Maternal and Child Health Services Title V Block Grant

State Narrative for Northern Mariana Islands

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements 4
A. Letter of Transmittal 4
B. Face Sheet 4
C. Assurances and Certifications 4
D. Table of Contents 4
E. Public Input 4
II. Needs Assessment 6
C. Needs Assessment Summary 6
III. State Overview 7
A. Overview 7
B. Agency Capacity 13
C. Organizational Structure 20
D. Other MCH Capacity 22
E. State Agency Coordination 26
F. Health Systems Capacity Indicators 32
Health Systems Capacity Indicator 01: 32
Health Systems Capacity Indicator 02: 33
Health Systems Capacity Indicator 03: 35
Health Systems Capacity Indicator 04: 35
Health Systems Capacity Indicator 07A: 36
Health Systems Capacity Indicator 07B: 37
Health Systems Capacity Indicator 08: 38
Health Systems Capacity Indicator 05A: 39
Health Systems Capacity Indicator 05B: 40
Health Systems Capacity Indicator 05C: 40
Health Systems Capacity Indicator 05D: 41
Health Systems Capacity Indicator 06A: 41
Health Systems Capacity Indicator 06B: 42
Health Systems Capacity Indicator 06C: 42
Health Systems Capacity Indicator 09A: 43
Health Systems Capacity Indicator 09B: 44
IV. Priorities, Performance and Program Activities 45
A. Background and Overview 45
B. State Priorities 46
C. National Performance Measures 49
Performance Measure 01: 50
Performance Measure 02: 51
Performance Measure 03: 52
Performance Measure 04: 54
Performance Measure 05: 55
Performance Measure 06: 56
Performance Measure 07: 58
Performance Measure 08: 59
Performance Measure 09: 60
Performance Measure 10: 61
Performance Measure 11: 63
Performance Measure 12: 64
Performance Measure 13: 65
Performance Measure 14: 67
Performance Measure 15: 68
Performance Measure 16: 69
Performance Measure 17: 70
Performance Measure 18: 72

D. State Performance Measures ... 73
State Performance Measure 1: ... 73
State Performance Measure 2: ... 74
State Performance Measure 3: ... 75
State Performance Measure 4: ... 77
State Performance Measure 5: ... 78
State Performance Measure 6: ... 79
State Performance Measure 7: ... 80
E. Health Status Indicators ... 81
Health Status Indicators 01A: ... 81
Health Status Indicators 01B: ... 82
Health Status Indicators 02A: ... 82
Health Status Indicators 02B: ... 83
Health Status Indicators 03A: ... 84
Health Status Indicators 03B: ... 84
Health Status Indicators 03C: ... 85
Health Status Indicators 04A: ... 86
Health Status Indicators 04B: ... 86
Health Status Indicators 04C: ... 87
Health Status Indicators 05A: ... 88
Health Status Indicators 05B: ... 88
Health Status Indicators 06A: ... 89
Health Status Indicators 06B: ... 90
Health Status Indicators 07A: ... 90
Health Status Indicators 07B: ... 91
Health Status Indicators 08A: ... 91
Health Status Indicators 08B: ... 92
Health Status Indicators 09A: ... 93
Health Status Indicators 09B: ... 94
Health Status Indicators 10: ... 94
Health Status Indicators 11: ... 95
Health Status Indicators 12: ... 95
F. Other Program Activities ... 96
G. Technical Assistance ... 98
V. Budget Narrative ... 99
A. Expenditures ... 99
B. Budget ... 100
VI. Reporting Forms-General Information ... 102
VII. Performance and Outcome Measure Detail Sheets ... 102
VIII. Glossary ... 102
IX. Technical Note ... 102
X. Appendices and State Supporting documents ... 102
A. Needs Assessment ... 102
B. All Reporting Forms ... 102
C. Organizational Charts and All Other State Supporting Documents ... 102
D. Annual Report Data ... 102

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Signed copies of Assurances and Certifications along with the Orgranizational Chart and the Maternal and Child Health grant application are on file at the Division of Public Health. All Division staff have knowledge of this information and have access to the files.

/2008/ There are no changes here. //2008//

/2009/ Signed copies of Assurances and Certifications and a copy of the MCH grant application report are on file at the Division of Public Health.//2009//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input is gathered from the following sources:

- Advisory committee (please note that we also get comments/inputs from other committees such as Interagency Coordinating Council, Head Start Health Advisory Committee, Family Planning Advisory Committee)
- Surveys and focus groups-- i.e., tobacco survey, community health survey, patient satisfaction survey, prenatal focus group
- Radio, television, and newspaper -- we also appear on a local live tv show with a call-in format
- Brochures about services we provide with contact names and numbers
- Community events -- we have a jar full of questions such as how often must a woman get a pap smear, what is prenatal, recommendations to improve service delivery, etc. so that we can raise awareness of preventive services
- Presentations at leadership meetings such as the Public School System Leadership Team meeting
- CNMI state point of contact for grants is the Office of Management and Budget -- this year we will be sending out hrsa mchb's Title V web-site address to various agencies

/2008/ The different programs at the Division have advisory committees/coalition, continue to participate in community events, conduct media campaigns, are members of advisory committees for different agencies, etc. Grant applications are also available to the public. One very successful committee is the Early Childhood Comprehensive System Committee - 22 members from agencies, parents, and community members. Some of our members appeared in the local tv show talking about medical homes, parent education, family support, mental health, and early care and education. Survey results are printed in newspapers. //2008//
/2009/ A suggestion box was put at the Dental Clinic, Immunization Clinic and the Southern

Community Wellness Center from November 2007 to May 2008. Some of the comments are:
-Open clinic up in San Roque -- Due to staffing shortage and budget cutbacks -- the Division closed the clinic that is located in the northern part of Saipan. We are in discussion regarding having other federally funded programs such as WIC use the clinic. Although the facility is there, there are other needs such as generator, water pump, utilities payment, etc. Other comments include "where's the doctor". The Wellness Center has Women's Health Nurse Practitioners and the medical director comes to the Center once a week.
-Translator-on-site: The garment factories provided translators for their employees but since the closing of the factories clients are coming in with not translators. The range for Chinese and Koreans interpreters is $50-$75 per hour; also costly to translate materials in these languages. We do have Filipino, Chinese, and Korean staff.
-Dental appointment too long -- Due to an illness that required off island care, one of the 2 dentists was away for 6 months. Fees too high -- there have been no changes in fees for dental services since 1986. The fees were changed 2 years -- it is still lower than the private dental clinics. Dental assistants are rude -- this is addressed but has to do with waiting too long. Thank you for opening the walk-in clinic for Immunization. Please open on weekends. Due to auterity measures no overtime is approved regardless of funding source.//2009//

/2010/The most significant activity for increasing public input is the Division of Public Health website, www.dphsaipan.com. There will be general information on all the Programs and including current events (both with Public Health and Partners) including the opportunity to write comments. We are also working with the high school students on identifying and prioritizing area specific to adolescent health determinants like behaviors. We continue to work with DPH Programs' advisory committees as well as other agencies' committeess/councils to assist the MCH Program in identifying priorities as well as in provision of outreach activities.//2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2009/Some of the work we are doing to conduct the needs assessment includes:

Prenatal Care Assessment -- The main purpose of this report is to assess the process of prenatal care at the Southern Community Wellness Center and hence a) determine the flow of patient care at the clinic, b) the types of prenatal screenings and tests administered, and c) determine areas for improvement and need. It a process assessment and information presented is a compilation of general facts of the overall prenatal care service at the SCWC.

It is hoped that through this assessment, information will be made available that can determine gaps in the prenatal care process at the SCWC, areas of need for both provider and patients can be identified, and ways to better integrate other pertinent PH programs needed for healthy birth outcomes for both mother and child can also be identified. Other prenatal care service areas will be assessed and evaluated in the future and this assessment is one of the first phases of the MCH Program's initiative in improving the quality and access of prenatal care here in the CNMI. Attached are some of the findings from the assessment.

2008 Health Services Report: The Health Statistics Report Committee was formed consisting of program manager. A memo requesting for data elements to be used in the report has been given to all program managers. The format to report data elements will be similar to information on performance measures detail sheet.

Focus Group: We conducted focus groups on students at all the public high schools for the HPV School Campaign. One of the questions was on priorities for adolescent health. We used the format from last year's training by Dr. Gwendolyn Adams on Adolescent Health Leadership.

We will continue to conduct focus groups or meet with different ethnic group, review data system especially on linkage, conduct patient satisfaction survey, assess Dental Clinic i.e., also write a strategic plan for dental unit, conduct PRAMS-like survey and CSHCN survey, use information on YRBS and YTS, work with other programs and their committees/coalition, evaluate health status indicators by ethnicity, complete 2008 Health Services Report, recruit staff for data collection and analysis, etc.//2009//

III. State Overview

A. Overview

The Commonwealth of the Northern Mariana Islands (CNMI), an archipelago of 14 volcanic islands, is approximately 3,700 miles west of Hawaii, 1,300 miles from Japan and 2,900 miles east of the Philippines. (See Map) The population of CNMI lives primarily on three islands, the major island being Saipan (12.5 miles long by 5.5 miles wide), followed by Tinian and Rota. CNMI became a U.S. Commonwealth in 1975 and its residents (excluding foreign contract workers) are U.S. citizens. The 2000 U.S. Census reported the total population of the CNMI at 69,221 residents with Chamorros and Carolinians (indigenous population) comprising 34% of the total population with approximately 90% living in Saipan. The remaining 66% of the population is comprised of guest workers from the Philippines, China, and other Asian countries; business owners from Japan and Korea; other Pacific Islanders; and Caucasians.

The Department of Public Health is a line department in the Executive Branch. The CNMI's State Title V Program is administered through the Division of Public Health's Maternal and Child Health Program, including Children with Special Health Care Needs. Maternal and child health services are provided at the following:

- Northern Community Wellness Center located in the village of San Roque;
- Southern Community Wellness Center located in the village of San Antonio;
- Women's and Children's Clinic located in the village of Garapan at the Commomwealth Health Center;
- Rota and Tinian Health Center.

Services are provided in collaboration with other agencies, both private and governmental. For example, through a memorandum of agreement, immunization services are provided at five private health clinics on the island of Saipan.

The authorized representative is the Secretary of Public Health, James U. Hofschneider, MD, who is appointed by the Governor. The Governor also appoints the Deputy Secretary for Public Health Administration, Pedro T. Untalan, MHA.

The Department of Public Health (DPH) is the sole provider of comprehensive health care services in the CNMI. The Department, through the Commonwealth Health Center (CHC), provides a wide range of preventative (public health) and curative health services aimed at protecting and improving the health and quality of life for the people of the CNMI. CHC is a 74 bed capacity facility located on Saipan. Sub-hospitals are located on the islands of Rota and Tinian. The single greatest factor straining the resources of the health care system is the rapid population growth over the past decade. As a result of this unanticipated population increase, the health care system cannot provide adequate services. There has not been an expansion of the health care infrastructure considering the rapid increase in population. Insufficient human and material resources hamper strategic health planning.

The Division of Public Health's initiatives include:

- To lessen health disparities by providing accessible primary care, enhancing disease prevention activities and intensifying public health awareness.
- To provide appropriate primary care to everyone in the CNMI, especially for targeted populations such as women and children, including children with special health care needs, indigent, and the elderly.
- To provide sustainable school based clinic programs in the high schools.
- To establish a fully operational community health center in Kagman/Chacha and to expand and renovate the wellness centers in San Antonio and San Roque.
- To establish a comprehensive approach to health problems rather than a vertical approach such as more multi-sectored that would include major stakeholders.
- To "delink" structurally and programmatically from the Hospital Division in such areas as data and financial system.

- To develop a data infrastructure unique to the needs of all the programs in the Division;
- To decrease the burden of diabetes such as the high incidence of end stage renal disease associated with diabetes, lower extremity amputations and blindness by detection, management, and education of the community.
- To reestablish environmental health as an integral component in the health care model.
- To build up local manpower capacity for sustainability;
- To continually review how we deliver care (acute, prevention, promotion) and develop innovative processes to address budgetary and manpower constraints.

The need to build and improve our current local health care manpower for sustainability of our public health programs is imperative to improving delivery of services to our community. This is also in line with the strategic plan for future health initiatives stated in the Institute of Medicine (IOM) report. One of the four recommended approaches includes promoting the education and training of the health care workforce (IOM, 1998). Through the University of Hawaii, John A. Burns School of Medicine, the CNMI has an Area Health Education Center (AHEC) grant. The CNMI AHEC's mission is to improve the health services of the Commonwealth by establishing a sustainable healthcare manpower program through strengthening CNMI's capacity to recruit and retain allied health professions to serve the health needs of the islands. The program will develop competent, committed and compassionate health professionals for the CNMI. Its vision is to improve the quality of healthcare services and reduce disparities in health conditions in the CNMI. In addition, there are currently three Division staff attending the MCH Certificate Program from the University of Hawaii; we are in collaboration with WHO, Dr. Peter Milgram from University of Washington and Dr. Ohnmar Tut from the Republic of Marshalls to conduct training for Dental Assistants to effectively conduct outreach activities in oral health; and in collaboration with the Pacific Islands Health Officers Association (PIHOA) we are sponsoring a series of courses dealing with public health disease surveillance and investigation. The shortage of local manpower impacts health service delivery in that there is the need to recruit manpower from the U.S. or other countries such as Canada. This recruitment process is lengthy and at a high cost for the Department plus the turnover rate is high.

The need to improve our data infrastructure impacts the way we plan activities for the programs and evaluate the effectiveness of services/activities we provide to the community. Data elements were submitted to the system administrator using the MCH performance measure detailed sheet format for warehousing. Key staff has had meetings with other Departments regarding required data needs for grant submissions.

Other factors impacting health services delivery include the size of the facilities -- plans are underway to begin renovation and expand both facilities in July 2005 - and shortage of funds and availability and accessibility of health services.

The development of homestead lots in the CNMI is growing rapidly and is a geographic challenge in reducing health disparities. These homestead lots are both residential and farming community. Majority of the larger homestead lots are located miles away from the nearest health facility -- private or governmental. There is no public transportation on the island. This has pose as a challenge for the Division in ensuring the availability and accessibility of services. For example, the Kagman Homestead area is located in the northeast side on the island of Saipan with a population of about 8,000. These are young families living in the area. There is two Head Start Schools, one elementary, middle, and high schools. The nearest health facility is located on the west side of the island which is about 7 miles away.

The CNMI Division of Public Health, Department of Public Health, conducted the Kagman Community Health Survey to examine the health care status and health care needs of residents in the village of Kagman. The results of this survey were included in a pending community health center Section 330 grant application. The Division of Public Health conducted a house-to-house survey in the village of Kagman in April and May of 2004. Four hundred and fifty eight household residents participated in the survey. Kagman village is one of the fastest growing villages in the

CNMI with a projected growth to 10,000 within the next three years. It is a residential and farming community. Survey results indicate that 24% of those surveyed were unemployed. The following are some key findings of the Kagman Community Health Survey (Please see attached Kagman Community Health Survey Report):

- 91% responded that distance and lack of transportation are the major factors for not getting health care for their family;
- 75% receive their health care from public health facilities;
- 61.7% of the household respondents admitted that they are not getting regular medical care for their chronic illness due to financial, lack of transportation, and distance to the nearest health facility;
- As far as health insurance, 37.3% said Medicaid; 22.5% said government health insurance, and 10.7% are uninsured.

The Division will start renovation of the former Juvenile Detention Building to establish the Kagman Community Health Center. The health center will be a freestanding, single facility outpatient clinic for all residents of District 10. The Health Center will combine both wellness services focusing on preventive programs, along with low-cost but effective primary care services. The proposed service delivery model and programs will be focused on comprehensive outpatient primary care to include, but not limited to, prevention, outreach, community education, dental care, school-based health programs, case management of high risk patients, especially those with or at-risk for diabetes, and substance abuse and mental health counseling. Enabling services will also be provided to those who are identified as being in need of such services. Community outreach workers will work with other social service providers for eligibility assistance.

Another challenge in reducing health disparities involves the Medicaid Program and the government sponsored health insurance plan. Out of approximately 30,000 women of childbearing age within the CNMI, only 8,723 (men and women) people were enrolled in the Medicaid program. The Medically Indigent Assistance Program had only 912 enrollees in FY2002. The Medicaid program, itself, is very limited because the US federal government caps CNMI Medicaid expenditures--effectively creating a block grant program that remains at the same level regardless of expenditures. Currently, the CNMI Medicaid program spends $7,297,828 (FY'04) per year but gets only $2,381,000 (FY'04) n federal Medicaid funds. This accounts for 18% of the total expenditures. Medicaid is only accepted at the government run health facilities. This presents a unique challenge in reducing health disparities in that Medicaid clients cannot access the health care available at the private clinics. In addition, Medicaid's first priority for payment is the off-island providers. Also, the government sponsored health insurance plan (HPMR) is currently not being accepted at the private clinics due to non-payment for the past three years. Again, the priority for the insurance program is to pay off-island providers first.

Finally, employers of contract workers (imported laborers brought on contract to work in CNMI) are required to pay either directly or through insurance for the people they employ. The contract workers are usually low-paid service jobs including garment workers; hotel, restaurant, and domestic; construction; and agricultural workers. More than 15,000 women are non-resident workers whose employers pay for emergency medical care and childbirth costs. However, some employers comply with this requirement but many do not. Therefore, majority of non-resident workers that deliver had no prenatal visits.

/2007/ The newly appointed Secretary of Public Health is Mr. Joseph Kevin Villagomez, MA. Ms. Lynn F. Tenorio is the newly appointed Deputy Secretary for Public Health Administration.

Updates on some of the public health initiatives:

- To decrease health disparities: Some activities to enhance disease prevention activities and increase public health awareness include printing of health/program information (see attached) in the local television program, newspaper, including magazines and North Star -- flu ad, prenatal ad, and the breast and cervical. The Division continues to host the annual Basketball Jam, Open House for the Early Intervention Services Program, Pressure Point Project,

and the Pap project. As an activity for the Women's Health Week, public health staff went to the beach pathway where we distributed the 'Important Tests for a Woman's Good Health' brochures. We discussed the different tests and part of the information that we were giving to the women was where they can go to get the tests (besides the Commonwealth Health Center), costs of the tests, and whether insurance covered the tests. We also asked them what topics they would like to be put on the agenda for a future Women's Health Conference. We continue to participate in events sponsored by other agencies.

- To build up local manpower capacity for sustainability: The NCLEX review class was conducted to 15 ADNs; 4 have passed the NCLEX. Training consisted of 3 months didactic instruction weekly and 2 weeks intensive test preparation. The case management training consisted of 20 hours training on case management skills for all direct service providers in the CNMI including Tinian and Rota. A total of 115 personnel participated; 40 participants applied and received 3 credits of CEU from Eastern Michigan University. Participants included MCH staff from CSHCN and immunization, STD/HIV Prevention Program, Public School System school counselors, Division of Youth Services and Child Protection Service social workers, Head Start, Work Investment Agency, Probation, and Northern Marianas College. Through the AHEC grant, we support health career opportunities for high school students. The two graduates of the Women's Health Care Nurse Practitioner Program at University of California Los Angeles Medical Center just finished their clinical rotations. Two of our staff continued with the MCH Certificate Program with University of Hawaii this summer. The Dental Assistant Outreach Training was completed by 9 Dental Assistants and 2 nurses; participants included Rota and Tinian. This was done in collaboration with WHO, RMI Dental Unit, and University of Washington.

- To establish a fully operational community health center in Kagman/Chacha and to expand and renovate the wellness centers in San Antonio and San Roque.
Department of Public Health's Section 330 grant application to open a health center in the Kagman/Chacha vicinity was denied. Although local funds from the Tobacco Sin Tax money was appropriated to the renovation project last summer, other priorities took the funding away. We continue to host events such as the Kagman Community Health Fair and Immunization campaigns to the residents. Renovation to Southern Community Wellness Center was completed December 2005.

- To develop a data infrastructure unique to the needs of all the programs in the Division: The Public Health Information Technology (PHIT) office is continually working toward improving the technology infrastructure within the Department of Public Health as well as between the Department and outside partners. In the past few years, the Division of Public Health has expanded its Local Area Network (LAN) into a Wide Area Network (WAN) by allowing its peripheral offices and clinics to access the data system located at the Commonwealth Health Center via Virtual Private Networking (VPN). Improvements to the WAN are in progress, and greater usability is expected in the near future. Additionally, PHIT is working with the Maternal and Child Health program as well as other Division of Public Health programs to develop a more effective and efficient data management system. Currently, data is being kept in silos, and horizontal expansion and linkage between databases is needed. While it is not feasible at this time to launch a public health information system which can manage all the data the Department of Public Health needs to collect, analyze and report, PHIT is taking small steps to improve systems which are already in place as well as ensure new systems will be compatible to exchange data. Currently, PHIT is working with the Commonwealth Health Center to upgrade the health information system, RPMS, which is used at the hospital. The Commonwealth Health Center is expected to switch to the Veteran Affairs' VistA system within the next few years. An implementation and planning group is currently forming and PHIT is ensuring that Public Health is involved in this process.

- To decrease the burden of diabetes such as the high incidence of end stage renal disease associated with diabetes, lower extremity amputations and blindness by detection, management, and education of the community: The Diabetes Resource Center was opened last

year. One activity is the "Cooking Show" with a live audience. We solicit the help of community volunteers to come and do healthy cooking demonstration. We continue with the Walk on Wednesday Project. The Wound Care Course was conducted and the Foot Clinic was initiated.

Finally, the 6th Micronesian Games got underway on Saipan on June 23 with 9 of the 10 Micronesian islands participating in the regions celebration of unity in diversity through friendly sports competition.//2007//

//2008//Updates: Due to budget cuts, working hours was reduced to 72 hours in September 2006. This means that every other Friday government offices are closed. This affects the Southern Community Wellness Center and the Women's Clinic where MCH services are provided. Services at Northern Community Wellness Center have been suspended temporarily. There has been a decrease in patient flow to the clinics and an explanation for this is that there are people that are not renewing their health insurance due to the cutback in salary. In addition, the CNMI has the highest utilities rate (.23 cents per kilowatt) and also gas prices ($3.55) has continued to increase. Although we do not have the numbers, there has been a decreased in enrollment in private insurance and an increase in enrollment in the Medicaid Program which puts a strain on the Program. The closing of 5 garment factories left thousands of workers, mostly from China, jobless. Although there are some that opted to leave the island, some also opted to stay. Again, these workers don't have any health insurance and they do not qualify for Medicaid.

We continue to enhance our work to ensure that the community is well informed with information and tools to empower them to live healthier lifestyles. The programs have intensified media campaigns for oral health, prenatal care, immunization, developmental delays, newborn screening and newborn hearing screening and intervention, breast and cervical screening, childhood obesity, prevention of diabetes, STD/HIV prevention, Flu Watch, etc. Informational booths during community events continue to be set up. The HIV/STD Prevention Program's collaboration with the only community-based organization -- NAPU Life -- has been very successful in outreach activities and conducting surveys. The MCH Program has very good working relationships with the Public School System Early Intervention Services Program and the Head Start Program, and Division of Youth Services. In our work to provide access to care for the women in our community we have formed a partnership with the Catholic Church on the Wise Women Village Project. We will be going to churches' social halls at each village and provide pelvic exam, pap test, and breast exam in addition to counseling and health education three times a month. Please note that we continue to collaborate with our partners, both public and private, and the community on activities to decrease health disparities.

The Division through its leadership has been successful in getting back the Tobacco sin tax funds. We will be purchasing a mobile clinic with the funds. This will provide the programs with the ability to go into the community to provide preventative services such as dental exams and women's exam in addition to counseling and health information.

Training continues for dental staff, Bureau of Environmental Health staff, and nursing staff. Trainings include the Risk Communication Training for all Department of Public Health Staff; two Dental Staff are attending a preventive oral health training (one of the objectives of the training is to integrate Oral Health into MCH and other Public Health Programs and identify ways to further collaborate with other agencies to support efforts); Training to early intervention and related service staff in all elements of programming for infants and toddlers with hearing loss and their families was conducted; in addition the trainer provided consultation to staff who will receive these infants in pre-school settings; There was also training for clinical providers on HIV.//2008 //

/2009/The impact of meeting the health care needs of the CNMI residents within the struggling CNMI health care system plays an important role in overwhelming the capacity of the system. A large portion of our population is considered hard to reach due to socioeconomic, cultural, and language barriers that make it difficult for them to not only communicate their health care needs but to understand the information and services that we provide. To improve access to care,

Medicaid recipients can now seek health care services at 2 private clinics since February 2008. As was previously mentioned our residents consists of two indigenous population -- Chamorro and Carolinian, Micronesians from FSM, Republic of the Palau and the Marshall Islands and foreign contract workers from Asia (primarily Chinese and Filipino) which comprise over half of the population. Of the entire CNMI population, 28 percent are age 19 years or under, 41 percent are age 20-34, 18 percent are age 35-44, 9 percent are age 45-54, and 4 percent are age 55 or older. Females outnumber males, comprising 54 percent of the population.

The past year the Division of Public Health's initiatives included HPV School Campaign, Prenatal Care Campaign, PRAMS-like survey, Collaborative work with Northern Marianas College in the planning of the meeting to write the 5-Year Strategic Plan to address nutrition and non-communicable diseases in the CNMI (meeting will be held July 15-17), and Wise Women Village Project. The MCH Program is a key partner in all the initiatives.
The HPV School Campaign created a model for other prevention programs by localizing education materials and going beyond the clinic-based setting. The focus is educating parents and high school girls on cervical cancer and HPV vaccine and providing the HPV vaccine at all the public and private schools in Saipan, Tinian, and Rota to all girls with signed consent forms. The community as a whole was educated on the importance of pap smear in cervical cancer prevention and the benefits of HPV vaccine. The partnership and the involvement of students made the campaign successful. 80% of the students received the first shot.
The Wise Women Village Project completed it first year with services provided at 9 villages in Saipan and Rota and Tinian Health Centers. In Saipan, 188 women received women preventive health screening services including culturally and linguistically appropriate counseling on healthy behaviors. We conducted the project in Tinian and Rota last month. We will start the second year of the project in Saipan on July 13. The project consultant from the Office of Women's Health ASSIST 2010 Program conducted a site visit earlier this year. The strongest collaborative community partner for this project is the Diocese of Chalan Kanoa.
The headlines in the local newspapers tell the story of the declining economic situation for the residents. Headlines include: Gas prices up 25 cents ($5.05 per gallon); NAP needs $5 million to meet rising food costs; Another garment factory closed; NMHC (Housing Corporation): Most residents are low-income earners; CHC (Hospital) maximizing workforce; Residents face highest every electric rate -- 38 cents per kilowatt; Closure on garment factory leaves 144 homeless; etc. On the other hand visitor arrivals up nearly 21 percent in April and 3 percent increase in June compare to last year.//2009//

/2010/As an impact of the downturn in the economy, the CNMI's small population is experiencing a major decline, from a peak of approximately 70,000 in 2004 down to an estimated population of 60,400 in 2007. Total CNMI employment plunged from 40,200 in 2004, to 26,010 in 2007, a 35.6% decline. One contributing factor is the closing of the garment industry. Programs at the Division of Public Health have been considerate of the financial situation of families. For example, we have programs such as Wise Women Village Project (WWVP) and the Breast and Cervical Cancer Screening that focuses on the needs of the different ethnic group in our culture taking into account their financial status. WWVP is a Saturday clinic that provides preventive health screenings for women including counseling and education and referrals. Our work with WWVP has made us aware of the need to also develop gender base counseling or educational activities. For example, The Club Hinemelo'ta is an exercise program for larger women who have diabetes or pre-diabetes; are overweight; and have high blood pressure. The MCH Program brought 2 volunteers for training from Tinian and Rota and they have started the program over there. Our programs current initiatives puts an emphasis on reducing health system duplication, coordinating services, and providing mutual support to help ensure that increasingly limited resources are used more effectively. For example, the MCH Program's role with the WWVP is to provide staff for counseling in nutrition, educational printed materials, transportation, and referral while other programs provide the screening services and tobacco counseling. This helps us with our priorities to increase the proportion of women aged 18 years and older who have ever received a pap

smear and to increase the proportion of women aged 40 years and older who have ever received a mammogram.
We also worked with lawmakers to bring Medicaid out into the private health and dental clinics. As of February 2008, Medicaid participants can access health care at 4 private health clinics and as of February 2009, Medicaid participants can access dental care at 2 private dental clinics. In addition, we continue to build on our collaboration with our partners in our work to provide comprehensive health care services to the community. The strength of the programs at the Division of Public Health lies in the commitment and dedication of staff. Even with staffing shortages, we still send one public health dentist and a dental assistant to Rota to provide basic dental services. Our outreach work in the villages is again provided by existing staff and partners such as Northern Marianas School of Nursing and Emanuel Nursing School.//2010//

B. Agency Capacity

The Maternal and Child Health Program is under the Division of Public Health. We provide comprehensive and holistic community health services, including medical, dental, mental health, substance abuse counseling, perinatal, nutrition, and family planning, all supplemented by enabling services including outreach, case management, and transportation to MCH target population. The strategy is to work with the community so that we can empower the community with tools and information to live healthier lifestyles. Other strategies are: 1) work with schools to ensure that all children enrolled are up to date with their immunization; 2) collaborate and partner with other agencies, both private and governmental, during island-wide community events which will strongly emphasize lifestyle behavioral changes especially with health care practices, diet, and physical fitness; 3) establish a network linkage with other providers to inform them of health news, health alerts, awareness events, training, etc.; 4) develop partnership with other agencies to ensure continuity of care.

Preventive and primary care services for pregnant women and mothers:

- Prenatal Care: Prenatal care is provided at the Southern and Northern Community Wellness Centers, Women's Clinic located at the Commonwealth Health Center, and Rota and Tinian Health Center. It is also provided at the Adolescent Health Center. The first visit involves prenatal first visit intake/interview by nurse, physical exam (pap smear), blood work, counseling, including HIV testing. The revisit exams include monitoring fetal's growth and development and the mother's condition, and providing education. Information on the prenatal education classes is provided at this time. As mentioned in the organizational structure narrative, staffing at the Northern and Southern Community Wellness Center includes a family practitioner, a midwife, two women's health nurse practitioners, two nursing assistants, one LPN, and six registered nurses. There are four OB/GYNs at the Women's Clinic for referrals of high risk cases such as diabetes, heart problems, or with a special health need. Please note that the Women's and Children's Clinic is under the organizational structure of the Hospital Division. Prenatal care visits are provided five days a week from 7:30 a.m. to 4:30 p.m. Increasing the percentage of adequate prenatal care visits, especially during first trimester, continues to be a focus for the Division. Another focus area is to have all mothers screened during pregnancy for the following: Hepatitis B, Syphilis, Gonorrhea, Chlamydia, Rubella, Diabetes, Hypertension, Cervical Cancer, Group B Streptococcus, and antibody screening.

- Postpartum Care: Postpartum clinic is held on Mondays, Tuesdays, and Thursdays. There is a one-week postpartum clinic in which women are educated on body changes, breastfeeding, nutrition, etc one week after delivery. The six weeks postpartum clinic provides family planning counseling and contraceptives.
- Breastfeeding Clinic: Newborn assessments -- make sure that lungs are clear, weight gain is appropriate, regular rhythm of the heart, condition of cord, check testicles for boys, vaginal discharge. Check mother's breast for nipple sores, engorgement, reinforce breastfeeding techniques. We send two staff to attend a breastfeeding training this year. This service is

provided on Mondays, Tuesdays, Wednesdays, and Fridays.

• Family Planning: The primary focus of the Family Planning Program is to reduce the numbers of unplanned pregnancies and the prevention of teen pregnancy. More than 55 percent of all pregnancies occurring in the Commonwealth of the Northern Mariana Islands were unintended in 2004. One important determinant of pregnancy and birth rates is contraceptive use. The proportion of all females aged 15-44 years who currently are practicing contraception in the CNMI is unknown. However, in the CNMI's 2004 Family Planning Annual Report, we recorded 1,471 unduplicated female family planning users of various methods. Using this known number of female family planning users, we can estimate that less than five percent of females within the total female childbearing population of the CNMI [30,703 women] utilize a family planning method through the CNMI Title X Family Planning program. Services are provided every day for scheduled appointments and walk-ins.

• STD/HIV Prevention: The program moved into their new office, STD/HIV Resource and Treatment Center, in December 2002. The center, located away from the Commonwealth Health Center, provides pre and post counseling, partner identification and notification, treatment, and case management. Some goals of the program include opening test sites out in the community and mass media campaigns emphasizing on behavioral change. It works closely with the school system and other community groups to conduct educational awareness activities. Training for staff, including nurses at the public and private sectors, on HIV pre and post counseling is done every two years. The program has an educational booth at the Northern Marianas College. There are plans to include testing at the college. Testing is currently done at the Northern and Southern Wellness Centers, Adolescent Health Center, and the Commonwealth Health Center.

There have been a total of twenty-eight (28) persons with known HIV infection in the CNMI since 1997. No new HIV infection reported from 2002 to 2005. Twenty-four (24) persons tested positive for HIV in the CNMI. Four (4) migrated to the islands and were already diagnosed HIV positive (+) elsewhere.
- All of the twenty-eight cases (28) consist of the following risk transmission:
a) Two (2) perinatal transmissions (1 male/1 female).
b) Seven (7) men who have sex with other men (MSM).
c) Fifteen (15) were of heterosexual background (4 male/11 female).
d) Four (4) were of unknown preferences (3 male/1 female).
- Out of the twenty-four (24) cases/including the four (4) people that migrated to the islands and were already HIV (+), thirteen (13) tested positive through the Alien Health Screening (contract workers). All of the thirteen (13) contract workers voluntarily left the CNMI and have gone back to their place of origin. Nine (9) have died - five (5) died in CNMI and four (4) died elsewhere. The remaining six (6) (2 originally diagnosed outside CNMI -- HI, Guam) are still residing in the CNMI and are receiving care, four (4) are in Saipan and one (1) in Tinian.

The program works closely with the Office of Health Promotion and Wellness in promoting public awareness regarding STD/HIV prevention. Community outreach activity is done in collaboration with other agencies, such as the public and private schools, and Karidat. The Program provides health education and awareness, as well as HIV testing, to private entities and surveys are also conducted. The primary challenge is to modify the behavior of the populace in regards to their sexual behavior, e.g., understanding the consequences of engaging in high-risk behavior and being responsible for their health.

- Breast and Cervial Screening: Breast cancer and cervical cancer screening exams such as pap smears, clinical breast exams, and mammograms are provided to women over 40 years of age at no cost to women that meet the program's criteria. Eligibility assistance and transportation is provided to clients; transportation includes air fare tickets to clients in Rota and Tinian for mammograms. In addition, program staff conducts outreach presentations on early detection and prevention including risk factors. Supplemental activities include providing services at night and free mammograms for one month for all women. The program is currently being funded by the

Tobacco Control Fund since 1999.

• Women's Health: Gynecological services -- pap smears and consultations - are provided at the Wellness Centers, and Rota and Tinian Health Centers. The referral clinic for complicated cases to the Women's Clinic.

Preventive and primary health care services for infants and children:

• Immunization: The Immunization Program provides the vaccines for children, works with the schools to ensure that all children are up to date with their vaccinations, collaborates with the private clinics to ensure availability and accessibility of service, continues to work with different ethnic groups to promote awareness of the importance of age appropriate immunization, and overall continue to work to achieve goals and objectives in the measles elimination plan for the CNMI. Immunization is provided at the public health facilities and all of the six private clinics. The basic immunization series includes Diphtheria, Pertussis and Tetanus (DPT), Polio (OPV), Mumps, Measles, and Rubella (MMR), Hepatitis B (HBV), and Hemophilus influenza type b (Hib).

The staff are daily tracking children that are not up-to-date and making telephone calls to parents. For those children that have no transportation the nurse goes on home visits to give the shots. Supplemental activities are done during immunization awareness month with extended clinic hours, providing immunization during community events, going to the villages, and collaboration with other agencies. Walk-in policy has been reinstated. One of the challenges that the program has struggled with is that we have no idea how to identify children that have exited the islands. As an update to this challenge, we have met with the Secretary of Labor and Immigration and we have worked out a solution to this challenge.

In addition, the program is responsible for the issuance of the school health certificate upon completion of immunization. By law, all children are required to be up-to-date on their immunizations before they can enter school.

• Well Baby/Child Clinic: Well Baby/Child Clinic is provided at the two wellness centers and the Children's Clinic. The function has been transferred out to the wellness centers and appointments are made to the Children's Clinic only if parents make a request. Services provided include immunization, health education and counseling including nutrition, assessment and monitoring for growth and development and other underlying health problems, and physical examinations. Referrals are also being done such as for dental care, hearing screening, early intervention services, specialty clinics, and home visits. The promotion of breastfeeding is actively done during these visits. Physical examinations include vision and hearing screening. Again, the referral site for complicated cases or for consultation is the Children's Clinic. There are currently four full-time pediatricians. This clinic is held every Mondays, Tuesdays, and Thursdays.

• Outreach Program: This consists of the home visit nurses. The two barriers to the program are first the inadequate numbers of staff to fully attend to the increase load for home visit and transportation.

• School Health Program:

1. A school health certificate is required for all children entering school for the first time in the CNMI. In order to get the school health certificate a physical examination (including hearing and vision screening) is required and they must have completed the required immunization series for that age group. Parents continue to call to schedule physical examinations in late July and August. Physical examination is also provided at the private clinics.

2. Dental Fluoride and Sealant Program: This program has proven to be one of the successful collaboration between the Division and the School System (both public and private) and the parents. Our collaboration with the Public School System involves the Head Start Program and children in grades first, fifth, and sixth, the same for the private schools. Our collaboration with the Head Start Program involves parents bringing their children to the Dental Clinic for fluoride varnish and sealant application. Oral health education is also provided at the Clinic. During school year 2003-2004, we have started for children requiring treatment and

procedures. In addition, the staff follows up with telephone call reminders. There have been a high number of no shows for the scheduled appointments. The Head Start Program provides the Division with fluoride and sealant application kits and toothbrushes. They also pay for travel for Dental staff to go to Rota and Tinian to conduct outreach activities and also to assist with the program in each island. The children in first, fifth, and sixth grades in the public and private schools, including Rota and Tinian, are bussed to the Dental Clinic per an agreement with the public school system. Services provided include mouth examination in which they are assessed for caries and periodontal diseases, sealant application, and education. The children are given report cards on their dental assessments so parents can make necessary appointments for further dental treatment and procedures.

The Dental Clinic provides services that include general dentistry such as sealant application, fluoride tablets, education/counseling, community outreach activities, cleaning, extraction, fillings, prophylaxis, and dentures. With the recruitment of another dental hygienist, more awareness and education on oral health will be provided at the school level. Building up the skills of staff and replacing/upgrading the equipment continues to be a focus of the Dental Unit.

- Mental Health and Social Services: School counselors and other service providers work closely with the staff of the Community Guidance Center. Health. The staff consists of two Clinical Psychologists, two Psychiatrists, three substance abuse counselors, two Social Worker I, three Social Worker II, one Mental Health Counselor and administrative and support staff.

Services for children with special health care needs:
The Children with Special Health Care Needs (CSHCN) Program: is a component of the MCH Program. Services are set up to promote an integrated service delivery system for CSHCN from birth to twenty-one years of age and their families. We work to ensure that children not only receive specialized health care that they need but that they are up-to-date with their immunizations and that they avail, if qualified, to the different social service programs on island. One priority of the program is to identify these children at the earliest age possible, preferably right after birth. The entry point is a referral to the early intervention services program located at the Children's Developmental Assistance Center. However, most of our referrals are for children 8 months and older. We want to make the referral age to be at 7 months. There are care coordinators, special education teachers, social worker, and occupational, physical, and speech therapists on staff for the 0-3 years old. We have a community health nurse who oversees the coordination of specialty care that our children need.
The Program works collaboratively and cooperatively with other agencies and departments to provide appropriate education and support services needed to meet their social, emotional, physical, and medical needs. Specialty clinics, such as Pediatric Cardiology, and Shriners, are conducted throughout the year. We continue with activities such as parents' night.
The challenges of the program include the following:

- the lack of qualified professionals on-island for specialized services;
- clients who do not qualify for SSI, Medicaid, etc., because of citizenship status
- the lack of respite care facility for families of CSHCN -- please note that through the CNMI Developmental Disabilities Council in which the MCH Coordinator is the secretary of the executive council, we did apply for a Real Choice Systems grant to provide respite care. However, funds are not enough for everyone and only one provider applied.
- Pediatricians are on a two year contract and we continue to struggle with the shortage of pediatricians. Parents/children get use to one particular provider and after two years he/she does not renew and thus a change in provider. This was one thing mentioned from the survey as far as continuity of care.

Preventive and primary health care services for adolescents:
The Division of Public Health, through its preventive and primary health care service delivery, continues to emphasize decreasing the numbers of unplanned pregnancies and teen births in the CNMI. Our goal is to provide comprehensive interventions at age-appropriate levels in a culturally sensitive manner that will impact the possibilities of teenage sexual activity, including,

but not limited to unplanned pregnancies and teen births, HIV in the adolescent and young adult population, sexually transmitted infections, and emotional and physical coercion in sexual activity. Through the Adolescent Health Center, the Division has managed to remove the barrier of access to service by meeting teens in their environment thus eliminating disparities. This clinic meets the students in a confidential setting where education and clinical exams are achieved on site. On-site educational and clinical services in the high school setting allow ease of access, confidentiality, and personal counseling within an environment that is neither restrictive nor intimidating. Students are always encouraged to include their parents or families in decision-making about sexuality. We have plans to implement a collaborative effort with the Public School System to introduce an abstinence curriculum into the middle schools, including sexuality and STIs in addition to clinical services.

For the Healthy Teen Piolot Program Grant Proposal a survey was conducted to 174 students from Marianas High School. Some services that students would like to be offered at the school clinic include HIV/STD (70%), Physical Examinations (64%), Suicide/Substance abuse counseling (61%), Diet and Nutrition (60%), Family Planning (47%), and Immunization (46%). These services are currently being provided at the Adolescent Health Center. Some barriers that were mentioned in preventing students from visiting Public Health Clinics include No Time (39%), Money (36%), Shame (30%), Transportation (29%), Afraid of Result (26%), and Afraid of Parents finding out (24%). When asked if there was a need for a school-based health center 83% responded yes and 14% responded no. The Community Health Nurse stationed at the Health Center also works closely with school counselors in providing educaiton and educational materials to the students.

//2008// Newborn hearing screening is conducted to all babies born at the Commonwealth Health Center. We submitted the Early Childhood State Comprehensive System (ECCS) grant and the Early Hearing Detection and Intervention (EHDI) grant. We are working on recruitment of a Data Surveillance and Tracker and we have contracted a consultant for the development of the EHDI Tracking and Surveillance System. We have been working collaboratively with the Public School System Head Start Program and the Childcare Program and the Day Care Centers in the development of the Health and Safety Manual, collaborated with the Reach Out and Read group in purchasing of reading materials to be used by volunteer readers at the clinics and wellness centers, and updating and printing of the resource directory in collaboration with other agencies such as the Ayuda Network. We are also in the process of recruiting an ECCS project coordinator.

An MOA is signed with SPC to conduct the Second Generation HIV Surveillance. With the recruitment of the public health dietician, case management is provided pregnant women with gestational diabetes. We are also continuing with the Pap Project in which the clinic is open in the evening for those women that have been identified as not having a pap test for the past 5 years. The protocols and procedure manual for the family planning has been completed and implemented.

The Adolescent Health Center sees an average of 178 students per month. The overall goal of the Center is to make health services available to teen while educating them onhow totake responsibility for their own wellness. Clinic appointments are often full booked. Other Department staff continue to provide services at the Center including Community Guidance Center, STD/HIV Prevetion Program, Family Planning Program, etc. One full-time RN staffs the clinic and other providers are rotated through to provide specialized services. Educational pamphlets on health issues specific to adolescents are readily available and classroom presentations are provided upon request.

The Shriners Children Hospital from Honolulu comes to Saipan, Rota, and Tinian twice a year to evaluate children that have bone and muscle problems or problems related to burns. When an orthopedic procedure cannot be performed on Saipan, the child is referred to the Shriners

Hospital in Honolulu in which they cover the cost of the hospitalization. 7 children were send to Honolulu in 2005. There are currently 156 children from Saipan being served. In addition, Shriners send a specialist in orthotics to come and fit children for braces and to monitor their effectiveness four times a year.

We have formed a partnership with a non-profit organization, Reach out Pacific (REPAC) Foundation, which takes surplus hospital supplies from Hawaii and delivers them throughout Micronesia. The foundation donated three wheelchairs, a case of braces, canes, and a number of diaper boxes.

Newborn hearing screening is conducted to all babies born at the Commonwealth Health Center. We submitted the Early Childhood State Comprehensive System (ECCS) grant and the Early Hearing Detection and Intervention (EHDI) grant. We are working on recruitment of a Data Surveillance and Tracker and we have contracted a consultant for the development of the EHDI Tracking and Surveillance System. We have been working collaboratively with the Public School System Head Start Program and the Childcare Program and the Day Care Centers in the development of the Health and Safety Manual, collaborated with the Reach Out and Read group in purchasing of reading materials to be used by volunteer readers at the clinics and wellness centers, and updating and printing of the resource directory in collaboration with other agencies such as the Ayuda Network. We are also in the process of recruiting an ECCS project coordinator. On December 30, 2005, the Department of Public Health was awarded a $4.6 million grant through the Food and Nutrition Services (FNS), a Federal agency of the U.S. Department of Agriculture, to establish and operate the Women, Infants, and Children Program-better known as the WIC Program -- in the CNMI. WIC is a special supplemental nutrition program which serves to safeguard the health of low-income women, infants, & children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to other health services. The CNMI WIC program is presently setting up its infrastructure to provide provide these services. Projected date of opening clinic is in FY 2006.

With the assistance of CDC, the Department recruited Dr. JP Chaine as the Regional Public Health Consultant. He will provide assistance by working as a member of the Regional Immunization Program management team in order to implement an effective program within the policy and general organizational structure of the region. He is responsible for providing assistance and oversight with the National Immunization Program (NIP) Project officer for the Pacific Islands to provide technical assistance on immunizations to the program managers of American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Federated States of Micronesia, Republic of the Marshall Islands and the Republic of Palau.

Pandemic Influenza Preparedness:

1. CNMI Pandemic Influenza Plan was developed, finalized and approved March 2006. The plan is an annex to the Department's All Hazards Emergency Operations Plan.

2. The Plan utilized the guidelines established by CDC and WHO and is NIMS based.

3. Recently, DPH with CDC conducted a tabletop and field exercise of the CNMI Pandemic Influenza Plan. The after action report is now being prepared but as a whole, the response to the exercise was good.

4. Initiated Public Awareness Campaign through the electronic and print media. DPH is also conducting regional Pan Flu Summit in Rota, Tinian, and Saipan.

5. During the FY 06 -- 07 Public Health Emergency Preparedness grant, DPH will work with the MCH Coordinator and the CNMI Council on Developmental Disabilities to identify and plan for the population with special needs.//2008//

/2009/ The WIC Program will start services on August 8. The challenge was the recruitment of the director and the nutritionist. We continue to request for assistance in training for our staff from institutions such as University of Hawaii's Area Health Education Center (AHEC) and WHO. The ECCS Coordinator was recruited and we received technical assistance from MCHB and Health System Research Inc in the development of our ECCS strategic plan. We have a strong ECCS coalition working together to assist families in the development of their children aged 0-5 years. The Department's grant application for the CDC Breast and Cervical Screening program was approved. We are working on our implementation plans for the program. We submitted two Office of Women's Health grant to assist the Division in providing well-women exams in the evenings and at the villages and the Targeted State MCH Oral Health Service Systems grant. There is currently 87 staff working in the Division of Public Health. The staffing for the MCH Program consists of program manager, nurses, dental assistants, social worker, public health analyst, case management workers, clinical attendants, data clerk, CSHCN Coordinator, and nutritionist. The MCH program partners and collaborates with other Division programs such as Immunization Program, HIV/STD Prevention Program, Diabetes Prevention and Control Program, WIC Program, and with Community Guidance Center, Hospital Division, and Rota and Tinian Health Centers to provide preventive and primary care services to the community. We have facilities that are located away from the Commonwealth Health Center such as the wellness center located in the southern part of the island, Children's Developmental Assistance Center located in the village of Garapan, Adolescent Health Center at Marianas High School, and at the Navy Hill campus such as WIC Program, HIV/STD Resource and Treatment Center, Diabetes Resource Center, and Bureau of Environmental Health. The Wise Women Village Project works out of social halls of the churches that are located throughout the villages in Saipan. The Immunization Walk-in Clinic is located at the Old Children's Clinic at CHC. Again, we set up informational exhibits/booths at various community events.//2009//

/2010/The EHDI surveillance system has been instrumental in identifying babies that are not screened for hearing loss and those that do not come back for the second hearing test. By reviewing our numbers we have conducted activities such as media campaigns, parent survey, doing 3 telephone reminder callbacks, and the need for a Hearing Screening Waiver Form. We are finding that the our "missed" numbers includes those babies whose parents refused to have the initial hearing test and then the numbers transfer on to our lost to follow up.
Contractual services: We have procured the contractual services of the developer of the EHDI Surveillance and tracking system to develop the metabolic screening system and the birth defects registry. In addition, we have contractual services for audiologist.
Trainings: 1) the UH LEND Program provided training to physicians, nursing staff, and early intervention services staff (includes private clinics and Public School System Special Education Program staff) on disability that included cultural aspects, developmental screening, autism, etc. 2) 49 nurses from the nursery, NICU, labor and delivery, Children's Clinic as well as several student nurses received training on all aspects of newborn hearing screening and the follow-up process. Each section had learning objectives and a test at the end of each section was taken and was used to assess hospital competencies. 3) Family planning training was conducted to clinic providers and staff at the Women's Clinic and as of September 2008, all family planning services is provided at the Women's Clinic. 4) Department of Public Health IT staff attended the Managing and Maintaining a Microsoft Window Server 2003 Environment training on Guam; 5) Ms. Roxanne Diaz completed the University of Hawaii's MCH Certificate Program 6)SPC conducted training on developing materials for behavioral change
Funding Opportunity: We got approved for the Early Childhood Comprehensive System Implementation Grant and CDC's Diabetes and Tobacco Integration Cooperative Agreement (MCH Program Coordinator was part of the grant writing team).
As was reported in the Region IX Act Early Summit on Autism, the Program have been working with Autism Commission (formed by parents of children diagnosed with autism spectrum disorder) and its partners to provide training to clinical staff, early intervention

program services staff, and the public school system special education program staff. In addition, printed materials are provided to parents and the "Learn the Signs. Act Early" dvds are being played at the maternity wards and the children's clinic waiting area.
Policy: Through DPH efforts, Medicaid participants can now access dental health at 2 private dental clinics. We are working to reduce the number of Medicaid participants coming to the Public Health dental clinic for treatment by being a referral source to the private clinics.
Last summer we met with the USN 4th Medical Battalion with the lead of Capt. Anita Kobuszewski to provide dental care services to children with special health care needs as part of their Innovative Readiness Training mission. In addition to dental care, we will also conduct 2 health fairs focusing on prevention that includes healthy weight, nutrition, physical activity, sports injury prevention, tobacco cessation, suicide prevention, oral health, and healthy mother/healthy baby.
We have been utilizing the Mobile Clinic during village projects and at community events. Finally, we have increased our public awareness activities especially with media campaigns and printed matierials. For example, we worked with the ECCS committee to conduct focus groups/surveys with clients they serve to assist us with the topics for printed materials. Our work with daycare settings providers identified oral health as mateirals they need, parents identified developmental checklists including autism, our partners wanted a calendar with information on the agency and awareness events, etc. //2010//

C. Organizational Structure

A Secretary of Public Health who is appointed by the Governor and serves as a Cabinet Member heads the Department of Public Health (DPH). DPH consists of three Divisions: the Hospital Division (Commonwealth Health Center), Public Health Division, and the Community Guidance Center. A Deputy Secretary that is appointed by the Governor with the recommendation of the Secretary of Public Health oversees the three Divisions. There are two Program Offices: Medicaid Program and the Medical Referral Program. The mission of the Department is to "Promote the health and well being of the residents of the Northern Mariana Islands by protection through sanitation, immunization, and other communicable and non-communicable disease programs; Improve the quality of life through encouraging and empowering the community to achieve its highest possible level of wellness and; Ensure the availability of efficient and quality health care and prevention services".

The Department is under the umbrella of the CNMI government. PL 1-8, Chapter 12, SS2 give the Department the powers and duties:

- to maintain and improve health and sanitary conditions;
- to minimize and control communicable disease;
- to establish standards of medical and dental care and practice and to license medical and dental practitioners;
- to establish and administer programs regarding vocational rehabilitation, crippled children's services, infant care, Medicaid, Medicare, mental health and related programs including substance abuse;
- to establish standards for water quality; and
- to administer all government-owned health care facilities.

The Division of Public Health is responsible for administering the State's Title V Maternal and Child Health Program, including children with special health care needs. It is responsible for preventative health programs such as Diabetes Prevention and Control, Breast and Cervical Screening, Immunization, Prenatal and Postpartum Care, Women, Infants, and Children's Program, and Health Promotion. It also is responsible for the Bureau of Environmental Health;

Early Intervention Services Program-Children with Special Health Care Needs, Adolescent Health Center, Public Health Liaison Office, Dental Unit, Chest Clinic. Other units include Health and Vital Statistics Office, Accounting and Administrative Support Service. There are program mangers that oversee these different programs/units. These services are also provided at the Tinian and Rota Health Centers. A Resident Director oversees services provided in Rota and Tinian.

The Division of Public Health, headed by the Deputy Secretary for Public Health Administration, currently operate and administer two wellness centers in the southern and northern communities on Saipan.
The Southern Community Wellness Center (SCWC) located in San Antonio village encounters approximately 300 women each month. The clientele is very diverse, including indigenous women and women who are non-resident workers in the garment and tourism industry, coming to Saipan from other Micronesian islands, China, Korea, Japan, the Philippine Islands, Thailand, Vietnam, Bangladesh and others. This clinic is dynamic and fast-paced. A permanently-assigned Women's Health Nurse Practitioner (WHNP) provides care to the majority of women with the nursing staff playing a large role in this nurse-run clinic. The Public Health Medical Director supervises clinical practice of midlevel providers. Consultation and referral to the obstetrics/gynecology unit is always available.

(See attached Map of Saipan)

The Northern Community Wellness Center (NCWC) located in San Roque village opened its doors approximately 21 months ago and has enjoyed steady growth. It offers the same services as the southern clinics and services approximately 175 women per month. A WHNP provides clinical services under the supervision of the Medical Director. This is a quieter, more rural area of the island.

The Adolescent Health Center, a school-based health center, opened on April 19, 2004, on the campus of Marianas High School. The CNMI Department of Public Health has collaborated with the CNMI Public School System (PSS) through a pilot study grant that the PSS received from the office of the CNMI Governor Juan Baubata. The Healthy Student Pilot Program from the Governor's Education Initiative provided grant funding, effective 2/1/2004 and has ended on 2/1/2005. The grant funds were deposited with the Public School System's account and the Division of Public Health is reimbursed through this account. This pilot program has been very successful in opening dialogue with teens about abstinence, sexuality, and STD/HIV. The clinic was closed during the summer months of June and July for summer break, reopening in August, 2004. (Detailed narrative is provided in the needs assessment section)

The Women's Clinic is situated within the main Commonwealth Health Center complex. Four US board-certified obstetrician/gynecologists provide care to complicated gynecology, and high-risk pregnancies as well as routine gynecology and prenatal care. The ob/gyn unit acts as consultants and referral physicians to the other clinics, including Rota and Tinian. This clinic is the referral center for abnormal pap test management, gynecology pathology suspected at the community-based level and high-risk pregnancies. Recently, these physicians have been able to see patients for evaluation in the community clinics on a scheduled basis.
Rota and Tinian Health Centers provide preventive and primary care also with a Resident Director in charge. Each health center employs a full-time WHNP to provide reproductive health care under the supervision of a physician. These sites maintain contact with the program manager with monthly reports. The program manager maintains contact regarding supply inventories, policies and procedures, clinical updates, and plans to organize continuing education and staff development offerings.

Commonwealth Health Center (CHC), managed by the Hospital Division is a 74-bed Medicare-certified acute care facility. It houses an internal medicine clinic, women's clinic, pediatric clinic, as well as the in-patient services which include ICU, NICU, surgical department, medical/surgical

units, labor/delivery/postpartum, hemodialysis and an emergency department. A privately owned pharmacy is situated within the CHC complex.

(Please refer to attached Organizational Chart)

The Department of Public Health under the authorized representative of the Secretary of Public Health is responsible for the administration of all federally funded programs. These include DHHS/HRSA grants such as Title V and the Early Childhood Comprehensive System grant to Centers for Disease Control and Prevention grants such as Immunization and the STD Prevention.

The Department of Finance and Accounting is responsible for the financial management of all funds, both local and federal. The Department is responsible for draw downs, submission of financial status reports, and checking/approving all funds to be used. The Governor's Office approves all usage of funds such as personnel, travel, purchase orders, contracts, etc.

/2006/ There are no major changes in the organizational structure for the Division of Public Health, Department of Public Health. However, as previously mentioned, due to the new administration a new Secretary of Public Health and a new Deputy Secretary of Public Health Administration was appointed. We are happy to mention that the CNMI's Women Infant Children application was approved. We have been working on building the WIC infrastructure such as the facility, program policies, recruitment of staff, information system, etc. We also have the Area Health Education Center which provides the foundation to sustain local manpower with trainings, health opportunity programs, etc. Rota and Tinian Health Centers received their Hill-Burton certification.//200//

/2008/ Due to the reduction in work hours, the Women's Clinic and the SCWC is closed every other Friday since September 2006. The major update is the addition of the WIC Program to the Organization Chart that was signed earlier this year. //2008//

/2009/The Secretary of Public Health is the authorized representatives for the Department of Public Health. All program staff working in the Division of Public Health is under the direct supervision of the Deputy Secretary for Public Health Administration. These include MCH, Immunization, HIV/STD Prevention, Diabetes Prevention and Control, Breast and Cervical Screening, Family Planning and Reproductive Health, Wise Women Village Project, Bureau of Environmental Health, Tuberculosis Control, Dental Clinic, etc. (Please see attached organizational chart)//2009//

/2010/ There is no change to the organizational structure and placement of the Title V program. Mr. John Tagabuel is the Acting Deputy Secretary for Public Health Administration and replaces Ms. Lynn Tenorio.//2010//

An attachment is included in this section.

D. Other MCH Capacity

Key personnel involved in MCH activities include the:
Secretary of Public Health: /2007/ Mr. Joseph Kevin Villagomez, MA was appointed by Governor Benigno R. Fitial to be the Secretary of Public Health in 2006. Mr. Villagomez holds a B.S. in Psychology from Washington State University where he graduated with honors and holds a Masters of Science in Counseling Psychology form Antioch University of New England where he also graduated with honors. Mr. Villagomez established the first ever Substance Abuse Treatment Program and the Substance Abuse Prevention Program in 1993. He has been with the Department since 1992 and he was the former Secretary of Public Health from 1998-2002.

He was also the primary reviewer for American Samoa's MCH grant application in 2001.//2007//

Deputy Secretary for Public Health Administration: /2007/ Ms Lynn Tenorio holds a Bachelor's Degree of Science in Bacteriology from the University of Wisconsin-Madison, Madison, Wisconsin. Ms. Tenorio is responsible for the management of the Division of Public Health under the Department of Public Health. She oversees management, administrative and fiscal responsibilities of local and federal funded public health related programs and activities. She was the former program manager for the Diabetes Control and Prevention Program.//2007//

Public Health Medical Director: Richard Brostrom, MD, has been the Public Health Medical Director since July 2001. He received his medical degree with honors from University of North Carolina School of Medicine. He also received his MSPH from North Carolina School of Public Health. He is a licensed physician and is board certified by the American Board of Family Practice. He currently provides leadership and expertise for the Division's many programs. He continues to provide regular medical care services focusing on women's health, obstetrics, and pediatrics.

Area Health Education Center Director: /2007/ Faye Untalan, MSW, MPH, DSW, is the Director of the CNMI Area Health Education Center Program. She is also an associate Professor at the University of Hawaii.//2007//
/2008/ AHEC moved to the Northern Marianas College. The Department continues to work with the program to provide training to build manpower capacity. //2008//

Public Health Dentist: Dr. Alberto Ventura received his Doctorate degree in Dental Medicine (Cum Laude) from the University of the East, Manila, Philippines. He is licensed by the CNMI Medical Profession Licensing Board, and has been providing his services to the Division since 1982. He performs a wide variety of dental work such as teeth and gum examinations, administers anesthesia for fillings and extractions, performs minor and major dental surgery, attends to prosthetic cases, and prescribes dental related medications. /2007/ Dr. Irma Hallaby, Doctor of Dental Surgery, received her doctorate from the Columbia Dental University. She is licensed by the CNMI Medical Profession Licensing Board and board certified by the Dental Board and Department of Commerce and Consumer Affairs from the State of Hawaii. Dr. Hallaby worked at the Public Health Dental Unit in 1999-2000. She rejoined the Unit April of this year.//2007//

Nursing Manager: Ms. Latisha Lochabay MSN, CNM has extensive experience as a midlevel clinician and clinical services manager. She was recruited in January 2004. She also teaches the prenatal education classes.
/2007/ Ms. Lochabay is currently the Family Planning Program Manager.//2007//

Women's Health Nurse Practitioner: /2007/ Mrs. Luise Q. Noisom, RN, BSN, WHNP, is a nationally licensed Women's Health Nurse Practitioner since 2002. She has been working for the Division of Public Health since 2001; however, she has been practicing as a nurse for the Commonwealth Health Center since 1989. Mrs. Noisom received advanced education and training from a master's certificate Women's Health Care Program at the University of Texas, Southwestern Medical Program in 2000. She currently works in the outreach public health clinics, which is the Southern and Northern Community Wellness Centers functioning as a primary care provider. The services provided include pap smears, prenatal care, family planning, STD screening and treatment, and other related health promotions.//2007//

Women's Health Nurse Practitioner: /2007/ Mrs. Bertha Peters Camacho is a nationally licensed Women's Health Nurse Practitioner since 2001. She has been working for the Division of Public Health since September 2001; however, she has been practicing as a nurse for the Commonwealth Health Center since September 1997. After working for 2.5 years as a nurse at the Commonwealth Health Center, she received advanced education and training from a master's certificate Women's Health Care Program at the University of Texas, Southwestern Medical

Program in 2000. She currently work in an outreach public health clinic, which is the Southern Community Wellness Center functioning as a primary care provider. As with the mission of public health, she aims to increase access to care and promote preventive health care to decrease the morbidity and mortality of preventive health illness. Mrs. Camacho is a scholarship recipient of the MCH Certificate Program from the University of Hawaii.//2007//

Pediatric Nurse Practitioner: Ms. Barbara Reilley-Schmidt, ARNP, joined the Division of Public Health in March of this year. She provides pediatric services at the wellness centers as well as the Children's Clinic. Her special interest is in reducing the incidence of bottle mouth syndrome. She received her education from University of Oklahoma and the University of Colorado. /2008/ This position is vacant with the resignation of Ms. Reilley-Schmidt in March 2007. //2008//

Public Health Program Analyst: Ms. Roxanne Diaz received her Bachelor's Degree of Science in Biology from Chaminade University, Honolulu, Hawaii. Her primary function is to monitor all federally and locally funded programs, correspond with the local academic community, explore and identify various education, training, funding, and/or technical assistance available that may be beneficial to the Department.
/2007/ Ms. Diaz is a participant of the MCH Certificate Program from the University of Hawaii.//2007//

MCH Coordinator: The MCH Coordinator is Mrs. Margarita Torres-Aldan. Mrs. Torres-Aldan holds a Master's Degree in Public Health (Health Service Administration) from the University of Hawaii and A Bachelor of Science Degree from the University of Colorado, Denver. She has experience in the field of social work, including interagency liaisons, adolescent health, and services for children with special health care needs. She has been the MCH Coordinator since October 1996.

Community Health Nurse: Ms. Carol Paez, RN joined the Division in August of 2004. She received her nursing degree from the University of Hawaii. She currently provides services and manages the Adolescent Health Center. In addition, Ms. Paez is the liaison for specialty clinics/providers for our children with special health care needs.

Public Health Registered Dietitian: /2007/ Ms. Louise Oakley received her Bachelor of Human Ecology Degree with a major in foods and nutrition from the University of Manitoba; Winnipeg, Manitoba, Canada. She completed a one year dietetic internship at the Health Sciences Centre in Winnipeg, Manitoba. Ms. Oakley is licensed with the College of Dietitians of Manitoba and holds a professional membership with Dietitians of Canada. She provides nutrition counseling on an outpatient basis to clients of all ages with varying nutritional disorders. She also works closely with the Diabetes Prevention and Control Program and does presentations to the public as requested.//2007//

Epidemiologist: Mr. Edward Diaz, graduated with a Masters of Public Health Degree in Epidemiology from the University of Hawaii. He joined the Division staff in May 1998. Some of his professional interests include disease intervention programs, data collection, disease reporting, and health information system, communicable and non-communicable disease surveillance and outbreak investigation. He currently is the director for the communicable disease program.

Statistician IV: Mr. Isidro Ogarto joined the Division in April of 2003. He brings his statistics experience with him working at the Department of Commerce, Central Statistics Division.

System Administrator: Ms. Elizabeth Palacios was recruited in April of 2004. She graduated from Florida State University in management information system and multinational business operations. She has been instrumental in the installments of VPN and LAN. /2007/ Ms. Palacios is currently attending the Telecommunications and Information Resource Management Graduate Certificate Program out of University of Hawaii.//2007//

Accountant IV: Ms. Frances Pangelinan has been with the Division for the past 15 years. She has extensive experience in banking and financial management. She currently manages all federal and local accounts.

Laboratory Manager: /2007/ Mr. Albert Gurusamy resigned in February 2006. The current Acting Lab Manager is Mr. John Duenas.//2007//

Immunization Program Manager: Ms. Mariana Sablan has been with the VFC Immunization Program since 1995. She is responsible for the administration of the program and consults with the PHA Medical Director in regards to vaccines and other medical assistance. Ms. Sablan is also responsible for the coordination and collaboration with the Rota and Tinian Health Centers, public and private schools, as well as private health clinics on administering vaccines and following immunization standards and protocols. /2008/ Ms. Sablan is also the Clinical Coordinator for the wellness center. //2008//

Breast and Cervical Screening Program Manager: Ms. Jocelyn Songsong has been with the Division of Public Health since August 1998, and currently manages the Breast and Cervical Screening Program. She received her associate degree in Liberal Arts at the Northern Marianas College in 1995 and has attended various professional education sessions. /2008/ Ms. Songsong has been the Acting WIC Director since October 2005. //2008//

Diabetes Control and Prevention Program Manager: /2007/ Ms. Tayna Belyeu-Camacho is the Program Manager.//2007//

Health Promotion Program Manager: //2006// Ms. Rosa Palacios, MPH, retired from government service in December of 2005. There is currently no one in the position.//2006//

HIV/STD Program Manager: /2007/ Ms. Ayesha Adelbai, DCHMS, resigned from this position earlier this year. The Epidemiologist is currently the acting manager for this program.//2007// /2008/ Mr. John Moreno took over this position late last year. //2008//

Current administrative staff provides support in clerical, procurement of supplies, inventory control, processing of travel papers, and time and attendance. The Health and Vital Statistics Office is responsible for processing birth and death certificates in addition to data collection for the Division.

Parents of CSHCN have been active since the creation of the Parent-to-Parent group. We provide transportation, educational materials, translation, and other enabling services that are requested. Although, there is no parent of a child with special health needs employed in the Division, we do have staff that has family members with children with special needs. We have on staff care coordinators, social worker, registered nurses, and have referral sites for pediatricians. We also continue to include parents/families in training to educate and empower them to advocate for their children. In addition, we solicit and include their input in our public awareness and child find activities. We continue the annual meeting with service providers and agencies such as Medicaid, SSI, Public School System, Hospital Division, MCH Program, etc. When the CSHCN survey was being conducted, we had telephone calls from parents that were willing to participate in the survey and also provide referrals. Parent/family referral was our number three referral source to the early intervention services program.

/2007/ The CSHCN Coordinator has been very successful in her work with parents of cshcn. She has improved the attendance and participation/involvement of parents in training, care coordination, referral, etc. She is multi-lingual and has a nursing background. Please see the updates by each key personnel. //2007//

/2009/ We are pleased to welcome Ms. Ariiel Buyum, RN, BSN, MPH, to the Division as the

Family Planning Program Manager. She comes to the CNMI with thirteen years of nursing experience and a Master of Public Health from Emory University.
We were successful in our grant application for the ASSIST 2010 - Wise Women Village Project (WWVP). Ms. Latisha Lochabay, MSN, CNM is the WWVP coordinator. Ms. Lochabay has extensive experience as a midlevel clinician and clinical services manager. She was the Family Planning Program Coordinator for the Division.
There are currently 87 staff in the Division of Public Health providing direct health care services - i.e., Southern Community Wellness Center, Immunization Clinic, and Dental Clinic; Enabling services - i.e., transportation, case management, eligibility assistance, outreach activiites; Population-based services - i.e. early intervention services and Immunization; infratructure building - i.e., health and vital statistics, tracking, coalition building, training. We have campuses located away from the Commonwealth Health Center like the Diabetes Resource Center, WIC, and HIV/STD Prevention Office.
We continue to work with parents from CSHCN/EIS Program.
Finally, we want to mention the death of our dear colleague Ms. Elizabeth Palacios who was the Systems Administrator under the SSDI grant in March. //2009//

/2010/The Division of Public Health's MCH Program continues to enhance and strengthen its work with existing partners, including parents/families, while forming new partners to assist us with our mission to provide the community with the tools and knowledge to live healthier lifestyles.

Arielle Buyum, MPH, CPH, is the CNMI Family Planning Program Manager. She received her master's degree in public health from the Rollins School of Public Health at Emory University. Ms. Buyum is also a bachelor prepared registered nurse. She currently implements the Title X family planning services grant, coordinates adult and adolescent reproductive health services, and directs the family planning/HIV integration special project.

Dianne Francisco is the Adolescent Health Center Coordinator at the Marianas High School. She is a registered nurse who received her degree from Northern Marianas College. Ms. Francisco provides health services to the adolescent population, primarily in the field reproductive care. Her duties include family planning counseling and services and sexually transmitted disease education, prevention, and testing.

John Tagabuel has been the Chief for Bureau of Environmental Health. He has been working for the Department of Public Health for 16 years.//2010//

E. State Agency Coordination

The Department of Public Health includes the Division of Public Health, Hospital Division, and the Community and Guidance Center. As mentioned previously, the Commonwealth Health Center is the only hospital in the CNMI; Rota and Tinian have health centers. The Commonwealth Health Center (CHC) serves as the central acute care facility in the CNMI. Many patients from Rota and Tinian are referred to CHC. Almost all of health and human services are provided through the Commonwealth of the Northern Mariana Islands (CNMI) government including the Public School System, Department of Community and Cultural Affairs, CNMI Developmental Disabilities Council, Medicaid, and Office of Vocational Rehabilitation. All of the departments and/or agencies within the CNMI government have secretaries and/or directors that are appointed by the Governor and are all members of the executive cabinet.

The Department of Public Health is the only government-run health care facility here in the CNMI

thus collaboration and partnership with other agencies, both public and private, is important to ensure the continuity of the delivery of services to the people of the CNMI. Collaborative efforts in prevention and educational outreach activities among the programs within the Department are necessary to ensure accomplishments in improving the health and quality of life for the people of the CNMI. The State System Development Initiative Grant has greatly enhanced the MCH Program's efforts in primary and preventive care services. Infrastructure building for the CNMI includes training, improving systems of care, especially in the area of information system. Funds have been used for training of care coordinators, nurses, staff from the Health and Vital Statistics, administrative support staff in the areas of computer, outreach program, nursing home care, telemedicine, etc. It has been instrumental in the efforts to improve not only data collection for the MCH Program but for the Division of Public Health. Funds were also used to purchase computer equipment for the different units and other programs to ensure data collection.

Collaboration and partnership among the different programs within the Division of Public Health:

- Funding for HIV prevention and STD prevention comes from the Centers for Disease Control. Training to clinical staff to provide pre and post counseling for HIV to pregnant women is a collaborative activity with the HIV/STD program. In addition, counseling and testing for STD, including HIV, amongst the young adult population is another collaborative work with the maternal and child health program. Staff from the program comes to the Northern and Southern Community Wellness Centers and the Adolescent Health Center to provide services on site.
- In addition we receive funding from the Centers for Disease Control for the Diabetes Control and Prevention Program. Tracking pregnant women with gestational diabetes is a collaborative activity with the Program. Another activity is providing intervention measures, i.e., educational outreach presentations, to the schools, including Rota and Tinian.
- The Breast and Cervical Screening Program was federally funded from 1996-2002 from the Centers for Disease Control and Prevention. The maternal and child health program staff and the breast and cervical screening program staff collaborated to provide a more effective case management of patients. However, funding was not renewed in 2003. Through the hard work, dedication, and commitment of senior management and program staff, we were able to receive funding from the CNMI legislature from the "sin tax" revenue. We continue to work together to develop protocols, i.e., Management of Pap Test Results, and to provide services to women, especially those of low-income and that are uninsured. In addition, we provide eligibility assistance to Medicaid and the Medically Indigent Assistance Program. Local funding supports the salaries of current staff.
- The Immunization and Vaccines for Children Program also receives funding the Centers for Disease Control and Prevention. Collaborative work include opening after normal operating hours including Saturdays; conducting outreach presentations; developing protocols, etc. The assessment coverage survey will be conducted in July to determine the true coverage rate of children 19 to 35 months.
- Family Planning Program is funded by Office of Population Affairs. Training for family planning counseling and conducting outreach activities provided by the program to MCH staff. Local funds support salaries for registered nurses and mid-level providers.

Community Guidance Center: Staff from the Community Guidance Center provides substance abuse counseling and education on-site at the Adolescent Health Center. We also collaborate in conducting outreach presentations such as betel nut chewing. The center is the referral site for pregnant women that want to stop smoking. The community guidance center provides the wellness centers and the adolescent health center with educational materials. The Tobacco and Substance Abuse Program conducts public education on tobacco prevention through radio announcements, community events and school activities. Laws against selling cigarettes to minors have been passed and occasionally sotres are checked for compliance with this law.

Hospital Division -- The Medical Referral Program at the Hospital Division has provided off-island medical care services for CSHCN. The Program facilitates the referral of clients to recognized referral health care facilities outside the CNMI for extended medical care. It provides financial assistance for medical care and other related costs (i.e., lodging) outside the CNMI.

The Division of Public Health's collaboration with other Departments and/or Agencies:
Public School System -

- Early Intervention Services Program -- Since the inception of the early intervention services program in 1986, the Public School System has been lead agency. Through an MOU (please see attached), early intervention services is provided to children and families 0-3 years of age. The program is housed at the Children's Developmental Assistance Center (C*DAC) and we are responsible for maintenance of the facility and for providing public awareness and child find activities. The salaries for Care Coordinators and the Social Worker is supported by the Department of Public Health while the Public School System employs the related services providers including special education teachers and data management.
- Newborn Hearing Screening Program: This has been one of the "best practice" in the area of collaboration. The support for collaboration between the two agencies made possible for the grant application to be submitted. The services is provided at the Commonwealth Health Center and key staff are members of the advisory committee with the Audiologist from the Public School System taking the lead in tracking the success of the program. Please note that the MCH Coordinator and the Audiologist recently applied for the Early Hearing and Detection Tracking and Surveillance grant and we received word in June that the grant was approved for funding. We also submitted a grant application for the Early Comprehensive Childhood System Grant.
- Oral Health: The provision of transportation of children by the Public School System has been the key factor for the success of the school health program fluoride varnish and sealant.application component. The MCH Coordinator will take the lead in writing the grant application for the Administration for Young Children and Families Oral Health Initiative Grant for Head Start Children.

Northern Marianas College (NMC) --
As was mentioned in the State Overview narrative section, one of the Division of Public Health's initiatives is building local staff capacity. The Department is working the college in the area of nursing and allied health area. In addition, we collaborate in working together the NMC -- Cooperative Research Education Extension Services to provide nutritional education and also in cooking demonstrations. The nursing students at the college volunteer for screening activities during community events for the Department.

Department of Community and Cultural Affairs (DCCA)--
Training for public health staff to be certified to provide parenting skills class such as parents anonymous was provided by DCCA Division of Youth Services staff. We also provide counseling and conduct presentations to the youths at the Juvenile Detention facility.

Department of Commerce -- we work closely with the Central Statistics Unit in the area of data collection and population estimates.

University of Hawaii, John A. Burns School of Medicine --
Area Health Education Center (AHEC) -- The CNMI government became a subcontractor of the Hawaii/Pacific Basin Area Health Education Center in September 2004. The AHEC's goal is to improve the health of the underserved through collaborative regional training initiatives across the Pacific. The CNMI AHEC's mission is to improve the health services of the Commonwealth by establishing a sustainable healthcare manpower program through strengthening CNMI's capacity to recruit and retain allied health professions to serve the health needs of the islands. Its vision is to improve the quality of health care services thus reducing disparities in health conditions in the CNMI.

Maternal and Child Health Certificate Program -- One of our women's health nurse practitioner, Ms. Bertha P. Camacho, received a scholarship to attend this program.

Healthy Living in the Pacific Islands survey is currently being conducted to help determine some of the health needs of the islands' children.

Western Michigan University -- "Project Familia" - provides intervention measures to decrease physical inactivity and improve dietary habits thus ensuring living healthier lifestyle.

Developmental Disabilities Council -- The MCH program staff has been executive members for the past 6 years. We have been able to assist in grant writing for transportation -- CALL-A-RIDE -- and respite care -- LITTLE DARLINGS and assistive technology.

Medicaid Program -- eligibility assistance for clients coming to the wellness centers. Medicaid program staff has consistently been panel members for forums to parents of children with special health care needs.

Karidat, a non-profit agency, has assisted in enhancing our outreach activities by allowing public health staff use of their "Manhoben (Chamorro word meaning young) Center" to conduct outreach activities. In addition, staff provides health education classes during their summer camps. They also have assisted us with our indigent clients for provision of clothing, shelter, and food items.

The Ayuda Network, another non-profit agency, collaborates with the MCH program in the developing and printing of resource directory for our clients.

As was mentioned earlier, our most successful collaboration with all the private clinics on the island of Saipan is with the Immunization Program. During awareness events, i.e., public health awareness week, women's health week, and breast and cervical cancer prevention awareness month, we have collaborated with two private clinics in providing pap smears to our indigent population. We have revisited with participating providers and others to continue this collaboration. We have also collaborated with private dental clinics to provide outreach activities.

Secretariat of the Pacific Community (SPC) -- training, pacific public health surveillance network, health alerts.

Please note that we also collaborate in serving our target population by being members of councils, advisory committees, board members, etc. and vice versa.

/2007/ Update on collaborative projects:
1. Secretariat of the Pacific Community (SPC): Second Generation HIV Surveillance for youths and pregnant women. We have been meeting with Mr. Tim Sladen from SPC about this project since last year. We have revised the questionnaires and have signed a Memorandum of Agreement but because of the new senior level management and travel/work schedule issues we have had to hold off the project. We will be starting on this project next month.
2. University of Hawaii: MCH Certificate Program: Mrs. Bertha P. Camacho, WHNP, and Ms. Roxanne Diaz, PH Program Analyst, continued on with the program. They took PH 647 -- Analytic Approaches to MCH and PH 671 -- Community & Public Health Practice. .
3. University of Hawaii -- Health Living in the Pacific Islands: Below is the preliminary findings on the survey: (Survey Purpose: To identify rates of overweight & obesity among children in CNMI and related risk factors for chronic disease and To identify dietary, physical activity, and socio-economic factors influencing nutrition)

EXECUTIVE SUMMARY

Four hundred twenty children, ages six months-10 years old were studied for indicators of nutrition and health in the Commonwealth of the Northern Mariana Islands in June and July of 2005 using a two-stage cluster survey. Seventy-three percent were breast fed. 25% were still breastfeeding at six months and 22% were still breastfeeding at 12 months. Nine percent breastfed exclusively until six months. 47% introduced complementary food before six months.

In preliminary analysis of the diets of 60 children, high energy intakes were found, especially from protein and fat sources. Sodium (salt) intake was high and calcium intake was low. Only one quarter of the children met Healthy People 2010 objectives of <10% of calories from saturated fat

and =30% of calories from total fat.

One third of children had no physical activity in school. Most children had three days of physical activity per week (both in school and outside of school) and watched television an average of four hours per day.

Thirty-four percent of children over two years were overweight or at risk for overweight. Overweight prevalence was similar across ethnic groups. One fifth of the children had high blood pressure. Nine cases of Acanthosis nigricans were identified, all among overweight children. These children were significantly more likely to have high blood pressure and early pubertal maturation.

Between 2-5% of children were identified as underweight (using different indicators) and, 26% of children under five years had anemia, as did 17% of 5-10 year old children.

Alternative activities to television and video games and alternative foods to high fat meats are recommended to improve nutritional status, weight status and health among children in the CNMI.
4. Public School System: We submitted the Early Childhood Comprehensive System Grant. Part of the planning include establishment of a committee, recruitment of an ECCS Project Coordinator, partnering with other agencies to ensure that topics on early childhood including mental health, parenting skills, family support, etc., are provided to families, procurement of educational resource materials, development of health and safety manual for childcare providers, resource directory, etc. We will include a copy of the final survey report in next year's application.
5. Council on Developmental Disabilities: Families are being referred to the Family Hope Center, which is a one-stop referral and information service center. When the staff from the Family Hope Center goes to Tinian and Rota, the early intervention services program staff calls up the families for the appointments. The Center has been instrumental in assisting families fill out forms for other services.
6. Northern Marianas College: We continue with the planning and conducting of outreach activities to promote healthy lifestyles in the CNMI.//2007//

/2008/ Updates:
1) The HIV Second Generation Surveillance Survey (SGSS) youths and pregnant women have been completed. We are working with SPC in the analysis and final report of the survey.
2) An STD intensive training for health care providers, including the private clinics was conducted in March 2007. The training provided continuing medical education for the participants.
3) The Division of Public Health submitted the BCSP grant application in March 2006. The MCH Program Coordinator was a member of the grant writing committee assigned to write the grant application. We are happy to announce that the grant was approved. We continue to collaborate during Women's Health Week in education of early screening and detection.
4) Please see attached executive summary for the 2005 Immunization Coverage Survey report in the Discussion of National Performance Measures Narrative Section.
5) The Wise Women Village Project will start June 2007. We have formed a partnership with faith-based organizations and we will be at different villages for one month providing pap test, breast exam, and education. Again, the MCH Program Coordinator is a member of a grant writing team that is currently working on grant applications from the Office of Women's Health to ensure sustainability of project. Also, the pressure point projects have been successful in bringing in adolescents aged 11-18 years through the schools to use any media form to promote skills building sessions.
6) The No Smoking, No Chewing Policy for the Department of Public Health has been strict on enforcing policy for both employees and visitors to the health care facility. CGC has a hotline to assist those that want to quit. One key component for the Office of Women's Health Grant is to provide tobacco cessation service. If the grant gets approved we will develop a memorandum of agreement with Community Guidance Center to provide such service to our target population.
7) The Director of Medical Affairs, who also specializes in Internal Medicine, has been assisting

with projects of the various programs at the Division. For example, he has been providing medical counseling for the women coming to the Wise Women Village Project.
8) Through the Early Childhood Comprehensive System Strategic Plan, training to assist clients fill the application and assess eligibility will be provided to Clinical Attendants in August by Medicaid Program staff.
9) The nursing students played a big role in the success of the two Mass Flu Vaccination Drive event. Please note that these nursing students from the Northern Marianas College Nursing School are very instrumental in the Department's health screening activity.
10) Staff conducted presentations during Division of Youth's Services' Family Support Week.//2008//

/2009/ Forming collaboration and partnership has been very successful with state human services agencies and the Department of Public Health. We have memorandum of understanding with Medicaid Program for outreach activities and data sharing and Public School System for provision of services for early intervention and also Head Start. We are committee members of VocRehab, Developmental Disabilities, Tobacco Coalition, Division of Youth Services, etc. As mentioned, there is only one government run hospital located in Saipan that provides primary care. There are two smaller health centers located in Tinian and Rota. These are under the umbrella of the Department of Public Health. The Medical Referral Program works with off-island tertiary care facilities in Hawaii and Philippines for patients needing such care. The Pacific Islands Health Officers Association (PIHOA) consists of health officers from the six jurisdictions.
The Northern Mariana Islands is considered a manpower shortage area. Therefore, we work with NHCS to recruit physicians and dentists to work at the Department. We also have students working on their MPH come to the CNMI to work on projects such as Childhood Obesity and currently PRAMS. One of the Department's strategic plans is building local manpower capacity so we continue to partner with University of Hawaii, SPC, WHO, USDA, FDA, University of Michigan, Northern Marianas College, CDC, MCHB, etc. for training. There is currently 7 staff participating in the MCHB MCH Leadership Competencies Project.
The WIC clinic was opened in August 2007. There are currently 2,819 participants. A site visit for the WIC Program was conducted in June. An ISA (Information Sharing Agreement) has been drafted with all programs and WIC that will include for general information sharing such as name, contact information and reason for referral, eligibility status, etc. The WIC Program Outreach Plan in coordination with the MCH Program includes awareness promotion activities, referral system, building community partnerships, and increasing accessibility. Clinical staff, CSHCN staff, and EIS staff received training on Medicaid eligibility assistance. The Social Worker also assists parents with other applications such as food stamp, SSA, housing, utilities.
The annual Parent forum was conducted. The forum brings in a panel of service providers for parents of CSHCN that include SSA and VocRehab. The panel format is a short presentation and then questions and answers. There are interpreters at the forum. Questions from parents who do not want to talk are given to staff or interpreter to ask to the panel members. Group family support activities were conducted: Trainer demonstrated strategies early intervention services staff who are not professional counselors can use to facilitate a family support group with associated children's program. The second family retreat was held: Family Counselor Marlyn Minkin worked with parents individually and in groups, provided counseling, and trained EIS and SPED staff. Two CSHCN parents will be attending a family support conference in July//2009//.

/2010/As was mentioned in the Organizational structure section the CNMI government provide majority of health and human services. The MCH Program has a successful working relationship with these agencies to enhance the capacity of the program. In addition, the coordination of services with other programs within the Division of Public Health, the Hospital Division, and the Community Guidance Center (CGC) has ensured the provision of comprehensive health services.

- ***WIC Program: We have collaborated in breastfeeding promotion -- we also worked with pediatricians as part of our H1N1 community education. Trainers from the Center for Breastfeeding will be conducting the Certified Lactation Counselor's training on August 10-14, 2009.***

- ***Wise Women Village Project: MCH Program continues to be one of the partners in providing preventive health screenings to indigenous women in the villages.***
- ***Family Planning Program: MCH Program staff is a member of the Family Planning Information and Educational Materials committee in which we review and solicit comments from the community on printed materials.***
- ***Medicaid: We continue with our work in eligibility assistance into the Program. We also provide information to Head Start Program and Early Intervention Services Program and at Public Health Clinics. As of February 2009, participants can access dental care at 2 private dental clinics. Thus, we are a referral source for the Program and its partners.***
- ***MCH Program and the Early Childhood Comprehensive System grant project in collaboration with agency partners that work with families of children 0-5 years of age and parents has increased outreach awareness in growth and development, oral health, parenting skills, mental health, literacy, nutrition, physical activity, etc.***
- ***Reach Out and Read Program: We have purchased books for this program in addition to MCH Program staff and partner volunteers reading at children's clinic.***
- ***MCH Program Coordinator was one of the grant writing team for CDC's Diabetes and Tobacco Integration Cooperative Agreement grant which got approved. One activity is smoking cessation classes will be conducted specifically for pregnant women.***
- ***Head Start Community Assessment Report: MCH Program staff were part of the team to write the report.***

We continue with ongoing collaboration activities such as the School Dental Program in which students are bussed to the Public Health Clinic for education, mouth examination, and fluoride varnish and sealant application; conduct presentations during Parent Leadership Week with Division of Youth Services; Cooking Show with Diabetes Prevention and Control Program; Work with Northern Marianas College Cooperation Research Education Extension Services on providing educational intervention measures for living healthier lifestyles; and the Public School System with provision of early intervention services and care coordination for children with special health care needs and training for parents/families. Our partnership with Shriners' Honolulu Hospital has been ongoing for the past 20 years to provide outreach services to children with orthopedic problems//2010//

F. Health Systems Capacity Indicators

Introduction

/2009/The MCH Program works with 1) all programs within the Division of Public Health 2) Hospital Division 3) Community Guidance Center 4) other agencies to report on health systems capacity indicators including participating or supporting activities. There is a memorandum of understanding with the Medicaid Program to provide data and eligibility assistance training to MCH Program staff. Our continued challenge is developing databases so that we can gather data/information electronically. With the unexpected death of the Division's Systems Administrator, Ms. Elizabeth Palacios, we have no one working on this. For the upcoming needs assessment, one of the area we are looking into is again data collection method and the quality of the data collected. We will review health status indicators by ethnicity, insurance status, residence, etc.//2009//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	91.0	184.7	198.7	83.5	296.9
Numerator	51	106	110	47	167
Denominator	5606	5738	5536	5627	5624
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2008
In 2008, 167 children 0-4yrs diagnosed with Asthma were hospitalized.

Notes - 2007
47 children aged 0-4 hospitalized for asthma. Denominator was revised to 5627.

Notes - 2006
110 less than 5 yrs hospitalized for asthma. Denominator revised from 5886 to 5536 to reflect the latest population estimate and projection.

Narrative:
The data is collected through the RPMS - the health information system for the Department of Public Health. Because albuterol treatments for asthma are provided at the Children's Clinic this may affect the true rate of hospitalization. In addition, nebulizer machines can be purchased by insurance, including Medicaid. The most current effort is our discussion with the Area Health Education Center Program that will be bringing a consultant whose expertise is in developing asthma surveillance system next month. The MCH Program continues to purchase materials per pediatrician's recommendations for parents. We continue to participate in activities of the Community Guidance Center on second hand smoking. Please note, that because we are in the same Department and the same facility, MCH Program can access this information.

/2009/The Program continues to work with providers to educate parents on asthma and upper respiratory illnesses with materials. We release public service announcements when there's a volcano eruption or fire that affects the air quality on the islands. The nurses provide albuterol treatments at Children's Clinic. We also collaborate with Immunization Program to prioritize children with asthma for the flu shot. The Hospital Division is scheduled to upgrade from MSM to Cache. This will allow CHC (Commonwealth Health Center) to progress to electronic medical records. It is the goal of the SSDI project to assist CHC in this upgrade so that the Maternal and Child Health program has data of a higher quality on a timely manner. Other collaborations include promoting smoke free policies and information on second hand smoking.//2009//

//2010//The MCH Program purchases brochures and dvds as requested or recommended by pediatricians or nurses for parents. Thus, our activities on children and asthma continue with providing parents/families with information to lessen the onset of asthma or decrease the need for hospitalization or the length of hospital stay. Again, Medicaid participants can also access care to 4 private health care clinics located in different villages. We have also worked with the Gift Shop located at the hospital to sell the nebulizer machine that can be purchased by Medicaid participants.//2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	36.1	24.4	37.0	43.3	32.5
Numerator	489	325	526	438	267

Denominator	1353	1332	1422	1012	821
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
In 2008, 267 <1yr medicaid enrollees received at least one initial periodic screen at 6 six immunization screening. Enrollees pending immunization.

Notes - 2007
1012 medicaid enrollees less than 1 year old in 2007; 438 under medicaid had initial screen. Need to finalize figure.

Notes - 2006
526 medicaid enrollees aged less than 1 year received at least one initial periodic screen in 2006. Data derived from RPMS. Denominator revised from 1422 to 1129, medicaid enrollees in 2006

Narrative:
Medicaid enrollees whose age is less than one year received their health care only at public health clinics -- Southern Community Wellness Center, Children's Clinic, Commonwealth Health Center, Tinian Health Center, Rota Health Center, and the Dental Clinic. The MCH Program continues to work with the well baby care clinic and the Immunization Program to track Medicaid enrollees. We have been in discussion with both the Immunization Program and the WIC Program to assist us in our tracking efforts and to make sure these enrollees receive screenings. The new Immunization Registry -- Web IZ - will be implemented next month. This will greatly influenced our ability to improve our work to plan for activities. Please note that we also continue to work with Medicaid Program in educating their clients about the importance of accessing and utilizing preventive health care services. Brochures are provided to the Medicaid Program.

/2009/As of February 2008, Medicaid enrollees can access health care services at two private clinics. This has been a strategy for many years for we wanted to make sure the enrollees have options for health care. This will also help out with the limited resources of the hospital. There are currently 3 pediatricians staffing the Children's Clinic. Another new initiative is that developmental screening information is included in the new "My Baby's Health Passport" record. We also have MOUs with private clinics and one of the private clinics does waive immunization administrative fee. We continue with outreach activities on preventive services with Medicaid Program. We are also in discussion regarding allowing enrollees to access dental care at private clinics.//2009//

/2010/The granting of Medicaid participants to access health care and dental care services at private clinics has greatly influenced the program's ability to maintain and improve on this health system capacity indicator. Furthermore, the Immunization Program have an MOU with four private clinics in to provide vaccines free of charge including waiving of administrative fees. We have focused our preventive activities to provide parents with the developmental checklist starting from 0-3 months, 3-6 months, etc. The nurses and pedicatricians has commented on how parents are asking questions because they read the developmental checklist that was provided. In addiition, we have internal referral agreements with Immunization Program, WIC Program and Newborn Hearing Screening Program. There are additional information for preventive screenings on the Yellow

Immunization Shot Record that includes developmental screening, dental care, and newborn hearing screening.//2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	36.1	24.4	46.6	43.3	32.5
Numerator	489	325	526	438	267
Denominator	1353	1332	1129	1012	821
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Same as Medicaid. Actual figure pending immunization.

Notes - 2007
SCHIP same as medicaid.

Notes - 2006
SCHIP same as Medicaid.

Narrative:
/2009/The SCHIP is used as an expansion of the Medicaid Program, thus our work with SCHIP enrollees is the same as HSCI #02.//2009//

/2010/Again, the SCHIP is used an an expansion of the Medicaid program//2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	18.2	24.2	32.8	43.5	18.8
Numerator	172	323	466	515	22
Denominator	943	1332	1422	1183	117
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The data reported is from a face-to-face interview with 135 patients after delivery.

Notes - 2007
Beginning with the 2007 annual report, the Pacific Basin Jurisdictions may have changed to the World Health Organization (WHO) standard rather than the Kotelchuck Index to report indicator data for HSCI04. The WHO standard recommends as essential that pregnant women make four prenatal care visits.

1183 qualified pregnant women to determine kotelchuck index. 515 had adequate prenatal care checkup.

Notes - 2006
499 women were in the kotelchuck index and 156 were at 80 and above percentile kotelchuck index. 446 is the representation of the 1422 pregnant women

An attachment is included in this section.

Narrative:
Once we get the women in for the initial visit they complete their visits. Thus through our review of our prenatal care data, we need to enhance our work to make sure that pregnant women do come in for early prenatal care visit. The public health medical director conducted a presentation on prenatal care visit using the Kotelchuck Index in 2004. We have plans to do another one in September. We will conduct the PRAMS-like survey this coming October. There are 3 private clinics that provide prenatal care services. Some of our awareness activities include billboards, educational materials, and focus groups.

/2010/The Assessment of Prenatal Care Visit Report by an MPH student last year will influence the program's ability to improve on this health system capacity indicator. The MCH Program will include in the SSDI project activities that will improve data collection. We have discussed some of the recommendations of the report -- i.e. Review of data entered in the delivery log book; standardization of abbreviations used; and digitization of delivery log book using check boxes. One activity to assist us in identifying interventions and outreach programs is to conduct postpartum survey of women with emphasis on those who did not receive prenatal care.//2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	31.9	26.1	32.6	27.4	29.2
Numerator	6673	6313	7261	6113	6550
Denominator	20934	24150	22248	22319	22409
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
In 2008, 6550 1-21yrs old received service paid by Medicaid program.

Notes - 2007
6,113 children 1-21 yrs received service paid by Medicaid Program. Data derived from RPMS. Denominator revised from 25466 to 22319.

Notes - 2006
Medicaid enrollees 1-21 yrs received service paid by Medicaid Program. Data derived from RPMS. Denominator revised to reflect children 1-21 year old in state, from 24808 to 22248.

Narrative:
The MCH Program does not assist in efforts to receive payment from the Medicaid Program for provision of services to Medicaid Program. This is true for both the current enrollees and the potentially Medicaid eligible children. The Medicaid program is very limited because the US federal government caps CNMI Medicaid expenditures. For example, the CNMI Medicaid program spend $7,297,828 in FY'04 but got only $2,381,000 in federal Medicaid funds. This accounts for 18% of the total expenditures. Medicaid is only accepted at the government run health facilities. This presents a unique challenge in reducing health disparities in that Medicaid clients cannot access the health care available at the private clinics. Thus, the MCH Program works to provide Medicaid enrollees or potentially eligible enrollees access to health care service regardless of insurance status.

/2009/All public health clinics and the Commonwealth Health Center (Hospital) provide services to residents of the CNMI regardless of insurance status or ability to pay. When patients inform us that they have submitted Medicaid applications or are waiting for their Medicaid Card, we do put write this down as part of their patient information on the insurance section.//2009//

/2010/We continue to provide eligibility assistance to patients accessing care at southern community wellness center and the early intervention services program. In addition, the CSHCN Social Worker continues to go with families as requested to the Medicaid Program Office for appointments. We met with the 4 private health clinics that provide services to Medicaid participants to include eligibility assistance but all reported that people with no insurance do not come to their clinics. Those with no insurance come to the Department of Public Health for services and again no one is denied services regardless of insurance status.//2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	17.3	23.9	24.9	27.8	22.8
Numerator	889	1267	1035	1165	967
Denominator	5124	5307	4164	4186	4238
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
In 2008, 967 medicaid enrollees received dental services.

Notes - 2007
1,165 children 6-9 years received dental services in 2007. Data derived from RPMS. Denominator revised from 5671 to 4186.

Notes - 2006
1,035 EPST aged 6-9 yrs received dental services iin 2006. Denominator revised from 5489 to 4164 to reflect latest population in state.

Narrative:
The Dental Clinic has a School Oral Health Program in which fluoride varnish and sealant application are provided to students in Head Start, first, fifth, and sixth grades enrolled in public and private schools. These children are bussed to the clinic by the Public School System. Services include mouth examination, education -- including the parents -- and a 'report card' detailing the treatment plan required. Last school year, we worked with the Head Start Program to bring in the children enrolled in Medicaid to start their treatment plan. We submitted the Targeted State MCH Oral Health Service Systems Program grant application last month to assist us in our work to improve access to dental services.

/2009/The School Dental Program assists the MCH Program in improving this health system capacity indicator. We conduct mouth examination, do sealant application, and provide oral health education during the visits. The program is set up for 1st, 5th, and 6th grades. The percent of 1st grade EPSDT eligible children that were assessed was 58%. A database is being created at the Dental Clinic so that we can collect this information electronically.//2009//

/2010/The ability for Medicaid participants to access dental care at private dental clinics will assist the program to improve on this indicator. Please note the through the School Dental Program we provide oral mouth examination and sealant application to students in 1st, 5th, and 6th grades. Majority of the time, this is the first time that a child has been to a dental clinic. We are a referral source to the Medicaid Program for dental care services and to the private clinics.//2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	45.4	45.4	89.7	94.0	95.2
Numerator	147	147	209	221	239
Denominator	324	324	233	235	251
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
239 <16yrs old SSI beneficiaries received services.

Notes - 2007

Children 16 and less receiving SSI

Notes - 2006
209 < 16yrs received SSI payments in 2006. 233 beneficiaries in 2006.

Narrative:
The CSHCN Program is stationed at a community-based center -- Children's Developmental Assistance Center (C*DAC). We work with the Public School System to provide early intervention services which includes physical therapy, occupational therapy, speech therapy, etc. There is a physical therapy unit at the Commonwealth Health Center.

/2009/The number of state SSI beneficiaries for those that are less than 16 years old is reported in the Social Security Administration, Supplemental Security Record. Rehabilitative service such as physical therapy is provided at the home -- Early Intervention Services Program, the hospital -- Physical Therapy Unit, and at the schools -- Public School System Special Education Program. The challenge for getting data is that majority of programs, including public health, do not collect SSI information. We do provide SSI information and assist with application process but we do not keep a record whether they are receiving SSI benefits.//2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	20.3	60.8	5.8

Notes - 2010
20 percent under medicaid; 60 percent non-medicaid; 6 percent low birth weight of total birth.

Narrative:
We provide a copy of this health system capacity indicator to the Medicaid Program Director. We really do work with the program to provide awareness to utilization of preventive services. In addition, we also work with service providers that have Medicaid clients to assist us in our work. The MCH Program Coordinator will meet with the MCH Advisory Committee to assist the Program in planning activities. We will also work with the Early Childhood Comprehensive System Coalition in our promotional activities. Our clinic and nursing staff are multi-lingual and they do appear on radio and television campaigns to promote prenatal care, nutrition, etc.

/2009/We have provided the two private clinics with brochures such as prenatal care. We are consistent with our message to seek well care exams on a timely manner. We are currently conducting the PRAMS-like survey to provide us with additional information for program planning. For the upcoming needs assessment, one of the criteria we will review on the health status indicators is insurance status -- Medicaid, other private insurance, and uninsured. We will work with other programs, agencies, and community to assist us in developing strategies to improve outcomes. The Programs continue to provide information to the Medicaid Program Office on prenatal care, growth and development, oral health, nutrition, immunization, mammogram, pap smear, etc.//2009//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	0	0	3.9

Notes - 2010
infant death 5; medicaid 0; non-meidicaid 5; total death 179 for 2008.

Narrative:
We continue to put our work into educating the community to importance of prenatal care visits, immunization, well baby care visits etc. We provide training to clinical staff and again we provide information in the prenatal care packages, the public health clinics, private clinics, Medicaid Program Office, and other service providers. We will be working with the ECCS Coalition in our work to increase awareness.

/2009/Our work in this health system capacity is the same at HSCI 05A. Although, we did not conduct a chart review for infant mortality, we did conduct one for fetal death in which insurance status is one maternal risk factor we looked at.//2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	31.5	58.4	17.3

Notes - 2010
1st trimester=211; 67 medicaid; 144 non-medicaid; 211 of 1266

Narrative:
This would be the same as #04. Once we get the women in for the initial visit they complete their visits. Thus through our review of our prenatal care data, we need to enhance our work to make sure that pregnant women do come in for early prenatal care visit. The public health medical director conducted a presentation on prenatal care visit using the Kotelchuck Index in 2004. We have plans to do another one in September. We will conduct the PRAMS-like survey this coming October. There are 3 private clinics that provide prenatal care services. Some of our awareness activities include billboards, educational materials, and focus groups.

/2009/We continue to inform Medicaid clients that come to public health clinics that they can now

seek health care services at two private clinics. We have the names, phone numbers, and location of the two clinics. This is per our 2006-2207 goals in our Evaluation of Prenatal Care in the CNMI for 2006 report: 1) CNMI DPH should continue to focus on moving low-risk prenatal patients into the private sector and 2) CNMI DPH must work to improve the availability of Medicaid for those who are pregnant and eligible Program - eligibility assistance training was conducted to Clinical Attendants. We will gather more information on Medicaid clients for the upcoming needs assessment.//2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files			

Notes - 2010
Carry over data from the previous year pending kotelchuck report.
Medicaid=31.7;

Narrative:
Our work in this will be the same as #04 and #05C. We will provide this information to the Medicaid Program Director. Once we get the women in for the initial visit they complete their visits. Thus through our review of our prenatal care data, we need to enhance our work to make sure that pregnant women do come in for early prenatal care visit. The public health medical director conducted a presentation on prenatal care visit using the Kotelchuck Index in 2004. We have plans to do another one in September. We will conduct the PRAMS-like survey this coming October. There are 3 private clinics that provide prenatal care services. Some of our awareness activities include billboards, educational materials, and focus groups.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

Infants (0 to 1)	2008	150

Narrative:
/2009/The percent of poverty level required for program eligibility in the State's Medicaid and SCHIP programs for infants, children, and pregnant women is at 150%. Again, please note that enrolling our target population into the Medicaid Program is being actively being done. We work with other service providers with the same target population Early Childhood Comprehensive System Coalition, Head Start, etc. Again, Medicaid Program staff conducted a training on eligibility assistance to Clinical Attendants.//2009//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 4) (Age range 5 to 10) (Age range 11 to 18)	2008	 150 150 150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 4) (Age range 5 to 10) (Age range 11 to 18)	2008	 150 150 150

Narrative:
/2009/The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants, children, and pregnant women is at 150%. Again, please note that enrolling our target population into the Medicaid Program is being actively being done. We work with other service providers with the same target population: Early Childhood Comprehensive System Coalition, Head Start Program, etc. Eligibility assistance is provided at the wellness center. We also continue with referrals to Medicaid Program and we also bring completed application form to the Medicaid Program Office as requested.//2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	150

Narrative:
/2209/The same as HSCI #06A and 06B.//2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2010

Narrative:
Again, please note that although we do not have direct access to the electronic database, the MCH Program can get the key public health data sets related to women, children, and families. We do have access to the department's health information system, Resource Patient Management System (RPMS) and is MUMPs baaed. With previous funding from the SSDI grant, two staff from the Health and Vital Statistics Office has attended trainings on the system. We also have direct access to standalone databases such as the Early Hearing Detection and Intervention surveillance system and the birth and death certificates. Another factor is that there is one systems administrator at the Division that works with all the programs.

/2009/The MCH Program's strength is its collaboration with Division programs and other agencies. Some of the methods to assure access to policy and program relevant information include Memorandum of Understanding (MOU) -- Information Sharing Agreement ((ISA with WIC Program), committee members for other agencies such as Developmental Disabilities, and finally participating in events such as DYS Family Fun Day, PSS Teen Symposium, Connecting

Families Inc., Open House at day care centers, etc.//2009//

/2010/As has been mentioned, the MCH Program has established partners with all agencies that provide services to our target population. This has assisted us in strengthening our position in areas such as the Smoke Free Air Act. Our partners also need data from the MCH Program, for example the Head Start Program Community Assessment, so we are constantly working together. Programs such as WIC, Medicaid and the Hospital Division all fall under the Department of Public Health which provides for easier access to information.//2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:
The YRBS is conducted every two years here in the CNMI. The lead agency is the Public School System. The Division of Public Health assists in conducting the survey. Community Guidance Center (CGC) staff provides counseling services at the Adolescent Health Center located at one of the public high schools. Our work in the area is to provide the educational materials and participate in events and activities of CGC such as Kick Butt Day and Sting Operation. We conduct activities to encourage and promote healthy life choices.

/2009/Conintued collaboration with Public School System with the Adolescent Health Center, outreach activities, and conducting YRBS and the Community Guidance Center YTS (Youth Tobacco Survey) are assisting the MCH Program in our work for this indicator. The 2004 YTS shows that 39.3% currently smokes cigarettes and 52.5% currently uses other tobacco products. 2,439 students in grades 9-12 participated in the survey. The YTS will be conducted this coming school year. In the YRBS, the percentage of students who ever tried cigarette smoking, even one or two puffs went from 82.7 in 2005 to 78.1 in 2007. One new strategy is promoting smoke free environment at work places and at restaurants.//2009//

/2010/This information is provided to the Program by the Community Guidance Center (CGC) Prevention Office and the Public School System (PSS). The PSS conducts the YRBS every two years. We are provided with access to the survey results and we conduct outreach activities with the schools and other partners in this area. CGC also conducts the Youth Tobacco Survey and we are provided with survey results. We provide support with activities such as the sting operation.//2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2010/.Studies have shown that statistics on women, infant, and children combine with their ability to access health care services are precursors to high rates of morbidity and mortality. In addition, studies have shown that evidenced-based intervention programs and preventive health care can reduce or eliminate the risk factors. The 2005 needs assessment identified15,543 women aged 25-60 years that were identified as not having had a pap smear for the past 4 years in 2004. Because the most prevalent cancers in women in the CNMI are those that could be prevented and/or cured with early detection and treatment, we worked to overcome cultural barriers and educate women on the importance of screening and in making sure that they have access to these screenings. Thus with funding from the Office on Women's Health, the Wise Women Village Project (WWVP) was implemented in 2007. In reviewing the referrals for women that accessed service through the Project, we see a pattern of health problems that are associated with lifestyle. Women were counseled and referred for hypertension, diabetes, obesity, and tobacco use. The success of the project is through the leadership of the program manager and partners such as MCH Program, Breast and Cervical Cancer Screening Program, and Family Planning Program. The progress towards increasing the number of women that receive a pap test and a mammogram has improved especially since we give women the opportunity to receive preventive health screenings in an environment away from a hospital setting. In addition, WWVP paves the way to address nutrition and physical activity within the families. Although the focus is on the woman, we have received comments from the women on how the project benefits the family as a whole. The MCH Program has focused on media campaigns for the past two years. These include television, print media, and radio. We looked at opportunities to work with our partners to assist us with the information or message that would work for our community. To reiterate, the strength of the MCH Program is through the partners that we have established. As partners, the WWVP and BCCSP focused on promoting women's health while the MCH Program focused on promoting planned pregnancies and early prenatal care. We have met to discuss ways to improve the collection of prenatal care data per recommendations in the Prenatal Care Assessment Report by Dr. Jean-Olivia Grant in which we will focus for the coming year. We have increased awareness on children's growth and development, including awareness of autism spectrum disorders. Through the Early Childhood Comprehensive System strategic plan, we have been working together to empower families with information and knowledge. This is evident with the EIS Program in which 61% of the referral source is from parents and/or grandparents. One of the top 5 reasons why they are referring their child is because they read the developmental checklist provided to them at the public health clinics. We also continue to refer families to the WIC Program. There are 2,272 infants aged 0-48 months currently enrolled in the WIC Program. The program has been instrumental in providing nutrition education to families, including benefits of breastfeeding. They have providing incentives such as tote bags, infant t-shirt, and breastfeeding books.

Although the MCH Program has made progress to reducing and/or preventing mortality and morbidity for women, infants less than 1 year of age and children aged 1 to 14 years challenges remain to be seen. For example, we continue to struggle with low numbers for early and adequate prenatal care. As was mentioned in the report, these women tend to live in the southern part of the island of Saipan. Please note that the Southern Community Wellness Center is situated in this area staffed by 2 women's health nurse practitioners. In this part of the island there were 9 garment factories (some closed last year and all closed earlier this year due to the impending federalization of immigration and labor laws that was supposed to have been implemented in May 2009). By law all health care costs, including prenatal care, are to be paid by employers. Non resident workers normally do not report seek prenatal care for fear of being deported. Please note that partner programs are aware of national and state performance measures and national and state

outcome measures.
In looking at the expenditures and budget for the MCH Program, we still continue to use majority of the funds for direct health services. This is a reflection of the decreased in budget for the Department as a whole. Again, the program continues to also work with other programs that can provide direct health services while we focus on the other three service levels of the MCH pyramid. Finally, please note that emerging issues may arise that will move resources such as staff and funding away from current program plans. A case in point is H1N1.//2010//

An attachment is included in this section.

B. State Priorities

Direct Health Care: Currently, the greatest challenge to the health care system is to meet the increasing demand of human and financial resources for prevention, medical management, and off-island referral. The capacity and resource capability of the Division of Public Health to help achieve the goals of the national and state performance measures is very limited. The Division, through leadership of Mr. Pete T. Untalan, has reorganized its public health care facilities by bringing it out to the community. The Southern and Northern Community Wellness Centers are located in villages that are within several miles from the Commonwealth Health Center. Mid-level providers staff the wellness centers with support from the Medical Director who is a family practitioner. The Adolescent Health Center is the first ever school-based health center in the CNMI. Other new facilities that were established and are located away from the Commonwealth Health Center facility are the HIV/STD Treatment and Resource Center, The Diabetes Prevention Research and Resource Center, and the Bureau of Environmental Health. Renovations are pending for the Area Health Education Center and the Kagman Community Health Center. The strength in providing direct health care services for the maternal and child population is the dedication, competency, and commitment of the current staff.

Enabling: The Division in its commitment to ensure 100% accessibility to health care services has been providing transportation assistance to the community. In the brochure on the Northern and Southern Wellness Centers it is stated "Please call us if you cannot get to the clinic because you do not have a ride and we will do our best to help you". The Breast and Cervical Screening Program and the Children with Special Health Care Needs Program do provide transportation for doctor's appointment. Furthermore, we also provide transportation to other appointments, i.e., Nutrition Assistance Program, and the Social Worker assist with filling applications for parents of children with special health care needs. Division staff comes from multi-cultural background so translation is usually not a problem. The only thing is that we need to expand the translation of resource materials to other languages such as Bangladesh and Thai. We are working closely with the World Health Organization to focus training of staff to behavior change modification.

Population-based: The Office of Special Education conducted a site visit to the Early Intervention Services Program at the Children's Developmental Assistance Center. As was mentioned, early intervention services are provided in collaboration with the Public School System, Early Childhood Special Education Program. In the Memorandum of Understanding, the Division of Public Health is responsible to ensure a comprehensive public awareness and child find system. Activities we reported for public awareness and child find include radio interviews with early intervention providers and parents in the different languages, Open House at the Center (parents actively participate in this event -- they talk to the media and visitors about the benefits of the program), participation in community events, disseminate developmental checklist to all clinical providers, put program brochures at all health facilities and prenatal package, referral procedures provided to private clinics with an in-service, giveaways, information tables at local grocery stores, coordinate public awareness and child find activities with other departments/agencies, etc. It was highly recommended that materials be translated to other languages, i.e., Pohnapeian and Chinese. The results of the children with special health care needs survey was presented to parents of children enrolled in the early intervention services during their monthly parent night.

Although, parents of children with special health care needs are generally satisfied with their child's care, more resources need to be dedicated to assisting them to access other services, i.e., assistive technology. As public health staff, we need to be more active team members in the development of the Individualized Education Plan. Due to limited resources, services for children with special health care needs are provided in collaboration with other departments/agencies. We are fortunate to have a community health nurse that is a registered nurse to be the coordinator for the specialty clinics for children with special health care needs.
The recruitment of the pediatric nurse practitioner and the dental hygienist will enhance the work of the Division in providing education to the community in oral health including baby bottle syndrome, prenatal and oral health, providing outreach at the schools, etc. The pediatric nurse practitioner has been active in promoting awareness of child health issues. She was one of the trainers, along with the dentist, in providing in-service to the interviewers for the Healthy Living in the Pacific Islands survey.

Infrastructure Building: The Division of Public Health has made great strides in strengthening the current workforce capabilities to ensure sustainability of staff in providing services to the community. The most significant achievement is that the CNMI received the Area Health Education Center (AHEC) grant from the John A. Burns School of Medicine. Funds from the AHEC grant are currently supporting the NCLEX review class for thirteen local nurses. The CNMI Department of Public Health currently relies on recruiting nurses and other health professionals from the Republic of the Philippines. One recommendation from the prenatal focus group is to recruit nurses from other places. This will be one way to reduce recruitment costs and not to mention remove the burden of the lengthy process involved in the recruitment process. Another area that AHEC is supporting is that it provided funds and arrangements for high school students to go to Honolulu, Hawaii to attend the University of Hawaii --Kapiolani Community College health careers opportunity program. The students were introduced to different health careers. In addition, three science teachers, including the students, attended the 3rd Annual Health Professional Summer Institute. The recruitment of the System Administrator has assisted programs to submit data elements to be warehoused. The Division is seeking technical assistance in the implementation of an electronic medical record and data linkage to other units within the hospital.
The Division submitted the Community Health Center section 330 grant application, Early Childhood Comprehensive State System grant application, and the Early Hearing Detection and Intervention Surveillance and Tracking grant application and the WIC State Plan. The MCH Coordinator is working in collaboration with the Head Start Program to submit the Head Start Oral Health Initiative application.

/2007/ The residents of the CNMI, specifically the indigenous population of Chamorros and Carolinians, have a high rate of diabetes and breast and cervical cancer remain the first and sceond most prevalent canceers and the first and third leading causes of cancer deaths in women. Programs such as Maternal and Child Health, Breast and Cervical Screening Program, and the Diabetes Control and Prevention has been instrumental in its efforts to improve service delivery to empower the community through education and information to assist them live healthier lifestyles. Breastfeeding promotion, provision of nutrition and physical activity events, WIC Program, etc. decreases obesity among children and the Division in their collaboration with other agences work to provide familes the tools and skills in their lives tools to help them make better decisions. Prevention of vaccine preventable diseases and the sealant and fluoride varnish application supports our work to ensure that children are healthy and ready to learn. We continue to work hard to provide families of children with special health care needs with the comprehensive and continuous care coordination to assist them with the specialized care of their children. We bring in off-island physicians with specializations in pediatric cardiology, orhopedic problems, neurology, etc. and we also refer off-island for care and treatment. Regardless of austerity measures, we continue to recruit providers and train staff to enhance skills to provide primary and preventive health care services to the community. We also continue to apply for federal funds to assist the Department in its work to ensure a healthier community.//2007//

/2008/ Due to the economic crisis, the government working hours has been reduced from 80 hours to 72 hours. The need to enhance and strengthen our work to educate and provide the community with tools and knowledge to live healthier lifestyles is more critical now. Here in the CNMI we are facing factors such as decrease in salary, high utilities cost, high fuel costs, factories and other private businesses closing thus no jobs, budget cutbacks (Head Start Program budget was reduced by 35% thus need to decrease enrollment), and high health care costs. Our priority is to provide primary and preventive health care service to our community. This is evident with the opening of the WIC Program, HIV/STD Resource and Treatment Center, Adolescent Center, Wise Women Pap Project, Wise Women Village Project, and Breast and Cervical Cancer Screening Program (our CDC grant application for this program has been approved). Through the Early Childhood Comprehensive System strategic plan we need to work with our partners to assist families in the development of their children so that they are healthy and ready to learn at school entry. Because we have high rate of breast and cervical cancer, high rate of childhood obesity, high rate of Type II diabetes, children engaging in sexual activity at a much younger age, low prenatal care rate, we have to work with our community to assist them make healthier life choices. Most of the Division programs have advisory committees or coalitions. We also continue to collaborate with institutions such as University of Hawaii to conduct surveys to provide us with information to help us tell our stories to the community. Signs that we are getting through to our community includes 1) seeing more people out walking or running at the walkways/pathways, 2) more accessible places to exercise, 3) agencies, both public and private, giving staff time off to exercise, 4) water only at parties and fiestas, 5) the Sabalu Market in which farmers sell their crops is now held on Tuesday nights also, and 6) food is not allowed to be served at the church during rosary -- 9 nights of prayers held at the church in which dinner is served every night.//2008//

/2009/The priority needs for the CNMI MCH Program focuses on provision of direct health care services that was determined by conducting the needs assessment and using information such as health status indicators, performance measures, outcomes, resources and capabilities for the mch population to identify these needs. This in turn is strengthened by provision of enabling and population-based services and by improving or building infrastructure, including collaboration and surveillance, to ensure a system of care is in place. In collaboration with the BCSP (Breast and Cervical Screening Program) and the Wise Women Village Project, we are working to strengthen the public health infrastructure by providing access to pap test and mammograms to women. The target population for the MCH Program is all women whereas the target group for BCSP has to fall within the program's eligibility guidelines and the target group for WWVP is local indigenous women. Therefore, we refer women (especially those with no insurance) that qualify for these programs and plan and conduct outreach and awareness activities. In addition, we provide staffing for the evening clinics and the village clinics and in turn we get staffing assistance on case management for abnormal test results from BCSP. A major intervention activity for WWVP is participant education regarding physical activity, BMI, nutrition, and tobacco cessation counseling. These activities are related to Performance Measure #15, #18, and State Performance Measure #1, #2, and #6. We distribute information on the importance of all preventive screenings.
The CNMI conducted the HPV School Campaign in collaboration with Immunization Program, MCH Program, Commonwealth Cancer Association, Stellar Marianas, student organizations, and the Public School System. We provided HPV vaccines to girls in all the high schools in Saipan, Tinian, and Rota. This is because most of the cancers in women are those that can be cured with early detection. And every year 6 women are diagnosed with cancer in the CNMI. We make sure that preventive health screenings are part of the messages in our awareness campaigns. The activities are related to performance measure #08, #16, and SPM #4.
Because of the importance of providing early intervention services, we continue to enhanced child find and public awareness activities with our partners. Through these activities our referral numbers have increased thus an increase in the percentage of infants served. One of our collaboration is that we put developmental screening information on the new shot record which is called "My Child's Health Passport". (Please see attached) This activity is also related to performance measure #2-5 and SPM #6.

Our media campaign focused on importance of prenatal care. Prenatal care information are in all local newspapers and tv spots in the local talk show, and guest appearances by provider (public and private) to discuss prenatal care. Some of the information focused on gestational diabetes - diabetic and being pregnant, nutrition and physical activity, what is prenatal care, and also on postpartum care. This activity is related to PM#18 and SPM #7.
Our strength in our work is in our collaboration but we continue with challenges such as shortage of staff, budget cutbacks, high costs for health care services -- i.e., mammogram, geographic location, etc.//2009//

/2010/The capacity and resource capability of the MCH Program lies in the commitment of existing staff and the strong collaboration we have established. In addition, we continue to look for opportunities to extend our collaboration. For example, our upcoming activity Innovative Readiness Training with the USN 4th Medical Battalion and 4th Dental Battalion from San Diego, CA will provide us with not just the provision of dental service for children with special health care needs but also training and continuing medical opportunities for the medical providers and dental unit staff. Furthermore, the Health Fair will provide the community with the education and information on healthy weight, nutrition, exercise/fitness, sports injury prevention, tobacco cessation, suicide prevention, oral health, diabetes mellitus and hypertension prevention. This one activity will enhance our work with children with special health care needs -- NPM #03; NPM #09 on protective sealants and even HSCI #07B; SPM#06 on nutrition; and NPM ##16 on suicide.
The Program's continual projects with partners provide and improve the capacity to provide services for all levels of the MCH pyramid. Although we continue to provide the community with access to health care services away from the main hospital facility such as with the Wise Women Village Project and private clinics with the Medicaid participants, we have increased our enabling and population-based services activities. Per partners' survey results, we have provided written materials such as brochures, posters, flyers, booklets. For example, the Childcare Program conducted a parent survey and they listed needing more information on oral health. We worked with the dental unit and researched information from the American Academy of Pediatrics and developed the Parents Checklist for Good Dental Health Practices. We also purchased toothbrushes to be given to the children that come to the dental clinic. The ability for Medicaid participants to access dental care at 2 private dental clinics will help improve overall outcomes for children. We worked with physicians and providers on the developmental checklist and had flyers printed and color coded per age group. We continue with prenatal care campaign, newborn hearing screening, early intervention services, and breast and cervical screening awareness. We continue with exhibits/information tables during community events and our partners' awareness events, i.e., Developmental Disabilities Month, Week of the Young Child, Women's Health Week. Dental Awareness Week, etc. These activities focuses on all the national and state performance measures.
Due to the shortage of Lab Unit staff, we have procured the contractual services of Mr. Quan Shensong to develop the newborn screening data system. Again, this is a new collaboration for the MCH Program with the Oregon State Public Health Laboratory. We have been granted a username and a password to access newborn screening results. In addition, we have established a reporting system to include the MCH Program Coordinator as one of the recipients of the final closure letter on a case. This has been one of the SSDI project's accomplishment for the year and will greatly improve tracking efforts. This activity is related to NPM #1. We are also working with the same contractor on the birth defects registry. The completion date for these two data systems is September 2009.//2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80	82	96.5	97	98.5
Annual Indicator	87.0	96.1	0.0	0.0	0.1
Numerator	1177	1280	0	0	1
Denominator	1353	1332	1422	1385	1266
Data Source					Lab
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					Yes
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98.5	98.5	98.5	98.5	98.6

Notes - 2008
In 2008, newborn metabolic screening 1112. Hypothyroidism 1 positive case receiving treatment.

Notes - 2007
Metabolic screening 1075. There were no positve case for newborn condition in 2007.

Notes - 2006
Newborn metabolic screening 1303. There were no confirm cases in 2006.

a. Last Year's Accomplishments
1)Continue to provide newborn screening brochures as part of the prenatal care package.
2)Procured contractual services to develop newborn screening data system linking with birth certificates.
3)Conduct chart reviews to ensure that results are filed in the charts.
4)Me with Pediatricians and Lab Unit manager to address issues and concerns on data collection and reporting

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Purchase newborn screening brochures		X	X	
2. Procured contractual services to develop newborn screening data system linking with birth certificates.		X	X	
3. Conduct chart reviews to ensure that results are filed in the charts.		X	X	
4. Meet with Lab Unit manager to address issues and concerns on data collection		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1) Discussions with Oregon State Public Health Laboratory regarding development of data system.
2) Received approval for MCH Program Coordinator to have authorized access to newborn screening results - username and password process completed.
3) MCH Program Coordinator learning Oregon's Lab system and working with Lab Unit staff at the Commonwealth Health Center.
4)Working with contractor on the data system - i.e., time frame on when to download newborn screening data -weekly or monthly. The Lab Unit over here receives monthly reports from the Oregon Lab.

c. Plan for the Coming Year
Completion of Newborn Screening Data system including linkage to birth certificates and training.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		87	87	87	88
Annual Indicator	87.0	87.0	87.0	87.0	87.0
Numerator	147	147	147	147	147
Denominator	169	169	169	169	169
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88	88	88	88.1	88.1

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2005 for this performance measure.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

1)CSHCN Survey committee established
2) Survey questionnaires reviewed and completed
3) Survey form printed

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Survey committee established; Survey questionnaires reviewed and approved; Surveys are being printed		X	X	X
2. Continue with working with one pediatrician for the child - when a child is sick, parent will ask for the same pediatrician that the child has seen	X	X	X	
3. Seek health care service at private clinics for Medicaid participants - have choices for Medical Home now	X	X	X	X
4. Provide interpreter when requested		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)CSHCN being conducted - started June 15, 2009.
2)Working with Public School System's Special Education Program in Saipan, Rota, and Tinian to conduct the survey
3)Continue to work with families of Children with Special Health Care Needs on all aspects of care coordination including working and partnering with their providers.
4)Continue to provide interpreters as needed during specialty clinics.

c. Plan for the Coming Year
Complete survey and analyze survey data. This will be done in a report. Provide survey results to the families - we will work with our partners to do this.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective		68	69	69	69
Annual Indicator	68.0	68.0	68.0	68.0	68.0
Numerator	115	115	115	115	115
Denominator	169	169	169	169	169
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-					

year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70	70	70	70.2

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2005 for this performance measure.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1)CSHCN Survey committee established
2) Survey questionnaires reviewed and completed
3) Survey form printed

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Can seek care at 4 private clinics if Medicaid participant	X	X	X	X
2. Provide transportation when requested		X	X	
3. Work with parents to request to see same pediatrician most of the time - i.e. when child is sick ask to see same provider	X	X	X	
4. Facilitate and coordinate specialty clinics such as Shriners and Pediatric Cardiology	X	X	X	X
5. Process referral papers for off-island care	X	X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)CSHCN being conducted - started June 15, 2009.
2)Working with Public School System's Special Education Program in Saipan, Rota, and Tinian to conduct the survey
3)Continue to provide service coordination with early intervention services program clients.
4)Medicaid participants can access health and dental care services at private clinics.

c. Plan for the Coming Year
Complete survey and analyze survey data. This will be done in a report. Provide survey results to the families - we will work with our partners to do this.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		68	69	69	70
Annual Indicator	68.6	68.6	68.6	68.6	68.6
Numerator	116	116	116	116	116
Denominator	169	169	169	169	169
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70	70	70	70.5

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2005 for this performance measure.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1)CSHCN Survey committee established
2) Survey questionnaires reviewed and completed
3) Survey form printed

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Eligibility assistance provided at Children's Developmental Assistance Center		X	X	
2. Continue to participate in cross agency training to learn of resources that are being provided to target population		X	X	
3. Refer to Medically Indigent Assistance Program		X	X	
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
1)CSHCN being conducted - started June 15, 2009.
2)Working with Public School System's Special Education Program in Saipan, Rota, and Tinian to conduct the survey
3)Continue to provde Medicaid eligiblitiy assistance to clients at wellness center and early intervention services program.
4)Provide interpreters as requested during interviews
5)Provide transportation as requested to Medicaid Program Office.

c. Plan for the Coming Year
Complete survey and analyze survey data. This will be done in a report. Provide survey results to the families - we will work with our partners to do this.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		44	45	45	46
Annual Indicator	43.2	43.2	43.2	43.2	43.2
Numerator	73	73	73	73	73
Denominator	169	169	169	169	169
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46	46	46	46.1	46.2

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2005 for this performance measure.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1)CSHCN Survey committee established
2) Survey questionnaires reviewed and completed
3) Survey form printed

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Program staff a member of Developmental Disabilities Council (DDC) - funds Family Hope Center		X	X	X
2. Refer famlies to work with system navigators at Family Hope Center		X	X	X
3. Social worker and service coordinators assists families for enrollment to other services, transportation, etc.		X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)CSHCN being conducted - started June 15, 2009.
2)Working with Public School System's Special Education Program in Saipan, Rota, and Tinian to conduct the survey
3)Early Childhood Comprehensive System project works with partners including those that provder services CSHCN and their families.
4)Provide resource directory to families.
5)Participate in cross training of agencies panel to provide information of all the programs at the Division of Public Health
6)Refer families to Family Hope Center to work with the Center's System Navigators.

c. Plan for the Coming Year
Complete survey and analyze survey data. This will be done in a report. Provide survey results to the families - we will work with our partners to do this.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective		6	6	7	7
Annual Indicator	5.9	5.9	5.9	5.9	5.9
Numerator	10	10	10	10	10
Denominator	169	169	169	169	169
Data Source					CSHCN survey

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8	8	8	8	8.1

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2005 for this performance measure.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1)CSHCN Survey committee established
2) Survey questionnaires reviewed and completed
3) Survey form printed

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DDC writes grant for assistive technology devices and financing for home loans.		X	X	X
2. Adolesecent Health Center nurse a member of IEP team		X	X	
3. Included question on whether families discuss with pediatricians the move of their child to adult providers on new CSHCN survey being conducted		X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)CSHCN being conducted - started June 15, 2009.
2)Working with Public School System's Special Education Program in Saipan, Rota, and Tinian to conduct the survey
3)Adolescent Health Center Coordinator a member of IEP team at the schools.
4)Continue to work with partners to implement programs/services for transitional living - i.e. Developmental Disabilities Council's Assistive Technology Program.
5)Please note that we are including a new question on the survey which asks if pediatrician

discussed with parents the transition of their child's care to adult providers.

c. Plan for the Coming Year
Complete survey and analyze survey data. This will be done in a report. Provide survey results to the families - we will work with our partners to do this.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	90	75	75	88
Annual Indicator	67.8	66.9	72.3	76.9	77.1
Numerator	1167	852	1273	1109	1125
Denominator	1720	1274	1761	1442	1459
Data Source					Immunization Registry
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88.5	88.5	88.5	89	89

Notes - 2008
In 2008, 1125 19 to 35 month olds received full schedule of appropriate immunization.

Notes - 2007
Of 1442 19-35 month old, 1109 received full immunization schedule

Notes - 2006
1273 19 to 35 months olds received full schedule of age appropriate immunization.

a. Last Year's Accomplishments
1)Conducted the 2007 Immunization Coverage Survey
2)Enter information into WebIZ Immunization Registry
3)Training on WebIZ Registry

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Open Immunization Walk-in Clinic	X	X	X	
2. Recruit staff for tracking		X	X	X
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)Recruit staff for tracking and follow up
2)Implementing the WebIZ Immunization Registry
3)Partner with MCH and WIC Program for referral of children
4)Work with early intervention services program and CSHCN to ensure age appropriate immunization for target population

c. Plan for the Coming Year
Work with CDC National Immunization Program to complete the analysis of the 2007 Immunization Coverage Survey.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	30	28	31	30	26.5
Annual Indicator	35.4	31.3	22.2	21.5	20.3
Numerator	41	37	33	33	32
Denominator	1159	1184	1485	1533	1573
Data Source					live birth certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	26.5	26.5	26.5	26.5	26

Notes - 2008
32 teens 15-17yrs gave birth in 2008.

Notes - 2007
33 births for mothers 15-17 years old in 2007. Denominator revised.

Notes - 2006
33 teenagers aged 15-17 years for 2006.

a. Last Year's Accomplishments
1)Partner with family planning program in promoting planned pregnancies

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. As of September 2008, family planning services can be accessed at Women's Clinic	X	X	X	X
2. Recruit Coordinator for Adolescent Health Center (Ms. Carol Paez resigned)	X	X	X	X
3. Continue to work with parents and students in our activities such as HPV School Campaigns and focus group activity on health determinants		X	X	
4. Title X Pacific Basin Family Planning Conference provided training in which nursing staff can receive continuing education credits		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1)Adolescent Health Center -- a school-based health center continues to provide services to students

2)Partnered with other parent support programs to provide sessions to parents on communication, parenting tips, focusing on adolescents at village youth centers.

3)As of September 2008, family planning services can be accessed at Women's Clinic.

c. Plan for the Coming Year

Work with the Public School System for the upcoming YRBS survey.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	82	81.5	60	60	66
Annual Indicator	56.9	58.8	65.0	65.9	90.7
Numerator	1564	1582	1650	1907	691
Denominator	2748	2690	2537	2892	762
Data Source					Dental program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	67	68	68.5	69	69

Notes - 2008
First graders only. First sealant application. Of the 762 first graders, 691 students received at least 1 protective sealant in 2008.

Notes - 2007
1,907 1st, 5th, and 6th graders received protective sealant in 2007; 2,892 1st, 5th, and 6th grade enrollees.

Notes - 2006
1st, 5th, & 6th graders received sealants for 2006.

a. Last Year's Accomplishments
1)The Public Health Dental Clinic has been working with Head Start Program's Family Advocates in which they go to homes to provide education and counseling to the entire family. The benefit of sealant application is discussed at the homes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue with bussing of students to Public Heatlh Dental Clinic	X	X	X	X
2. Purchase sealant application kits		X	X	
3. Conduct outreach activities during community events including doing fluoride varnish application	X	X	X	
4. Dental Assistants from Saipan went to Tinian to assist with School Dental Program	X	X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)Continue with School Dental Program in collaboration with Public School System, private schools, and parents
2)Purchase sealant application kits

c. Plan for the Coming Year
The Public Health Mobile Clinic is currently being used provide preventive health screening to women at the villages. There are discussions with other program such as Immunization, CSHCN, Dental Clinic, to use the mobile clinic for services focusing on children which may include sealant application.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	20	20	6	6	0
Annual Indicator	0.0	12.5	12.5	0.0	6.1
Numerator	0	2	2	0	1
Denominator	15699	15978	15973	16443	16372
Data Source					Death certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	10	10	6	6

Notes - 2008
Only 1 MVA death in 2008.

Notes - 2007
Denominator revised

Notes - 2006
Average number for the last 3 years is 2, fewer than 5, therefore a 3 year moving average cannot be applied.

a. Last Year's Accomplishments
1)MCH Program and ECCS purchased activity booklets for children on safety which includes seat belts and car seats.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide information (printed materials) on child safety		X	X	
2. Refer to Office of Highway Safety for coupon to assist in buying car seats		X	X	
3. Collaborate and participate during child safety awareness event and community events		X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)Continue with education to parents on seat belts and car seats usage.
2)Refer to Office of Highway Safety for coupon to purchase car seats.
3)Brochures on the Department of Public Safety's "Driving Under the Influence" are available at the SCWC and the Immunization Walk-in Clinic.

c. Plan for the Coming Year
Re-introduce the Safety Awareness event activities with the Department of Public Safety in which an information table is set up at the public health clinics and inspection of car seats is also provided.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			80	80	80
Annual Indicator			47.8	35.0	33.7
Numerator			680	485	63
Denominator			1422	1385	187
Data Source					WIC program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	33	33	40	50	50

Notes - 2008
WIC data collection for mothers breastfeeding at 6 months started in October 2008. 245 mothers reported breastfeeding at 6 months of age.

Notes - 2007
Data provided by WIC, incomplete 2007.

Notes - 2006
WIC data not available yet. These figures are estimated from the birth registration. However, data from WIC will be collected for this performance measure.

a. Last Year's Accomplishments
1)Partner with WIC program to promote breastfeeding
2)Purchase brochures and posters on breastfeeding for the clinics and maternity ward
3)Breastfeeding materials part of informational tables/exhibits
4)Media campaign on breastfeeding
5)Opening of the new WIC Clinic

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Data collected from WIC Program will be used to report on this measure.		X	X	X

2. Lactation Counseling Certificate Training will be conducted next month to 50 participants in collaboration with WIC Program	X	X	X	X
3. Continue Media Campaign		X	X	
4. Video are being shown at WIC Clinic, Women's Clinic, and maternity wards		X	X	
5. Promotional items being given to breastfeeding mothers such as tee shirts, breastfeeding booklet, tote bags, etc.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
We are bringing in the Healthy Children Project to train all of our Nutrition Assistants (NA) and the public health community on breastfeeding and supporting it here on our islands (all three).
There is more focus on breastfeeding in the WIC clinic-- including promotional items (tote bag, breastfeeding book, and infant tee shirt) for mothers intending to breastfeed at delivery.
Continue with showing informative video on breastfeeding in our clinics waiting room (Breastfeeding, A magical bond of love), that our participants-- even children-- are watching (it includes some animated characters).

An attachment is included in this section.

c. Plan for the Coming Year
One NA will be attending a breastfeeding training program by Every Mother, Inc. and will eventually be the Breastfeeding Coordinator. This key staff will network with Labor and Delivery and Women's Clinic to make morning hospital visits to support moms with breastfeeding while at the hospital.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	99
Annual Indicator	100.0	99.3	99.4	97.7	98.3
Numerator	1353	1323	1414	1353	1244
Denominator	1353	1332	1422	1385	1266
Data Source					EHDI
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99	99	99	99	98.9

Notes - 2008
In 2008, 1244 newborn screened for hearing, 4 positive, 2 left and 2 receiving treatment.

Notes - 2007
1,383 newborns screened before discharge in 2007

a. Last Year's Accomplishments
1)Conducted training to 49 nurses on the components of Hearing Screening Program and Protocols following NCHAM recommendations
2)Mass Media Campaigns including infomercials
3)Recruiment of staff for follow-up

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Procured contractual services of Audiologist	X	X	X	X
2. Recruit EHDI Follow-up Coordinator	X	X	X	X
3. Training on components of hearing screening program was conducted to 49 hospital nursing staff		X	X	X
4. Continue with mass media campaign		X	X	
5. Revised brochures - including translation		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)Redid brochures per parents' recommendation
2)Purchase hearing screening supplies
3)Parents Retreat Weekend
4)Hearing Screening Waiver Form Approved
An attachment is included in this section.

c. Plan for the Coming Year
We are and will continue to work to first of all make sure that all babies received newborn hearing screening before hospital discharge and work to bring back those needing either a first screening or second screening following the 1-3-6 process (all babies are screened before 1 month, those babies that need a second hearing test do so by 3 months, and babies that need early intervention services receive it by 6 months).

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	13.9	12.9	44	44	43
Annual Indicator	15.6	44.6	48.7	50.7	61.7
Numerator	3138	9211	10335	9961	12155
Denominator	20064	20647	21230	19636	19707
Data Source					RPMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	60	55	55

Notes - 2008
2551 children 0-17yrs with no insurance.

Notes - 2007
9,961 children 17 years and under without health insurance in 2007. Total children in state revised to reflect new estimate projection.

Notes - 2006
Data derived from RPMS. Total number of non-insured children Less than 18 yrs were 10,335 for 2006. Will meet with Medical Records staff to explain variables of insurance coverage in the RPMS system.

a. Last Year's Accomplishments
As part of our outreach activity for information to the community Medicaid Program brochures is also included.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide eligibility assistance to Medicaid Program		X	X	X
2. Refer to Medically Indigent Assistance Program		X	X	
3. Participate in agency cross training to learn resources of agencies in the community that provide services to target population		X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)Continue with eligibility assistance at clinics and early intervention services program
2)Provide Medicaid Program information
3)Refer to Medicaid Program
4)Reviewing insurance status of all patients that come to Commonwealth Health Center and Public Health Clinics

c. Plan for the Coming Year
We have been working with the Financial Unit to identify how we can improve data collection for children with no health insurance. Again, we continue to have the problem of those paying for their share of their health insurance to be entered as 'self pay' in the system.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			50	50	50
Annual Indicator			0.0	0.0	25.9
Numerator			1	1	308
Denominator			5059	5220	1188
Data Source					WIC program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30	30	30	30	30

Notes - 2008
In 2008, total children in the WIC program aged 2-5 yrs. 308 were at or above the 85th percentile.

Notes - 2007
Estimated population 2-5 years in 2008. Data not readily available during this report

Notes - 2006
Number of children 2-5 years for 2006 is 5,059. WIC is not in operation yet.

a. Last Year's Accomplishments
1)Opening of the new WIC Clinic
2)Initiated healthy snacking group class

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Met with 2 Registered Dietician of WIC Program to discuss performance measure and doing collaboration		X	X	X
2. WIC voucher can be redeemed at local farmers markets for fresh fruits and vegetables		X	X	
3. Opening of new WIC Clinic Building	X	X	X	X
4. Healthy Cooking group classes - new building has a kitchen which allows for cooking demonstrations can be		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)Provide nutrition counseling to families on a one-to-one basis
2)Referral of families to RD
3)Nutrition Assistants (NAs) conduct presentations on healthy eating at Head Start Centers or at health fairs.
3)Continue with training of NAs on nutrition and physical activity

c. Plan for the Coming Year
Researching training opportunities for NAs to attend an online guided course on Maternal, Infant, Early Childhood Nutrition.
WIC will provide vouchers for fresh fruits and vegetables that can also be redeemed at the farmer's market.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			1	1	60
Annual Indicator		100.0	100.0	100.0	15.8
Numerator		1	1	1	12
Denominator		1	1	1	76
Data Source					PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	20	20	20	20

Notes - 2008
10% variance of 1266 pregnant women to be surveyed. Preliminary report based on 76 completed surveys. Final result pending completion of 51 remaining data entry.

Notes - 2007
Data on women smoked in the 3 months of pregancy is not available at the time of reporting

Notes - 2006
Surveillance on women smoked in the 3 months has not being implemented in the Women's Clinic, hence annual performance objective cannot be determined yet.

a. Last Year's Accomplishments
1)Prenatal Health Book that includes information on Pregnancy and Tobacco with the contact number of the Tobacco cessation program (please note that this was one of the information that was recommended to be included in the health book from a focus group we conducted)
2)MCH Program staff attended the Brief Tobacco Intervention Skills Certification Training
3)Provided comments and supported the Smoke Free Air Act

4)Participated in Kick Butts Day event

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Revised birth certificate will be able to capture this information		X		X
2. Integrate health promotion education with nutrition counseling, including anti-tobacco messages, and risk behaviors to the pregnant women		X	X	
3. Provided comments and supported the Smoke Free Air Act		X	X	X
4. Implement Wise Women Village model of care to wellness center in which counseling on smoking is included	X	X	X	X
5. MCH Program Coordinator part of grant writing team for the approved CDC Diabetes and Tobacco Integrated grant	X	X	X	X
6. Participated in Kick Butts Day event		X		
7.				
8.				
9.				
10.				

b. Current Activities

1)Integrate health promotion education with nutrition counseling, including anti-tobacco messages, and risk behaviors to the pregnant women
2)Initiate group tobacco cessation sessions for pregnant women

c. Plan for the Coming Year

The completion of the PRAMS-like survey. The survey is done on Rota and Saipan and we are working with Tinian Health Center staff on the logistics of conducting the survey over there. There has been priorities that have emerged that have relocate staff to work on activities, i.e., H1N1.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	50.5	50.5	5	5	1
Annual Indicator	0.0	0.0	0.0	0.0	18.9
Numerator	0	0	0	0	1
Denominator	4411	4528	4645	4762	5279
Data Source					Death certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

	2009	2010	2011	2012	2013
Annual Performance Objective	20	20	20	15	15

Notes - 2008
In 2008, only 1 suicide death 15-19 yrs.

Notes - 2007
No case of suicide for 15-19 years teens in 2007

Notes - 2006
No cases of deaths 15-19 yrs for 2006. Average 3 yrs, zero.

a. Last Year's Accomplishments
The Programs at the Division of Public Health, including MCH, with the lead of the Immunization Program conducted a successful HPV campaign at the public and private high schools. We worked with the students before we even conducted the campaign to guide us in the planning and implementation process. We worked with them on the incentive plan, providing education to parents and the students on HPV, printed materials including brochures and posters, the HPV packet, etc. This collaboration built not just leadership skills but trust in working with agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Counseling and mental health services provided at Adolescent Health Center	X	X	X	X
2. Conduct parent/families presentations focusing on parenting topics such as communication, parenting your teens, etc at village centers.		X	X	
3. Work with partners to conduct surveys or focus groups to guide us in our intervention work.		X	X	X
4. Partner with adolesecents on activities such as HPV Schools Campaign		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
We are currently working with high school students on identifying and prioritizing area specific to adolescent health determinants-like behaviors that contribute to unintentional and intentional injuries.
The school-based clinic provides counseling on a walk-in basis.

c. Plan for the Coming Year
The MCH Program with its partners will continue to work with adolescents toward the completion of the Title V 2010 Needs Assessment.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	1	1	1	1	1
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1	1	1	1	1
Denominator	1	1	1	1	1
Data Source					No high risk facility
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1	1	1	1	1

Notes - 2008
CNMI is excluded from this PM. There is no high risk facility in the CNMI.

Notes - 2007
CNMI is excluded from this PM. There is no high risk facility in the CNMI.

Notes - 2006
CNMI is excluded from this PM.

a. Last Year's Accomplishments
The CNMI is exempted from reporting on this national performance measure.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CNMI is exempt from reporting on this performance measure				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The CNMI is exempted from reporting on this national performance measure.

c. Plan for the Coming Year
The CNMI is exempted from reporting on this national performance measure.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	30.2	31.4	28	29	29.9
Annual Indicator	26.2	28.2	22.9	29.1	17.3
Numerator	354	375	326	403	219
Denominator	1353	1332	1422	1385	1266
Data Source					Birth registration
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30	30.9	31	31	31.1

Notes - 2008
PNC visit in 1st trimester in 2008 birth registration showed 213.

Notes - 2007
Derived from Birth certificates. 403 first visit in the 1st trimester 2007.

Notes - 2006
Based on the live birth registration data, only 326 women received prenatal care begining in the 1st trimester in 2006.

a. Last Year's Accomplishments
1)Partnered with Wise Women Village Project and Family Planning Program to promote planned pregnancies and early and continuous prental care.
2)Media campaigns
3)Development of Prenatal Care Booklet

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Prenatal Media Campaign		X	X	
2. Working on recommendations from assessment of prenatal care visit report		X	X	
3. Prenatal care services provided at all public health and private clinics	X	X	X	X
4. Medicaid participants can access prenatal care visits at 4 private health clinics	X	X	X	X
5. Working to improve data collection for this measure		X	X	X
6.				
7.				
8.				
9.				

10.				

b. Current Activities
1)Continue to provide prenatal care services at the clinics
2)Continue to refer Medicaid participants to private health clinics
3)Improve data collection for analysis of prenatal care rate - i.e. review data entered in delivery log book to see what can be deleted and replaced with relevant information
4)An MPH student is currently conducting a survey of postpartum women with emphasis on those that did not receive prenatal care

c. Plan for the Coming Year
1)Computerized the delivery log using check boxes
2)Review results of postpartum survey to direct interventions aimed at increasing access to care and guiding outreach activities.

D. State Performance Measures

State Performance Measure 1: *The percent of unplanned pregnancies of birth (per 1,000) for women aged 15-44 years*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			52.5	50	75
Annual Indicator	55.0	55.4	57.8	78.8	66.4
Numerator	744	738	822	1091	844
Denominator	1353	1332	1422	1385	1272
Data Source					Family Planning Program
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70	65	65	60

Notes - 2008
Estimated 66.7 percent reported unplanned pregnancies from the 196 mothers in 2008. Full report on family planning on prenatal care visits will be implemented for the proceeding years.

Notes - 2007
Total intended pregnancies in 2007 is 294, unintended 1091

Notes - 2006
822 women 15-44 yrs had unplanned pregnancies for 2006. Data derived from the Women's Clinic logbook.

a. Last Year's Accomplishments
1)Partner with Family Planning Program to promoting planned pregnancies and early prenatal care
2)Medicaid participants can access health care services including family planning at 4 private health clinics
3)Waive family planning services fees to adolescent

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with Family Planning Program to promoting planned pregnancies and early prenatal care		X	X	
2. Family planning services through the Title X funds can be accessed at Women's Clinic as of September 2008	X	X	X	X
3. Medicaid participants can access health care services including family planning at 4 private health clinics	X	X	X	X
4. Training provided to clinical staff at Women's Clinic		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1)Family planning services through the Title X funds can be accessed at Women's Clinic as of September 2008

2)Monthly review of log book at Southern Community Wellness Center for unintended pregnancy (looking at first prenatal care visit only)

c. Plan for the Coming Year

Implement Wise Women Village health care model at Southern Community Wellness Center

State Performance Measure 2: *Percent of women who have ever received a pap smear.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			7.9	7.9	7.9
Annual Indicator	7.4	7.9	10.0	11.0	11.1
Numerator	2550	2808	2512	2623	2533
Denominator	34239	35634	25140	23945	22760
Data Source					BCSP & Wise Women Project
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8	8	8	8	10

Notes - 2008

There were 2509 number of women ever received pap smear in 2008.

Notes - 2007

Denominator revised.

Notes - 2006

There were 2,512 women received pap smear in 2006. Data derived from Lab, Becky. Vital stats will set a collection system to keep track of all lab tests and newborn screenings. Denominator revised.

a. Last Year's Accomplishments
1)Successful partner with Wise Women Village Project and Breast and Cervical Cancer Screening Program
2)Recruitment of Case Manager
3)Purchase printed materials
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partner with Wise Women Village Project	X	X	X	X
2. Partner with Breast and Cervical Cancer Screening Program	X	X	X	X
3. Purchase printed materials to complement counseling		X	X	
4. Be a referral source for other programs		X	X	
5. Participate in awareness events such as Cervial Cancer Awareness Month and Marianas March Against Cancer		X	X	
6. Conduct presentations on preventive health screenings during women's health week		X	X	
7.				
8.				
9.				
10.				

b. Current Activities
1)Participate in awareness events such as Cervical Cancer and Marianas March Against Cancer

c. Plan for the Coming Year
Implement Wise Women Village model of care at Southern Community Wellness Center. It is a model of care that is:
- Integrated, one-stop shopping model of community-based health screening, education and referral
- Focusing on the identified health issues of women in the community
- Partnering with federally-funded programs , a faith-based organization and community-based organizations to build a consolidated effort to bring health care to the community
- Extension of model into community wellness centers

State Performance Measure 3: *Percent of women who have ever received a mammogram.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12.8	12.8	12
Annual Indicator	14.2	12.8	11.9	5.9	5.4
Numerator	1084	1014	1087	558	521
Denominator	7615	7949	9160	9387	9599

Data Source					lab
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	12	12.5	12.5	11

Notes - 2008
The number of mammogram decrease due to lack of professional staff from July to November 2008.

Notes - 2007
The decrease in mammography was due to lack of Radiologist in 2007. Denominator revised.

Notes - 2006
There were 1,087 women received mammogram in 2006. Data derived from radiology unit, Mina. Denominator revised.

a. Last Year's Accomplishments
1)Participated in Breast Cancer Awareness Month and Marianas March Against Cancer activities
2)Purchased brochures on self breast exam for Rota and Tinian Health Centers
3)Continue partnership with WWVP clinical breast exams
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partner with Breast and Cervical Screening Program	X	X	X	X
2. Provide referral to other programs		X	X	
3. Purchase printed educational materials		X	X	
4. Participate in awareness events such as Breast Cancer Awareness Month		X	X	
5. Conduct presentations on preventive screenings during Women's Health Week		X	X	
6. Worked with health department's radiology task force to address absence of mammography services. Mammography certified Radiologists from Guam were identified and contracted enabling the radiology unit to provide mammography services.	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
Worked with health department's radiology task force to address absence of mammography services. Mammography certified Radiologists from Guam were identified and contracted enabling the radiology unit to provide mammography services in December. There were no mammography services from July to November of 2008. We have been informing women regarding availability of services.

c. Plan for the Coming Year
We will continue to work to provide education and awareness on the importance of breast exam with our partners. We continue to assist with activities such as outreach and public education at various government and private offices

State Performance Measure 4: *Percent of eligible infants with disabilities under the age of 1 year receiving early intervention services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			132	132	30
Annual Indicator		132.9	17.6	30.3	43.4
Numerator		177	25	42	55
Denominator		1332	1422	1385	1266
Data Source					CDAC
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	45	45	50	50

Notes - 2008
In 2008, 55 infants were refered for early intervention. Four (4) infants received early intervention services but two (2) left the island since.

Notes - 2007
42 under 1 year old C DAC services in 2007

Notes - 2006
C DAC database. 99 were referals and 25 received early intervention services.

a. Last Year's Accomplishments
1)Continue with follow up of referrals at nursery and NICU
2) Continue to conduct presentation on early intervention services to doctors, nurses, related services staff, and at schools to encourage students to choose a career in either physical therapy, special education teacher, speech therapy, occupational therapy, etc. during Developmental Disabilities Awareness Month.
3)Developmental screening schedule on the baby's yellow immunization shot record.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CHSCN Coordinator continue to pick up referrals at NICU, children's clinic, and southern community wellness center	X	X	X	X
2. Met with nurses and pediatricians on filling out the referral forms to the early intervention services program		X	X	
3. Procured contractual services to develop data systems for newborn screening and birth defects registry		X	X	X
4. Early Intervention Services Program brochures part of prenatal care packet		X	X	
5. Conduct presentations at the physicians weekly meeting during Developmental Disability Awareness Month		X	X	
6. Developmental checklist ad printed in local newspapers and magazines		X	X	
7.				
8.				
9.				
10.				

b. Current Activities
1)The EIS, MCH, and ECCS Programs are working together to educate parents on developmental milestones for their children.
2)Please note that whenever there is a new provider, the EIS staff will meet with him/her/them regarding services including referral process.

c. Plan for the Coming Year
Increase our public awareness and child find activities and working with our partners - Early Childhood Comprehensive System Committee.

State Performance Measure 5: *The rate of chlamydia for adolescents aged 13-19 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			7	7	6
Annual Indicator	8.4	9.3	3.0	4.1	3.3
Numerator	52	59	22	30	25
Denominator	6191	6355	7241	7386	7544
Data Source					HIV/STD program
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	6	6	5	5

Notes - 2008
In 2008, 25 children ages 13-19 were positive for chlamydia.

Notes - 2007
13-19 year old with chlamydia in 2007. Denominator revised.

Notes - 2006
Adolescents aged 13-19 yrs positve for chlamydia were 22 in 2006.

a. Last Year's Accomplishments
We continue to provide services at Adolescent Health Center. As of September 2008, family planning services can be accessed at Women's Clinic. STD testing fees for adolescents are waived.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide services including counseling at the Adolescent Health Center	X	X	X	X
2. Partnered with students at each of the public and private middle and high schools for the HPV School Campagin	X	X	X	
3. Recruitment of Adolescent Health Center Coordinator	X	X	X	X
4. Partner with STD/HIV Prevention Program and Family Planning Program in prevention, early detection and treatment of sexually transmitted diseases	X	X	X	
5. Provide preventive health services such as patient education and counseling		X	X	
6. Purchase printed educational materials		X	X	

7.				
8.				
9.				
10.				

b. Current Activities
1) We continue with conducting presentations at schools.
2) Provide brochures on sexually transmitted illnesses at all public health centers.
3) Exhibits during community events include information on STIs.

c. Plan for the Coming Year
Working with teens on identifying and prioritizing area specific adolescent discussion of health determinants in whcih one of them is "Sexual Activity/Sexual Activity that Leads to Unintended Pregnancy and Sexually Transmitted Diseases". The MCH Program Coordinator and the Adolescent Health Coordinator attended a training on Adolescent Health in Palau by Dr. Wendy Adams and we are using the format from the training.

State Performance Measure 6: *The degree to which State provides nutrition education information to children aged 6 through 11 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	65	71.5	50	50	52.5
Annual Indicator	16.1	20.3	18.2	15.1	13.7
Numerator	140	468	800	525	663
Denominator	872	2310	4400	3485	4837
Data Source					Nutritionist
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	20	20	25	25

Notes - 2008
Total enrollment for 6-11yrs. Nutrition education est. at 662.

Notes - 2007
Preliminary figure for nutrition education 6-11 yr old.

Notes - 2006
2006 data is estimated only. Actual numbers pending Nutritionist.

a. Last Year's Accomplishments
1)Participated in school events
2)Conducted presentations during parent teachers meetings
3)Continue to work with partners in promoting nutrition and physical activity to families in general

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Cooking contest that includes this age group		X	X	
2. Participate in school events and health fairs		X	X	

3. Conduct presentations during parent teachers meetings		X	X	
4. Healthy food ads currently focuses on this age group		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)Cooking contest that includes this age group
2)Healthy food ads currently focuses on this age group
An attachment is included in this section.

c. Plan for the Coming Year
We met with WIC Program to utilize nutrition assistants (NAs) to assist with evening and weekend activities at the elementary schools. In additiion, we are working on researching for training opportunities for NAs to attend an online guided course on Maternal, Infant, and Early Childhood Nutrition.

State Performance Measure 7: *The percent of pregnant women that are screened for chlamydia.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	96	98	99	100	100
Annual Indicator	100.0	96.2	124.5	102.9	49.8
Numerator	1353	1281	1770	1425	633
Denominator	1353	1332	1422	1385	1272
Data Source					Lab
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	55	60	60	65

Notes - 2008
estimated number of pregnant women screened.

Notes - 2007
Provisional figure for pregnant women screened for chlamydia in 2007

Notes - 2006
1770 women were screened for chlamydia in 2006. 1422 pregnant women delivered in 2006.

a. Last Year's Accomplishments
1) Our activity has been to continue working with other programs to promote and provide education on preventive health.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. STD brochure included in prenatal packet		X	X	

2. Provide counseling and education	X	X	X	
3. STD/HIV information included in the prenatal health book		X	X	
4. Medicaid participants can access prenatal care services at 4 private health clinics	X	X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Most of our activity for chlamydia was focused with the teens. Again, as we are working on the 2010 needs assessment we as a Division need to come up with a user friendly environment for women. Women still have to carry their specimen to the Lab Unit in addition to having to pay for it first. Again, the MCH Program will take the lead to developing a plan on how to better assist women when they seek care.

c. Plan for the Coming Year
The Division of Public Health will conduct the BRFSS in January 2010.

E. Health Status Indicators

Introduction
/2010/The reporting of health status indicators to the community via committees, councils, coalitions, etc. has not only been shared by MCH Program but is information that is also requested. For example, unintentional injuries overall has been requested by Childcare Program and Department of Public Safety. In addition to being used when agencies conduct their presentations, we also get request from high school and college students especially on sexually transmitted diseases or birth outcomes for teens that include birth weight. We even provide information via charts and graphs as part of exhibits or informational tables. Because for example, chlamydia is a reportable disease, we do work with our data when we are working on new initiatives. One weakness is that although programs work together, we tend to do evaluation individually instead of together as a program - the lead in a project usually does the evaluation.//2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.8	7.4	8.0	5.8	5.8
Numerator	92	99	114	80	74
Denominator	1353	1332	1422	1385	1266
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
77 low birth weight in 2008 with 1266 live birth.

Notes - 2007
80 low birth weight in 2007.

Notes - 2006
114 live births less than 2500 grams in 2006.

Narrative:
/2010/Although, the rate has decrease slightly, we still have to work harder to imporve overall access to prenatal care. With headlines such as "700" on waiting list for government housing"; Nutrition Assistance Program participants increased"; $8M budget shortfall, Layoffs Imperative", etc. we need to work harder to promote the importance of early and continuous prenatal care visits. Our prenatal book has information on tobacco as was recommended by a focus group. Other ads include messages such as "Mothers who do not get prenatal care are three times more likely to have a low birth weight baby and five times more likely for the baby to die."//2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.2	6.5	7.0	5.3	4.0
Numerator	84	87	100	73	50
Denominator	1353	1332	1422	1385	1242
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Twenty (20) were preterm at <37 gestational age. There were 12 sets of twins - the most we have had in the CNMI.

Notes - 2007
73 singleton births less than 2,500 grams in 2007

Notes - 2006
There were 100 singleton live births less than 2500 grams in 2006.

Narrative:
/2010/There were 20 babies that were born less than 37 weeks. There were 7 sets of twins born. One of the method to collect smoking information is that smoking during the last 3 months of pregnancy will be included in the revised birtth certificate that will be implemented in January. Currently, most of the data we have is just the basic question of "do you smoke". We feel that if we put more effort into bringing in women for prenatal care we can decrease the rate more. We get our information from the birth certificate database so we get accurate data.//2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	0.7	1.0	1.1	0.5	0.2
Numerator	10	13	15	7	3
Denominator	1353	1332	1422	1385	1266
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
3 very low birth weight <1500g. 2 out of 3 were preterm less than 37 gestational age.

Notes - 2007
7 Very low birth weight in 2007

Notes - 2006
15 live births less than 1500 grams in 2006.

Narrative:
/2010/We conducted a chart review and we found out that 1 of the mothers smoked but again it was asked as a general question (birth certificate has a 1 number by yes - which is the same mother). Two were Medicaid participants and one had high blood pressure being treated and two of the babies were born less than 37 weeks. We continue to provide prenatal education and information with information on smoking and low birth weight babies and messages with "mothers who do not get prenatal care are three times more likely to have a low birth weight baby and five times more likely for the baby to die." We also have brochures on low and very low birth weight babies at public health clinics. We will also work with recommendations from a postpartum survey currently being conducted asking women why they do not go for prenatal care.//2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	0.7	0.8	0.9	0.5	0.2
Numerator	9	11	13	7	3
Denominator	1353	1332	1422	1385	1266
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
3 singleton very low birth weight <1500g; 2 preterm births.

Notes - 2007
7 singleton very low birth weight

Notes - 2006
13 singleton live births less than 1500 grams in 2006.

Narrative:
/2010/This will be the same for Health Status Indicator 02A.//2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.3	18.8	0.0	0.0	18.3
Numerator	1	3	0	0	3
Denominator	15911	15978	16395	16443	16372
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Three 0-14 yrs old unintentional injury mortality in 2008. One due to drowning, 1 due to MVA, and one due to seizure disorder.

Notes - 2007
Zero death unintentional injuries in 2007. Denominator revised.

Notes - 2006
3 yr average fewer than 5 events therefore, 3 yr moving average cannot be applied. Denominator revised from 15973 to 16395.

Narrative:
/2010/The cause of the two deaths are drowning and motor vehicle accidents. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	12.5	0.0	0.0	6.1
Numerator	0	2	0	0	1
Denominator	15911	15978	16395	16443	16372
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes

Is the Data Provisional or Final?				Final	

Notes - 2008
1 MVA death in 2008.

Notes - 2007
No MVA fatality for 14yrs and younger in 2007

Notes - 2006
3 yr average fewer than 5 events, therefore 3 yr moving average cannot be applied.

Narrative:
/2010/This is our first death since 2005. We continue to work with our partners especially Department of Public Safety. During the proclamation signing of child safety awareness month, parents of children that died from motor vehicle accidents participated in the reading of the proclamation. As stated, we will continue to educate our community on injuries especially this age group. Per 2007 YRBS results for middle school the percentage of middle school students who never or rarely wore a seat belt when riding in a car increased from 12.2 in 2003 to 15.7 in 2007.//2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	31.1	7.6	9.2	19.0	9.7
Numerator	4	1	1	2	1
Denominator	12859	13123	10838	10516	10271
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2008
1 MVA death 15-24yrs old in 2008.

Notes - 2007
There were only 2 MVA mortality aged 15-25 years in 2007. Denominator revised from 14111 to 10516 to reflect the latest population.

Notes - 2006
Average fewer than 5 events therefore a 3 yr moving average cannot be applied. Denominator revised from 13558 to 10838 to reflect the latest population estimate and projection.

Narrative:
/2010/Although we tend to focus our injury and safety education and information to younger children, we do provide printed information as requested by our partners. Per 2007 YRBS results;
-The percentage of high school students who never or rarely wore a seat belt when riding in a car driven by someone else increased from 14.1 in 2003 to 15.8 in 2007.

-The percentage of high school students who rode one or more times during the past 30 days in a car or other vehicle driven by someone who had been drinking alcohol decreased from 53.8 in 2003 to 48.1 in 2007.
-The percentage of high school students who drove a car or other vehicle one or more times during the past 30 days when they had been drinking alcohol also decreased from 19.4 in 2003 to 15.0 in 2007.
This is also one of the topics that we are working on with adolescents in identifying and prioritizing area specific adolescent health determinants: Behaviors that Contribute to Unintentional and Intentional Injuries".//2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8,396.7	7,597.9	6,770.4	2,882.7	2,504.3
Numerator	1336	1214	1110	474	410
Denominator	15911	15978	16395	16443	16372
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The top 3 nonfatal injuries are:
1) Accidental falls
2) stings/bites
3) cut piercing object

These numbers are from ER visits.

Notes - 2007
Number of children age 14 years and younger unintentional injuries was 681 in 2007

Notes - 2006
There were 1,110 non-fatal injuries aged 14 yrs and younger in 2006.

Narrative:
/2010/The three causes of nonfatal injuries are accidental falls, stings/bites, and cuts. We continue to provide the narrative for the Health Manual given to the childcare centers and relative care that participate in the Childcare Program. One of the incentive for last year's Head Start Parent Symposium was health kits that included antispetic cream for cuts. We do have brochures on stings - i.e., bees. We will provide this information at the next ECCS partners meeting so we can address this indicator.//2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	264.0	206.5	206.6	150.3	61.1
Numerator	42	33	33	24	10
Denominator	15911	15978	15973	15966	16372
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The numbers are from ER visits.

Notes - 2007
There were 24 children 14 years and younger in non-fatal MVA in 2007.

Notes - 2006
There were 33 non-fatal motor vehicle injuries in 2006 for children age 14 yrs and less.

Narrative:
/2010/Our numbers show a decrease of nonfatal injuries due to motor vehicle crashes for this age group over the years. To reiterate, the Department of Public Safety has been very visible in the community as far as conducting checkpoints, billboard ads, media ads ,etc. We are working to bring them back to Public Health Clinics during child safety awareness month.//2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1,065.4	866.1	599.7	351.8	311.6
Numerator	137	105	65	37	32
Denominator	12859	12123	10838	10516	10271
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
32 15-24yrs old nonfatal MVA injuries in 2008.

Notes - 2007
37 non-fatal MVA injuries among 15-24 years old in 2007. Denominator revised from 14111 to 10516 to reflect the latest population.

Notes - 2006

There were 65 non-fatal motor vehicle injuries among 15-24 yrs youth in 2006. Denominator revised.

Narrative:
/2010/The hard work of our partners has influenced our ability to improve on this status indicator. We tend to focus our work more on the 14 years and younger because we work with the parents. We also realize that we do not do anything for the college students as far as safety education. We will work with our partners to increase our efforts to ensure that the rate keeps going down.//2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	15.7	22.9	20.3	11.9	8.6
Numerator	46	58	52	30	22
Denominator	2926	2529	2567	2517	2544
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
22 cases of chlamydia 15-19 yrs olds in 2008.

Notes - 2007
30 15-19 women positive chlamydia. Denominator revised from 2658 to 2517 to reflect the latest population.

Notes - 2006
There were 52 women 15-19 yrs reported. Denominator revised to reflect the latest population.

Narrative:
/2010/All fees for STD testing are waived for adolescents. They can access service at the Adolescent Health Center, Tinian and Rota Health Centers, STD/HIV Resource Center, Southern Community Wellness Center, and Women's Clinic. Per YRBS results among high school students the percentage of students who ever had sexual intercourse decreased from 53.9 in 2003 to 49.7 in 2007. However, among students who had sexual intercourse during the past three months, the percentage who used a condom during last sexual intercourse increased from 35.6 in 2003 to 40.1 in 2007. We continue with our efforts with not just services at the school-based center, but also with education and counseling. The HPV School Campaigns for both junior and senior high schools also provided the opportunity to conduct STD prevention education to both parents and students. We still need to also increase awareness of STI testing//2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.3	4.4	3.7	5.5	2.1
Numerator	122	128	66	89	32
Denominator	28186	29226	17696	16320	14888
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
32 women with chlamydia aged 20-44yrs old in 2008.

Notes - 2007
89 women 20-44 yrs positive chlamydia. Denominator revised to reflect the latest population.

Notes - 2006
There were 66 women aged 20-44 yrs reported chlamydia. 17,696 ages 20-44 women in state.

Narrative:
/2010/Again, STD testing is provided at all the public health centers. In addition, it is also done at the 6 private clinics. We need to work to improve a more user-friendly service for women coming in for STD testing or even pap test. All fees have to be paid before they can go to the lab to drop off the specimen. We also need to put more effort into awareness of sti testing. We need better collection on our data which we will be working on. We have numbers of testing in general but not broken down to age group.//2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	0	0	0	0	0	0	0	0
Children 1 through 4	5335	110	0	0	1919	2315	991	0
Children 5 through 9	5243	9	0	0	1580	2540	1114	0
Children 10 through 14	5621	9	0	0	1461	2975	1176	0
Children 15 through 19	4972	33	0	0	1072	2989	878	0
Children 20 through 24	6261	68	0	0	4147	1647	396	3
Children 0	27432	229	0	0	10179	12466	4555	3

through 24								

Notes - 2010
Less than 1yr old is not shown. Combined with Less than 5 yr olds. The figures derived from the 2005 HIES.

Narrative:
/2010/Large portion of women of childbearing age are contract workers from asian countries. We also get tourists from asian countries that come to Saipan to deliver their babies on U.S. soil. This becomes a challenge for us in tracking and lost to follow up efforts. These babies tend to be send off-island and we don't have a way of knowing if they exit the islands. They end up in our numbers for lost to follow up. We will see a decrease in this demographic because of the closure of the garment industry and the upcoming federalization of immigration and labor laws.//2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	0	0	0
Children 1 through 4	5335	0	0
Children 5 through 9	5243	0	0
Children 10 through 14	5621	0	0
Children 15 through 19	4972	0	0
Children 20 through 24	6261	0	3
Children 0 through 24	27432	0	3

Notes - 2010
Less than 1 yr old not available. Population combined with Less than 5 yr olds. Source: 2005 HIES.

Narrative:
/2010/We do look at the demographics of the target population but for the CNMI it is from the asian countries.//2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	1	0	0	0	0	1	0	0
Women 15 through 17	32	0	0	0	7	25	0	0

Women 18 through 19	63	0	0	0	10	50	3	0
Women 20 through 34	919	2	0	0	524	387	6	0
Women 35 or older	251	2	0	0	202	47	0	0
Women of all ages	1266	4	0	0	743	510	9	0

Notes - 2010
Source: Live birth registration

Narrative:
/2010/The federalization of labor and immigration laws was supposed to be implemented in May 2009. However, it got extended to November 2009. The garment industry started closing last year and the last 9 closed January 2009. Some of the workers chose to leave the island but some also stayed behind. There is also a misconception among the guest workers that if they have a baby on U.S. soil, they can stay. Majority of the babies born last year were to Filipino and Chinese mothers. This also provides us with challenges as they don't seek early and continuous prenatal care.//2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	1	0	0
Women 15 through 17	32	0	0
Women 18 through 19	63	0	0
Women 20 through 34	919	0	0
Women 35 or older	251	0	0
Women of all ages	1266	0	0

Notes - 2010
No hispanic women give birth in 2008.

Narrative:
/2010/Our public health work involves the demographics of the indigenous population of chamorro and carolinian and women from asian countries and not hispanic or latino.//2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	5	0	0	0	2	3	0	0
Children 1 through 4	1	0	0	0	0	1	0	0
Children 5 through 9	0	0	0	0	0	0	0	0
Children 10 through 14	2	0	0	0	0	2	0	0
Children 15 through 19	2	0	0	0	0	2	0	0
Children 20 through 24	2	0	0	0	1	1	0	0
Children 0 through 24	12	0	0	0	3	9	0	0

Notes - 2010
Source: Death registry.

Narrative:
/2010/We do have asian children in the above age category living in the CNMI as listed in health status indicator #6A. We will conduct a chart review of the deaths above to provide us with more information such as whether the 2 are newborns. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	5	0	0
Children 1 through 4	1	0	0
Children 5 through 9	0	0	0
Children 10 through 14	2	0	0
Children 15 through 19	2	0	0
Children 20 through 24	2	0	0
Children 0 through 24	12	0	0

Notes - 2010
No hispanic death in 2008.

Narrative:
/2010/We do not have people that puts hispanic or latino as their ethnicity. In the CNMI it would be asian that will eventually outnumber the indigenous population//2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	21171	161	0	0	6032	10819	4159	0	2008
Percent in household headed by single parent	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Number enrolled in Medicaid	2309	6	0	0	1478	825	0	0	2008
Number enrolled in SCHIP	2309	6	0	0	1478	825	0	0	2008
Number living in foster home care	15	0	0	0	0	9	6	0	2008
Number enrolled in food stamp program	6669	26	0	0	1668	4975	0	0	2008
Number enrolled in WIC		0	0	0	0	0	0	0	2008
Rate (per 100,000) of juvenile crime arrests	946.8	0.0	0.0	0.0	73.9	766.7	101.6	4.6	2008
Percentage of high school drop-outs (grade 9 through 12)	3.6	0.0	0.0	0.0	11.5	78.1	0.0	10.5	2008

Notes - 2010
Source: 2005 HIES

Data not available from the 2005 HIES.

Not applicable.

Data derived from NAP program. 0-19yrs totaled 6669 in 2008.

Data not available yet.

205 Juvenile arrest in 2008

Total drop out 9-12 graders total 114 in 2008.

Narrative:
/2010/The CNMI's economic downturn has resulted in an increase of the population seeking government assistance as is evident in headlines. Unfortunately, we also see headlines about increase in juvenile crime arrests. There has also been an increase for presentations on basic health and hygiene at the juvenile detention center (among discussions with other program staff, some have even mentioned that they do not even know where the center is located since this is the first time for them to go there). We feel that the increase in Medicaid participants is because it is not being accepted at 4 private health clinics and 2 private dental clinics. Even our calls to the main line (hotline) is for information on the Medicaid Program. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	21171	0	0	2008
Percent in household headed by single parent	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	0.0	0.0	0.0	2008
Number enrolled in Medicaid	2309	0	0	2008
Number enrolled in SCHIP	2309	0	0	2008
Number living in foster home care	15	0	0	2008
Number enrolled in food stamp program	6669	0	0	2008
Number enrolled in WIC	0	0	0	2008
Rate (per 100,000) of juvenile crime arrests	946.8	0.0	4.6	2008
Percentage of high school drop-outs (grade 9 through 12)	3.6	0.0	10.5	2008

Notes - 2010
Data not available.

Not applicable.

Data not available yet.

Narrative:
/2010/Again, in the CNMI we have Asians and not hispanic or latino.//2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	0
Living in urban areas	21171

Living in rural areas	0
Living in frontier areas	0
Total - all children 0 through 19	21171

Notes - 2010
urban population, derived from 2005HIES

no boundary

no boundary identified

Narrative:
/2010/We are aware of transportation problems for our population. We also work with communities that are situated farther away from health care facilities in our prevention work. The Kagman community is located in the northeastern part of Saipan. There are about 4,000 residents in that community. We applied twice for the Section 330 grant to open a community health center in that village but did not get approved. We continue to participate in health fairs and conduct presentations at the schools in that village - elementary, middle, and high school. We also provide home visits when requested.//2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	55179.0
Percent Below: 50% of poverty	22.1
100% of poverty	62.5
200% of poverty	77.7

Notes - 2010
Total persons 55179

Below 125 percent of poverty level based on 2005HIES or 34387 persons

Below 185 percent of poverty level or 42878 persons based on the HIES 2005.

Narrative:
/2010/We are reporting on the HIES 2005 survey. The data is indicating to us that our population cannot afford to pay for health care services. Again, this is why we continue with our outreach activities to provide the community with the knowledge and tools to live healthier lifestyles.//2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	17638.0

Percent Below: 50% of poverty	35.0
100% of poverty	0.0
200% of poverty	0.0

Notes - 2010
Total population from the census 2000 ages 0-19 years.

Based on the 2000 Census, 35 percent of 0-19 yrs old was below 50% of poverty level.

Not available

Narrative:
/2010/Medicaid Program works with the guidelines of 150% below the poverty level. We do not have accurate numbers to report on this health status indicator. We do have programs in the Division that work with poverty level guidelines but for adults. We are reporting on 2000 census data.//2010//

F. Other Program Activities

-Food and Drug Administration (FDA) Regional Food Code Training -- inspectors from Guam and CNMI Bureau of Environmental Health were trained on food code standards.
One staff attended the Food and Drug Administration Inspection Standardization Training in Guam.
-Training for Bio-Terrorist First Respondents -- a multidisciplinary approach on responding to major disasters and/or bioterrorist. Trainees from Saipan, Rota, and Tinian that attended were from Emergency Management System, Division of Public Health, Hospital Division, Department of Public Safety, Fire Department, and Commonwealth Ports Authority (Seaport/Airport).
-Eco-Arts Festival -- awareness and education on using environmental friendly products. Festival activities included were using local products for cooking and serving food on recycled products, and making clothes from recycled products for the fashion show.
-Asunton Hinemlo -- quarterly newsletter that is given out to the community. The newsletter contains information about some of the Division's projects/activities, gives background information of staff, provide contact information, calendar of events, and tips on staying healthy.
-Village Inspections - inspections at all the villages to provide education on vector borne places, etc.
Cooperative-Education Program -- students from two public high schools came to work at the Division of Public Health. They rotated among all the programs and then did an evaluation of the programs.
-Hillbloom Pacific Resident Training Program -- Third year residents in pediatric and internal medicine from the University Of San Francisco School Of Medicine will do clinical rotations at the Commonwealth Health Center as part of their training program. The will provide clinical services to the community and will be potential recruits for longer term employment in the future.
-Pacific Basin Interagency Leadership Conference -- CNMI hosted the conference this year. Participants from the Pacific Jurisdictions attended the conference. The CSHCN survey results were presented at one of the session. The conference brought together all the different agencies/disciplines that serve people with disabilities.
-Smokefree Facility -- TDepartment of Public Health facility is a smoke-free facility; Quitline -- a Hotline for people who needs help to stop smoking; Smoking Cessation Class -- in collaboration with Community Guidance Center, Medical Director facilitates the class with the staff of the Tobacco Prevention Program. The patch is also provided to participants.
-The Division's staff attended the annual infection control in-service that is mandatory for all

health care workers with patient contact.
-Division of Public Health Employees Rules and Regulations manual was completed.
-Family Health Fair -- This is the second year for this event in which the Division of Public Health were a committee members. Over 300 people attended the health fair. We noted that 190 stopped by Division of Public Health's informational table. We had the opportunity to talk about preventative services and provided education/information. We also asked for recommendations on how to improve our services.
-Walk on Wednesday (WOW) -- blood pressure and glucose screening is provided along with nutritional and physical fitness information.
-Speaker's Bureau -- Speakers from the Division are identified as to the specific topics they can talk on. This makes any request from the community much easier for referral.
-Leadership Award -- For the first time, Mr. Pete Untalan, Deputy Secretary for Public Health Administration, nominated all program managers for the Department's Leadership Award.

/2007/ The Department of Public Health has reinforced its Non-smoking and no chewing betel nut policy.
Pressure Point Project - a community outreach project on preventing sexual coercion targeted at middle and high school adolescents. The format for the outreach project is theatrical or performance format such as short film, one-act play, music-oriented and other performance venues to explore empowerment of our youth to resist sexual pressure or coercion, thus assisting them in building skills and self-confidence to make better choices in their lives and extending their options. All renovation projects are completed except for the Kagman Wellness Center.
Environment health awareness - DPH collaborated with the Department of Environmental Quality to educate the community in keeping a health CNMI environment. "Our Environment, the Pride of the Marianas" is the theme for last year's environmental awareness wee. The Department adopted a beach in which staff go and clean the beach and surrounding areas once a month. In addition, the Department has provided trash receptacles (drum cans) for beach goer. Future plans include providing more trash receptacles and also recyclable bins; conduct outreach to business owners, provide "No Littering" signboards; recommend legislation for lids for trash receptacles, fix and paint pavilions, etc.
Parent Resource Library in which we provide not just reading materials but computers for internet access, web-sites, DVDs, and names of speakers with expertise in parenting skills, anger management, health related topics, family support group, etc. //2007//

/2008/ 1)Mass Flu Drive 2) Exhibits at the Marianas Basketball League 3) HPV Vaccination Initiative 4) Completed the Immunization Handbook 5) G-mail training 6)Foot Care Training 7) Diabetes presentation at the Aging Center//2008//

/2009/The second Immunization Coverage Survey was conducted. We are waiting for survey analysis from CDC National Immunization Program.
The CNMI Comprehensive Cancer Control Plan was developed. The plan describes priorities for cancer prevention and control activities in the following sections: Burden; Prevention; Screening and Early Detection; Diagnosis; Treatment; Survivorship; Palliative Care; Data, Registry and Surveillance and, Implementation, Evaluation and Evolution. The achievement of such comprehensive cancer care, include partnerships with our communities, non-governmental organizations, regional and international partners. In July 2007, The CNMI was awarded $200,000 to implement the proposed plans.
The Family Planning/ HIV Integration Grant provide HIV testing for family planning adults, adolescents, and pregnant women.
Particpated in Head Start Program Advisory Council, Special Education Interagency Coordinaing Council, and Connecting Families, Inc.
An emergency preparedness tabletop exercise was also conducted last year.
The Division continues to provide training, partner and collaborate with other agencies' awareness events, work with families, including CSHCN, provide enabling services to the community, and continue to put in more effort to bring services out into the community like the Wise Women Village Project.//2009//

/2010/1)Participated in the 3rd Annual Chamorro Conferencew;2)Attended the Developing Effective Communication Campaigns and Materials for Behavioral Impact training;3)Accountant attended training on Administrative Requirements and Cost Principles for Grants and Other Agreements;4)MCH Program one of the partners for the HPV Campaign for the junior high schools;6)MCH Program through its Early Childhood Comprehensive System projects participated in many events focusing on literacy, parenting, oral health, nutrition, etc. in community settings such as Big Truck Day; 7)MCH Program Coordinator a member of the Pacific Diabetes Summit Team for the CNMI 8) MCH Program a partner in the Flu W.A.T.C.H. Campaign;9)Exhibited at the Micronesian Youth Network Seminar;10)Emergency Preparedness activities with a focus on Risk Communication.//2010

G. Technical Assistance

We are requesting technical assistance not just from MCHB but also from CDC for the following:

Evidenced-based training: There has been newly hired staff at the Division that work for the maternal and child health program. Because we are data driven in the work that we do, we want all staff to receive this training. We have also been looking into having three key staff be trained so that they can come back home to conduct the training to the Department staff.

Research Report Writing: In order to enhance our service delivery, the Division has conducted and will be conducting more community health surveys. Again, we have key staff that has not have training in writing reports from data that was analyzed from surveys.

PRAMS Survey: The CNMI Division of Public Health has conducted surveys and focus group regarding prenatal care but we have never done a PRAMS or PRAMS-like study. In reviewing our prenatal care numbers, we are very much interested in doing one so that we can have a guide on where to focus our efforts and resources.

Data Linkage: Because the units, i.e., Laboratory, all have their own data system, we are requesting for technical assistance to link and/or network the different units within the hospital so that we can better case managed clients and gather data for grant purposes.

Electronic Medical Records: We currently transport medical charts of patients to and from the two wellness centers and the Hospital. We want to implement the electronic medical record system at the wellness centers.

/2007/ PRAMS Survey: One of our goal for this coming year is to conduct this survey. I will be talking to Ms. Cassie Lauver and Mr. Michael Kogan regarding this activity during the Partnership meeting in October. This is one of the projects for the SSDI grant. We have already formed a committee that is reviewing the survey.

Data Linkage: We really still need help in this area - linkage between the databases. We have a contract for the development of the Early Hearing Detection and Intervention Surveillance Tracking System.//2007//

/2008/ Assessment of the Division of Public Health's data infrastructure and analysis of the PRAMS-like survey//2008//

/2009/ Our technical assistance for 2009 is the analysis of the PRAMS-like survey; we have plans to apply for the CDC PRAMS grant.//2009//

V. Budget Narrative

A. Expenditures

/ 2007/ This year's reporting required of us to fill in the FY2005 expenditure total. The FY2005 budget period is from 10/01/04 through 09/30/06, therefore, the annual final Financial Status Report will not be due until 12/31/06.

At this time when we are preparing the FY2007 budget, the FY2005 expenditure projection is at 72%. The unobligated total is due to difficulty in filling positions, e.g. Children with Special Health Care Needs Specialist and Nutritionist, and also there were lapsed funding due to prolong recruitment processing when vacated positions are being fulfilled. Where there is unobligated cost in personnel, there would be an unobligated cost was well on the fringe benefits and on the indirect cost line items.

There is updated information of FY2004 expenditures. The final Financial Status Report was completed and the expenditure for FY2004 was at 85.44% instead of 92% projected amount reported last year. Amendments on the figures were adjusted and notes were indicated.

Other expenditures incurred, as follow:

Training - In collaboration with the Public School System a Child Health Assessment Workshop was conducted; the MCH Program had contributed to the Diabetes and Obesity conference; presentation at the Headstart Symposium on oral education; assisted on the project oversight of the CNMI Area Health Education Center; recruited a consultant to provide case management skills in interviewing and counseling to personnel involved in direct client/case services, those who have responsiblity to conduct cast assessments and prepare service plans, implement service plans, monitor and evaluate client services, etc.; and continue to enhance the MCH Porgram by sending key personnel to the MCH annual and the MCH Epidemiology conferences.

Supplies - Support the costs of replacing worn out operational clinic supplies, such as , stethoscopes, sphymomanometer, and blood pressure monitors.

Other costs -- Support the costs of communication, printing of educational materials and replenishment of clinic forms, repair cost for office equipment and vehicles, courier services and fuel./2007//

/2008/ This year's (2008) reporting required of us to fill and finalize the FY2006 expenditure (budget period 10/10/04 through 09/30/06) in the FY2006 expenditure total. The FY2007 budget period is from 10/01/05 through 09/30/07, therefore, the annual final Financial Status Report will not be due until 12/31/07.
At this time when we are preparing the FY2008 budget, the FY2007 expenditure projection is at 85%. The unobligated total is due to difficulty in filling positions, e.g. Nutritionist and Health Promotion/Wellness Coordinator, and also there were lapsed funding due to prolong processing in filling in vacated positions, e.g. Community Health Worker, Nursing Assistant, and a Dental Assistant.
Where there is unobligated cost in personnel, there would be an unobligated cost as well on the fringe benefits and on the indirect cost line items.

The financial reporting (Form 3) showed completed reporting on both the budgeted and expended columns from period FY2001 through FY2006.
This is a recap report on the last three years of final and completed reporting, as follow:

Period	Budgeted	Expended	Expenditure percentage
FY2004	504,836	444,633	88.1%
FY2005	500,990	395,483	79%
FY2006	498,075	344,613	69.2%

Other expeditures include off-island travel to attend mandatory meetings, Training, and purchase of education materials/resources, supplies, assist parent support group activities, assist collaborative work with othe agencies, etc. //2008//

/2008/ This year's (2009) reporting required of us to fill and finalize the FY2007 expenditure (budget period 10/10/05 through 09/30/07) on the FY2007 expenditure total. 78% of the total budget of FY2007 was expended. The unobligated total is due to vacancy positions not being filled - Nutritionist and Dental Asst.; lapsed funding from vacated positions - Nursing Assistant and Clinical Attendant.
Where there is unobligated cost in personnel, there would be an unobligated cost as well on the fringe benefits and on the indirect cost line items. The financial reporting on Form 3 showed completed reporting on both the budgeted and expended columns on period FY2007.

This is a recap report on the last four years of final and completed reporting, as follow:

Period	Budgeted	Expended	Expenditure percentage
FY2004	504,836	444,633	88.1%
FY2005	500,990	395,483	79%
FY2006	498,075	344,613	69.2%
FY2007	498,075	394,261	78%

The final Financial Status Report for FY2008 will expire on 12/31/2008, therefore, the expenditure amount is projected at 85% of total budget.

Other expenditures include off-island travel to attend mandatory meetings, Training, and purchase of education materials/resources, supplies, assist parent support group activities, assist collaborative work with other agencies, etc. //2008//

//2009// 2010 reporting reflected a projection of 90% expenditure of the FY2008 budget. The actual expenditure amount will refelct on the Final Financial Status Report which is due on 12/31/2009. The unobligated total consisted of postions not being filled - Nutritionist, Dental Assistant, and Social Worker. There was a proposed restructuring of two positions (Dental Assistant and Social Worker) to an MCH Data Analyst. There is a need for this FTE to accommodate the MCH Program data collections.
Training - Participation on the 23rd Annual Pacific Basin Family Planning Conference held in Saipan; Early Hearing, Detection and Intervention to accommodate families of Deaf-and-Hard-of-Hearing children to reach their highest potential.
Supplies and Others - support the costs of office supplies; repairs and maintenance for our office equipment and vehicles; fuel for vehicles; operaitonal supplies for our satellite and mobile clinics; flouride varnish for our dental dental services targeting the school-age children; courier and communication costs.

The 2010 budget justification is attached. It specified the allocation of funds within the Maternal and Child Health Block Grant and the State. The federal allocation of the 30-30-10 is reflected on this reports. Drawdowns of funds and preparation of Financial Status Report are the responsibility of the central CNMI Government, Office the Treasury and Department of Finance and Accounting. The Division of Public Health is responsible for budget preparations, monitoring of funds, and internal custodial of accounts.

B. Budget

The budget justification that is attached outlines the allocation of funds used within the Maternal and Child Health block grant and the State. It describes the required 30-30-10 allocation by

category and by services, for example children with special health care needs is allocated at 33%, children and adolescent at 32% and the administrative or indirect cost at 8.88% (not exceeding 10%) The CNMI Department of Finance and Accounting will be limited to use 8.88% of total grant amount for indirect cost even though the negotiated indirect cost is currently at 14.57%. The Department of Finance and Accounting ensures that funds are expended accordingly and processes the Financial Status Reports for all programs at the Division of Public Health.

/2009/ Please see attached budget justification //2009//
An attachment is included in this section.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.