed through six months remains a priority for the CNMI MICAH Program and aligns with National Performance Measure (NPM) 4B.

According to data reported by the CNMI Women, Infants, and Children (WIC) Program, exclusive breastfeeding rates remained very low between 2019 and 2022, ranging from 0.0% to 1.1%. Beginning in 2023, however, the CNMI experienced a marked improvement in exclusive breastfeeding, with rates increasing to 11.1% in 2023, 11.6% in 2024, and 10.1% in FY2025. Although the FY2025 rate represents a slight decrease from the previous year, exclusive breastfeeding has remained substantially higher than levels observed prior to 2023, indicating sustained progress over the past three reporting years.

The improvement observed since 2023 coincides with continued investments in breastfeeding education, expanded lactation support, strengthened partnerships with the WIC Program, and increased emphasis on breastfeeding promotion across maternal and child health programs. While these initiatives may have contributed to improved breastfeeding practices, continued monitoring will be important to better understand the factors influencing breastfeeding duration and to identify opportunities for further improvement.

Despite this encouraging progress, exclusive breastfeeding through six months remains an area requiring continued attention. Families continue to experience barriers that may limit breastfeeding duration, including limited access to postpartum lactation support, challenges returning to work, transportation constraints, scheduling difficulties, and social or cultural factors that may influence infant feeding practices. Addressing these barriers through coordinated clinical and community-based interventions remains a priority for the MICAH Program.

Although breastfeeding initiation rates in the CNMI continue to exceed recent U.S. national estimates, maintaining exclusive breastfeeding through six months remains more challenging. These findings highlight the importance of continuing evidence-based interventions that support families beyond delivery and throughout the postpartum period. During FY2025, the MICAH Program continued collaborating with the WIC Program, CHCC Women's Clinic, Hospital Nursery, Neonatal Intensive Care Unit (NICU), Pediatrics, and community partners to strengthen breastfeeding education, expand access to lactation support, and promote environments that enable families to successfully initiate and sustain breastfeeding.

The MICAH Program will continue monitoring NPM 4B annually while strengthening strategies that improve

breastfeeding continuation through six months. Planned efforts include expanding prenatal breastfeeding education, increasing access to lactation consultation and peer support, enhancing postpartum follow-up, promoting breastfeeding-friendly workplace and community environments, and strengthening partnerships that support families across the continuum of maternal and infant care.

Strategy: Develop or strengthen prenatal clinic policies on breastfeeding education and counseling.
In FY 2025, 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.

World Breastfeeding Week (WBW) 2025

In recognition of World Breastfeeding Week 2025, the Commonwealth Healthcare Corporation (CHCC) Women, Infants, and Children (WIC) Program coordinated a week-long series of educational and community engagement activities from August 11–15, 2025, under the global theme, "Prioritize Breastfeeding: Create Sustainable Support Systems." The initiative aimed to raise awareness of the importance of breastfeeding and strengthen community support for breastfeeding families through education, outreach, and interactive participation.

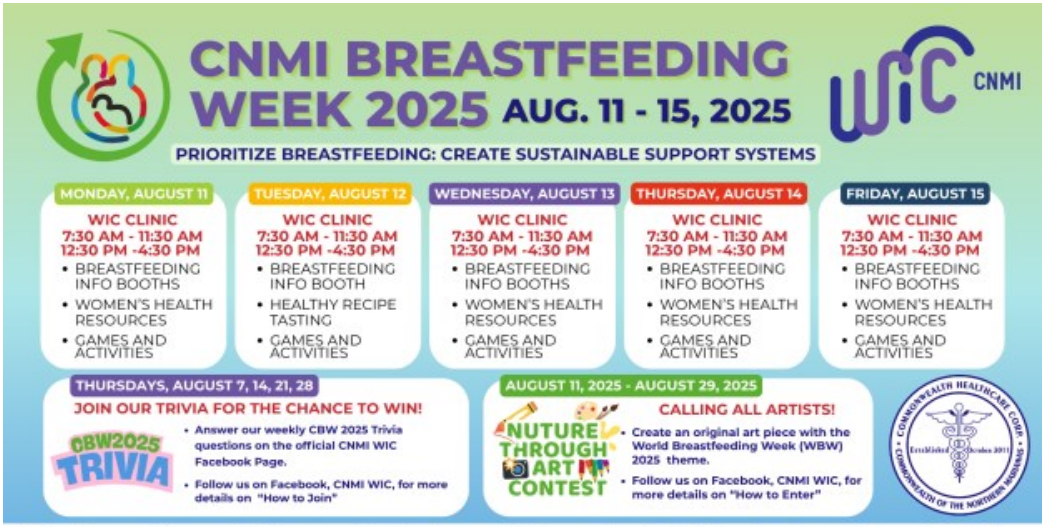
Throughout the week, WIC clinics hosted breastfeeding information booths that provided evidence-based education, breastfeeding resources, and one-on-one support for pregnant and postpartum families. Additional activities included women's health resource displays, healthy recipe tastings, and family-friendly games designed to promote healthy lifestyles while encouraging community engagement.

To further increase public participation and awareness, the WIC Program launched two community-wide initiatives:

- CNMI Breastfeeding Week Trivia Contest: Weekly breastfeeding-themed trivia questions were posted on the official CNMI WIC Facebook page throughout Breastfeeding Week. The contest encouraged community members to learn about the benefits of breastfeeding while increasing engagement through social media participation. Participants had the opportunity to win prizes by correctly answering the weekly trivia questions.
- "Nurture Through Art" Contest: Community members of all ages were invited to create original artwork reflecting the 2025 World Breastfeeding Week theme, "Prioritize Breastfeeding: Create Sustainable Support Systems." The contest encouraged participants to explore the importance of breastfeeding, family well-being, long-term health, and community support through artistic expression. Artwork submissions were accepted from August 11–29, 2025, and showcased on the official CNMI WIC Facebook page for public voting. The top three entries receiving the highest public engagement were recognized with special awards, while the top twelve selected artworks will be featured in the 2026 CNMI WIC Calendar, extending the campaign's health promotion messaging throughout the following year.

Collectively, these activities strengthened community awareness of breastfeeding, promoted positive attitudes toward breastfeeding support, and expanded public engagement through both in-person outreach and digital

platforms. By combining education, interactive learning, and creative expression, the CNMI WIC Program reinforced the critical role of breastfeeding in improving maternal and child health outcomes while fostering sustainable community support systems for breastfeeding families.





The CNMI Maternal, Infant, Child, and Adolescent Health (MICAH) Program continues to partner closely with the Commonwealth Healthcare Corporation (CHCC) Hospital Nursery, Neonatal Intensive Care Unit (NICU), Pediatrics, Women's Clinic, and the Women, Infants, and Children (WIC) Program to strengthen breastfeeding support throughout the continuum of maternal and infant care. Through Title V funding, breastfeeding resources—including hospital-grade breast pumps, breast pump kits, and donor human milk for medically eligible infants in the NICU—continue to be available to support breastfeeding initiation and continuation during the postpartum period.

Recognizing the critical role of the WIC Program in supporting breastfeeding families, the CNMI selected the percentage of WIC infants breastfed through six months of age as Evidence-Based Strategy Measure (ESM) 4.1 for the Infant Health domain. The WIC Program serves as a primary partner in implementing breastfeeding education,

individualized counseling, lactation support, peer encouragement, and ongoing follow-up for eligible families. Accordingly, Title V breastfeeding initiatives are coordinated in close collaboration with WIC to maximize the reach and effectiveness of breastfeeding promotion and support services throughout the Commonwealth.

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

Year	Numerator	Denominator	Value (%)
2021	187	419	44.63
2022	164	411	39.90
2023	183	424	43.20
2024	200	448	44.64
2025	197	473	41.60

Data Source: WIC

WIC data indicate that the percentage of enrolled infants who continued breastfeeding through six months remained relatively stable between 2021 and 2025, ranging from 39.9% to 44.6%. The measure reached 44.6% in both 2021 and 2024, declined to 39.9% in 2022, and measured 41.6% in FY2025, with 197 of 473 enrolled infants breastfeeding at six months.

Although the FY2025 rate declined modestly from the previous reporting year, the overall trend suggests that approximately two out of every five WIC-enrolled infants continue breastfeeding through six months. These findings demonstrate continued progress in supporting breastfeeding duration while also highlighting opportunities to strengthen interventions that help families sustain breastfeeding during the postpartum period.

Several factors may influence breastfeeding continuation through six months, including return-to-work demands, limited access to ongoing lactation support, transportation and scheduling challenges, and competing family responsibilities. Continued collaboration among healthcare providers, WIC staff, and community partners remains essential to addressing these barriers and improving breastfeeding duration.

The previous performance objective of increasing the percentage of WIC infants breastfed through six months to 58% by 2025 was not achieved. However, the measure continues to provide valuable information for monitoring breastfeeding continuation and evaluating the effectiveness of breastfeeding support strategies. Based on current performance and ongoing assessment of community needs, breastfeeding remains a priority for the upcoming reporting period.

During the next reporting cycle, the MICAH Program will continue collaborating with the WIC Program and clinical partners to strengthen breastfeeding education, expand access to lactation consultation and peer support, improve postpartum follow-up, and promote breastfeeding-friendly healthcare, workplace, and community environments. The updated objective is to increase the percentage of infants who are breastfed through six months by five percentage points above the baseline by 2030. Progress toward this objective will continue to be monitored annually to inform quality improvement efforts and ensure that families receive the support needed to successfully initiate and sustain

breastfeeding.

Strategy: Implement workplace breastfeeding policies/support

During the reporting period, the CNMI continued to make incremental progress toward strengthening workplace and community breastfeeding support. Efforts focused on expanding partnerships with organizations interested in improving breastfeeding accommodations and support services for breastfeeding families. Technical assistance and consultation were provided to organizations exploring opportunities to enhance breastfeeding-friendly environments and improve access to lactation support.

Within healthcare settings, discussions continued regarding implementation of workplace lactation accommodations in accordance with federal requirements. While organizations recognize employees' rights to reasonable break time and appropriate space for expressing breast milk, challenges remain in identifying and establishing dedicated lactation spaces due to facility and space limitations.

Additional planning efforts were also initiated to expand breastfeeding education and peer support opportunities through group breastfeeding classes, with the goal of increasing access to breastfeeding information, encouragement, and ongoing support for families. These activities represent continued progress toward creating more supportive environments for breastfeeding across workplace, healthcare, and community settings and will continue to be advanced during the next reporting period.

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	2025
Percent	47.9	55	67	62	61	68	75
Numerator	334	347	382	290	327	338	382
Denominator	697	631	572	470	537	500	509

Data Source: CNMI HVSO

According to data from the CNMI Health and Vital Statistics Office (HVSO), the percentage of resident women who initiated prenatal care during the first trimester has generally improved over the reporting period. The rate increased from 47.9% in 2019 to 75.0% in FY2025, representing the highest level observed during the seven-year period. Although utilization fluctuated between 2021 and 2024, the overall trend demonstrates continued improvement in early access to prenatal care across the Commonwealth.

The increase from 68.0% in FY2024 to 75.0% in FY2025 reflects continued progress toward improving timely entry into prenatal care. Early prenatal care remains a critical component of maternal and infant health because it supports early identification of pregnancy-related risks, promotes appropriate clinical management, and facilitates referral to supportive health and social services. During the same period, the CNMI also observed improvements in selected

birth outcomes, including reductions in preterm birth and low birth weight between 2023 and 2024. While multiple factors contribute to these outcomes, improving access to prenatal care remains an important strategy for supporting healthy pregnancies and infant health.

Strategy: Provide Service Navigation for Pregnant Women

During FY2025, Title V funding supported the continued expansion of service navigation for pregnant women through the placement of a Community Health Worker (CHW) within the CHCC Women's and Children's Clinics. Integrating a CHW into the clinical setting strengthened coordination between healthcare providers and public health programs, allowing pregnant women to receive timely referrals and supportive services while minimizing loss to follow-up.

The MCH CHW assists pregnant women with enrollment in Medicaid, including expedited application processing through the established memorandum of understanding between the MICAH Program and the CNMI Medicaid Program. In addition, women are connected with a range of supportive services, including prenatal dental care through the CHCC Oral Health Program, enrollment in the CNMI MIECHV HOME Visiting Program, WIC nutrition services, transportation assistance for prenatal appointments, and referrals to other community-based resources based on individual needs.

By strengthening care coordination and improving access to essential health and social services, the service navigation model helps reduce barriers to prenatal care and supports earlier engagement in comprehensive maternal healthcare. The MICAH Program will continue to build upon this integrated approach during the next reporting period to further improve timely prenatal care utilization and promote positive maternal and infant health outcomes throughout the Commonwealth.

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:

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

Premature and Low Birth Weight

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 nearly doubled—from 6% to 11%—over the same time frame. 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 involved in the 2025 CNMI Comprehensive MCH Title V Needs Assessment emphasized that education is a powerful tool for prevention; it 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.

Breastfeed Support

While the CNMI has seen steady improvement in breastfeeding initiation—with 96% of infants ever breastfed in 2023—exclusive breastfeeding through six months shows low participations rate, however, recent data highlights a positive shift. 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: Implement a coordinated prenatal care navigation and referral system to ensure pregnant women are connected to prenatal care as early as possible.

Following analysis of the 2022–2023 CNMI Pregnancy Risk Assessment Monitoring System (PRAMS) data, which identified the populations most likely to delay prenatal care and the primary barriers contributing to late entry into services, the CNMI MCH Title V Program will implement a coordinated early prenatal care navigation and referral program. Findings from the PRAMS analysis demonstrated that delays in prenatal care are influenced by a combination of individual, structural, and system-level barriers, highlighting the need for a coordinated approach that supports women from pregnancy recognition through initiation of prenatal care. This strategy is designed to address multiple barriers simultaneously by ensuring women receive timely education, individualized support, and coordinated referrals to prenatal care and related maternal health services.

Assessment findings demonstrated that delays in prenatal care are influenced by a combination of factors, including limited awareness of the importance of first-trimester prenatal care, difficulty navigating the healthcare system, transportation challenges, competing work and family responsibilities, insurance enrollment needs, and delays in obtaining appointments. Rather than addressing each barrier independently, this strategy provides individualized care coordination based on each woman's unique needs while strengthening collaboration across maternal and child health programs.

The FY2027 implementation strategy will focus on establishing standardized referral pathways and strengthening coordination among programs serving women of reproductive age to ensure pregnant women are connected to prenatal care as early as possible.

The CNMI MCH Title V Program will utilize the following implementation timeline:

1. Program Planning and Coordination (October–December 2026)

- Convene a multidisciplinary workgroup including the MCH Program, Reproductive Health Program, CHCC Women's Clinic, Public Health Nursing, WIC, Family Planning, Home Visiting, and the Health Promotion and Partnerships Unit (HPPU).
- Develop standardized prenatal care referral protocols across participating programs.
- Establish referral workflows to ensure women with confirmed pregnancies are immediately connected to prenatal care services.
- Identify or designate a prenatal care navigator, case manager, or community health worker to coordinate referrals and provide individualized follow-up.

2. Staff Training and Resource Development (January–March 2027)

- Train participating program staff on standardized referral procedures, early prenatal care recommendations, and available maternal support services.
- Develop culturally and linguistically appropriate educational materials emphasizing the importance of initiating prenatal care during the first trimester.
- Create referral resource guides outlining available transportation assistance, insurance enrollment resources, social services, and community support programs.
- Establish communication procedures among participating programs to facilitate timely referrals and follow-up.

3. Program Implementation (April–September 2027)

- Initiate immediate referrals to prenatal care following pregnancy confirmation through Family Planning, WIC, Primary Care, Public Health Nursing, Home Visiting, and other participating programs.
- Provide individualized navigation services to assist women with:
    - Scheduling prenatal appointments as early as possible.
    - Medicaid or insurance enrollment, when applicable.
    - Transportation and childcare resource referrals.
    - Appointment reminders and follow-up to reduce missed visits.
    - Referrals to additional maternal health and social support services based on identified needs.
- Monitor referral completion and identify opportunities to improve coordination and reduce delays in accessing prenatal care.

Evidence-Based Strategy Measure (ESM): Percent of pregnant women referred through participating CHCC programs who initiate prenatal care during the first trimester.

Implementing this strategy will strengthen coordination across maternal and child health programs and create a seamless pathway connecting women to prenatal care as early as possible. By providing individualized navigation and reducing barriers related to healthcare system navigation, appointment scheduling, insurance enrollment, transportation, and access to supportive services, the program aims to increase the proportion of women initiating prenatal care during the first trimester.

This coordinated referral approach builds directly upon the FY2026 assessment findings by translating identified barriers into actionable interventions that improve access to care. Over time, the strategy is expected to increase timely prenatal care utilization, improve continuity of maternal healthcare services, reduce missed opportunities for early intervention, and contribute to improved maternal and infant health outcomes, including reductions in preterm birth and low birthweight. Additionally, strengthening partnerships among clinical, public health, and community-based programs will support a more integrated maternal health system that promotes equitable access to high-quality prenatal care for all women throughout the Commonwealth.

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: Strengthen coordinated breastfeeding education, referral, and early postpartum support through existing maternal and child health programs.

Following implementation of breastfeeding promotion activities during previous reporting periods, the CNMI MCH Title V Program will strengthen coordination of breastfeeding education and early postpartum support across existing maternal and child health programs. While breastfeeding initiation remains relatively high, recent data demonstrate continued challenges in sustaining breastfeeding through the first six months of life. Barriers identified through program data include limited postpartum follow-up, workplace constraints, transportation challenges, and inconsistent access to breastfeeding support services.

Recognizing the CNMI's limited lactation workforce, the MCH Program will maximize existing resources by strengthening collaboration among the WIC Program, CHCC Women's Clinic, pediatric providers, CHWs, the MIECHV Home Visiting Program, and other maternal and child health partners. Rather than relying on specialized lactation services alone, the program will focus on ensuring that mothers receive timely breastfeeding education, encouragement, basic breastfeeding assessment, and referral to available services whenever concerns are identified.

Activities will include:

- Providing consistent breastfeeding education during prenatal and postpartum encounters.
- Incorporating breastfeeding check-ins during postpartum, newborn, and well-child visits.
- Strengthening referrals between WIC, MCH, pediatric providers, Home Visiting, and other community programs.
- Expanding community education and public awareness activities through World Breastfeeding Week and other health promotion campaigns.
- Providing breastfeeding educational materials and information on available local resources.
- Continuing efforts to encourage breastfeeding-friendly workplace environments where feasible.

This coordinated systems approach strengthens breastfeeding support throughout pregnancy and the postpartum period while building upon existing services and partnerships across the CNMI.

Evidence Based Strategy Measure (ESM): Percent of postpartum women who receive breastfeeding education, assessment, or referral during a postpartum or infant healthcare encounter within two weeks of delivery.

This measure tracks the percentage of postpartum women who receive breastfeeding education, assessment, or referral during a postpartum or infant healthcare encounter within two weeks of delivery. Services may be provided by healthcare providers, nurses, WIC staff, Community Health Outreach Workers (CHOW), Home Visiting staff, or other trained maternal and child health personnel.

The first two weeks after delivery represent a critical period for establishing breastfeeding and identifying concerns that may contribute to early discontinuation. Ensuring that breastfeeding is discussed during routine postpartum or newborn visits provides opportunities to reinforce breastfeeding education, address common concerns, and connect families with available community resources.

This measure helps the CNMI MCH Program:

- Assess implementation of coordinated breastfeeding support across existing maternal and child health programs;
- Strengthen referrals between WIC, MCH, pediatric providers, and Home Visiting;
- Identify opportunities to improve early breastfeeding education and support;
- Promote consistent breastfeeding messaging across healthcare settings; and
- Support the CNMI's goal of increasing exclusive breastfeeding through six months.

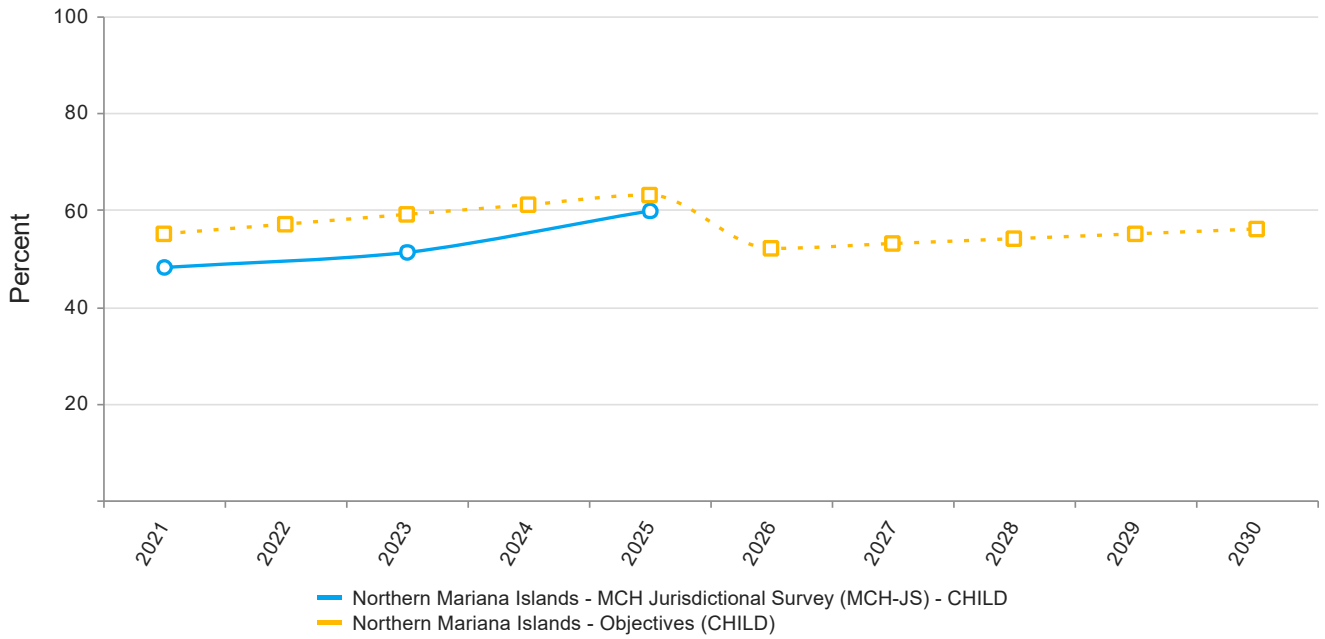
Data for this measure will be collected through:

- Electronic health records documenting postpartum or newborn visits;
- WIC breastfeeding education and counseling records;
- MCH service navigation documentation;
- Community Health Worker (CHW) records;
- MIECHV Home Visiting documentation; and
- Referral logs maintained by participating programs.

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	55	57	59	61	63
Annual Indicator	43.5	43.5	60.7	51.3	59.6
Numerator	2,393	2,393	2,775	2,584	2,601
Denominator	5,498	5,498	4,572	5,035	4,367
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2021	2021	2024	2021_2023	2023_2025

This measure definition is identical to the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdiction NPM Data Notes for more details.

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.2 - Percent 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.

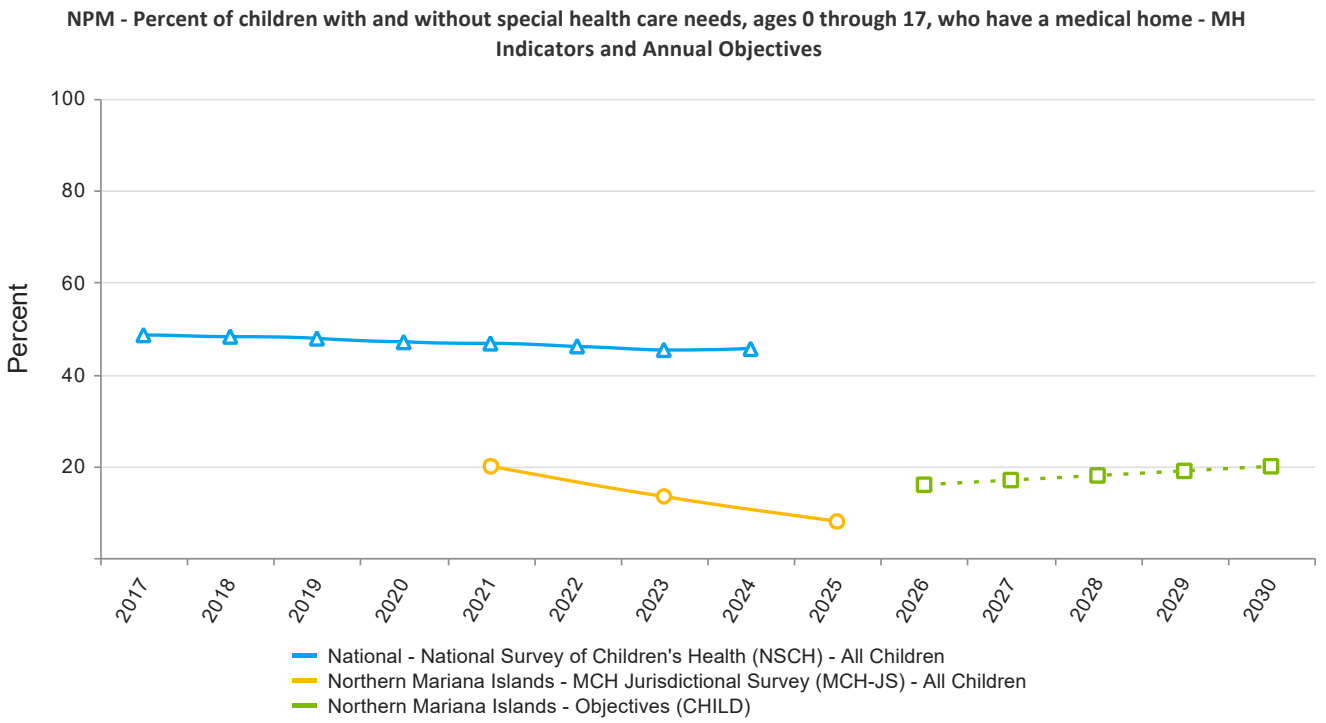
Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5.0	10.0	15.0	20.0	25.0

ESM PA-Child.3 - Number of collaborative physical activity initiatives or events supported by the MCH Program through the CNMI Physical Activity Council that engage children ages 6–11 and their families.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	3.0	5.0	7.0	9.0	11.0



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**	**2025**
Annual Objective			
Annual Indicator	8.9	13.4	7.9
Numerator	1,208	2,060	1,077
Denominator	13,620	15,385	13,620
Data Source	MCH-JS-All Children	MCH-JS-All Children	MCH-JS-All Children
Data Source Year	2024	2021_2023	2023_2025

The effective care coordination sub-component is modified from the NSCH definition such that satisfaction with communication among the child's doctors and school, child care provider, or special education program is not included because the question was not asked in the survey. Caution should be used when comparing jurisdiction estimates to national or other state estimates because of the different measure definition. See All FAD - Jurisdication NPM Data Notes for more details.

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:	Inactive - Will be inactivated and a correct ESM created to accurately capture the strategy being measured.

State Provided Data					
	2021	2022	2023	2024	2025
Annual Objective	10	20	30	55	60
Annual Indicator	81	81	52.3	40.5	0
Numerator	51	51	45	45	0
Denominator	63	63	86	111	111
Data Source	F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey	CSHCN Program
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

ESM MH.2 - Percent of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	20.0	40.0	60.0	80.0	100.0

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

Collaborate through the CNMI Physical Activity Council to increase opportunities for children ages 6–11 and their families to participate in safe, accessible, and community-based physical activity programs through coordinated outreach, education, and partnership activities.

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 - Percent of children ages 6-11 years who enroll in after school sports or other group activities.	Active
ESM PA-Child.3 - Number of collaborative physical activity initiatives or events supported by the MCH Program through the CNMI Physical Activity Council that engage children ages 6–11 and their families.	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).	Inactive
ESM MH.2 - Percent of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).	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, 2023 and 2025.

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.

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	2025
Percent	48.0*	48.0*	51.3*	51.3*	59.6	59.6
Numerator	2,581	2,581	2,584	2,584	2,601	2,601
Denominator	5,376	5,376	5,035	5,035	4,367	4,367

Data Source: 2020-2021 (2019-2021) 2022-2023 (2021-2023), 2024-2025 (2023-2025) 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 CNMI continues to prioritize the prevention of childhood obesity through strategies that promote healthy nutrition and regular physical activity. National Performance Measure (NPM) 8 monitors the percentage of children ages 6 through 11 years who achieve at least 60 minutes of physical activity each day, consistent with national physical activity recommendations for children.

Data for this measure are obtained from the CNMI Maternal and Child Health Jurisdictional Survey (MCH-JS). Because the MCH-JS is conducted using a rolling survey methodology, estimates are derived from combined survey years to improve reliability. Accordingly, the 2020 and 2021 reporting years are based on the 2019–2021 survey cycle, the 2022 and 2023 reporting years are based on the 2021–2023 survey cycle, and the 2024 and 2025 reporting years are based on the 2023–2025 survey cycle.

According to the MCH-JS, an estimated 48.0% of children ages 6 through 11 years achieved at least 60 minutes of daily physical activity during the 2020 and 2021 reporting years. This estimate increased to 51.3% during the 2022 and 2023 reporting years and further increased to 59.6% during the 2024 and 2025 reporting years. Overall, the data demonstrate a positive upward trend in the proportion of children meeting recommended daily physical activity levels over the reporting period.

It is important to interpret the earlier estimates with caution. The estimates reported for 2020 through 2023 are accompanied by an asterisk, indicating that the confidence intervals are wider than recommended for reliable

interpretation. These estimates should therefore be viewed as approximate and interpreted within the context of the survey's sampling limitations. The 2024 and 2025 estimates are not flagged for statistical instability, providing a more reliable baseline for monitoring future progress.

Although nearly six in ten children now meet the recommended level of daily physical activity, approximately 40% of children ages 6 through 11 years are still not achieving the recommended 60 minutes of physical activity each day. These findings reinforce the continued importance of implementing evidence-based strategies that increase opportunities for physical activity in schools, neighborhoods, and community settings while promoting active lifestyles among children and families.

The MICAH Program will continue collaborating with schools, community organizations, healthcare providers, and public health partners to expand access to safe and inclusive physical activity opportunities, strengthen health education, and support family-centered initiatives that encourage lifelong healthy behaviors and reduce childhood obesity across the Commonwealth.

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

In FY2025, the Public Health Dietitian Nutritionist continued to lead initiatives promoting healthy eating and nutrition across the CNMI. Key activities included collaboration with the Nutrition Council to improve in-store signage and food placement strategies that encourage healthier food choices. The dietitian also contributed to planning and implementation efforts for several health awareness campaigns, including National Nutrition Month, Kidney Health Awareness Month, and Child and Adolescent Health Month.

A major milestone was the continued implementation of the CNMI's first Produce Prescription (Produce Rx) Program, piloted at the CHCC Women's Clinic. This 12-week program supported pregnant women in increasing their fruit and vegetable intake through six nutrition education sessions covering pregnancy nutrition, strategies to increase produce consumption, food demonstrations, recipe sharing, and educational resources. Participants also received weekly $20 vouchers redeemable for fresh fruits and vegetables, including frozen options without added sugar, salt, or fat. The pilot program continues to support improved maternal and child health while encouraging long-term, healthy eating habits among families.

Building on the success of the pilot, additional funding was secured from the Johns Hopkins Health Initiative to expand the Produce Prescription Program to additional CHCC clinics. During FY2025, planning and implementation activities were initiated to support the expansion of the program and increase access to nutrition education and healthy foods for more patients across the CNMI.

Additionally, the Public Health was selected to participate in Building Healthy Families (BHF) Scale Up Project through the University of Utah and the University of Nebraska at Kearney to implement a family-based weight management program aimed at preventing and reducing childhood obesity. Planning efforts began during FY2025 to develop and roll out this evidence-based program, which will provide families with education, resources, and support to promote healthy eating, physical activity, and sustainable lifestyle changes. This project will be implementation in collaboration between CNMI MCH Title and the Public Health Dietician.

Strategy: Increase community awareness on physical activity for children.

During FY2025, the CNMI MCH Title V Program continued to promote physical activity through community partnerships that encourage healthy lifestyles among children, adolescents, and their families. In collaboration with Run Saipan, a local nonprofit organization dedicated to promoting health and wellness through running, the MCH Program supported the annual "May the 4th Be With You" 5K Fun Run, held on May 4, 2025, in recognition of Star Wars Day.

The event was conducted as part of the CNMI's Adolescent Health Awareness Month (AHAM) activities and provided a family-friendly opportunity for community members to participate in organized physical activity. A total of 128 participants registered for the event, which promoted regular physical activity, healthy lifestyles, and community engagement among children, adolescents, and adults.

In addition to encouraging physical activity, the event increased awareness of the importance of active living as a key strategy for preventing childhood obesity and reducing the risk of chronic disease. Community-based events such as the annual Fun Run provide accessible opportunities for families to be physically active together while reinforcing positive health behaviors in a supportive environment.

The MCH Title V Program continues to strengthen partnerships with community organizations, schools, and local stakeholders to expand opportunities for physical activity and encourage lifelong healthy habits among children and families throughout the Commonwealth. These collaborative efforts support the Title V priority of preventing childhood obesity by increasing access to safe, enjoyable, and inclusive physical activity opportunities across the CNMI.



Health Promotion and Partnerships Unit (HPPU) Monthly Communications Calendar

The Health Promotion and Partnerships Unit (HPPU) maintains a monthly communications calendar to support the structured and consistent dissemination of public health messaging throughout the reporting period. This calendar includes:

- Planned social media content aligned with public health priorities, including physical activity promotion, nutrition education, and child health messaging
- Promotion of community outreach activities and events, including those encouraging physical activity for children and families

- Coordination with program leads to ensure timely and relevant messaging dissemination

This structured approach ensures that content is regularly published and aligned with health observances, campaigns, and community events, supporting increased awareness of healthy behaviors, including physical activity among children ages 6–11.

HPPU also utilizes this calendar to monitor and evaluate engagement, allowing for continuous refinement of communication strategies.

Key Awareness Campaign Activities (FY 2025)

During the reporting period, HPPU supported multiple national and local awareness campaigns to promote child health, nutrition, and physical activity through coordinated communications and outreach efforts. These included:

National Nutrition Month (March)

- Developed and disseminated social media content promoting healthy eating habits for children and families
- Shared culturally relevant nutrition tips, meal ideas, and portion guidance
- Coordinated messaging with nutrition and NCD programs to reinforce consistent education
- Promoted community events and outreach activities related to healthy lifestyle behaviors

Adolescent Health Month (May)

- Published digital content highlighting the importance of physical activity, mental wellness, and healthy behaviors among youth
- Promoted youth-friendly services and engagement opportunities
- Supported cross-program messaging to address healthy development and preventive care

Back-to-School (BTS) Health Fairs (July–August)

- Promoted BTS health fairs through social media, flyers, and community outreach
- Highlighted availability of child health services, including physical exams, immunizations, and health screenings
- Conducted on-site outreach and engagement with families, reinforcing the importance of preventive care and healthy habits for school-aged children
- Attended by 668 community members, majority being children and teens.

World Breastfeeding Week (August)

- Disseminated educational materials emphasizing the importance of breastfeeding for infant and child health
- Promoted breastfeeding support services and resources available in the community
- Coordinated messaging with maternal and child health programs to increase awareness and participation

Childhood Obesity Awareness Month (September)

- Developed targeted messaging promoting physical activity and healthy eating for children ages 6–11
- Shared educational posts on reducing screen time, increasing daily movement, and improving nutrition

- Highlighted community-based activities and programs that support healthy lifestyles for children and families

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 12 Well-Child outreach clinics were conducted in FY 2025 reaching 46 children ages 0-19 years. Additionally, in partnership with the Public School System (PSS) a total of 22 school-based vaccination clinics providing routine pediatric vaccinations to CNMI children in FY 2025.

Continuing Efforts Through 2030

The CNMI MCH Title V Program remains committed to achieving its 2030 priority of increasing the percentage of children ages 6–11 who are physically active. Building on successful community-based initiatives, the program will continue to promote physical activity through family-centered events, community outreach, and partnerships that encourage healthy, active lifestyles among children and their families.

Moving forward, the MCH Title V Program will strengthen collaboration with the Division of Public Health Services (DPHS) Non-Communicable Disease (NCD) Programs to better align physical activity promotion efforts across the Commonwealth. By coordinating outreach activities, health promotion campaigns, and community events, both programs will leverage shared resources, expertise, and partnerships to maximize their collective impact and expand the reach of evidence-based interventions.

The CNMI MICAH Programs will continue to work with community organizations, schools, and local partners to provide opportunities for children to participate in safe and enjoyable physical activities while reinforcing the importance of regular exercise for overall physical, mental, and emotional well-being. These collaborative efforts will support the development of sustainable strategies that foster lifelong healthy behaviors and contribute to improved child health outcomes throughout the CNMI.

The 2025 CNMI Maternal and Child Health (MCH) Five-Year Needs Assessment identified increasing screen time and declining physical activity among children and adolescents as emerging concerns affecting child health. Stakeholders expressed concern that excessive use of smartphones, tablets, computers, and televisions is contributing to more sedentary lifestyles and reducing opportunities for regular physical activity, outdoor recreation, and social interaction. These trends have important implications for children's physical health, mental well-being, and healthy development.

Findings from the 2023 CNMI Youth Risk Behavior Survey (YRBS) further underscore these concerns. The survey found that 69% of middle school students and 73% of high school students reported using social media several times each day. Research has shown that excessive recreational screen time is associated with lower levels of physical activity, reduced participation in muscle-strengthening activities, inadequate sleep, increased symptoms of depression and anxiety, poorer body image, and decreased social connectedness. Together, these factors increase children's risk for obesity, chronic disease, and poor mental health outcomes.

In response to these findings, the CNMI MCH Steering Committee selected Access to Healthy Physical Activity as Priority Need 5 under the Child Health domain. Increasing opportunities for regular physical activity is recognized as a key strategy for improving children's physical, mental, and emotional health while helping establish healthy behaviors that continue into adulthood.

This priority supports the CNMI's broader efforts to prevent non-communicable diseases by promoting active lifestyles beginning in early childhood. Through partnerships with schools, community organizations, healthcare providers, and local governments, the MCH Program will work to increase opportunities for safe and accessible physical activity for children and families across Saipan, Tinian, and Rota.

By expanding access to healthy physical activity, the MCH Program aims to:

- Increase participation in regular physical activity among children and adolescents.
- Reduce risk factors associated with childhood overweight and obesity.
- Improve mental health, emotional well-being, and social connectedness.
- Encourage lifelong healthy behaviors that support overall health and chronic disease prevention.

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: Collaborate through the CNMI Physical Activity Council to increase opportunities for children ages 6–11 and their families to participate in safe, accessible, and community-based physical activity programs through coordinated outreach, education, and partnership activities.

In FY 2027, the CNMI Maternal and Child Health (MCH) Title V Program will actively participate as a member of the

CNMI Physical Activity Council to support coordinated efforts that increase opportunities for children ages 6–11 and their families to engage in regular physical activity. As the Council reviews and updates its strategic framework to reflect changing organizational priorities, available resources, and environmental factors, the MCH Program will work collaboratively with Council partners to identify feasible, sustainable, and evidence-informed approaches that promote active lifestyles among children.

The MCH Program will contribute to the Council by providing maternal and child health expertise, participating in planning meetings, and supporting the development and implementation of community- and school-based physical activity initiatives. Emphasis will be placed on promoting family engagement in physical activity, increasing awareness of the Physical Activity Guidelines for Americans, and encouraging participation in safe, inclusive, and accessible opportunities that support healthy child development. When appropriate, the MCH Program will collaborate with partners to incorporate physical activity promotion into existing child and family health outreach events and educational activities.

Throughout the year, the MCH Program will assist in strengthening partnerships among public health, education, community organizations, and other stakeholders to maximize available resources and improve coordination of physical activity promotion efforts. Participation in the Physical Activity Council will also provide opportunities to share available data, identify emerging community needs, and support continuous improvement of collaborative strategies that contribute to National Performance Measure (NPM) 8—Physical Activity.

Through these collaborative efforts, the MCH Program seeks to support an environment that encourages children and their families to adopt and maintain active lifestyles, contributing to improved health and well-being across the CNMI.

FY2027 Activities

- Participate in quarterly CNMI Physical Activity Council meetings and strategic planning sessions.
- Collaborate with Council partners to support community and school-based physical activity events for children and families.
- Promote evidence-based physical activity recommendations for children through MCH outreach, health education, and social media.
- Incorporate physical activity messaging into existing MCH child health and family engagement activities whenever feasible.
- Share relevant child health and population data with Council partners to help inform planning and evaluation efforts.
- Support the identification of partnership opportunities that expand access to safe and inclusive physical activity opportunities for children throughout the CNMI.

Evidence-Based Strategy Measure (ESM): Number of collaborative physical activity initiatives or events supported by the MCH Program through the CNMI Physical Activity Council that engage children ages 6–11 and their families.

Priority Need 6: 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.

For FY2027, the MCH Program will place greater emphasis on developing a sustainable workforce development infrastructure by expanding access to high-quality professional development opportunities related to the medical home model. In collaboration with the Division of Public Health Services, the program will identify, curate, and implement evidence-informed training resources that can be incorporated into the CHCC's Learning Management System (LMS), creating a centralized and accessible platform for ongoing staff education. The program will also promote participation in national and regional conferences, webinars, continuing education courses, and other online learning opportunities offered by federal agencies, professional organizations, and academic institutions. By integrating these educational resources into the LMS, the MCH Program aims to establish a standardized approach to workforce development that supports continuous learning, improves provider competencies, and promotes consistent implementation of medical home principles across healthcare settings.

By investing in provider education, quality improvement, and system-level supports, this strategy seeks to strengthen care coordination, improve access to comprehensive and family-centered services, and enhance collaboration among healthcare providers, families, and community partners. Through continuous monitoring, evaluation, and feedback, the program will ensure that training opportunities remain responsive to local workforce needs while building a sustainable foundation for high-quality pediatric care throughout the Commonwealth. These efforts are expected to improve the capacity of healthcare providers to deliver coordinated, accessible, and family-centered services, ultimately contributing to improved health, developmental, and psychosocial outcomes for CNMI's children and youth.

Evidence Based Strategy Measure (ESM): Percentage of CNMI 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

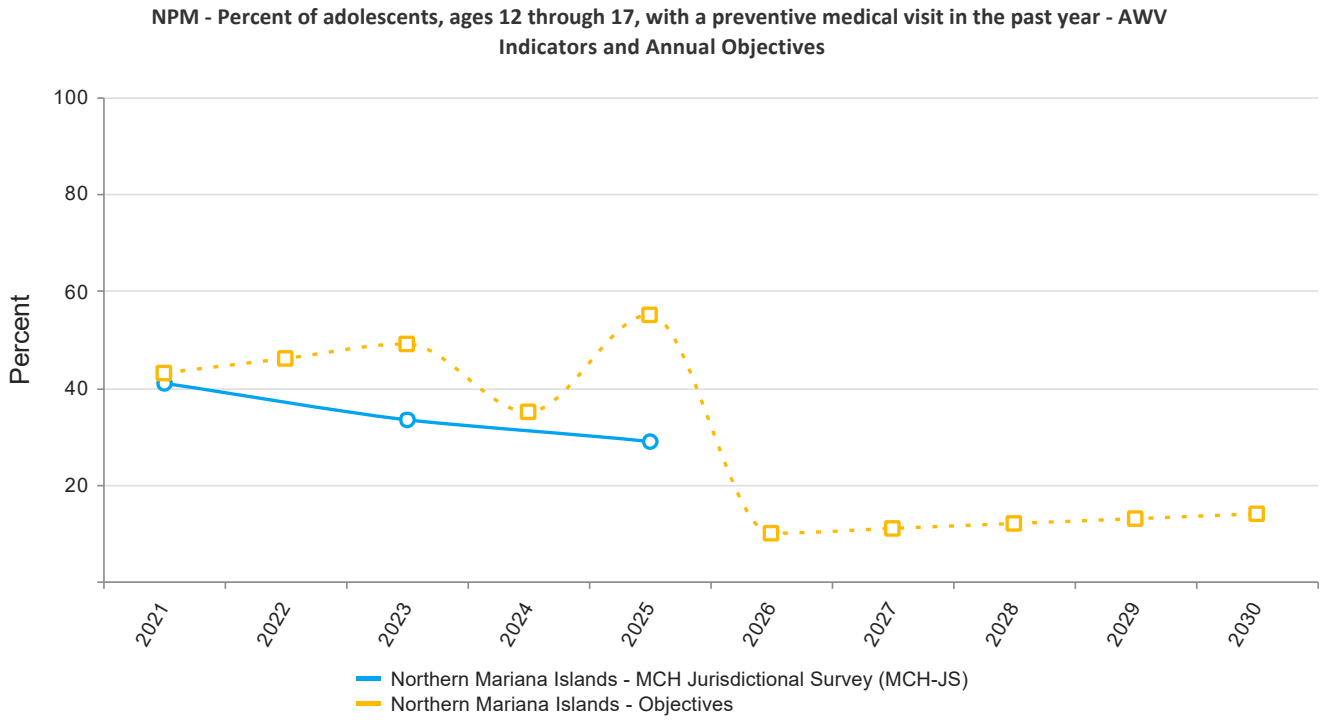
subsequently implemented at least one core component such as care coordination, family engagement, or team-based care—is critical for assessing the effectiveness of efforts to improve access to medical homes for children in the CNMI. The medical home model is widely recognized as a best practice framework 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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	43	46	49	35	55
Annual Indicator	39.3	39.3	27.3	33.5	28.9
Numerator	2,156	2,156	1,386	1,771	1,539
Denominator	5,493	5,493	5,072	5,282	5,323
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2021	2021	2024	2021_2023	2023_2025

This measure definition is identical to the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdiction NPM Data Notes for more details.

State Provided Data					
	2021	2022	2023	2024	2025
Annual Objective	43	46	49	35	55
Annual Indicator	22	12.1	16.6	6.9	8
Numerator	1,378	749	998	390	419
Denominator	6,256	6,177	5,994	5,661	5,269
Data Source	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue EHR	CareVue EHR	CareVue EHR
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10.0	11.0	12.0	13.0	14.0

Evidence-Based or –Informed Strategy Measures

ESM AWV.2 - Percentage of Public School System (PSS) high school students who participate in school-based health services.

Measure Status:	Active

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator		8.1
Numerator		257
Denominator		3,172
Data Source		MCH Program Records/PSS Enrollment Data
Data Source Year		2025
Provisional or Final ?		Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10.0	12.0	14.0	16.0	18.0

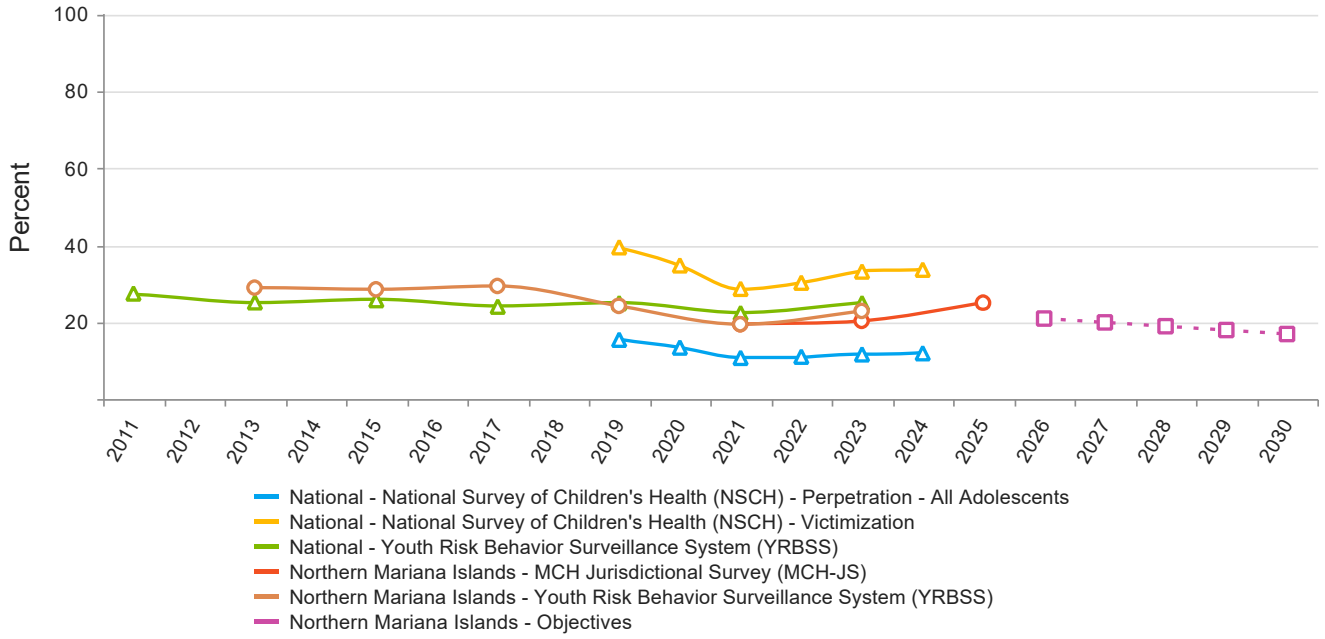
ESM AWV.3 - Number of teens who completed the PATCH Peer-to-Peer Workshops in the past year.

Measure Status:	Active

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator		83
Numerator		
Denominator		
Data Source		Program Administrative Records/Sign in Sheets
Data Source Year		2025
Provisional or Final ?		Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	85.0	105.0	125.0	150.0	175.0

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: MCH Jurisdictional Survey (MCH-JS)		
	2024	**2025**
Annual Objective		
Annual Indicator	20.5	25.0
Numerator	1,084	1,330
Denominator	5,282	5,323
Data Source	MCH-JS-All Adolescents	MCH-JS-All Adolescents
Data Source Year	2021_2023	2023_2025

This measure captures adolescents aged 12 through 17 years who are reported to have ever been physically bullied on school property or electronically bullied, which differs from the definition in the Block Grant guidance detail sheet given the question is from YRBSS but the denominator is the same as the NSCH denominator. See All FAD - Jurisdiction NPM Data Notes for more details.

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2024	**2025**
Annual Objective		
Annual Indicator	22.9	22.9
Numerator	718	718
Denominator	3,143	3,143
Data Source	YRBSS	YRBSS
Data Source Year	2023	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 participating in bullying prevention needs assessment and planning activities.

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) high school students who participate in school-based health services.	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

Collaborate with the Public and Private School Systems to assess bullying prevention needs and utilize survey feedback to identify gaps, strengthen implementation of existing evidence-based bullying prevention programs, and provide targeted support, training, and resources to improve student well-being and school safety.

ESMs	Status
ESM BLY.1 - Percent of schools participating in bullying prevention needs assessment and planning activities.	Active

NOMs

- Adolescent Mortality
- Adolescent Suicide
- Adolescent Firearm Death
- Adolescent Injury Hospitalization
- Adolescent Depression/Anxiety
- Adverse Childhood Experiences

Activities described in this section reflect the FY2025 reporting period (October 1, 2024–September 30, 2025). During the reporting year, the CNMI Maternal, Infant, Child, and Adolescent Health (MICAH) Program continued implementing evidence-based and community-informed strategies to improve adolescent health by promoting preventive healthcare utilization, supporting healthy behaviors, strengthening behavioral health awareness, and preparing youth for the transition to adult healthcare services.

The 2020 CNMI Comprehensive Maternal and Child Health Needs Assessment identified adolescent mental health, including the need to strengthen coping skills and suicide prevention, as a priority for the Commonwealth. This priority aligns with National Performance Measure (NPM) 10, which measures the percentage of adolescents ages 12 through 17 years who received a preventive medical visit during the past year. The MICAH Program promotes annual adolescent well-visits as an important opportunity to provide comprehensive preventive healthcare, including behavioral health screening, health risk assessments, anticipatory guidance, and referrals to appropriate services that support healthy development and emotional well-being.

The Needs Assessment also identified the importance of supporting adolescents with and without special healthcare needs as they prepare for adulthood. This priority aligns with National Performance Measure (NPM) 12, which measures the percentage of adolescents ages 12 through 17 years who receive services necessary to transition successfully into adult healthcare. The MICAH Program continues collaborating with healthcare providers, schools, families, and community organizations to strengthen transition planning and improve adolescents' access to coordinated health services.

Recognizing that schools provide an effective setting for reaching adolescents, the MICAH Program continued its longstanding partnership with the CNMI Public School System (PSS) during FY2025. Planning meetings and implementation activities were conducted to coordinate school-based outreach and expand access to preventive health education and services. Through the Teen Health Initiative, the MICAH Program partnered with the Division of Public Health Services' Non-Communicable Disease (NCD) Programs and Communicable Disease Programs to deliver comprehensive health promotion activities to middle and high school students throughout the Commonwealth.

As part of the initiative, multidisciplinary public health staff provided classroom presentations, health education, and preventive health screenings designed to increase awareness of healthy lifestyles and identify students who may benefit from additional medical evaluation. Screening services included blood pressure measurement, blood glucose testing, body mass index (BMI) assessment, interpretation of screening results, and referrals for adolescent well-visits and other appropriate healthcare services.

To further improve access to adolescent-friendly healthcare services, the CHCC Mobile Clinic participated in selected high school outreach events by providing sexual and reproductive health services, including pregnancy testing, contraceptive counseling and provision of contraceptive methods, sexually transmitted infection (STI) testing, and recommended immunizations. Integrating clinical services with school-based outreach reduced barriers to care and provided adolescents with convenient access to preventive health services in a familiar community setting.

Through these collaborative partnerships, the MICAH Program continued to expand opportunities for adolescents to access preventive healthcare, behavioral health support, and health education while promoting early identification of health concerns and strengthening connections to ongoing care. The program will continue building on these

partnerships during the next reporting period to improve adolescent well-visits, strengthen transition planning, and support the overall health and well-being of adolescents throughout the Commonwealth.

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	2025
Percent	40.9	40.9	33.5	33.5	28.9	28.9
Numerator	2375	2375	1771	1771	1539	1539
Denominator	5806	5806	5282	5282	5323	5323

Data Source: 2020-2021 (2019-2021), 2022-2023 (2021-2023), 2024-2025 (2023-2025) CNMI MCH Jurisdictional Survey

Improving access to preventive healthcare for adolescents remains a priority for the CNMI Maternal, Infant, Child, and Adolescent Health (MICAH) Program. Annual adolescent well-visits provide important opportunities to assess physical, behavioral, and emotional health; deliver age-appropriate preventive services; identify risk factors; and connect youth to needed healthcare and community resources. These visits also support the CNMI's priority of strengthening coping skills and suicide prevention by facilitating routine behavioral health screening, anticipatory guidance, and early intervention when concerns are identified.

National Performance Measure (NPM) 10 is monitored using data from the CNMI Maternal and Child Health Jurisdictional Survey (MCH-JS). Because the survey uses a rolling data collection methodology, reporting years reflect combined survey cycles to improve estimate reliability. Accordingly, the 2020 and 2021 reporting years are based on the 2019–2021 survey cycle, the 2022 and 2023 reporting years are based on the 2021–2023 survey cycle, and the 2024 and 2025 reporting years are based on the 2023–2025 survey cycle.

According to the MCH Jurisdictional Survey, the percentage of adolescents ages 12 through 17 years who received a preventive medical visit declined across the reporting period. An estimated 40.9% of adolescents received a preventive medical visit during the 2020 and 2021 reporting years. This percentage decreased to 33.5% during the 2022 and 2023 reporting years and further declined to 28.9% during the 2024 and 2025 reporting years

The observed decline indicates that fewer adolescents are accessing recommended annual preventive healthcare services. While the survey does not identify the reasons for this trend, several factors may influence adolescent healthcare utilization, including appointment availability, transportation, competing family priorities, awareness of preventive health services, and adolescents' healthcare-seeking behaviors. Continued monitoring of this measure, together with community engagement and needs assessment findings, will help inform future program planning and targeted interventions.

During FY2025, the MICAH Program continued collaborating with healthcare providers, schools, behavioral health partners, and community organizations to promote adolescent well-visits through school-based outreach, health education, behavioral health awareness, and referral to preventive healthcare services. These coordinated efforts are intended to increase adolescent engagement in routine preventive care, strengthen early identification of physical and behavioral health concerns, and improve overall health outcomes for adolescents throughout the Commonwealth.

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

During FY2025, the MICAH Program collaborated with the CNMI Public School System and other Division of Public Health Services programs to deliver classroom-based health education and outreach activities at middle and high schools on Saipan. Educational sessions emphasized the importance of annual adolescent well-visits, the components of comprehensive preventive healthcare, and the availability of confidential adolescent health services through the Commonwealth Healthcare Corporation (CHCC) Title X Family Planning Program.

A key component of this strategy is the Providers and Teens Communicating for Health (PATCH) Teen Educator Program, which uses a peer-to-peer education model to promote healthy behaviors and increase awareness of available health services. PATCH Teen Educators receive annual training to strengthen their knowledge and communication skills before conducting outreach within their schools and communities. During FY2025, the PATCH Program conducted four PATCH for Peer workshops, reaching 83 adolescents from youth-serving partner organizations with education on adolescent wellness, healthy decision-making, and available healthcare resources.

To further improve access to preventive services, the MICAH Program partnered with CHCC clinical programs to conduct school-based outreach events during the 2024–2025 and 2025–2026 academic years. These outreach events provided students with basic preventive health screenings, including blood pressure, blood glucose, and body mass index (BMI) assessments, along with individualized education on chronic disease prevention and referrals to adolescent well-visits and other appropriate healthcare services when indicated. Students also received information on available public health programs and community resources that support adolescent health and well-being.

By integrating health education, peer engagement, school-based outreach, and preventive health screenings, the MICAH Program continues to reduce barriers to care and strengthen connections between adolescents and the healthcare system. These collaborative efforts support the Title V priority of increasing adolescent preventive health visits while promoting early identification of physical and behavioral health concerns and improving access to appropriate follow-up care and supportive 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	2025
Percentage	22.0	12.1	16.6	9.7	8.0
Numerator	1378	749	998	550	419
Denominator	6256	6177	5994	5661	5269

Data Source: CHCC EHR and U.S. Census International Database

The CNMI uses the percentage of adolescents ages 12 through 17 years who access preventive health services at Commonwealth Healthcare Corporation (CHCC) facilities as its Evidence-based/Informed Strategy Measure (ESM) to monitor progress toward improving adolescent preventive healthcare utilization.

Between 2021 and 2025, the percentage of adolescents receiving preventive services at CHCC declined from 22.0% (1,378 of 6,256 adolescents) to 8.0% (419 of 5,269 adolescents). Although utilization rebounded temporarily to 16.6% in 2023, the overall trend indicates that fewer adolescents are accessing routine preventive healthcare

services. In FY2025, an estimated 5,269 adolescents ages 12–17 resided in the CNMI, and 419 received preventive services through CHCC, resulting in an ESM value of 8.0%.

Multiple factors may have contributed to the continued decline in preventive care utilization. These include changes in health insurance coverage following the expiration of Medicaid Presumptive Eligibility, limited availability of pediatric and adolescent primary care appointments, transportation challenges, competing family priorities, and barriers to navigating the healthcare system. Together, these factors may have reduced adolescents' access to recommended annual preventive visits.

To improve access to preventive healthcare, the MICAH Program continued strengthening partnerships with the CNMI Public School System, CHCC primary care clinics, and other Division of Public Health Services programs during FY2025. School-based outreach remained a key strategy for increasing awareness of preventive health services and identifying adolescents who would benefit from follow-up medical care.

During the 2025–2026 school year, school-based outreach activities were conducted at four of the CNMI's six public high schools, reaching approximately 67% of public high school campuses. As part of these activities:

- 257 students received preventive health screenings for hypertension, diabetes, and obesity risk factors.
- 910 students participated in health education sessions addressing chronic disease prevention, sexually transmitted infection (STI) prevention, adolescent reproductive health, and teen pregnancy prevention.
- 47 students identified through screening were referred to the CHCC Children's Clinic for follow-up evaluation and care coordination.

To facilitate timely access to care, the Children's Clinic reserved appointment slots for students referred through school-based outreach, while MICAH staff provided service coordination to assist adolescents and families with scheduling and completing recommended follow-up visits.

The MICAH Program also continued promoting adolescent access to confidential reproductive healthcare services through the CHCC Family Planning Program. In FY2025, 139 adolescents ages 12 through 17 years accessed Family Planning services, an increase from 120 adolescents in FY2024 and substantially higher than the 82 adolescents served in 2019. The program also maintained increased utilization among male adolescents, with seven male adolescents accessing Family Planning services in both FY2024 and FY2025, compared with no male adolescent clients in 2019. These findings suggest continued progress in increasing awareness of confidential adolescent reproductive health services and engaging youth in preventive healthcare.

Improving adolescent preventive healthcare utilization will remain a priority during the next reporting period. The MICAH Program will continue expanding school-health partnerships, strengthening referral pathways between schools and primary care providers, enhancing care coordination, and promoting adolescent-friendly services to increase annual preventive visits and improve health outcomes for adolescents throughout the Commonwealth.

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	2025
Percent	46.5 *	46.5*	40.6	40.6	33.2	33.2
Numerator	2,428	2,428	1,946	1,946	1,767	1,767
Denominator	5,222	5,222	4,795	4,795	5,323	5,323

Note: *- Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution
Data Source: 2020-2021 (2019-2021), 2022-2023 (2021-2023), 2024-2025 (2023-2025) CNMI MCH Jurisdictional Survey

National Performance Measure (NPM) 12-B monitors the percentage of adolescents without special health care needs, ages 12 through 17 years, whose families report receiving the services necessary to support the transition to adult health care. Data for this measure are obtained through the CNMI Maternal and Child Health Jurisdictional Survey (MCH-JS). Because the survey uses a rolling data collection methodology, reporting years reflect combined survey cycles to improve estimate reliability. The 2020 and 2021 reporting years are based on the 2019–2021 survey cycle, the 2022 and 2023 reporting years are based on the 2021–2023 survey cycle, and the 2024 and 2025 reporting years are based on the 2023–2025 survey cycle.

According to the MCH Jurisdictional Survey, the percentage of adolescents without special health care needs whose families reported receiving transition services declined across the reporting period. The estimate was 46.5% during the 2020 and 2021 reporting years, decreased to 40.6% during the 2022 and 2023 reporting years, and declined further to 33.2% during the 2024 and 2025 reporting years.

It is important to note that the estimates for the 2020 and 2021 reporting years are marked with an asterisk, indicating that the confidence intervals are wide and should be interpreted with caution. Nevertheless, the data suggest a decline in the proportion of families reporting receipt of services that support adolescents in transitioning to adult health care. This finding highlights the continued need to strengthen transition planning, increase awareness of transition services among adolescents and families, and improve coordination between pediatric and adult healthcare providers. The MICAH Program will continue collaborating with healthcare providers, schools, and community partners to promote early transition planning and improve access to resources that support successful transitions into adult-oriented healthcare systems.

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

During FY2025, MICAH collaborated with the CNMI Public School System, the Providers and Teens Communicating for Health (PATCH) Program, and other Division of Public Health Services programs to provide health education sessions that emphasized the importance of establishing a medical home, accessing routine preventive healthcare, understanding available healthcare services, and developing the knowledge and skills needed to navigate the adult healthcare system.

Through the PATCH Teen Educator Program, trained peer educators reinforced key messages related to preventive healthcare, self-advocacy, healthy decision-making, and available community resources. These peer-led activities complemented classroom presentations and school-based outreach events designed to increase awareness of adolescent health services and encourage continued engagement with healthcare as youth transition into adulthood.

The MICAH Program also incorporated transition planning into school-based outreach and referral activities by connecting adolescents to primary care providers, reproductive health services, behavioral health resources, and other community-based programs, as appropriate. These coordinated efforts help adolescents and their families

better understand available healthcare resources while promoting continuity of care beyond adolescence.

Other Adolescent Health Activities:

During FY2025, the MICAH Programs expanded its collaborative approach to adolescent health promotion by strengthening partnerships with the CNMI State Mental Health Agency, the Community Guidance Center (CGC), and other youth-serving organizations. Through this collaboration, the annual National Adolescent Health Month campaign was integrated with the CNMI Mental Health Awareness Month campaign to promote a coordinated approach to adolescent physical, behavioral, and emotional well-being.

The campaign brought together a broad coalition of partners, including the Community Guidance Center, the 988 Suicide and Crisis Lifeline Program, the Pediatric Mental Health Care Access (PMHCA) Program, the CNMI Public School System's Haligi Aware Program and Youth Advisory Panel, the CNMI PATCH Program, WestCare Pacific, the CNMI Youth Congress, and other community- and youth-serving organizations. This collaborative approach leveraged resources across agencies to deliver consistent messaging and expand community engagement around adolescent health and mental wellness.

The FY2025 campaign was launched through proclamation signings on the islands of Saipan, Tinian, and Rota and featured a series of community outreach activities throughout the month of May. Under the theme "Wellness in Action," partners implemented health education activities, community events, social media campaigns, and local media outreach to increase awareness of adolescent health, promote positive coping skills, reduce stigma surrounding mental health, and encourage youth and families to access available health and behavioral health services.

These activities support the CNMI MCH priority of strengthening coping skills and suicide prevention among adolescents by increasing public awareness, promoting resilience, fostering youth engagement, and strengthening collaboration among healthcare providers, schools, behavioral health programs, and community organizations.

2025 CNMI Mental Health Awareness Month and National Adolescent Health Month Calendar of Events


May is..
MENTAL HEALTH Awareness Month
and
NATIONAL ADOLESCENT Health Month
988 SUICIDE & CRISIS LIFELINE
WestCare
Wellness in Action
EVENT DETAILS
April 25- Lucia "Chiang" Villagomez Arizapa Health Center and Rota Health Center Wellness in Action Professional Development
Proclamation Signing Events
Saipan- April 30 @ 9 AM
Partnership with PSS Mental Health and Public Health for Sources of Strength and Patch Teens
Tinian- May 01 @ 10 am
Multipurpose Center followed by a 2-day Volleyball Tournament
Rota- May 10 @ 4 pm
Community Block Party
Roadside Waving: 4-5 pm at Ada Gymnasium, Susupe & Marina Heights Intersection, Puerto Rico
Radio Panelist Schedule KKMP @ 8 AM
Youth Wellness
Women's Wellness
Men's Wellness
Man'amko Voices
Wellness in Action Youth Summit
Da'Ok Academy
SUNDAY
MONDAY
TUESDAY
WEDNESDAY
THURSDAY
FRIDAY
SATURDAY
27
28
29
30
Proclamation Signing - Saipan
RHI Teen Health Outreach (Rota)
1
Proclamation Signing - Tinian
RHI Teen Health Outreach (Rota)
2
Da'Ok Academy Wellness in Action Youth Summit
Roadside Waving at Ada Gym & MHI
Wear Green Friday
3
4
May the 4th Run/Walk
5
6
7
KKMP Radio Show @ 8am (Youth)
8
9
TLC/WLNS/ASU Open House
Youth Advisory Panel Summit
Wear Green Friday
10
Proclamation Signing - Rota
11
Happy Mother's Day
12
13
14
MHAM Radio Show on KKMP @ 8am (Women)
15
Youth Vaping Presentation (FMS)
16
Wear Green Friday
17
Wellness in Action 5k Run/Walk
Women's Health Week
National Prevention Week
18
19
20
21
MHAM Radio Show on KKMP @ 8am (Men)
Rota: Pacific Way to Wellness
22
23
Youth Vaping Presentation (SVES)
Wear Green Friday
24
25
26
Memorial Day
27
28
MHAM Radio Show on KKMP @ 8am (Man'amko)
29
WestCare Pacific Islands Open House
Youth Vaping Presentation (FMS)
30
Wear Green Friday
31
Calendar event time and dates are subject to change. For the most recent calendar of events, visit www.chcc.health, give us a call, or follow us on social media:
cnmipublichealth
cnmichcc
cnmicgc
cnmi.chcc.cgc
(670) 323-6560

Improving adolescent health remains a priority for the Commonwealth Healthcare Corporation (CHCC) Maternal, Infant, Child, and Adolescent Health (MICAH) Programs and its community partners. The MICAH Programs will continue their longstanding partnership with the CNMI Public School System (PSS) to develop and implement coordinated strategies that address the health needs of adolescents throughout the Commonwealth.

Because the CNMI does not currently have school-based health centers, schools provide an important setting for reaching adolescents with preventive health education, outreach, and referrals to healthcare services. Through collaboration with PSS, MICAH will continue implementing school-based and community-based initiatives that increase awareness of available health services and promote healthy behaviors among youth.

The 2025 CNMI MCH Comprehensive Needs Assessment identified improving access to teen pregnancy prevention services, sexually transmitted infection (STI) prevention and education, and bullying prevention and support as key priorities for adolescents. Addressing these issues during adolescence provides an opportunity to establish healthy behaviors early in life and reduce the risk of adverse health outcomes in adulthood.

The MICAH Programs will continue promoting annual adolescent preventive health visits as an important strategy for improving adolescent health. Preventive visits provide opportunities to assess physical, behavioral, and emotional health; deliver age-appropriate immunizations and screenings; discuss nutrition and physical activity; provide sexual and reproductive health education; and identify concerns related to mental health, substance use, bullying, and interpersonal relationships. These visits also create opportunities for healthcare providers to connect adolescents with appropriate counseling, treatment, and community resources when needed.

Strengthening protective factors is another important component of the CNMI's adolescent health strategy. Through partnerships with schools, families, youth-serving organizations, and community leaders, MICAH will support programs that foster positive youth development, healthy relationships, resilience, leadership, and life skills. These efforts recognize adolescents as active partners in their own health and encourage meaningful engagement in their schools and communities.

Consistent with findings from the 2025 Comprehensive Needs Assessment, the MICAH Programs will prioritize increasing adolescent access to preventive healthcare services as a pathway to improving sexual and reproductive health outcomes. Increasing the number of adolescents receiving annual preventive visits will expand opportunities for STI screening, sexual health education, pregnancy prevention counseling, mental health screening, and referrals to appropriate services. These efforts are intended to contribute to reductions in sexually transmitted infections and teen pregnancies while promoting the overall health and well-being of adolescents across the CNMI.

Priority Need 7: 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. 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 FY2027.

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, linguistically appropriate, and confidential, ensuring that young people feel respected and supported when accessing care.

For FY 2027, October 2026 through September 2027, 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) high school students who participate in school-based health services.
To measure the impact of the strategy on the priority area and objective, the MCH program will report on the percentage of students who participate in school-based health services and the percentage that are 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 2027, October 2026 through September 2027, 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 8: 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: Collaborate with the Public and Private School Systems to assess bullying prevention needs and utilize survey feedback to identify gaps, strengthen implementation of existing evidence-based bullying prevention programs, and provide targeted support, training, and resources to improve student well-being and school safety.

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:

- **Assess School Needs:** Analyze counselor survey results and engage school personnel to identify strengths, challenges, and opportunities related to bullying prevention and student well-being.
- **Strengthen Existing Programs:** Collaborate with schools to support the continued implementation of existing evidence-based bullying prevention programs and practices.
- **Provide Training and Technical Assistance:** Offer training opportunities, educational materials, and technical assistance to school staff on bullying prevention, early identification, intervention strategies, and referral pathways.
- **Enhance Resource Coordination:** Facilitate communication and resource sharing among public and private schools to promote collaboration and the dissemination of effective practices.
- **Support Positive School Environments:** Work with schools to identify strategies that promote respectful interactions, student connectedness, and safe learning environments.
- **Monitor Progress and Inform Future Planning:** Review feedback and available data to evaluate activities, identify emerging needs, and inform future bullying prevention efforts.

Through strong collaboration with educational partners, the MCH Program remains committed to supporting safe and supportive learning environments where all students have the opportunity to succeed academically, socially, and emotionally.

Evidence Based Strategy Measure (ESM): Percent of schools participating in bullying prevention needs assessment and planning activities.

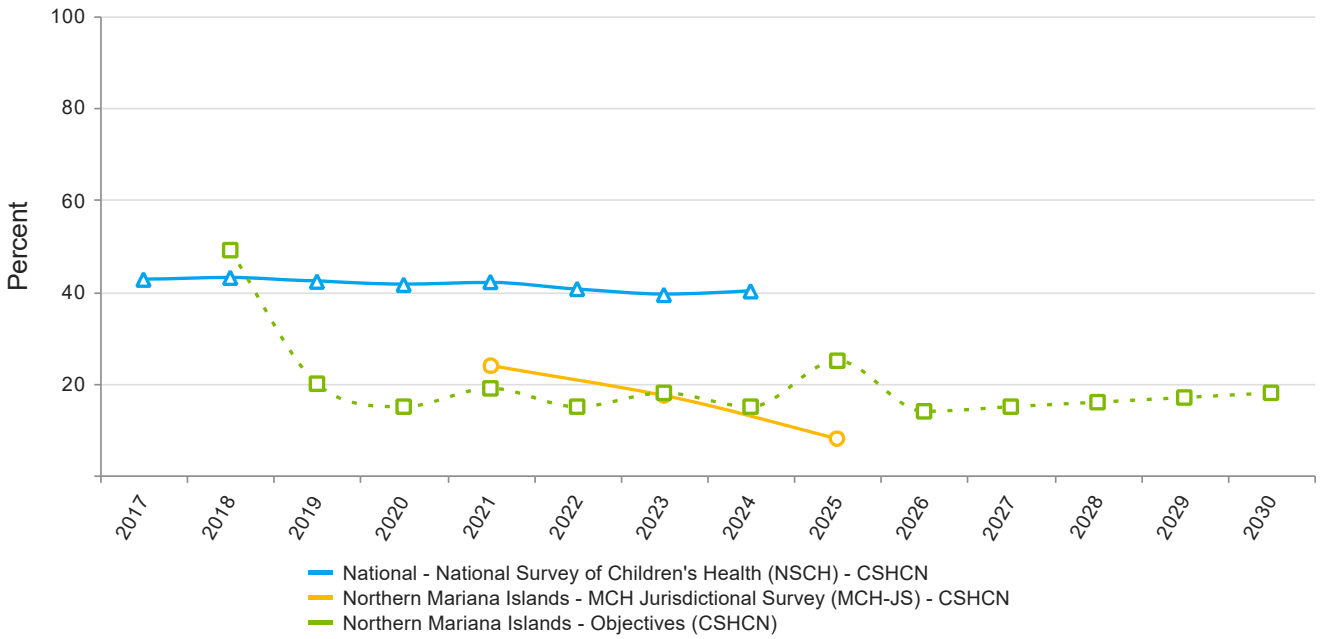
To measure the impact of the strategy on the priority area and objective, the MCH program will report on the percentage of schools, public and private, participating in bullying prevention needs assessment and planning activities. Additionally, the MCH Program will collaborate with public and private school partners to assess bullying prevention needs, monitor the effectiveness of existing prevention efforts, and evaluate the impact of trainings,

technical assistance, and resource-sharing activities using identified evaluation methods. Findings from the survey, stakeholder feedback, and program data will be used to identify gaps, inform continuous quality improvement efforts, and guide future bullying prevention initiatives that support safe and positive learning environments.

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	19	15	18	15	25
Annual Indicator	14.1	14.1	12.5	17.4	8.2
Numerator	176	176	138	290	127
Denominator	1,252	1,252	1,101	1,666	1,554
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2021	2021	2024	2021_2023	2023_2025

The effective care coordination sub-component is modified from the NSCH definition such that satisfaction with communication among the child's doctors and school, child care provider, or special education program is not included because the question was not asked in the survey. Caution should be used when comparing jurisdiction estimates to national or other state estimates because of the different measure definition. See All FAD - Jurisdication NPM Data Notes for more details.

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:	Inactive - Will be inactivated and a correct ESM created to accurately capture the strategy being measured.

State Provided Data					
	2021	2022	2023	2024	2025
Annual Objective	10	20	30	55	60
Annual Indicator	81	81	52.3	40.5	0
Numerator	51	51	45	45	0
Denominator	63	63	86	111	111
Data Source	F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey	CSHCN Program
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

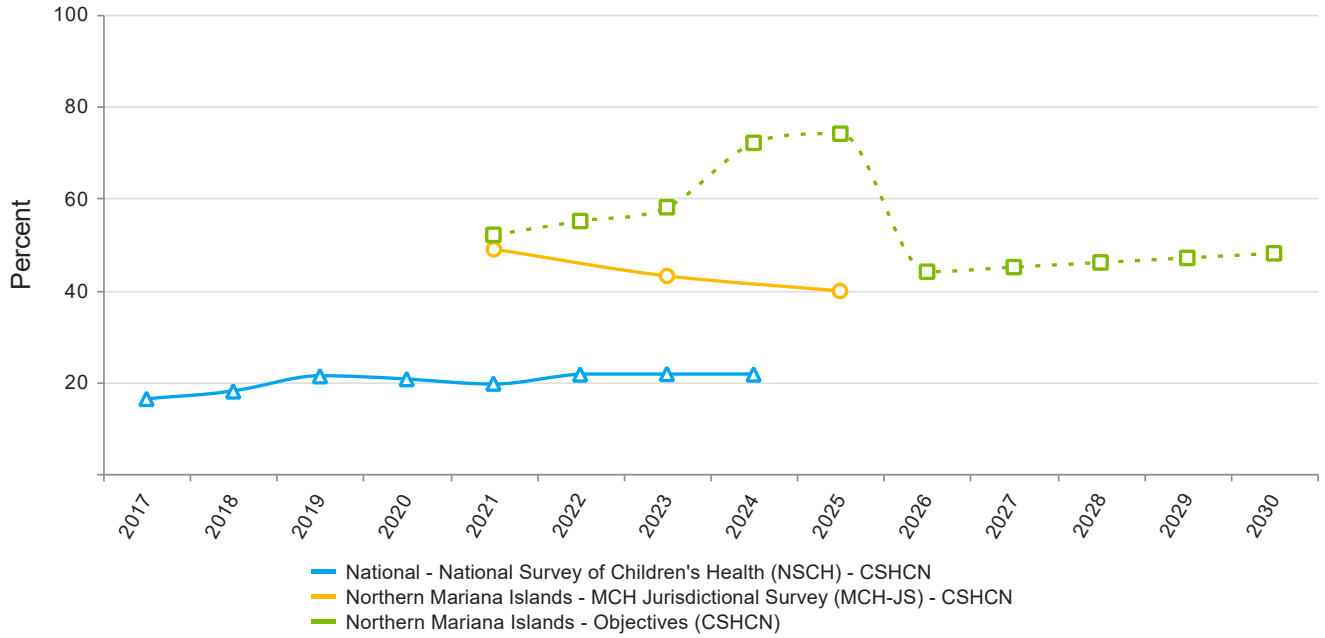
ESM MH.2 - Percent of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	20.0	40.0	60.0	80.0	100.0

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	52	55	58	72	74
Annual Indicator	32.8	32.8	70.7	43.0	39.7
Numerator	167	167	322	299	281
Denominator	511	511	455	695	709
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2021	2021	2024	2021_2023	2023_2025

The ‘time spent alone with the health care provider’ is not captured in this measure because it was not asked in the survey. The 'anticipatory guidance' component of transition care used the 2016 and 2017 wording from the NSCH and asked, "Have they talked with you about having this child eventually see doctors or other health providers who treat adults?" See All FAD - Jurisdication NPM Data Notes for more details.

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.2 - Percent 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).	Inactive
ESM MH.2 - Percent of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).	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 - Percent of parents who complete transition training.	Active

NOMs

CSHCN Systems of Care

Consistent with the Maternal and Child Health (MCH) Title V Block Grant Guidance, the following section summarizes activities implemented during FY2025 (October 1, 2024, through September 30, 2025) to address the CNMI's priority needs for Children with Special Health Care Needs (CSHCN).

The 2020 CNMI Maternal and Child Health (MCH) Comprehensive Needs Assessment, which established the priorities for the 2021–2025 Title V Block Grant cycle, identified two priority areas for Children with Special Health Care Needs (CSHCN): (1) supporting parents and caregivers in navigating health and community service systems and (2) improving transition planning for adolescents with special health care needs as they move into adult-oriented healthcare services. These priorities correspond to Priority Need 6: Support for Parents and Caregivers in Navigating Systems and Priority Need 7: Support Individuals, Families, and Communities to Make Changes that Promote Healthy and Successful Youth. They align with National Performance Measure (NPM) 11, the percentage of children with and without special health care needs, ages 0 through 17 years, who have a medical home, and National Performance Measure (NPM) 12, the percentage of adolescents with and without special health care needs, ages 12 through 17 years, who receive the services necessary to transition to adult health care. This FY2025 report summarizes the final year of activities and progress achieved toward these priorities during the 2021–2025 Title V Block Grant cycle.

Performance data for NPM 11 and NPM 12 are obtained through the CNMI Maternal and Child Health Jurisdictional Survey (MCH-JS), which is conducted on a biennial basis. The most recent survey estimates that 8.2% of children in the CNMI have a special health care need. These data continue to inform program planning, priority setting, and evaluation of the CNMI's Title V activities.

During FY2025, the CNMI continued to strengthen its system of care for children and youth with special health care needs through coordinated partnerships within the CHCC, healthcare providers, educational institutions, family support organizations, and community partners. Core services, including developmental screening, early identification, care coordination, and referrals for infants and children enrolled in the Early Intervention Program, continued throughout the reporting period. Specialized outreach clinics, including partnerships with pediatric specialty providers such as Shriners Children's, also continued to improve access to specialty care for children and families residing throughout the Commonwealth.

The MICAH Program also continued to support families and professionals through education, training, and family engagement activities. Training opportunities were offered using both in-person and virtual formats to increase accessibility across the islands of Saipan, Tinian and Rota. Family support groups for children with Down syndrome, autism spectrum disorder, and children who are deaf or hard of hearing (DHH) remained active during FY2025, providing opportunities for peer support, caregiver education, and connection to community resources. These activities strengthen family capacity, improve care coordination, and support the long-term health and well-being of children and youth with special health care needs and their families.

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	2020	2021	2022	2023	2024	2025
Percentage	23.8*	23.8*	17.4*	17.4*	8.2*	8.2*
Numerator	432	432	290	290	127	127
Denominator	1,811	1,811	1,666	1,666	1,554	1,554

Data Source: 2020-2021 (2019-2021), 2022-2023 (2021-2023), 2024-2025 (2023-2025) CNMI 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

National Performance Measure (NPM) 11A monitors the percentage of children with special health care needs (CSHCN), ages 0 through 17 years, who have a medical home. Data for this measure are obtained through the CNMI Maternal and Child Health Jurisdictional Survey (MCH-JS). Because the survey uses a rolling data collection methodology, reporting years reflect combined survey cycles to improve estimate reliability. The 2020 and 2021 reporting years are based on the 2019–2021 survey cycle, the 2022 and 2023 reporting years are based on the 2021–2023 survey cycle, and the 2024 and 2025 reporting years are based on the 2023–2025 survey cycle.

According to the MCH Jurisdictional Survey, the estimated percentage of children with special health care needs who had a medical home declined across the reporting period. The estimate was 23.8% during the 2020 and 2021 reporting years, decreased to 17.4% during the 2022 and 2023 reporting years, and further declined to 8.2% during the 2024 and 2025 reporting years. During the most recent survey cycle, an estimated 127 of 1,554 children with special health care needs were reported to have a medical home.

It is important to note that all estimates for this measure are marked with an asterisk, indicating that the confidence intervals are wide or the estimates are statistically unstable and should be interpreted with caution. While the data suggest a decline in the proportion of children with special health care needs who receive care within a medical home, the statistical limitations underscore the need for continued monitoring over time. Ensuring that children with special health care needs have access to a coordinated medical home remains a priority for the CNMI MICAH Program, as medical homes play a critical role in improving care coordination, facilitating referrals to specialty services, supporting family-centered care, and promoting better health outcomes for children and their families.

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

The CNMI MCH Title V Program continues to strengthen family engagement and improve care coordination for children and youth with special health care needs (CSHCN) through outreach, peer support, and family leadership activities coordinated by the Family-to-Family Health Information Center (F2F HIC). Supported by Title V, the F2F HIC is staffed by a Family Support Specialist, a Community Health Outreach Worker (CHOW), and trained Parent Leaders who provide family-centered education, resource navigation, and peer support to families of children and youth with special health care needs.

Support is provided through both individualized assistance and group-based activities designed to help families navigate healthcare, educational, and community service systems. During FY2025, the F2F HIC continued to coordinate support groups for families of children with autism spectrum disorder, Down syndrome, attention-deficit/hyperactivity disorder (ADHD), and children who are deaf or hard of hearing (DHH). During the 2024–2025 project year, 15 support group meetings were conducted, with 12 parents and caregivers participating.

A key component of the Family-to-Family program is its network of Parent Leaders, who use their lived experience to

provide peer mentorship, connect families to available resources, and promote family-centered care. During FY2025, all 11 Parent Leaders renewed their Family Leader Agreements, demonstrating continued commitment to supporting families of children and youth with special health care needs. Parent Leaders also participated in outreach activities, advisory groups, and collaborative planning efforts to ensure that family perspectives remain central to program development and service delivery.

In addition to peer support activities, the F2F HIC conducted five community outreach events during FY2025, reaching 610 community members with information on available services, family supports, and resources for children and youth with special health care needs. Many of these outreach activities were implemented in partnership with the Disability Network Partners (DNP), a multidisciplinary coalition of agencies and organizations working to improve services and community inclusion for individuals with disabilities. Through active participation in the DNP, the MICAH Program continues to strengthen interagency collaboration, improve coordination of services, and increase awareness of resources available to children with special health care needs and their families.

These activities support the CNMI's Title V priority of helping parents and caregivers successfully navigate healthcare and community service systems while strengthening family capacity, improving care coordination, and promoting family-centered, comprehensive care for children and youth with special health care needs.

CNMI CSHCN Outreach Activities October 2024 – September 2025

DATE	COMMUNITY OUTREACH EVENTS	FACILITATORS	Community Members Reached
October 2024	Annual PSS Headstart Family Fun Day	CNMI PSS Early Headstart/Headstart Program	57
December 2024	Family Fun Day for International Day of Persons with Disabilities	Disability Network Partners	33
January 2025	CPIC Parent Meetings	CNMI PSS Early Headstart/Headstart Program	109
March 2025	Project Higai	CNMI Division of Youth Services & CNMI PSS Special Education Program	150
April 2025	Autism Awareness Month: Family Fun Day	CHCC Family-to-Family Health Information Center	205
August 2025	Annual Breastfeeding Week	CHCC-WIC Program	56

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

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

The CNMI Family-to-Family (F2F) Health Information Center utilizes the ESM 11.1 measure to assess the extent to which families of children and youth with special health care needs (CYSHCN) are connected to a medical home. A medical home represents a coordinated, family-centered approach to healthcare where children receive accessible, continuous, comprehensive, and culturally responsive care in partnership with their families.

Survey data collected from families served by the CNMI F2F Health Information Center indicate variability in reported access to a medical home between 2021 and 2024. In 2021, 81% of families surveyed (51 out of 63 families) reported that their child had a medical home. In 2023, the percentage decreased to 52% (45 out of 86 families), and in 2024, 41% of families surveyed (45 out of 111 families) reported having a medical home.

The decline in the reported percentage of families identifying a medical home may reflect several contributing factors, including an increase in the number of families served by the F2F program, changes in the population accessing services, healthcare system disruptions, and ongoing challenges related to continuity of care and provider access in the CNMI. Despite these challenges, the F2F Health Information Center continues to support families by providing education, care coordination assistance, referrals, and resources to help families establish and maintain relationships with healthcare providers.

The CNMI F2F Health Information Center survey was not conducted in 2025 due to operational challenges associated with staff turnover and transition. These workforce challenges impacted the program's ability to administer the survey and collect measure data during the reporting period. The program plans to resume survey implementation in 2026 to continue monitoring progress toward improving medical home access and strengthening family-centered systems of care for children and youth with special health care needs.

In addition to monitoring access to a medical home, the CNMI Family-to-Family Health Information Center (F2F HIC) conducted a client satisfaction survey in January 2025 to assess program effectiveness, family experiences, and the extent to which services supported families in navigating healthcare systems, accessing resources, and strengthening care coordination for children and youth with special health care needs (CYSHCN).

Of the 111 active families enrolled in the CNMI F2F HIC, 53 families completed the survey, resulting in a 48% response rate. Overall, survey results demonstrated positive experiences among participating families, with many reporting that the program provided meaningful support, improved access to information and resources, and strengthened their ability to navigate systems of care.

Key findings from the survey included:

- 90% of families reported that information and resources provided through the CNMI F2F HIC were clear and easy to understand.
- 68% of families reported that F2F HIC services improved their understanding of their child's health needs and available supports.
- 72% of families reported that they received the support they needed from the program.
- 82% of families reported that they were very likely to recommend CNMI F2F HIC services to other families of children with special health care needs.

Families also reported accessing a variety of F2F HIC services to support care coordination, advocacy, and family empowerment. The most frequently utilized services included:

- Information and resources: 83.7%
- Parent-to-parent support: 75.5%
- Referral services: 63.7%
- Workshops and educational events: 55.1%
- Advocacy support: 49.0%

These findings demonstrate the continued value of the CNMI F2F HIC in providing family-centered support and helping families of CYSHCN access information, resources, and coordinated services. The results also highlight the importance of maintaining strong family engagement strategies and continued investment in programs that empower families to actively participate in healthcare decision-making and navigate complex systems of care.

In addition to outreach and peer support, the CNMI Family-to-Family Health Information Center (F2F HIC) continued to strengthen family capacity through educational and professional development opportunities for families, caregivers, and professionals serving children and youth with special health care needs (CSHCN). These learning sessions are designed to increase participants' knowledge of available services and resources, strengthen family leadership and advocacy skills, and improve families' ability to effectively partner with healthcare providers, educators, and other professionals involved in their child's care.

During FY2025 (October 2024–September 2025), the F2F HIC hosted seven virtual learning sessions, reaching 289 parents, caregivers, family members, and professionals (see Table Learning Sessions October 2024 – September 2025). Educational topics focused on navigating healthcare and community systems, understanding available supports and services, promoting family-centered care, and strengthening collaboration between families and service providers.

To maximize participation and expand access to education across the Commonwealth, the F2F HIC continued leveraging partnerships with programs across the Division of Public Health Services and external community organizations to deliver both virtual and in-person training opportunities. These collaborative efforts support the MCH Title V priority of helping families successfully navigate complex healthcare and community service systems while strengthening family engagement, care coordination, and partnerships that improve outcomes for children and youth with special health care needs.

Learning Sessions October 2024 – September 2025

Month	Topics	Facilitators	Participants
10/2024	Raising a Child with Down Syndrome	Dr. Patrick Castillon, CNMI F2F HIC Parent Leader	20
11/2024	Early Language & Literacy	PSS Early Intervention Program	26
01/2025	Mental Health 101	Bridget Lizama, CHW CHCC Community Guidance Center	24
02/2025	Family & Youth Engagement Program	CNMI Division of Youth Services	16
04/2025	Understanding Ages & Stages 3 Questionnaire (ASQ-3)	CHCC MICAH Programs, CYSHCN CHWs	14
08/2025	Tips for Back to School	Lynette Villagomez, Principal WSR Elementary School	13
09/2025	Family Friendly Eating	Jessie Willsey, RD CNMI PH Registered Dietician Rachel Aldan, RD WIC Program	176

Source: CNMI F2F Health Information Data

To increase awareness of CYSHCN services and improve cross-sector collaboration, the MCH Title V Program partnered with multiple agencies to provide professional development and educational opportunities for healthcare providers, educators, families, and community partners. These activities promoted a shared understanding of available services, referral pathways, and family-centered approaches to care while strengthening communication across systems.

One major activity during the reporting period was the Autism Family Engagement Workshop, hosted by the Division of Public Health Services (DPHS) MICAH Programs in partnership with the CNMI Public School System (PSS) Special Education Program. More than 70 parents, caregivers, children, educators, and community partners participated in the workshop, which was designed to strengthen family leadership, increase knowledge of autism spectrum disorder (ASD), and promote collaboration between families and service providers.

Workshop participants received education on evidence-based interventions, behavioral supports, and available community resources while also participating in peer networking opportunities. The workshop featured presentations

by Dr. Amanda Hughes, Child Psychologist with the CNMI Public School System, who provided training on evidence-based interventions, including Parent-Child Interaction Therapy (PCIT) and Pivotal Response Treatment (PRT). These interventions have demonstrated effectiveness in improving communication, social engagement, and behavioral outcomes for children with ASD.

A parent panel composed of three parents of children with ASD also shared their lived experiences navigating healthcare, education, and community support systems. The panel provided practical guidance, emotional support, and peer mentorship to participating families while reinforcing the importance of family leadership in improving systems of care.

To promote family participation, the Division of Youth Services (DYS) partnered with the MCH Program to provide childcare and sensory-friendly activities for children attending the workshop. This collaboration reduced participation barriers for families while creating an inclusive environment that supported the diverse developmental needs of participating children.

Building upon the success of this partnership, the CNMI Public School System invited the MCH Title V Family-to-Family Health Information Center (F2F HIC) Parent Leaders to collaborate on the State Personnel Development Grant (SPDG) Project Higai. Project Higai is designed to strengthen educator capacity through sustainable professional development focused on evidence-based practices for students with disabilities.

During FY 2025, F2F Parent Leaders participated in two structured review sessions of the Project Higai online training modules coordinated by the Division of Youth Services Parent Training and Information (PTI) Program. Parent Leaders reviewed training materials addressing autism spectrum disorder and the 13 disability categories recognized under the Individuals with Disabilities Education Act (IDEA), providing recommendations to improve clarity, accessibility, cultural relevance, and usability for CNMI families.

Following completion of the module reviews, Parent Leaders participated in facilitated focus group discussions with the SPDG Project Coordinator and the Progress Center Technical Assistance Team. Feedback from families informed revisions to the online training modules prior to statewide implementation, ensuring that the materials reflected family priorities and were responsive to the needs of parents navigating special education and healthcare systems.

The MCH Title V Program also continued efforts to strengthen provider awareness of CYSHCN resources across all three inhabited islands. During FY 2025, the CSHCN Program Manager conducted outreach visits to the islands of Rota and Tinian to provide professional education for healthcare providers and nurses on services available through the Early Hearing Detection and Intervention (EHDI) Program and the Family-to-Family Health Information Center. These educational sessions increased provider awareness of available referral resources and reinforced coordination between local health centers and specialty services. Additional outreach and training activities are planned during the next reporting period to further strengthen provider capacity and referral networks.

Community outreach activities were also expanded through collaboration between the MCH Community Health Workers (CHWs) and the Early Intervention Program. Outreach teams conducted developmental screening activities on Saipan, Tinian, and Rota using the Ages and Stages Questionnaires (ASQ-3), provided follow-up hearing screening services at local health centers, conducted home visits, and participated in Parent Café events to engage families in discussions regarding child development and available supports. Children identified with developmental concerns through these activities were referred to appropriate diagnostic, early intervention, or specialty services to

promote timely evaluation and intervention.

Collectively, these activities strengthened partnerships among healthcare providers, educational systems, community organizations, and families while advancing a coordinated, family-centered system of care for CYSHCN throughout the Commonwealth. The MCH Title V Program will continue to build on these collaborations during the next reporting period by expanding family leadership opportunities, strengthening provider education, increasing community outreach, and improving coordination across healthcare and educational systems to support improved outcomes for children and families.

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	2020	2021	2022	2023	2024	2025
Percentage	48.9	48.9	43.0	43.0	39.6	39.6
Numerator	282	282	299	299	281	281
Denominator	576	576	695	695	709	709

Data Source: 2020-2021 (2019-2021), 2022-2023 (2021-2023), 2024-2025 (2023-2025) CNMI 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

Data for NPM 12 are obtained from the CNMI MCH Jurisdictional Survey (MCH-JS). To improve the stability of estimates for the CNMI's relatively small population, survey data are combined across two reporting cycles (2019–2021, 2021–2023, and 2023–2025), resulting in the same estimates being reported across paired fiscal years.

Based on the MCH-JS, the percentage of adolescents with special health care needs (CSHCN) who received services necessary to support the transition to adult health care declined across the reporting periods. The estimate decreased from 48.9% during the 2019–2021 survey period to 43.0% during 2021–2023, and further to 39.6% during the 2023–2025 survey period. The corresponding weighted population estimates include 282 of 576 adolescents during the first reporting period, 299 of 695 during the second period, and 281 of 709 during the most recent period.

Although the proportion of adolescents receiving transition services has declined over time, the findings should be interpreted with caution. All estimates are marked with an asterisk, indicating that the confidence intervals are wide or otherwise statistically unstable because of the CNMI's small population size. Consequently, the observed changes may reflect both true variation in access to transition services and normal sampling variability.

Despite these limitations, the data highlight an ongoing need to strengthen transition planning for adolescents with special health care needs as they prepare to move from pediatric to adult-oriented health care systems. During FY 2025, the MCH Title V Program continued to prioritize transition planning through family education, provider collaboration, service coordination, and partnerships with healthcare, education, and community organizations. These efforts are intended to improve transition readiness, increase family awareness of available resources, and strengthen coordinated systems of care to support successful transitions into adulthood.

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

During FY 2025, the CNMI MCH Title V CYSHCN Program continued to strengthen partnerships with organizations

serving individuals with disabilities to improve transition readiness among adolescents with special health care needs. A longstanding collaboration with the Disability Network Partners (DNP), a coalition of agencies and organizations serving individuals with disabilities across the Commonwealth, supported coordinated outreach activities during Developmental Disabilities Awareness Month (DDAM) in March 2025.

As part of this collaboration, the CNMI Family-to-Family (F2F) Health Information Center partnered with the CNMI Center for Living Independently (CLI) to provide transition education for high school students, including adolescents with special health care needs. A total of 51 students from the CNMI Public School System participated in educational sessions focused on preparing youth for the transition from pediatric to adult-oriented health care services.

The sessions emphasized the importance of developing self-advocacy skills, understanding individual health care needs, communicating effectively with healthcare providers, and increasing independence in managing health care as adolescents move into adulthood. To reinforce these concepts, students participated in interactive role-playing activities that simulated real-life healthcare scenarios. These exercises allowed participants to practice communication, decision-making, and problem-solving skills while exploring the evolving roles of youth and caregivers during the transition process.

These activities support the MCH Title V goal of increasing transition readiness by equipping adolescents with the knowledge, confidence, and skills needed to successfully navigate adult health care systems. The partnership between the MCH Title V CYSHCN Program, the Family-to-Family Health Information Center, the Center for Living Independently, and the Public School System continues to strengthen coordinated transition services and expand opportunities for youth with special health care needs to prepare for healthy, independent adulthood.

Evidence Based Strategy Measure 12.1 - Percentage of high school students served by SPED who received information on transition

Year	2021	2022	2023	2024	2025
Percentage	0	4.9	34.4	78.5	71.6
Numerator	0	16	115	205	190
Denominator	322	329	334	261	265

Data Source: CNMI PSS Special Education Program

The CNMI MCH Title V Program uses ESM 12.1 to monitor progress toward improving health care transition readiness among adolescents receiving Special Education services. During FY 2025, 71.6% of high school students enrolled in the CNMI Public School System (PSS) Special Education Program received education and information on health care transition planning. This measure reflects continued efforts to increase awareness of transition services, promote self-advocacy, and prepare youth with disabilities and special health care needs for successful transition to adult-oriented health care, education, employment, and independent living.

To strengthen coordination between the healthcare and education systems, the Commonwealth Healthcare Corporation (CHCC) Division of Public Health Services and the CNMI Public School System executed a Memorandum of Agreement (MOA) in January 2025 to formalize collaboration on transition planning for students with special health care needs. The agreement supports participation by healthcare representatives in high school Individualized Education Program (IEP) transition meetings, ensuring that students' healthcare needs are

incorporated into individualized transition plans and that families receive coordinated guidance as youth prepare for adulthood.

The MCH Title V CYSHCN Program also continued its partnership with the CNMI Public School System to improve access to health care transition resources. During the reporting period, the CYSHCN Program, in collaboration with the Health Promotion and Partnerships Unit, developed and disseminated a culturally appropriate health care transition brochure for students, families, teachers, guidance counselors, and school staff. Adapted from evidence-based resources developed by the Got Transition® National Technical Assistance Center, the brochure provides practical guidance on transition planning, self-management skills, and available community resources to support youth and families throughout the transition process.

To further strengthen local capacity, the CNMI CYSHCN Program continued active participation in the Got Transition® Learning Community, a national collaborative of state and territorial CYSHCN programs dedicated to improving health care transition systems. Through monthly learning sessions, the CNMI shares promising practices, receives technical assistance, and collaborates with other jurisdictions to strengthen transition policies, clinical practices, and performance measurement. During FY 2025, the learning community also worked collaboratively to develop standardized national guidance on health care transition, including a common definition and recommended implementation framework that will support greater consistency across Title V programs nationwide.

These activities support the CNMI MCH Title V Program's ongoing efforts to build sustainable systems that improve transition readiness, strengthen collaboration between healthcare and educational partners, increase family engagement, and ensure that adolescents with special health care needs are equipped with the knowledge, skills, and resources necessary to successfully transition into adult health care and community life.

Other Children with Special Health Care Needs (CSHCN) Activities

MCH Title V funds support developmental screening activities in the CNMI as a key strategy to promote early identification of children with, or at risk for, developmental delays and to connect families with appropriate services and supports. Developmental screening is conducted through the Children’s Clinic during routine well-child visits using the Ages and Stages Questionnaire (ASQ).

In 2025, a total of 1,553 developmental screenings were completed. Of those screened, 578 children (37%) were identified as requiring additional monitoring or further evaluation due to concerns identified through screening results. Children identified with developmental concerns are monitored and receive follow from MCH CHWs or referred to the CNMI Early Intervention Program (Part C) or Early Childhood Special Education Program (Part B) for further assessment and intervention services.

Number of children screened with ASQ and identified as needing monitoring or below developmental cut-off, 2022 – 2025.

Year	Number Screened	Number Identified for monitoring or at below cut-off
2022	1,094	216
2023	1,122	473
2024	1,536	630
2025	1,553	578

Source: CNMI MICAH-CSHCN Program

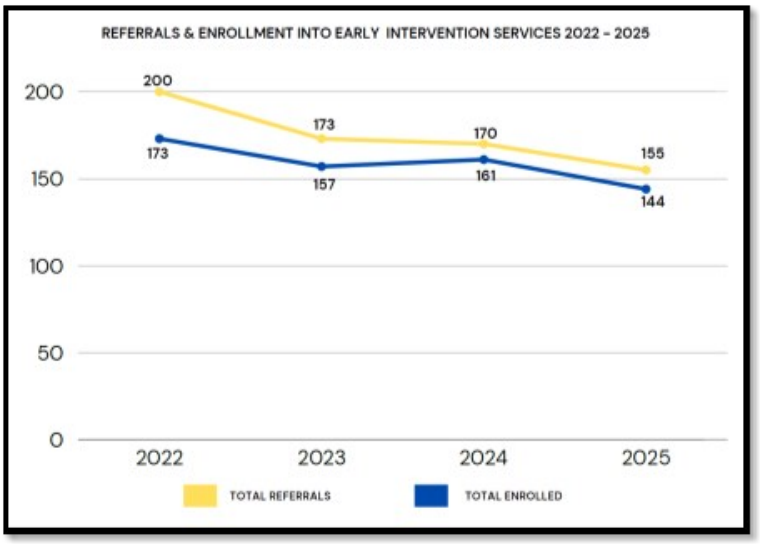
Early Intervention (EI) referral trends remained stable, with continued identification and enrollment of infants and toddlers requiring developmental services. During the 2024–2025 school year, the EI Program served 144 families. Of the children served, 67 infants and toddlers (birth to age three) qualified based on an established medical condition, while 77 were identified with developmental delays requiring early intervention services.

During the same period, 84 infants and toddlers exited the EI Program. Reasons for exiting included transitioning to Early Childhood Special Education (Part B), relocating to the U.S. mainland, or achieving developmental goals and no longer requiring EI services.

In 2025, 82.5% of EI referrals originated from CHCC clinical units, including the Children's Clinic, Nursery, Pediatrics, and Neonatal Intensive Care Unit (NICU). Referrals from CHCC pediatric providers increased from 71% in 2024 to 82.5% in 2025, demonstrating continued strengthening of the partnership between CHCC providers and the MICAH-CSHCN Program. This collaboration supports timely identification, referral, and linkage to developmental services for infants and toddlers who may benefit from early intervention.

Additional EI referrals were received from private clinics, childcare providers, the Early Head Start Program, public health programs such as MIECHV and WIC, and concerned parents.

Referrals to CNMI Early Intervention Services, 2022 - 2025



Source: CNMI Early Intervention Program

Newborn Screening Activities

Newborn screening is a critical public health service that enables early identification of potentially life-threatening or disabling conditions and allows for timely intervention to improve health outcomes. The CNMI MCH Title V Program supports newborn hearing and metabolic (bloodspot) screening activities to ensure that infants receive recommended screenings and follow-up services during the earliest stages of life.

At the Commonwealth Healthcare Corporation (CHCC), all newborns receive recommended screenings prior to hospital discharge. Newborn hearing screenings are completed by Nursery nursing staff, while bloodspot specimens are collected by the CHCC Laboratory and submitted to the Oregon State Public Health Laboratory for analysis.

The CHCC Early Hearing Detection and Intervention (EHDI) Program continues to meet national benchmarks established by the Joint Committee on Infant Hearing (JCIH). In 2025, 99% of infants born in the CNMI received a newborn hearing screening before one month of age. Among infants who did not complete screening within the recommended timeframe, four infants passed away shortly after birth, and one infant was born at home with parents declining all newborn screening services.

Of the 213 infants who required follow-up hearing screening by three months of age, five were lost to follow-up. These infants were born to visiting mothers from China who elected to complete follow-up screening in their home country. The EHDI Program documented all outreach attempts, communication with families, and parental decisions within the infants' electronic health records.

The program continues to prioritize tracking, follow-up, and family engagement efforts to minimize loss to follow-up and ensure infants receive timely diagnostic services and intervention when needed.

CNMI EHDI Data 2022- 2025

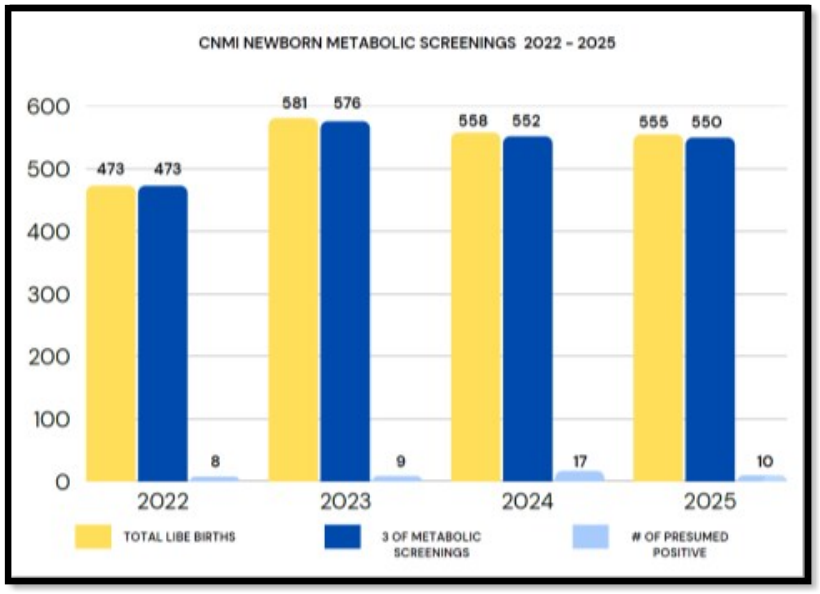
	2022	2023	2024	2025
Births	575	582	558	555
Screened	569	577	552	550
Inpatient Pass	469	414	397	337
Inpatient Refer	100	163	155	213
Outpatient Pass	90	157	149	202
Loss to Follow-Up	5	1	6	5
Refer to DAE	5	5	0	6
DAE with Pass Results	4	0	0	0
Confirmed Hearing Loss	1	2	0	5
Referral to EI	1	2	0	5

Source: CNMI EHDI-IS

The MICAH Program collaborates closely with CHCC Pediatrics and the CHCC Laboratory to ensure newborn bloodspot screening services remain accessible, timely, and uninterrupted. The program assists with tracking

abnormal screening results, coordinating confirmatory testing, and conducting family outreach to reduce loss to follow-up.

CNMI Newborn Bloodspot Screening, 2022-2025



Source: CHCC Carevue & CNMI EHDI-IS

In 2025, of the 555 live births in the CNMI, 99% completed newborn bloodspot screening. When an abnormal screening result is identified, the Oregon Public Health Laboratory promptly notifies Children's Clinic providers and the MICAH Program Coordinator, initiating follow-up activities that may include repeat screening, confirmatory diagnostic testing, or ongoing monitoring through periodic blood testing.

Of the 10 infants who initially screened positive in 2025, all received confirmatory testing and diagnosis and continue to be monitored by their primary care providers. MCH Title V funds support expedited shipment of newborn screening specimens and supplies through FedEx to the Oregon Public Health Laboratory, helping maintain

specimen integrity, timely processing, and uninterrupted newborn screening services for CNMI families.

CSHCN Professional Development

The CNMI Early Hearing Detection and Intervention (EHDI) Program conducted a newborn hearing screening training utilizing the National Center for Hearing Assessment and Management (NCHAM) Newborn Hearing Screening Training Curriculum (NHSTC). The NHSTC provides healthcare professionals and hearing screeners with the knowledge and skills needed to conduct accurate, timely, and effective newborn hearing screenings.

The curriculum focused on essential components of newborn hearing screening, including the importance of early hearing detection, standardized screening protocols, appropriate use and maintenance of screening equipment, accurate documentation, and referral processes for diagnostic evaluation and follow-up services. Training emphasized evidence-based practices that support early identification of hearing loss and timely intervention, which are critical for promoting optimal language development, cognitive outcomes, social-emotional development, and overall child health.

Through this training, CNMI healthcare providers and screening staff strengthened their capacity to deliver high-quality newborn hearing screening services and support coordinated early intervention efforts for infants and families.

To further strengthen the capacity of MICAH-CSHCN staff in their roles as Community Health Workers (CHWs) and Early Intervention service coordinators, staff participated in the Service Coordinator Apprenticeship Training. This evidence-informed training model utilizes competency-based instruction designed to enhance knowledge, skill development, and long-term retention through a combination of classroom learning, experiential activities, field-based practice, reflective learning, and mentorship.

The Service Coordinator Apprenticeship Training consists of eight modules designed to build participant knowledge of Early Intervention systems, family-centered service coordination, and the roles and responsibilities of service coordinators. The training emphasizes collaborative partnerships with families, providers, and community organizations to support coordinated and individualized services for infants and toddlers with developmental delays or disabilities.

The eight training modules included the following key areas:

Module 1: Federal and state policy foundations; Early Intervention organization and operations; family-centered service coordination; and embedding intervention into daily routines.
Module 2: Early Intervention teams; partnerships with agencies and community resources; family rights and procedural safeguards; and documentation and recordkeeping.
Module 3: Primary referral processes; family-centered intake; and initial family contact.
Module 4: Early Intervention evaluation and eligibility determination; child development and learning; exchanging information related to family routines, priorities, and services; and initial and ongoing assessment.
Module 5: Introduction to the Individualized Family Service Plan (IFSP); development of functional outcomes and

program indicators; and strategies, action steps, supports, and services.
Module 6: Embedding intervention within natural environments and daily routines; Florida Embedded Practices and Intervention for Caregivers (FL-EPIC) framework; and caregiver coaching practices.
Module 7: Sharing and summarizing child progress information and responding to developmental progress data.
Module 8: Transition planning processes and collaboration with transition partners.

Through participation in this training, MICAH-CSHCN staff enhanced their ability to provide family-centered coordination, strengthen referral pathways, and support families in navigating Early Intervention and related services.

During the 2024–2025 project year, Shriners Children's Honolulu continued its specialty outreach services in the CNMI, providing access to orthopedic evaluations and follow-up care for children with special health care needs. The outreach program served 100 children with orthopedic concerns and supported access to specialized medical interventions, including surgical care.

Through coordination with Shriners Children's Honolulu, nine CNMI children received needed surgical procedures. In addition, telehealth follow-up services provided ongoing support following surgery, helping families manage recovery, reduce potential complications, and promote improved health outcomes.

Shiners Outreach Clinic to the CNMI October 2024- May 2025

Outreach Date:	Total Patients Served:	
October 2024	**121**	**100 established patients / 21 new referrals**
May 2025	**111**	**80 established patients / 31 new referrals**

Advancing CSHCN Systems of Care Through Collaboration

The CNMI MICAH-CSHCN Program was honored to participate as a presenter at the inaugural CNMI Population Health Summit. In partnership with Dr. Patrick Castillon, a CSHCN Parent Leader, the program highlighted the importance of coordinated systems of care for children and youth with special health care needs across the CNMI. The presentation showcased the collaborative efforts of families, healthcare providers, community partners, and public health programs in strengthening access to services and improving outcomes for children with special health care needs. The session also emphasized the importance of family engagement and cross-sector partnerships in advancing a comprehensive and sustainable system of care throughout the Pacific Islands region.

Improving access to coordinated, family-centered care remains a priority for the CHCC Maternal, Infant, Child, and Adolescent Health (MICAH) Programs. The 2025 CNMI MCH Comprehensive Needs Assessment identified access to care coordination and navigation of healthcare and community services as the highest priority for children and youth with special health care needs (CYSHCN). Families reported ongoing challenges in understanding available resources, navigating multiple service systems, and accessing specialty healthcare, highlighting the need for a more coordinated and integrated system of care.

To improve care coordination, the MICAH CYSHCN Program will continue to strengthen partnerships with pediatric providers, the Early Intervention Program, schools, specialty care providers, and other community organizations. The program also invests in workforce development through professional training and technical assistance to improve providers' understanding of coordinated systems of care and best practices for serving CYSHCN and their families.

The 2025 needs assessment also identified family support and service navigation as continuing areas of need. Families expressed the importance of receiving clear information about available services, assistance navigating healthcare and community resources, and support in coordinating care across multiple agencies. Parent education, caregiver training, and improved access to specialty healthcare were also identified as priorities.

Recognizing that informed and empowered families are essential partners in coordinated care, the CYSHCN Program continues to build family capacity through education, outreach, and individualized support. The program currently employs five Community Health Workers who provide care coordination, resource navigation, and family support services, along with a full-time Family Peer Support Specialist dedicated to strengthening family engagement, connecting families to available resources, and helping parents develop the knowledge and skills needed to effectively advocate for their children.

Improving access to coordinated care and advancing the medical home model remain central strategies for improving health outcomes for CYSHCN in the CNMI. Through continued collaboration with healthcare providers, community partners, and families, the MICAH CYSHCN Program will work to strengthen integrated systems of care, improve access to specialty services, and increase the number of children and youth with special health care needs who receive comprehensive, coordinated, and family-centered care. These efforts support the Universal National Performance Measure on Medical Home and the program's goal of increasing the percentage of CYSHCN who report having a medical home by 2030.

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 accessible care and improving health outcomes for all children and youth, particularly those with special healthcare needs (CSHCN). To achieve this goal, the FY2027 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, and compassionate. It ensures that every child and youth have 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, 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 challenges related to language, 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 and lived experiences.

Evidence Based Strategy Measure (ESM) 5.3: Percent of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).

This Evidence-Based Strategy Measure assesses the adoption of medical home principles among pediatric healthcare providers following participation in medical home training. The measure tracks the number of providers who not only complete training but also implement at least one core component of the medical home model within their clinical practice.

Core components of the medical home model may include:

- Care coordination to improve communication and continuity of care across healthcare providers, specialists, schools, early intervention programs, and community-based services.
- Family engagement by partnering with families in shared decision-making, respecting family priorities, and supporting family-centered care.
- Team-based care through collaboration among physicians, nurses, behavioral health providers, care coordinators, and other professionals to address the comprehensive needs of children and youth with special health care needs (CYSHCN).

Monitoring implementation of these practices provides a meaningful indicator of systems change by measuring how training translates into improvements in clinical care. Rather than measuring participation alone, this ESM evaluates the extent to which providers adopt evidence-based medical home practices that strengthen coordinated, comprehensive, and family-centered care.

Increasing the number of providers implementing medical home components is expected to improve care coordination, strengthen partnerships between families and healthcare providers, enhance communication across service systems, and ultimately increase access to a medical home for children and youth with special health care needs in the CNMI. This measure also helps identify opportunities for additional technical assistance and quality improvement to support sustained implementation of the medical home model across pediatric care settings.

Priority Need 9: Parent training to support transition from pediatric to adult healthcare.

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 2027, October 2026 through September 2027, 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 (CSHCN) 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): Percent of parents who complete transition training.
The CNMI will report on the number of parents of CSHCN that complete training events that are focused on or include a component on healthcare 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

SPM ESM 2.1 - User research (i.e. surveys and focus groups) completed.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective					

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	10	15	20	50	55
Annual Indicator	2.1	34	49.2	91.7	91.7
Numerator	2	32	61	100	100
Denominator	94	94	124	109	109
Data Source	CHCC HUMAN RESOURCES	CHCC HUMAN RESOURCES	CHCC Training Spreadsheet	CHCC Public Health Training Logs	CHCC Public Health Training Logs
Data Source Year	2021	2022	2023	2024	2024
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

A key finding in the 2020 CNMI Maternal and Child Health (MCH) Five-Year Needs Assessment identified the need to strengthen the knowledge and skills of professionals serving maternal and child health populations. 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.

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 FY 2025, the MICAH Programs collaborated with other sections within the Division of Public Health Services to coordinate the annual CHCC Public Health Workforce Development Event, bringing together staff from across all public health programs. This annual professional development event serves as an important opportunity to strengthen the knowledge, skills, and competencies of the public health workforce to support the delivery of high-quality, evidence-based programs and services throughout the Commonwealth.

The 2025 Workforce Development Event featured educational sessions on recent public health policies, ethics in public health practice, mental health, and emerging innovations in oral cancer treatment. These training opportunities were designed to ensure staff remain informed of current public health practices, strengthen professional competencies, and support the Division's commitment to continuous quality improvement.

By investing in workforce development through annual training and professional development opportunities, the Division continues to build organizational capacity while enhancing the quality of care and services provided to individuals and families across the CNMI. Events such as the Workforce Development Event foster collaboration across programs, strengthen the public health workforce's ability to respond to evolving community needs, and support the Division's mission of improving the health and well-being of the populations it serves.

Throughout FY 2025, the CNMI MCH Title V Program continued to collaborate with CHCC leadership and the Division of Public Health Services to strengthen workforce capacity through organizational planning and infrastructure development. Recognizing that a skilled and competent workforce is essential to improving maternal

and child health outcomes, efforts during the year focused on building sustainable systems that support ongoing workforce development rather than relying solely on individual training events.

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.

Building upon the workforce planning activities initiated in FY 2024, the Division continued implementation of its comprehensive Workforce Development Program with technical assistance from national partners. Efforts focused on advancing the Workforce Development Plan, identifying workforce competency needs, and strengthening organizational capacity to provide coordinated professional development opportunities for public health staff across all programs.

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) was 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 FY 2024 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 the organizational procurement department and IT staff to outline system requirements, explore available platforms, and secure funding to support the acquisition and implementation of an LMS. The system is 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.

A major milestone during FY 2025 was the implementation of the Learning Management System (LMS). The Division worked collaboratively with Information Technology, Human Resources, program leadership, and other key stakeholders to launch the system and begin integrating workforce training into a centralized platform. While implementation remains phased and organization-wide adoption is ongoing, the LMS is now operational and is being utilized to assign, manage, and monitor employee training and professional development activities. As implementation continues, the system will expand its capacity to support competency-based workforce development across CHCC and the Division of Public Health Services by linking staff to required trainings based on their roles

and responsibilities while improving the organization's ability to track training completion, certifications, and continuing education activities.

The Learning Management System will improve access to required and elective trainings by linking employees to educational opportunities based on their specific job titles, duties, and responsibilities. In addition, the system will provide comprehensive tracking of completed trainings, pending requirements, certifications, and continuing education activities, allowing supervisors and program managers to better monitor workforce competencies, identify training gaps, and support employee career development. The LMS is also expected to strengthen succession planning and promote investment in developing local public health expertise throughout the CHCC.

Although updated workforce training completion data are not available for FY2025, substantial progress has been made in establishing the infrastructure necessary to support a more coordinated, sustainable, and data-driven approach to workforce development. These systems-level investments will improve the Division's ability to deliver high-quality training, monitor workforce competencies, and ensure staff possess the knowledge and skills necessary to address maternal and child health priorities.

The continued development of the Workforce Development Program and Learning Management System demonstrates the CNMI's commitment to strengthening public health infrastructure and building a resilient workforce capable of responding to the evolving needs of maternal and child health populations. These foundational efforts position the organization to sustain workforce development activities well beyond the current MCH five-year needs assessment cycle while improving the quality and consistency of services delivered to families throughout the Commonwealth.

Based on findings from the 2025 Comprehensive Maternal and Child Health (MCH) Five-Year Needs Assessment, improving communication about available health services and resources across the Commonwealth of the Northern Mariana Islands (CNMI) has emerged as a new priority. Families and providers continue to face challenges navigating the healthcare system, contributing to underutilization of essential services, missed appointments, and delays in accessing timely care. Many community members report difficulty identifying available MCH programs and understanding how to access them, with these challenges further compounded by language barriers, limited health literacy, geographic isolation, and inconsistent dissemination of information across Saipan, Tinian, and Rota.

To address this priority, the CNMI MCH Program will strengthen communication strategies to improve awareness, accessibility, and utilization of preventive, primary, and specialty maternal and child health services. Efforts will focus on delivering clear, culturally and linguistically appropriate information through multiple communication channels to ensure families can easily identify and access available services. Improved communication will enhance health literacy, strengthen connections between healthcare providers and the communities they serve, encourage earlier use of preventive and treatment services, and reduce barriers to care. Collectively, these efforts are expected to improve maternal and child health outcomes, support healthier pregnancies and child development, and promote more equitable access to health services 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, and interviews) to inform the ongoing refinement, expansion, and sustainability of the CNMI Maternal and Child Health (MCH) website.

To support the objective of developing a comprehensive and accessible centralized MCH website by 2030, the CNMI MCH Title V Program is implementing a phased, collaborative, and community-informed approach to design, develop, refine, and sustain a user-friendly online resource hub. The website serves as the program's centralized digital platform, providing families, healthcare providers, community organizations, and other stakeholders with easy access to maternal and child health information, available services, educational resources, and referral information across all MCH population domains.

During FY2026, the program completed the initial planning and development of the website, including stakeholder engagement, content development, resource identification, and user experience planning. The website was soft launched to establish its initial online presence and begin making MCH information and resources available to the public while allowing the program to gather user feedback and identify opportunities for improvement.

In FY2027, the CNMI MCH Title V Program will build upon this foundation by expanding website content, refining navigation and functionality based on user feedback, increasing stakeholder engagement, and strengthening

outreach to promote awareness and utilization of the website. Additional efforts will focus on improving accessibility, expanding available resources, evaluating website performance, and exploring opportunities to integrate the website with existing health information systems to enhance service navigation and care coordination.

The phased approach is outlined below:

Phase 1: Needs Assessment and Stakeholder Engagement (October 2025 – February 2027)
Continue conducting user experience (UX) research through surveys, focus groups, interviews, and website feedback mechanisms to identify information gaps, user preferences, and opportunities to improve website usability.
Continue engaging a multidisciplinary advisory group consisting of public health staff, information technology specialists, healthcare providers, community representatives, and family advocates to guide ongoing website enhancement.
Expand and update the inventory of available MCH programs, services, and community resources to ensure website information remains current and comprehensive.
During FY2027, the program will continue collaborating with internal programs and partner agencies to identify new resources, update existing content, and strengthen coordination across MCH programs. Information gathered will support expansion of the website's resource directory and improve families' ability to navigate available services.

Phase 2: Website Enhancement and Content Expansion (March 2026 – September 2027)
Use findings from ongoing UX research and website analytics to improve website navigation, accessibility, and user experience.
Expand website content to include additional service directories, educational resources, referral information, eligibility guidance, and family-centered materials across all MCH population domains.
During FY2027, the program will continue refining the website's structure, content organization, and search functionality to improve the user experience and ensure families can easily locate relevant health information and services.
The program will also continue assessing opportunities to integrate existing digital resources and health information systems, including Meditech Expanse care coordination functions (e.g., CareCompass), where appropriate, to strengthen referral pathways and improve coordination between public health programs and healthcare providers.
Continue enhancing multilingual content and ensuring website functionality aligns with Americans with Disabilities Act (ADA) accessibility standards.
FY2027 activities will include expanding translated materials, improving readability, and incorporating accessibility best practices to better meet the diverse communication needs of individuals and families throughout the Commonwealth.
Conduct periodic usability testing with families, providers, and community partners to inform continuous website improvements.

Phase 3: Outreach, Promotion, and Partner Engagement (October 2027 – September 2028)
Expand awareness of the MCH website through coordinated outreach with healthcare providers, schools, community organizations, social media, and public health campaigns.
Provide orientation and technical assistance to healthcare providers, public health programs, and community partners to encourage integration of the website into routine referrals, patient education, and service navigation

activities.

Phase 4: Evaluation and Continuous Quality Improvement (October 2028 – September 2030 and Beyond)
Monitor website utilization through web analytics, user satisfaction surveys, and stakeholder feedback to assess performance and identify opportunities for improvement.
Regularly update website content, resources, and functionality to ensure information remains accurate, relevant, and responsive to changing community needs.
Strengthen partnerships and identify sustainable funding opportunities to support long-term maintenance, enhancement, and expansion of the website as the CNMI's centralized maternal and child health resource hub.

Implementation of this strategy is expected to improve awareness of available maternal and child health services and resources throughout the Commonwealth while increasing timely access to accurate, family-centered information. Continued refinement and expansion of the MCH website will strengthen service navigation, improve communication between families and providers, support care coordination, and enhance community engagement across all MCH population domains. Over time, the website will serve as a sustainable public health communication resource that advances the CNMI MCH Title V Program's goals of improving access to care, reducing barriers to services, and improving maternal and child health outcomes throughout the Commonwealth.

Evidence Based Strategy Measure (ESM): Number of unique users accessing the CNMI Maternal and Child Health website.

Monitoring the number of unique users accessing the CNMI Maternal and Child Health (MCH) website provides an important measure of the program's success in increasing awareness and access to maternal and child health information and services. Growth in unique website users reflects the effectiveness of outreach, communication, and stakeholder engagement efforts to connect families, healthcare providers, and community partners with a centralized source of reliable MCH resources.

Tracking website utilization also provides valuable information to guide continuous quality improvement. Website analytics will help the CNMI MCH Title V Program identify patterns in user engagement, evaluate the effectiveness of website content and navigation, and inform future enhancements based on user needs and preferences. As the website continues to expand, increasing the number of unique users will demonstrate progress toward improving access to MCH information, strengthening service navigation, and promoting equitable access to resources for families across the Commonwealth.

III.F. Public Input (Last Modified: FY 2027 Application/FY 2025 Annual Report)

The CNMI MCH Title V Program values meaningful community engagement and ongoing stakeholder collaboration to ensure that program priorities, strategies, and activities are informed by the needs and perspectives of families, healthcare providers, community organizations, and partner agencies. Public input is solicited through multiple communication channels and is incorporated throughout the planning, implementation, and evaluation of the MCH Block Grant.

Multi-Channel Public Engagement
The MCH Title V Program utilizes a variety of approaches to engage stakeholders and encourage public participation. Program information, updates, and maternal and child health resources are shared through the CNMI MCH website, which serves as the program's centralized digital platform for communicating with families, providers, and community partners. Throughout the year, the program also distributes electronic communications and meeting invitations to partner agencies, advisory groups, and community stakeholders to solicit feedback and encourage participation in MCH planning activities.

Stakeholder and Partner Collaboration
The MCH Title V Program actively collaborates with healthcare providers, community organizations, government agencies, and advisory groups to identify emerging needs, review data, and inform program priorities. MCH staff participate in multidisciplinary workgroups, advisory committees, and cross-sector meetings to strengthen coordination, promote shared decision-making, and ensure that diverse perspectives are reflected in program planning and implementation.

Regular collaboration with pediatric, obstetric, family medicine, and other clinical providers supports ongoing assessment of maternal and child health needs while strengthening referral pathways, care coordination, and implementation of evidence-based strategies.

Community Outreach and Awareness
The program participates in community outreach events and health promotion activities throughout the year to increase awareness of available maternal and child health services and to gather feedback directly from community members. Events such as the Red Cross Walk-a-Thon, Safe Jamboree, Adolescent Health Awareness Month activities, and other public health outreach initiatives provide opportunities to share program accomplishments, educate families about available resources, and engage residents in discussions about community health priorities.

Transparency and Accessibility
To promote transparency and increase public access to program information, the CNMI MCH Title V Program publishes an executive summary of the annual Title V application and other key program updates on the CNMI MCH website. Given the length and technical nature of the full Title V application, the executive summary provides an accessible overview of program priorities, performance measures, and planned activities. The full application is shared electronically with partner agencies and other interested stakeholders, and opportunities for public comment are provided throughout the year. Contact information for the Title V Project Director is made available to encourage ongoing feedback and strengthen community-informed planning.

Through these activities, the CNMI MCH Title V Program promotes continuous stakeholder engagement, transparent communication, and collaborative decision-making to ensure that maternal and child health programs remain responsive to the evolving needs of children, families, and communities throughout the Commonwealth.

III.G. Technical Assistance (Last Modified: FY 2027 Application/FY 2025 Annual Report)

The CNMI MCH Title V Program values the ongoing technical assistance provided by the Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA/MCHB), the Association of Maternal & Child Health Programs (AMCHP), and other national partners. As a small island jurisdiction with limited workforce and specialized resources, the CNMI continues to benefit from technical assistance that strengthens program capacity, supports implementation of evidence-based and evidence-informed strategies, and advances maternal and child health outcomes throughout the Commonwealth.

During FY2027, the CNMI MCH Title V Program will continue implementing priorities identified through the 2025 Comprehensive Five-Year Needs Assessment and seeks technical assistance in several key areas.

A primary priority is continued support for the enhancement of the CNMI MCH website, which serves as the program's centralized digital platform for communicating with families, healthcare providers, and community partners. Technical assistance is requested to strengthen user-centered website design, multilingual communication, accessibility in accordance with Americans with Disabilities Act (ADA) standards, website analytics, search engine optimization, and strategies for evaluating user engagement and utilization. Guidance in these areas will support continuous quality improvement and ensure the website remains an effective resource for connecting families to maternal and child health services and information.

The CNMI also seeks technical assistance to strengthen systems of care for children and youth with special health care needs (CYSHCN). Priority areas include implementation of the medical home model, development of coordinated systems of care, family-centered care coordination, transition planning from pediatric to adult healthcare, and strategies to improve access to specialty services. Given the Commonwealth's geographic isolation and limited availability of pediatric subspecialists, technical assistance that supports innovative and sustainable models of care is particularly valuable.

The program also requests support to enhance family partnership, community engagement, and health literacy. Technical assistance related to meaningful family engagement, culturally and linguistically appropriate communication, and community-informed program planning will strengthen the program's ability to increase awareness, accessibility, and utilization of available MCH services while ensuring that family voices continue to inform program development and evaluation.

As the program continues to strengthen its performance management system, additional technical assistance is requested in the areas of performance measurement, program evaluation, and data utilization. Support in developing meaningful Evidence-based Strategy Measures (ESMs), applying data visualization techniques, interpreting website and program performance metrics, and integrating continuous quality improvement methodologies will enhance the program's ability to monitor progress, demonstrate impact, and inform decision-making.

The CNMI also welcomes technical assistance focused on improving access to specialty healthcare services through innovative approaches such as telehealth, regional partnerships, and coordinated referral systems. Strengthening these models will help reduce geographic barriers to care for families residing on Saipan, Tinian, and

Rota and improve access to specialty maternal and pediatric services that are not consistently available within the Commonwealth.

Finally, the program seeks continued support for workforce development and leadership capacity building. Technical assistance related to workforce planning, leadership development, quality improvement, implementation science, succession planning, and evidence-based public health practice will help strengthen organizational capacity and support the long-term sustainability of maternal and child health programs in the CNMI.

The CNMI MCH Title V Program greatly values its partnerships with HRSA/MCHB, AMCHP, and national technical assistance providers. Continued collaboration will strengthen local capacity, foster innovation, and support implementation of effective, family-centered, and data-informed strategies that improve the health and well-being of women, children, youth, children and youth with special health care needs, and families throughout the Commonwealth.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MOU wih Medicaid_2023 (1).pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MICAH ORGANIZATIONAL CHART (3).pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Northern Mariana Islands

	FY 27 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	$ 151,087	(30.8%)
B. Children with Special Health Care Needs	$ 151,284	(30.9%)
C. Title V Administrative Costs	$ 43,818	(9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 346,189	
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)	$ 411,605	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 411,605	
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)	$ 900,605	
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)	$ 8,368,881	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 9,269,486	

OTHER FEDERAL FUNDS	FY 27 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM)	$ 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	$ 116,029
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,658,857
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	$ 188,895
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 5,775,100

	FY 25 Annual Report Budgeted		FY 25 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 490,000 (FY 25 Federal Award: $ 491,181)		$ 473,159	
A. Preventive and Primary Care for Children	$ 149,378	(30.5%)	$ 146,304	(30.9%)
B. Children with Special Health Care Needs	$ 149,140	(30.4%)	$ 148,438	(31.3%)
C. Title V Administrative Costs	$ 43,818	(8.9%)	$ 43,909	(9.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 342,336		$ 338,651	
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)	$ 417,385		$ 417,381	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 417,385		$ 417,381	
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)	$ 907,385		$ 890,540	
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)	$ 8,364,630		$ 6,127,490	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 9,507,015		$ 7,018,030	

OTHER FEDERAL FUNDS	FY 25 Annual Report Budgeted	FY 25 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN	$ 96,750	$ 74,234
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,123,516	$ 1,010,370
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 175,000	$ 0
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 200,000	$ 180,046
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 6,669,364	$ 4,465,599
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM)		$ 113,556
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs		$ 183,685

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2025**
	Column Name:	**Annual Report Expended**

Field Note:
PRAMS expenditure not reported because this program has been transitioned under the Data, Surveillance and Performance Management Unit and no longer under the MICAH Unit and the direct supervision of the MICAH Programs Administrator.

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 27 Application Budgeted	FY 25 Annual Report Expended
1. Pregnant Women	$ 57,656	$ 51,608
2. Infants < 1 year	$ 57,655	$ 51,608
3. Children 1 through 21 Years	$ 151,087	$ 146,304
4. CSHCN	$ 151,284	$ 148,438
5. All Others	$ 27,500	$ 31,292
Federal Total of Individuals Served	$ 445,182	$ 429,250

IB. Non-Federal MCH Block Grant	FY 27 Application Budgeted	FY 25 Annual Report Expended
1. Pregnant Women	$ 63,616	$ 69,032
2. Infants < 1 year	$ 63,616	$ 69,031
3. Children 1 through 21 Years	$ 158,372	$ 161,963
4. CSHCN	$ 126,001	$ 117,355
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 411,605	$ 417,381
Federal State MCH Block Grant Partnership Total	$ 856,787	$ 846,631

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 27 Application Budgeted	FY 25 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	$ 242,706	$ 238,618
3. Public Health Services and Systems	$ 246,294	$ 234,541
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	$ 473,159

IIB. Non-Federal MCH Block Grant	FY 27 Application Budgeted	FY 25 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	$ 389,712	$ 396,531
3. Public Health Services and Systems	$ 21,893	$ 20,850
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	$ 411,605	$ 417,381

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: 555 **Data Source Year: 2025**

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	550 (99.1%)	5	5	5 (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	Duchenne Muscular Dystrophy (DMD)	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Guanidinoacetate Methyltransferase (GAMT) Deficiency
Hearing Loss	Holocarboxylase Synthase Deficiency	Homocystinuria	Infantile Krabbe Disease (Low Galactocerebrosidase [GALC] And Psychosine >= 10Nm)	Isovaleric Acidemia
Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Metachromatic Leukodystrophy (MLD)	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	550 (99.1%)	6	5	5 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The CNMI Early Hearing Detection and Intervention (EHDI) Program conducts ongoing follow-up for infants with a confirmed diagnosis of hearing loss through close coordination with the CNMI Early Intervention (EI) Program, audiologist, and family support services. Once a diagnosis is confirmed, infants are continuously monitored beyond the point of referral to ensure timely access to and engagement in appropriate services. The CNMI EHDI Program tracks each child through the continuum of care, including diagnosis, amplification (if applicable), and enrollment in early intervention.

For newborns identified through the Newborn Metabolic Screening Program, ongoing follow-up is conducted in coordination with the infant's primary care provider (PCP). Infants with confirmed or suspected metabolic conditions are regularly monitored by their PCP to ensure appropriate management and continuity of care.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2025**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Total number of Live birth count for reporting year	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2025**
	Column Name:	**Data Source Year Notes**
	Field Note: CHCC Health and Vital Statistics Office (HVSO)	

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 2025

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	549	59.0	0.0	15.0	26.0	0.0
2. Infants < 1 Year of Age	555	60.0	0.0	14.0	26.0	0.0
3. Children 1 through 21 Years of Age	6,569	50.0	0.0	13.0	20.0	17.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,092	0.0	0.0	0.0	0.0	100.0
4. Others	8,532	42.0	0.0	22.0	26.0	10.0
Total	16,205					

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	557	Yes	557	100.0	557	549
2. Infants < 1 Year of Age	556	Yes	556	100.0	556	555
3. Children 1 through 21 Years of Age	17,233	Yes	17,233	100.0	17,233	6,569
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,910	Yes	1,910	100.0	1,910	1,092
4. Others	33,096	Yes	33,096	25.8	8,539	8,532

^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:	**2025**
	Field Note: Total number of women who gave birth during the reporting year (excluding tourist)	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2025**
	Field Note: Total number of live births during the reporting year	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2025**
	Field Note: Total number of Children ages 1-21 who visited CHCC in 2025.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2025**
	Field Note: SPED Student data (SY 2025-2026)	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2025**
	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 reporting year	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2025**
	Field Note: MCH Title V supported services that impacted pregnant in the CNMI includes care coordination and navigation, referrals, support for completing Medicaid applications and access to expedited application processing, social media promotion targeting prenatal women, outreach and educational exhibits, training for nursing and other providers, and newborn baby and postpartum packets distributed after birth and prior to discharge.	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2025**
	Field Note: MCH Title V supported services that impacted infants in the CNMI includes care coordination and navigation, referrals, support for completing Medicaid applications and access to expedited application processing, social media promotion targeting families with infants, outreach and educational exhibits, access to newborn screenings services, training for nursing and other providers, and newborn baby and postpartum packets distributed after birth and prior to discharge.	
3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2025**
	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 Total % Served**
	Fiscal Year:	**2025**
	Field Note: The percentage reached in this population reflects the infants and children with special healthcare needs 0-21 years and their families who access services at CHCC locations, including service coordination and navigation, Peer Support, parent training, information and education made available via our social media and other campaign promotions, as well as through nursing or provider support where training, capacity building and other cross cutting systems support were provided by the CNMI MCH Title V Program/Title V funds.	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2025**
	Field Note: This percentage includes unduplicated males and females > 21 years old, who visited Family Care Clinic, Family Planning Mobile Clinic and Women's Clinic in year 2025. It also includes those within these groups that accessed informational and educational information via social media, educational outreach activities, etc.	

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.	Others, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

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

State: Northern Mariana Islands

Annual Report Year 2025

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	549	4	0	1	0	242	188	113	1
Title V Served	549	4	0	1	0	242	188	113	1
Eligible for Title XIX	326	0	0	0	0	91	154	80	1
2. Total Infants in State	555	4	0	1	0	243	192	114	1
Title V Served	555	4	0	1	0	243	192	114	1
Eligible for Title XIX	331	0	0	0	0	91	158	81	1

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2025**
	Column Name:	**Total**
	Field Note: Unduplicated count of deliveries by race/ethnicity to pregnant women served by Title V in 2025	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2025**
	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.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2025**
	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 2025	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2025**
	Column Name:	**Total**
	Field Note: Unduplicated count of infants who received services by the State’s Title V program during the reporting period.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2025**
	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.	
6.	**Field Name:**	**2. Eligible for Title XIX**

Fiscal Year:	**2025**
Column Name:	**Total**

Field Note:
Unduplicated number of newborns who were eligible for State's Title XIX (Medicaid) program.

Form 7
Title V Program Workforce

State: Northern Mariana Islands

Form 7 was last revised in FY 2027 Application/FY 2025 Annual Report

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	6.30
1a. Total Number of FTEs (State Level)	6.30
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
4. Total Number of Current Vacant FTEs	1.25
4a. Total Number of Vacant MCH Epidemiology FTEs	0
5. Total Number of FTEs onboarded in the past 12 months	0.65

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:

1.	**Field Name:**	**Total Number of FTEs (State Level)**
	Field Note: 6.59% FTEs including current vacancies	
2.	**Field Name:**	**Total Number of Current Vacant FTEs**
	Field Note: Vacant: Community Health Outreach Worker I at 50% FTE Vacant: Adolescent & Reproductive Health Program Manager at 25% FTE Vacant: MICAH Administrative Specialist at 50% FTE	
3.	**Field Name:**	**Total Number of FTEs onboarded in the past 12 months**
	Field Note: Family Planning Clinical Coordinator at 15% FTE on boarded on November 2025. MICAH Community Health Outreach Worker I at 50% FTE on boarded on December 2025.	
4.	**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.	
5.	**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 of Public Health Services
Address 1	1178 Hinemlu Street 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 Street Garapan
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 234-8950
Extension	2025
Email	shiella.deray@chcc.health

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

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 Street 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 – Application Year

State: Northern Mariana Islands

Application Year 2027

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 9 State Priorities – Needs Assessment Year – 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 10
National Outcome Measures (NOMs)

State: Northern Mariana Islands

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

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	
	2025
Annual Indicator	396.4
Numerator	22
Denominator	555
Data Source	HVSO
Data Source Year	2025

NOM SMM - Notes:

Numerator: # of delivery hospitalizations with an indication of severe morbidity
Denominator: # of live births in the year

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
2020_2024	NR	NR	NR	NR
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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	0.0
Numerator	0
Denominator	555
Data Source	HVSO
Data Source Year	YEAR

NOM MM - Notes:

Numerator - 0 no maternal mortality this year
Denominator - Number of live birth deliveries

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
2024	13.4	2.4	31	2,308
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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	16.7
Numerator	38
Denominator	2,274
Data Source	HVSO / IDB
Data Source Year	2025

NOM TB - Notes:

Numerator: Number of births to adolescents, ages 15 through 19 years

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023_2025	11.3 %	1.6 %	1,542	13,620
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

This measure captures the percent of children, aged 0 through 17 years, who are reported to have weighed less than 2,500 grams at birth, which differs from the definition in the Block Grant guidance detail sheets. It does not represent the incidence of low birth weight in the reporting year. See All FAD - Jurisdiction NOM Data Notes for more details.

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2024	7.5 %	1.1 %	42	557
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

State Provided Data	
	2025
Annual Indicator	8.8
Numerator	49
Denominator	555
Data Source	HVSO
Data Source Year	2025

NOM LBW - Notes:

LBW - less than 2500 grams

Data Alerts: None

NOM - Percent of preterm births (<37 weeks gestation) - PTB

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023_2025	15.5 %	2.0 %	2,117	13,620
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

This measure captures the percent of children, aged 0 through 17 years, who are reported to have been born more than 3 weeks before the due date (<37 weeks), which differs from the definition in the Block Grant guidance detail sheets. It does not represent the incidence of preterm birth in the reporting year. See All FAD - Jurisdication NOM Data Notes for more details.

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2024	7.6 %	1.1 %	42	556
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

State Provided Data	
	2025
Annual Indicator	11.2
Numerator	62
Denominator	555
Data Source	HVSO
Data Source Year	2025

NOM PTB - Notes:

Numerator: # of live births before 37 weeks of complete gestation

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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	9.0
Numerator	5
Denominator	555
Data Source	HVSO
Data Source Year	2025

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	17.3	5.0	12	694
2018	22.5	6.3	13	579
2017	32.0	9.4	12	375
2016	23.5	7.5	10	426
2015	NR	NR	NR	NR
2014	20.8	6.4	11	528

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a confidence interval width >160% times the estimate and should be interpreted with caution

In 2025, NCHS expanded the definition of perinatal mortality to include all fetal deaths with stated or presumed gestation of 20 weeks or more. All historical data have been updated to account for the expanded definition.

State Provided Data

	2025
Annual Indicator	16.2
Numerator	9
Denominator	555
Data Source	HVSO
Data Source Year	2025

NOM PNM - Notes:

None

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
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
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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	14.4
Numerator	8
Denominator	555
Data Source	HVSO
Data Source Year	2025

NOM IM - Notes:

None

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
2023	NR	NR	NR	NR
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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	10.8
Numerator	6
Denominator	555
Data Source	HVSO
Data Source Year	2025

NOM IM-Neonatal - Notes:

None

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
2023	NR	NR	NR	NR
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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	14.4
Numerator	8
Denominator	555
Data Source	HVSO
Data Source Year	2025

NOM IM-Postneonatal - Notes:

None

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	
	2025
Annual Indicator	360.4
Numerator	2
Denominator	555
Data Source	HVSO
Data Source Year	2025

NOM IM-Preterm Related - Notes:

None

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
2023	NR	NR	NR	NR
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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	540.5
Numerator	3
Denominator	555
Data Source	HVSO
Data Source Year	2025

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.

State Provided Data	
	2025
Annual Indicator	1.8
Numerator	1
Denominator	555
Data Source	CareVue
Data Source Year	2025

NOM NAS - Notes:

None

Data Alerts: None

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
2023_2025	23.8 %	2.2 %	3,087	12,987
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

This measure definition is identical to the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdication NOM Data Notes for more details.

State Provided Data	
	2025
Annual Indicator	0.5
Numerator	27
Denominator	5,579
Data Source	CareVue EHR
Data Source Year	2025

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
2024	NR	NR	NR	NR
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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	0.0
Numerator	0
Denominator	6,501
Data Source	HVSO / IDB
Data Source Year	2025

NOM CM - Notes:

None

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
2024	NR	NR	NR	NR
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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	22.9
Numerator	2
Denominator	8,733
Data Source	HVSO
Data Source Year	2025

NOM AM - Notes:

None

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
2022_2024	NR	NR	NR	NR
2021_2023	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data

	2025
Annual Indicator	0.0
Numerator	0
Denominator	4,953
Data Source	HVSO
Data Source Year	2025

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**
2022_2024	NR	NR	NR	NR
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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	11.5
Numerator	1
Denominator	8,733
Data Source	HVSO
Data Source Year	2025

NOM AM-Suicide - Notes:

None

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
2022_2024	NR	NR	NR	NR
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 confidence interval width >160% times the estimate and should be interpreted with caution

State Provided Data	
	2025
Annual Indicator	11.5
Numerator	1
Denominator	8,733
Data Source	HVSO / U.S. CENSUS INTERNATIONAL DATABASE (IDB)
Data Source Year	2025

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
2023_2025	6.5	2.0	453	6,916
2021_2023	6.8	1.9	555	8,178
2019_2021	3.3	1.1	313	9,440

Legends:

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

This measure captures the percent of children, aged 0 through 9 years, that were admitted to a hospital for an injury in the past year. Estimates may not be comparable between years 2019 and 2021 and beyond for AS, GU, PW, VI due to an earlier version of the question. Both definitions are different from the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdication NOM Data Notes for more details.

State Provided Data	
	2025
Annual Indicator	301.7
Numerator	22
Denominator	7,292
Data Source	CAREVUE
Data Source Year	2025

NOM IH-Child - Notes:

22 children age 0-9 yrs were hospitalize in year 2025

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
2023_2025	4.8	1.8	325	6,704
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

This measure captures the percent of adolescents, aged 10 through 17 years, that were admitted to a hospital for an injury in the past year. Estimates may not be comparable between years 2019 and 2021 and beyond for AS, GU, PW, VI due to an earlier version of the question. Both definitions are different from the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdication NOM Data Notes for more details.

State Provided Data

	2025
Annual Indicator	91.6
Numerator	8
Denominator	8,733
Data Source	CareVue
Data Source Year	2025

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
2023_2025	50.9 %	3.0 %	5,077	9,972
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

MCH-JS data for this measure are reported by the biological mother, aged 18 through 44 years, of the sampled child. This measure captures the percent of children, aged 0 through 17 years, whose biological mother reported being in excellent or very good health, which differs from the definition in the Block Grant guidance detail sheets. See All FAD - Jurisdication NOM Data Notes for more details.

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
2023_2025	78.1 %	2.2 %	10,636	13,620
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

This measure definition is identical to the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdication NOM Data Notes for more details.

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: MCH Jurisdictional Survey (MCH-JS) - Age 10-17

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023_2025	24.9 %	2.9 %	1,668	6,704
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

This measure captures the percent of children, aged 10 through 17 years, who are obese based on respondent-reported height and weight, which differs from the definition in the Block Grant guidance detail sheet.

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

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms - PPD

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

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

State Provided Data	
	2025
Annual Indicator	2.0
Numerator	11
Denominator	555
Data Source	CAREVUE / HVSO
Data Source Year	2025

NOM PPD - Notes:

CareVue = Numerator
HVSO = Denominator

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

State Provided Data

	2025
Annual Indicator	0.0
Numerator	0
Denominator	555
Data Source	CAREVUE / HVSO
Data Source Year	2025

NOM PPA - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disorder - BCD

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023_2025	1.3 %	0.7 %	58	4,367
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

This measure definition is identical to the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdiction NOM Data Notes for more details.

State Provided Data

	2025
Annual Indicator	0.3
Numerator	11
Denominator	4,168
Data Source	CareVue / IDB
Data Source Year	2025

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
2023_2025	5.0 %	1.6 %	268	5,323
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

This measure definition is identical to the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdiction NOM Data Notes for more details.

State Provided Data	
	2025
Annual Indicator	0.5
Numerator	27
Denominator	5,269
Data Source	CareVue / International Data Base
Data Source Year	2025

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
2023_2025	0 %	0	0	1,523
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

The components of the well-functioning system of care indicator are different from the definition in the Block Grant guidance detail sheet: 1) family partnership is not included; 2) frustration getting services is only included in estimates for PR and VI; 3) preventive dental care was replaced by any dental care; and 4) beginning with round 4, adequate insurance for AS, FM, and MH only refers to reasonable costs.

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:

Data is currently unavailable. The CNMI is exploring data sources and will provide updates on this measure in the next report.

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:

Data is currently unavailable. The CNMI is exploring data sources and will provide updates on this measure on the next report.

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:

Data is currently unavailable. The CNMI is exploring data sources and will provide updates on this measure on the next report.

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:

Data is currently unavailable as of reporting time. The CNMI is currently exploring data sources and will provide a report on the his measure on the next reporting period.

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: MCH Jurisdictional Survey (MCH-JS)			
	2023	**2024**	**2025**
Annual Objective			
Annual Indicator	75.1	82.4	82.4
Numerator	411	1,007	1,007
Denominator	548	1,222	1,222
Data Source	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2024	2021_2023	2021_2023

The measure captures the percent of children aged 0-1 years whose biological mother had a regular checkup 12 weeks after giving birth, which differs from the definition in the Block Grant guidance. See the All FAD Jurisdiction NPM data notes for more details.

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2023	**2024**	**2025**
Annual Objective			
Annual Indicator	56.0	56.0	56.0
Numerator	250	308	308
Denominator	447	550	550
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2022	2023	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	60.0	62.0	64.0	66.0	68.0

Field Level Notes for Form 10 NPMs:

None

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**	**2025**
Annual Objective			
Annual Indicator	67.0	63.3	63.3
Numerator	167	188	188
Denominator	249	296	296
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2022	2023	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	65.0	67.0	69.0	71.0	73.0

Field Level Notes for Form 10 NPMs:

None

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	**2025**
Annual Objective		
Annual Indicator	62.6	62.6
Numerator	340	340
Denominator	544	544
Data Source	PRAMS	PRAMS
Data Source Year	2023	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	65.0	66.0	67.0	68.0	69.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**

Field Note:
Transitioning to Meditech EHR in fall 2026, replacing the current Medsphere CareVue

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

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	97	98	98	98	98
Annual Indicator	88.2	88.2	89.4	88.7	91.0
Numerator	5,434	5,434	3,555	4,494	3,574
Denominator	6,158	6,158	3,976	5,067	3,930
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2021	2021	2024	2021_2023	2023_2025

This measure captures the percent of children, aged 0 through 5 years, who are reported to have ever been breastfed or received breast milk, which differs from the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdication NPM Data Notes for more details.

Federally Available Data			
Data Source: National Vital Statistics System (NVSS)			
	2023	**2024**	**2025**
Annual Objective	98	98	98
Annual Indicator	95.7	96.5	94.8
Numerator	440	557	527
Denominator	460	577	556
Data Source	NVSS	NVSS	NVSS
Data Source Year	2022	2023	2024

State Provided Data					
	2021	2022	2023	2024	2025
Annual Objective	97	98	98	98	98
Annual Indicator	93.7	94.9	93.1	93.5	90.3
Numerator	539	449	541	522	501
Denominator	575	473	581	558	555
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	2021	2022	2023	2024	2025
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	91.0	92.0	93.0	94.0	95.0

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	

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					
	2021	2022	2023	2024	2025
Annual Objective	5	6	6	13	15
Annual Indicator	0	0.5	11.1	11.6	10.1
Numerator	0	2	47	52	48
Denominator	419	411	424	448	473
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2021	2022	2023	2024	2025
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.	

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	55	57	59	61	63
Annual Indicator	43.5	43.5	60.7	51.3	59.6
Numerator	2,393	2,393	2,775	2,584	2,601
Denominator	5,498	5,498	4,572	5,035	4,367
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2021	2021	2024	2021_2023	2023_2025

This measure definition is identical to the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdication NPM Data Notes for more details.

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:

None

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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	43	46	49	35	55
Annual Indicator	39.3	39.3	27.3	33.5	28.9
Numerator	2,156	2,156	1,386	1,771	1,539
Denominator	5,493	5,493	5,072	5,282	5,323
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2021	2021	2024	2021_2023	2023_2025

This measure definition is identical to the definition in the Block Grant guidance detail sheet. See All FAD - Jurisdication NPM Data Notes for more details.

State Provided Data					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	43	46	49	35	55
Annual Indicator	22	12.1	16.6	6.9	8
Numerator	1,378	749	998	390	419
Denominator	6,256	6,177	5,994	5,661	5,269
Data Source	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue EHR	CareVue EHR	CareVue EHR
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	10.0	11.0	12.0	13.0	14.0

Field Level Notes for Form 10 NPMs:

1.	**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

2.	**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

3.	**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)

4.	**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)

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	19	15	18	15	25
Annual Indicator	14.1	14.1	12.5	17.4	8.2
Numerator	176	176	138	290	127
Denominator	1,252	1,252	1,101	1,666	1,554
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2021	2021	2024	2021_2023	2023_2025

The effective care coordination sub-component is modified from the NSCH definition such that satisfaction with communication among the child's doctors and school, child care provider, or special education program is not included because the question was not asked in the survey. Caution should be used when comparing jurisdiction estimates to national or other state estimates because of the different measure definition. See All FAD - Jurisdication NPM Data Notes for more details.

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:

None

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**	**2025**
Annual Objective			
Annual Indicator	8.9	13.4	7.9
Numerator	1,208	2,060	1,077
Denominator	13,620	15,385	13,620
Data Source	MCH-JS-All Children	MCH-JS-All Children	MCH-JS-All Children
Data Source Year	2024	2021_2023	2023_2025

The effective care coordination sub-component is modified from the NSCH definition such that satisfaction with communication among the child's doctors and school, child care provider, or special education program is not included because the question was not asked in the survey. Caution should be used when comparing jurisdiction estimates to national or other state estimates because of the different measure definition. See All FAD - Jurisdication NPM Data Notes for more details.

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:

None

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	52	55	58	72	74
Annual Indicator	32.8	32.8	70.7	43.0	39.7
Numerator	167	167	322	299	281
Denominator	511	511	455	695	709
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2021	2021	2024	2021_2023	2023_2025

The ‘time spent alone with the health care provider’ is not captured in this measure because it was not asked in the survey. The 'anticipatory guidance' component of transition care used the 2016 and 2017 wording from the NSCH and asked, "Have they talked with you about having this child eventually see doctors or other health providers who treat adults?" See All FAD - Jurisdication NPM Data Notes for more details.

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:

None

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: MCH Jurisdictional Survey (MCH-JS)		
	2024	**2025**
Annual Objective		
Annual Indicator	20.5	25.0
Numerator	1,084	1,330
Denominator	5,282	5,323
Data Source	MCH-JS-All Adolescents	MCH-JS-All Adolescents
Data Source Year	2021_2023	2023_2025

This measure captures adolescents aged 12 through 17 years who are reported to have ever been physically bullied on school property or electronically bullied, which differs from the definition in the Block Grant guidance detail sheet given the question is from YRBSS but the denominator is the same as the NSCH denominator. See All FAD - Jurisdication NPM Data Notes for more details.

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2024	**2025**
Annual Objective		
Annual Indicator	22.9	22.9
Numerator	718	718
Denominator	3,143	3,143
Data Source	YRBSS	YRBSS
Data Source Year	2023	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 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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	57	59	61	63	65
Annual Indicator	57.1	57.1	54.5	56.0	58.6
Numerator	7,415	7,415	5,531	6,473	5,846
Denominator	12,993	12,993	10,143	11,568	9,972
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2021	2021	2024	2021_2023	2023_2025

MCH-JS data for this measure are reported by the biological mother, aged 18 through 44 years, of the sampled child. This measure captures the percent of children, aged 0 through 17 years, whose biological mother reported visiting a doctor for a routine checkup in the past year, which differs from the definition in the Block Grant guidance detail sheets. See All FAD - Jurisdication SM Data Notes for more details.

State Provided Data					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	57	59	61	63	65
Annual Indicator	65.4	53.1			
Numerator	5,047	4,057			
Denominator	7,717	7,641			
Data Source	CHCC EHR/RPMS Preventive visits	CHCC CareVue EHR Preventive Visits			
Data Source Year	2021	2022			
Provisional or Final ?	Provisional	Provisional	Provisional		

Field Level Notes for Form 10 NPMs:

1.	**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.	
2.	**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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	53	70	72	65	75
Annual Indicator	67	61.7	61.1	67.6	75
Numerator	383	290	333	338	382
Denominator	572	470	545	500	509
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	76.0	77.0	78.0	79.0	80.0

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:**	**2025**
	Column Name:	**State Provided Data**
	Field Note: Transitioning to new data source in November 2026 to Meditech Expanse EHR	

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

SPM 3 - Percent of CNMI WIC infants breastfed at 6 months.

Measure Status:	Active

State Provided Data	
	2025
Annual Objective	
Annual Indicator	41.6
Numerator	197
Denominator	473
Data Source	CNMI WIC PROGRAM
Data Source Year	2025
Provisional or 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 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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	10	15	20	50	55
Annual Indicator	2.1	34	49.2	91.7	91.7
Numerator	2	32	61	100	100
Denominator	94	94	124	109	109
Data Source	CHCC HUMAN RESOURCES	CHCC HUMAN RESOURCES	CHCC Training Spreadsheet	CHCC Public Health Training Logs	CHCC Public Health Training Logs
Data Source Year	2021	2022	2023	2024	2024
Provisional or Final ?	Provisional	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.	
5.	**Field Name:**	**2025**
	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 - Percentage of women (age 18+) who are accessing well woman visits, prenatal care visits, and postpartum visits via mobile clinic and other clinical outreach.

Measure Status:	Active

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator	2.6	4.4
Numerator	70	132
Denominator	2,698	3,007
Data Source	CareVue EHR	CareVue
Data Source Year	2024	2025
Provisional or Final ?	Provisional	Provisional

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 MHS.1 - Number of maternal health clinics that participated in the assessment survey regarding maternal depression screenings.

Measure Status:	Active

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator		0
Numerator		
Denominator		
Data Source		Program Administrative Records/Survey Report
Data Source Year		2025
Provisional or Final ?		Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	6.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**
	Field Note: The baseline measure for FY2025 is 0. The CNMI MCH Program is conducting its initial assessment/survey in FY2026.	
2.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: This assessment is intended to capture whether or not the baseline assessment was completed. A subsequent ESM will be developed to capture percentage of maternal health clinics performing maternal depression screenings.	

ESM BF.1 - Percent of postpartum women who receive breastfeeding education, assessment, or referral during a postpartum or infant healthcare encounter within two weeks of delivery.

Measure Status:	Inactive - This measure is captured incorrectly. The CNMI will inactivate this ESM and recreate another one to accurately capture the measure that was intended.

State Provided Data

	2021	2022	2023	2024	2025
Annual Objective	10	57.4	57.6	57.8	58
Annual Indicator	44.6	39.9	43.2	44.6	41.6
Numerator	187	164	183	200	197
Denominator	419	411	424	448	473
Data Source	WIC Program	WIC Program	WIC Program	WIC Program	WIC Program
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Provisional	Final	Final	Provisional	Provisional

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:**	**2024**
	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	
5.	**Field Name:**	**2025**
	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	

ESM BF.2 - Percent of postpartum women who receive breastfeeding education, assessment or a referral during a postpartum or infant healthcare encounter within 2 weeks of delivery.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	40.0	45.0	50.0	55.0	60.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**

Field Note:
The CNMI is currently working on establishing a baseline for this measure.

ESM PA-Child.2 - Percent 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 PA-Child.3 - Number of collaborative physical activity initiatives or events supported by the MCH Program through the CNMI Physical Activity Council that engage children ages 6–11 and their families.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	3.0	5.0	7.0	9.0	11.0

Field Level Notes for Form 10 ESMs:

None

ESM AWV.2 - Percentage of Public School System (PSS) high school students who participate in school-based health services.

Measure Status:	Active

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator		8.1
Numerator		257
Denominator		3,172
Data Source		MCH Program Records/PSS Enrollment Data
Data Source Year		2025
Provisional or Final ?		Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10.0	12.0	14.0	16.0	18.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**

Field Note:
CNMI PSS Enrollment Data was obtained from PSS website: https://envisioncnmipss.org/district-data#d06145d2-2b30-42c8-985b-844f7a96cfa9

ESM AWV.3 - Number of teens who completed the PATCH Peer-to-Peer Workshops in the past year.

Measure Status:	Active

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator		83
Numerator		
Denominator		
Data Source		Program Administrative Records/Sign in Sheets
Data Source Year		2025
Provisional or Final ?		Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	85.0	105.0	125.0	150.0	175.0

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:	Inactive - Will be inactivated and a correct ESM created to accurately capture the strategy being measured.

State Provided Data

	2021	2022	2023	2024	2025
Annual Objective	10	20	30	55	60
Annual Indicator	81	81	52.3	40.5	0
Numerator	51	51	45	45	0
Denominator	63	63	86	111	111
Data Source	F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey	CSHCN Program
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Provisional	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 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.	
5.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**
	Field Note: Postponed - This measure aimed to focus on Pediatric provider receiving medical home training and implementation.	

ESM MH.2 - Percent of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	20.0	40.0	60.0	80.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Pediatric provider clinics include: CHCC Children's Clinic, Tinian Health Center, Rota Health Center, Marianas Medical Center, Medical Associates of the Pacific, and Isla Community Health Clinics.

ESM TAHC.2 - Percent 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 participating in bullying prevention needs assessment and planning activities.

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

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective					

Field Level Notes for Form 10 ESMs:

None

SPM ESM 2.1 - User research (i.e. surveys and focus groups) completed.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective					

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	5	49	53	35	40
Annual Indicator	65.4	53.1	28.6	21.5	31.1
Numerator	5,047	4,057	2,170	1,647	2,405
Denominator	7,717	7,641	7,595	7,648	7,732
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	CHCC CareVue EHR/US Census International Estimate
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	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)	
5.	**Field Name:**	**2025**
	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
Population Health 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
Population Health 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.

SPM 3 - Percent of CNMI WIC infants breastfed at 6 months.
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the percentage of CNMI babies who are breastfed at 6 months.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CNMI WIC infants who are breastfed at 6 months of age. **Denominator:** Number of CNMI WIC infants who are 6 months during the reporting year.
Healthy People 2030 Objective:	MICH-15 — Increase the proportion of infants who are breastfed exclusively through age 6 months. 2022 U.S. baseline/current: 27.9% 2030 national target: 42.4% "Exclusive" means the infant receives nothing but breast milk through 6 months. MICH-16 — Increase the proportion of infants who are breastfed at 1 year. 2022 U.S. baseline/current: 40.8% 2030 national target: 54.1% This measures whether the child is receiving breast milk to any extent at 1 year.
Data Sources and Data Issues:	Data will be obtained from the CNMI WIC Program via the HANDS system.
Population Health Significance:	Breastfeeding represents an important population health indicator because of its benefits for both infant and maternal health. While breastfeeding initiation in the CNMI is high, the substantially lower proportion of infants who are exclusively breastfed through 6 months highlights an opportunity to strengthen supports that enable mothers to continue breastfeeding. Addressing barriers to sustained breastfeeding through healthcare, home visiting, WIC, community, and workplace supports can contribute to improved maternal and infant health outcomes and advance health equity.

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.
Population Health 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 - Percentage of women (age 18+) who are accessing well woman visits, prenatal care visits, and postpartum visits via mobile clinic and other clinical outreach.
NPM – 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 percentage of women accessing preventive visits, including well-woman, prenatal, and postpartum visits.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of unduplicated women (age 18+) receiving well-woman, prenatal, or postpartum visits through outreach and mobile clinic. **Denominator:** Number of Women (age 18+) 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.
Population Health 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 survey regarding maternal depression screenings.
NPM – Percent of women who were screened for depression or anxiety following a recent live birth - MHS

Measure Status:	Active
Goal:	To gather data on provider screening practices.
Definition:	**Unit Type:** Count **Unit Number:** 6 **Numerator:** Number of provider clinics that participated in the survey. **Denominator:**
Data Sources and Data Issues:	Programmatic Assessment/Survey Target clinics include CHCC Women's Clinic, Medical Associates of the Pacific, Marianas Medical Center, Isla Health Clinics, Rota Health Center and Tinian Health Center.
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.
Population Health 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 postpartum women who receive breastfeeding education, assessment, or referral during a postpartum or infant healthcare encounter within two weeks of delivery.
NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

Measure Status:	Inactive - This measure is captured incorrectly. The CNMI will inactivate this ESM and recreate another one to accurately capture the measure that was intended.
Goal:	Increase percentage of breastfed infants.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of women who complete a postpartum visit and receive breastfeeding education, assessment, or referral.</td></tr><tr><td>**Denominator:**</td><td>Number of women who complete a postpartum visit.</td></tr></table>
Data Sources and Data Issues:	CHCC EHR System, Participant survey
Evidence-based/informed strategy:	This measure tracks the percentage of postpartum women who receive breastfeeding education, assessment, or referral during a postpartum or infant healthcare encounter within two weeks of delivery. Services may be provided by healthcare providers, nurses, WIC staff, Community Health Outreach Workers (CHOW), Home Visiting staff, or other trained maternal and child health personnel. The first two weeks after delivery represent a critical period for establishing breastfeeding and identifying concerns that may contribute to early discontinuation. Ensuring that breastfeeding is discussed during routine postpartum or newborn visits provides opportunities to reinforce breastfeeding education, address common concerns, and connect families with available community resources.
Population Health Significance:	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.

ESM BF.2 - Percent of postpartum women who receive breastfeeding education, assessment or a referral during a postpartum or infant healthcare encounter within 2 weeks of delivery.
NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

Measure Status:	Active
Goal:	To increase the percentage of CNMI infants who are breastfed through 6 months.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of postpartum women in the CNMI who report receiving breastfeeding education, assessment or a referral for breastfeeding support within 2 weeks after delivery.</td></tr><tr><td>**Denominator:**</td><td>Number of postpartum women in the CNMI.</td></tr></table>
Data Sources and Data Issues:	A survey among postpartum women.
Evidence-based/informed strategy:	The ESM measures CNMI strategy that focuses on strengthening breastfeeding education, referral, and early postpartum support.
Population Health Significance:	Breastfeeding is an important population health strategy that supports both maternal and infant health; however, the CNMI's breastfeeding data indicate an opportunity to strengthen postpartum healthcare practices that support continued breastfeeding. While 90.3% of infants were ever breastfed in 2025, only 10.1% were exclusively breastfed through 6 months. This gap highlights the importance of ensuring that breastfeeding support extends beyond the prenatal period and initial delivery hospitalization. Strengthening postpartum healthcare practices can include routine assessment of breastfeeding progress and barriers, timely lactation support and referrals, anticipatory guidance, culturally and linguistically appropriate education, and coordination with WIC, home visiting, pediatric care, and other community resources. Improving the consistency and quality of breastfeeding support during the postpartum period can help mothers address challenges earlier, make informed decisions about infant feeding, and maintain breastfeeding for longer periods. These efforts align with Healthy People 2030 MICH-15 and support the CNMI's broader goal of improving access to quality postpartum care and reducing disparities in maternal and infant health.

ESM PA-Child.2 - Percent 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.
Population Health 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 PA-Child.3 - Number of collaborative physical activity initiatives or events supported by the MCH Program through the CNMI Physical Activity Council that engage children ages 6–11 and their families.
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 opportunities within the community for children to be physically active.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of collaborative physical activity initiatives or events supported by the MCH Program through the CNMI Physical Activity Council that engage children ages 6–11 and their families. **Denominator:**
Data Sources and Data Issues:	Number of collaborative physical activity initiatives or events supported by the MCH Program through the CNMI Physical Activity Council that engage children ages 6–11 and their families.
Evidence-based/informed strategy:	The CNMI will work with partners on the creating of or enhancing access to places for Physical Activity Combined with Informational Outreach Activities. According to the US Community Preventive Services Task Force, "These interventions attempt to change the local environment to create opportunities for physical activity. Access to places for physical activity can be created or enhanced both by building trails or facilities and by reducing barriers (e.g., reducing fees or changing operating hours of facilities). Many of these programs also provide training in use of equipment, other health education activities, and incentives such as risk factor screening and counseling. Several programs reviewed were conducted at worksites".
Population Health Significance:	This strategy aligns with Healthy People 2030 objectives to increase physical activity among children and adolescents and reduce childhood obesity. By expanding access to safe, accessible, and community-based physical activity opportunities through coordinated partnerships, it helps remove barriers to active living, promotes healthy growth and development, supports lifelong healthy behaviors, and reduces the risk of obesity and chronic disease. Increasing opportunities for physical activity ensures more children and families across the CNMI have access to environments that support healthy, active lifestyles.

ESM AWV.2 - Percentage of Public School System (PSS) high school students who participate in school-based health services.
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.
Population Health 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:** 500 **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.
Population Health 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>Inactive - Will be inactivated and a correct ESM created to accurately capture the strategy being measured.</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>
</table>
</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>
</table>

Population Health Significance:	This ESM measures the reach and initial implementation impact of the training and technical 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 MH.2 - Percent of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Active
Goal:	The goal is to increase the percentage of CNMI children with or without special healthcare needs who report having a medical home by 5%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care). **Denominator:** Number of pediatric providers in the CNMI.
Data Sources and Data Issues:	Data will be obtained through program administrative records (training participant logs) and clinic surveys.
Evidence-based/informed strategy:	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).

Population Health Significance:	This ESM measures the reach and initial implementation impact of the training and technical 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.2 - Percent 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.
Population Health 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 participating in bullying prevention needs assessment and planning activities.
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:** Total Number participating in bullying prevention needs assessment and planning activities. **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.
Population Health 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.
Population Health 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.
Population Health 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The goal is to increase the number of women ages 18-44 accessing preventive medical services at CHCC sites.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of women ages 18-44 years accessing preventive health services at CHCC service sites.</td></tr>
<tr><td>Denominator:</td><td>Number of women ages 18-44 years</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CHCC Electronic Health Record System</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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.</td></tr>
<tr><td>Population Health Significance:</td><td>Evidence suggests that expanded hours increases access and provides opportunities for working women and others with schedule challenges to access care.</td></tr>
</table>

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

Annual Report Year 2025

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Quarterly	1		
2) Vital Records Death	Yes	Yes	Semi-Annually	3	Yes	
3) Medicaid	Yes	No	Annually	6	Yes	
4) WIC	Yes	Yes	Monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	Monthly	1	No	
6) Newborn Hearing Screening	Yes	Yes	Monthly	1	No	
7) Hospital Discharge	Yes	Yes	More often than monthly	1	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	1	No	

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) Immunization Registry	Yes	Yes	Daily	1	No	
10) Home Visiting Program	Yes	Yes	Monthly	1	No	
11) SPED	Yes	Yes	Annually	3	No	
12) NCD Bureau	Yes	Yes	Quarterly	1	No	
13) BRFSS	Yes	Yes	Annually	6	No	
14) ERASE MM	Yes	Yes	Annually	6	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 2025

Products and Publications information has not been provided by the State.