State Action Plan Table

State: Northern Mariana Islands

CNMI MCH Program Five-Year State Action Plan

Women's/Maternal Health:

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

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

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

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

DOMAIN: Women/Maternal Health

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

NOM: Low birth weight rate (%)

Pre-term birth rate (%)

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

Objectives	Strategies	Key Activities	Evaluation
By 2020, increase number of women who received a Pap and mammogram screenings by 10%.	Reduce barriers to Pap and mammogram screenings by improving access to services.	-Offer Pap screenings in mobile clinic, community health centers, and other non-traditional sites (i.e. NAP, WIC, and Village Centers).	Number of mobile clinic and outreach events offering Paps each year.
		-Advocate for Medicaid and Private Insurance coverage for patients not eligible for BCSP Pap and mammogram screenings.	Number of patients with insurance coverage each year.
		-Enhance administrative services such as improving scheduling and care coordination.	Scheduling and care coordination policies developed.
		-Maintain partnership with the CNMI BCSP, with a focus on improving follow-ups for women of childbearing age with positive screening tests.	Number of patients that receive follow up for positive screening tests.
		-Maintain partnership with CHCC Women's Clinic to	

DOMAIN: Women/Maternal Health

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

NOM: Low birth weight rate (%)

Pre-term birth rate (%)

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

Objectives	Strategies	Key Activities	Evaluation
		review existing screening policies and procedures and amend if necessary. -Maintain partnership with all public and private clinics to include as a part of the well woman visit, risk assessments and education and health promotion counseling for Pap and mammograms	Number of policies reviewed annually and amended as needed. Number of visits with risk assessments, education and health promotion counseling for Pap and mammograms included.
	Increase public awareness on the importance of regular checkups and preventative screenings such as Pap and mammograms	-Review existing educational materials and ensure they are culturally and linguistically appropriate. -Use mass and small media to promote women's preventive screening, provide appointment reminders, etc. -Include effective campaign strategies to increase Pap and mammogram screenings in the month long CNMI Women's Health Month activities.	Number of educational materials reviewed/developed. Number of patients that receive preventive screenings and schedule follow up appointments. Identified effective campaign strategies; number of campaigns during CNMI Women's Health month promoting Pap and mammogram screenings.

DOMAIN: Women/Maternal Health PRIORITY: Improve women's health through cervical and breast cancer and anemia screening. NOM: Low birth weight rate (%) Pre-term birth rate (%)			
NPM #1: Increase women receiving a well woman visit including Pap and mammogram.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**
		-Maintain partnerships with governmental, advocacy and community organizations to assure the availability of quality patient and public education materials, campaigns, and programs on women's preventive screenings.	MOUs developed with partners; number of statewide resources identified.

DOMAIN: Women/Maternal Health PRIORITY: Improve women's health through cervical and breast cancer and anemia screening. NOM: Low birth weight rate (%) Pre-term birth rate (%)			
SPM #1: Increase pregnant women screened for anemia.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**
By 2020, increase number of pregnant women screened for iron anemia by 10% of all pregnancies.	Integrate components of preconception health, including anemia screenings and other preventive screenings, into existing services/standard of care for pregnant women.	-Maintain and strengthen partnerships to develop comprehensive systems of care for pregnant women. - Include preconception care education in the WIC Group Prenatal Care curriculum.	MOUs developed detailing responsibilities. Number of patients receiving preconception care counseling.

DOMAIN: Women/Maternal Health PRIORITY: Improve women's health through cervical and breast cancer and anemia screening. NOM: Low birth weight rate (%) Pre-term birth rate (%)			
SPM #1: Increase pregnant women screened for anemia.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**
		-Enhance administrative services such as improving scheduling and care coordination of pregnant women.	Scheduling and care coordination policies developed.
		-Maintain partnership with the CHCC Women's Clinic, with a focus on improving access to and quality of primary care (i.e. preconception health care screening and follow-up)	Documentation of integrated/improved efforts; preconception health included in standard of care.
		-Maintain partnership with CHCC Women's Clinic to review existing screening policies and procedures and amend if necessary.	Policies reviewed annually and amended as necessary.
		- Advocate for Medicaid and Private Insurance coverage to improve financing of preconception health care services.	Number of patients with insurance coverage.
		-Maintain partnership with all public and private clinics to include as a part of the well woman visit, risk assessments and education and health promotion counseling for anemia screenings.	Number of visits with risk assessments, education and health promotion counseling for anemia screenings included.
		-Evaluate the capacity of ICare case management software to measure the impact of preconception services for pregnant women.	Software fully implemented and measures

DOMAIN: Women/Maternal Health PRIORITY: Improve women's health through cervical and breast cancer and anemia screening. NOM: Low birth weight rate (%) Pre-term birth rate (%)			
SPM #1: Increase pregnant women screened for anemia.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**
			identified.
	Increase public awareness on the importance of regular checkups and preventative screenings such as anemia screenings.	-Review existing educational materials and ensure they are culturally and linguistically appropriate. -Improve preconception care awareness in the villages and outlying clinics. -Use mass and small media to promote women's preventive screening, provide appointment reminders, etc. -Include effective campaign strategies to increase anemia screenings in the month long CNMI Women's Health activities. -Maintain partnerships with governmental, advocacy and community organizations to assure the availability of quality patient and public education materials, campaigns, and programs on women's preventive screenings.	Number of educational materials that are culturally and linguistically appropriate. Number of awareness campaigns in villages and outlying clinics. Number of patients that receive preventive screenings and schedule follow up appointments. Identified effective campaign strategies; number of campaigns during CNMI Women's Health month promoting anemia screenings. Documentation of integrated efforts; Number of partners that provide public education material, campaign, and/or programs on women's preventative screenings.

Perinatal/Infant Health

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

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

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

DOMAIN: Infant/Perinatal Health **PRIORITY:** Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep. **NOM:** Infant mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Sleep-related SUID per 1,000 live births			
NPM #4: Increase women reporting exclusive breastfeeding through 6 months.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**

DOMAIN: Infant/Perinatal Health

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

NOM: Infant mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Sleep-related SUID per 1,000 live births

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

Objectives	Strategies	Key Activities	Evaluation
By 2020, increase the percent of WIC mothers reporting exclusive breastfeeding by 30%.	Increase referrals to WIC Breastfeeding Peer Counselor(s).	- Include information about the WIC Breastfeeding (BF) Peer Counselor Program in Group Prenatal Care curriculum. -Refer new moms enrolled in the HOME Visiting Program to WIC Breastfeeding Peer Counselor(s). -Maintain partnership with CHCC L&D Unit to increase referrals to WIC Breastfeeding Peer Counselor Program. -Develop reporting systems for referrals. -Identify current referral systems and their effectiveness.	BF Peer Counselor Program included in Group Prenatal Care curriculum. Number of HOME Visiting Program moms that accessed services from WIC's BF Peer Counselor(s). Number of patients referred to the WIC BF Peer Counselor Program by the CHCC L&D Unit. Fully functional referral and tracking system. Evaluation report on current referral system completed.
By 2020, increase the number of hospital that achieve baby	Implement the ten (10) Steps to Successful Breastfeeding.	-Identify necessary trainings for hospital to become baby friendly and how to implement the ten (10) steps.	Number of necessary trainings identified.

DOMAIN: Infant/Perinatal Health

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

NOM: Infant mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Sleep-related SUID per 1,000 live births

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

Objectives	Strategies	Key Activities	Evaluation
friendly status from 0 to 1.		-Meet with CHCC management to discuss baby friendly initiative and ten (10) steps. -Maintain partnership with WIC to provide assistance in achieving baby friendly status.	Documentation of integrated effort (i.e. number of meetings, meeting minutes, agenda, sign-in sheets). MOU with WIC developed identifying roles and responsibilities in achieving baby friendly status.
By 2020, number of trainings on breastfeeding and lactation for health professionals at CHCC will increase from baseline.	Increase opportunities for evidence based trainings on breastfeeding and lactation.	-Maintain partnership with CNMI CoIIN Committee and other stakeholders to identify and develop continuing education. -Collaborate with OB/GYN Department Chair to ensure that continuing education on breastfeeding and human lactation is provided annually. -Identify online resources for continuing education.	Continuing Education Plan on breastfeeding and lactation developed. Number of health professionals at CHCC that receive annual training on breastfeeding and lactation. Number of online resources identified for continuing education.

DOMAIN: Infant/Perinatal Health **PRIORITY:** Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep. **NOM:** Infant mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Sleep-related SUID per 1,000 live births			
NPM #5: Increase mothers reporting they most often place the baby on its back to sleep in a separate sleep area.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**
By 2020, increase the number of HOME Visiting mothers reporting they most often place the baby on its back to sleep in a safe, separate area.	Implement Safe to Sleep Assessment Tool in HOME Visiting curriculum.	-Include assessment of a designated, safe baby sleep area within the program's Child Information Form being completed by Family Partner Advocates. -Assist families in creating goal plans for obtaining cribs or pack and plays that are safe sleep approved for those that do not have a designated, safe baby sleep area. -Collaborate with the Cribs for Kids organization to bring safe sleep approved cribs and/or pack and plays to the CNMI so that they are available and affordable. -Develop reporting systems for referrals.	Number of assessments completed by Family Partner Advocates. Number of goals plans created. Documentation of integrated efforts; number of cribs and/or pack and plays obtained through Cribs for Kids. Fully functional referral and tracking system.
By 2020, a Safe	Develop a written policy that	-Research safe sleep practices recommended by the AAP.	AAP approved Safe Sleep practices

DOMAIN: Infant/Perinatal Health

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

NOM: Infant mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Sleep-related SUID per 1,000 live births

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

Objectives	Strategies	Key Activities	Evaluation
Sleep Policy will be developed and distributed statewide.	describes the practices to be used to promote safe sleep.	-Meet with CHCC management and providers to develop policy. -Distribute policy to all key stakeholders. -Maintain partnership with WIC, HOME Visiting, other key stakeholders, and providers to ensure Safe Sleep Policy is reviewed annually and updated as necessary.	identified. Safe Sleep Policy developed. Number of key stakeholders that disseminate/provide information on Safe Sleep practice identified in the policy. Documentation of integrated effort; Annual review of Safe Sleep Policy and updated as needed.

DOMAIN: Infant/Perinatal Health

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

NOM: Infant mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births Sleep-related SUID per 1,000 live births			
SPM #: Increase early and adequate prenatal care women receiving prenatal care beginning in first trimester stratified by insurance.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**
By 2020, increase the number of women receiving prenatal care beginning in first trimester by 10%.	Reduce barriers to prenatal care by improving access to services.	-Offer prenatal care in mobile clinic, community health centers, and other non-traditional sites (i.e. NAP, WIC, and Village Centers). -Investigate sources of care for pregnant women who are uninsured or underinsured, including providers that offer payment options. -Enhance administrative services such as improving scheduling and care coordination. -Maintain partnership with the CNMI WIC, with a focus on improving prenatal care for WIC participants enrolled in Group Prenatal Care. -Maintain partnership with CHCC Women's Clinic to promote provider's adherence to ACOG guidelines pertaining to first trimester entry to prenatal care. -Maintain partnership with all public and private clinics to include as a part of the well woman visit, risk assessments	Number of mobile clinic and outreach events offering prenatal care each year. Resource guide/list of providers who offer services to pregnant women who are either uninsured or underinsured with information on payment options developed. Scheduling and care coordination policies developed. Number of WIC participants that receive early and adequate prenatal care. Number of CHCC Women's Clinic Providers that adhere to the ACOG guidelines. Number of visits with risk assessments, education and health promotion counseling for preconception care and inter-conception care completed.

DOMAIN: Infant/Perinatal Health

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

NOM: Infant mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Sleep-related SUID per 1,000 live births

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

Objectives	Strategies	Key Activities	Evaluation
		and education and health promotion counseling for preconception and inter-conception care. -Evaluate the capacity of ICare case management software to measure the impact of preconception services for pregnant women.	Software fully implemented and measures identified.
	Educate community on the availability of prenatal care resources, insurance eligibility, and other support services.	-Review existing educational materials and ensure they are culturally and linguistically appropriate. -Improve preconception care awareness in the villages and outlying clinics. -Use social media to promote early and adequate prenatal care campaign. -Include effective campaign strategies to increase early and adequate prenatal care in the month long CNMI Women's	Number of educational materials that are culturally and linguistically appropriate. Number of awareness campaigns in villages and outlying clinics. Number of pregnant women that receive early and adequate prenatal care. Number of activities during Women's Health Month that promote early and adequate prenatal care.

DOMAIN: Infant/Perinatal Health PRIORITY: Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep. NOM: Infant mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Sleep-related SUID per 1,000 live births			
SPM #: Increase early and adequate prenatal care women receiving prenatal care beginning in first trimester stratified by insurance.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**
		Health activities. -Maintain partnerships with governmental, advocacy and community organizations to assure the availability of quality patient and public education materials, campaigns, and programs on early and adequate prenatal care.	Documentation of integrated efforts; Number of partners that provide public education material, campaign, and/or programs on early and adequate prenatal care.

Children's Health

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

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

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

DOMAIN: Children's Health

PRIORITY: Improve child health through providing vaccinations and screening for developmental delays.

NOM: Percent of children meeting the criteria developed for school readiness.

NPM #6: Increase children receiving developmental screening.

Objectives	Strategies	Key Activities	Evaluation
By 2020, increase the proportion of young children who are screened, evaluated, and enrolled in special services in a timely manner from baseline to 25%, 5% each year.	Implement the Ages and Stages Questionnaire tools at all CHCC satellite clinics.	- Implement ASQ SOPs for each clinic site which includes the agreed upon quality components for each of the following essential roles: surveillance, screening, referral, evaluation, parent education, and support. - Evaluate capacity of the Electronic Health Record (EHR) Well Child Module to be used as a mechanism for electronic data capture, validation, analysis and reporting of ASQ results.	Number of clinics that administer the ASQ questionnaire. Evaluation report of EHR and its suitability in managing developmental screening data completed.
	Enhance partnerships with community by developing a partnership document that outlines function and partner roles and responsibilitiesto ensure increased screenings for developmental delays	- Meet with ECCS partners to identify roles, responsibilities, and strategies towards a coordinated approach in integrating program services to ensure screenings, referrals, evaluations, and connecting those in need to services they are eligible for. - Develop data and benchmark monitoring report to be assessed as part of regular partnership meetings.	MOU developed detailing roles, responsibilities, and strategies of all partners involved. Data plan completed detailing identified measures and frequency of reporting.

DOMAIN: Children's Health **PRIORITY:** Improve child health through providing vaccinations and screening for developmental delays. **NOM: Percent of children meeting the criteria developed for school readiness.**			
SPM #3: Increase children receiving routine vaccines.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**
By 2020, increase the percent of children 0 to 18 receiving routine vaccines by 10%.	Partner with Immunization's Vaccines for Children Program to improve access to vaccines for children.	- Include information about VFC Program in Group Prenatal Care curriculum. -Refer new moms enrolled in the HOME Visiting Program to VFC Program. -Maintain partnership with CHCC L&D Unit to increase referrals to VFC Program. -Develop reporting systems for referrals. -Identify current referral systems and their effectiveness.	VFC Program included in Group Prenatal Care curriculum. Number of HOME Visiting Program moms that access services through the VFC Program. Number of families referred to the VFC Program by the CHCC L&D Unit. Fully functional referral and tracking system. Evaluation report of the current referral system completed.

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Adolescent Health

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

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

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

DOMAIN: Adolescent Health

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

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

Adolescent suicide ages 15 through 19 per 100,000.

NPM #9: Decrease adolescents bullying.

Objectives	Strategies	Key Activities	Evaluation
By 2020, reduce the number of	Develop a comprehensive school-health approach to	-Secure and maintain administrative support and commitment by developing a MOU between MCH and	MOU between MCH and PSS' Teen Talk Program completed.

DOMAIN: Adolescent Health

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

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

Adolescent suicide ages 15 through 19 per 100,000.

NPM #9: Decrease adolescents bullying.

Objectives	Strategies	Key Activities	Evaluation
students who reported being bullied at school by 10%.	address health and safety issues, including bullying and cyberbullying.	PSS's Teen Talk Program. -Partner with PSS Teen Talk Program to establish a school health advisory council to address bullying and other risk behaviors. -Partner with PSS Teen Talk Program to develop a plan which would be incorporated into a school's overall improvement plan to link health with learning outcomes. -Partner with PSS Teen Talk Program to implement policies and programs to address health-risk behaviors. -Provide support for continuing education essential for teachers, administrators, and others included in school health approach to address adolescent risk behaviors.	School health advisory council members identified and council is formally established. Number of schools that have amended their improvement plan to link health with learning outcomes. Number of schools implementing policies and/or programs to address health-risk behaviors. Number of public school staff attending training and/or professional development in addressing adolescent risk behaviors.
	Provide opportunities for students to be meaningfully	-Partner with Youth Affairs Office to establish a cross-age mentoring program in the community youth centers.	Number of youth centers implementing mentoring programs.

DOMAIN: Adolescent Health

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

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

Adolescent suicide ages 15 through 19 per 100,000.

NPM #9: Decrease adolescents bullying.

Objectives	Strategies	Key Activities	Evaluation
	involved in the school and the community.	-Partner with sports associations to promote positive social interactions. -Maintain partnerships with governmental, advocacy and community organizations to assure the availability of volunteer opportunities/after school programs for students to engage in peer education and peer advocacy programs aimed at curving risk behaviors, including bullying.	Number of sporting events available to adolescents throughout the year. Number of volunteer opportunities and/or after school programs available throughout the year.
	Expand options for adolescents to report bullying incidences.	-Establish a reporting tool/anti bullying hotline that is user friendly; features include mass alert system for those that need to take action. -Maintain partnerships with school counselors to encourage students to utilize hotline.	Hotline established and fully operational. Number of calls to the hotline related to bullying.

DOMAIN: Adolescent Health

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

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

Adolescent suicide ages 15 through 19 per 100,000.

SPM #: Decrease adolescent suicide.

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

DOMAIN: Adolescent Health

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

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

Adolescent suicide ages 15 through 19 per 100,000.

SPM #: Decrease adolescent suicide.

Objectives	Strategies	Key Activities	Evaluation
	Enhance partnerships and collaboration between and among public and private entities that have made a commitment to public awareness of suicide and suicide prevention.	-Review existing educational materials and ensure they are culturally and linguistically appropriate. - Identify available counseling resources for at-risk youth to access. -Improve suicide and suicide prevention awareness in the schools and youth centers. -Use social media to increase awareness of suicide and suicide prevention. -Develop effective campaign strategies to prevent suicides and disseminate among partners.	Number of educational materials that are culturally and linguistically appropriate. Resource guide detailing available counseling services completed. Number of schools and youth centers providing/disseminating suicide prevention information. Number of suicide prevention information/material posted on social media outlets. Number of partners that receive information on strategies to prevent suicides.
By 2020, annual reports on Youth	Enhance the quality and quantity of data available on	-Partner with Child/Youth Mortality Committee to improve analysis and availability of child death review data.	Documentation of integrated efforts, i.e. agenda, meeting minutes, sign- in sheets.

DOMAIN: Adolescent Health

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

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

Adolescent suicide ages 15 through 19 per 100,000.

SPM #: Decrease adolescent suicide.

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

DOMAIN: Adolescent Health

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

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

Adolescent suicide ages 15 through 19 per 100,000.

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

Objectives	Strategies		Evaluation
By 2020, decrease teen pregnancy rates by 10%.	Develop a comprehensive school-health approach to improve health and safety poor outcomes, including suicide.	-Secure and maintain administrative support and commitment by developing a MOU between MCH and PSS's Teen Talk Program.	MOU between MCH and PSS' Teen Talk Program completed.
		-Partner with PSS Teen Talk Program to establish a school health advisory council to address teen pregnancies.	School health advisory council members identified and council is formally established.
		-Partner with PSS Teen Talk Program to develop a plan which would be incorporated into a school's overall improvement plan to link health with learning outcomes.	Number of schools that have amended their improvement plan to link health with learning outcomes.
		-Partner with PSS Teen Talk Program to implement policies and programs to address health-risk behaviors and poor outcomes.	Number of schools implementing policies and/or programs to address health-risk behaviors.
		-Provide support for continuing education essential for teachers, administrators, and others included in school health approach.	Number of public school staff attending training and/or professional development in addressing adolescent risk behaviors.
	Establish a community, evidence-based Teen Pregnancy Prevention Program.	-Review existing programs and ensure they are culturally and linguistically appropriate.	Report detailing a review of existing programs completed.
		-Identify a program that is effective in reducing teen pregnancy, sexually transmitted infections, and behavioral risks that fits the needs of the community.	Prevention program implemented.

DOMAIN: Adolescent Health PRIORITY: Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide). NOM: Adolescent mortality ages 10 through 19 per 100,000. Adolescent suicide ages 15 through 19 per 100,000.			
SPM: Decrease teen pregnancy rates among 13-14 and 15-17 year olds.			
Objectives	**Strategies**		**Evaluation**
		-Maintain partnerships with governmental, advocacy and community organizations to assure participation and buy-in of Teen Prevention Program.	Number of organizations that take part in Teen Prevention Program activities.

Children with Special Health Care Needs:

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In the CNMI, birth defects are a leading cause of infant mortality, accounting for 40% of all infant deaths for years 2009 through 2014. Furthermore, birth defects in the CNMI, like most other places, are a leading contributor of long-term disability. In reporting year 2014, 43.5% of families with identified CSHCN reported not having adequate insurance coverage or no insurance coverage at all. Thus, accessing specialized services for long-term disability or care associated with CSHCN becomes a hindrance for families with identified CSHCN. Evidence-based strategies are needed in order to identify and provided identified CSHCN and their families with continuous quality care. The CNMI will include a range of strategies to provide improved and quality care including 1) establishing medical homes for identified CSHCN; 2) advocating for improved coverage for CSHCN; 3) developing a state-wide/"universal" comprehensive care plan for all CSHCN; 4) reinstating the CNMI Birth Defects Registry; and 5) reinstating the Newborn Screening at CHCC.

With the priority to provide a medical home for children identified as Children with Special Health Care Needs, the Maternal and Child Health Bureau (MCHB) CSHCN Program, identify a medical home for all children with and without special health care needs who seek their program services. While there are many barriers that prevent CSHCN and their families from establishing a medical home, insurance coverage remains as one of the principal problem. In efforts to supports this measure the CSHCN Coordinator processes and expedites all new or renewal Medicaid applications of those enrolled in the CSHCN Program. MCHB has recently updated its Memorandum of Understanding (MOU) between the State Medicaid Office and the Division of Public Health Services (DPHS) –

MCHB to include amongst other data sharing services, the allowance of MCHB to receive, review, and submit MCH client's Medicaid application for processing, and furthermore, to expedite the processing of MCH such applications. MCHB anticipates that the provision of the updated MOU will allow CSHCN, who qualify for Medicaid or are current Medicaid recipients, be able to establish a medical home. For all CSHCN, the CSHCN Program on setting effective program activities that link CSHCN and their families to a medical home, if not already having one.

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

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

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

DOMAIN: Children with Special Health Care Needs

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

NOM: Children with Special Health Care Needs receiving care in a well-functioning system (%)
Children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations (%)

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

Objectives	Strategies	Key Activities	Evaluation
By 2020, increase	Reduce barriers to	-Identify CSHCN with medical homes and provide linkage	Number of outreach events each year

DOMAIN: Children with Special Health Care Needs

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

NOM: Children with Special Health Care Needs receiving care in a well-functioning system (%)
Children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations (%)

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

Objectives	Strategies	Key Activities	Evaluation
number of identified CSHCN provided with a medical home by 10%.	establishing a medical home by improving access to services.	to medical homes for those without one in CHCC, Private Clinics, community health centers, and other non-traditional sites (i.e. NAP, WIC, and Village Centers). -Advocate for Medicaid and Private Insurance coverage for patients not otherwise eligible for such coverages. -Apply Participatory Action to guide developed policies and practices surrounding ensuring identified CSHCN have a medical home. -Enhance administrative services such as improving scheduling and care coordination. -Maintain partnership with the CHCC and Private Clinics, with a focus on enrolling identified CSHCN.	offering medical home screenings and referrals for linkage to a medical home as needed. Number of identified CSHCN with adequate private and/or public insurance coverage each year. Number of identified CSHCN who receive coordinated ongoing comprehensive care within a family centered medical home. Number of CSHCN and their families who access necessary services and supports. Number of CSHCN who receive preventive and treatment health services within a medical home.

DOMAIN: Children with Special Health Care Needs

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

NOM: Children with Special Health Care Needs receiving care in a well-functioning system (%)
Children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations (%)

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

Objectives	Strategies	Key Activities	Evaluation
		-Maintain partnership with CHCC Children's Clinic to review existing screening policies and procedures that ensures CSHCN are current with health insurance coverage and amend if necessary to include automatic referral to MCHB Services Coordinator for insurance application assistance/processing. -Maintain partnership with all public and private clinics to include as a part of the well children visit a medical home assessment, insurance coverage/primary provider confirmation, and barriers to accessing a medical home checklist.	Number of policies reviewed annually and amended as needed. Number of visits with risk assessments, education and medical home promotion for identified CSHCN included
	Increase public awareness on the importance of establishing a medical home with a primary care provider.	-Review existing educational materials and ensure they are culturally and linguistically appropriate. -Use mass and small media to promote the provision of medical homes for CSHCN, provide appointment reminders, etc.	Number of educational materials reviewed/developed. Number of identified CSHCN that are linked to a medical home and have schedule follow up appointments with an identified primary care provider.

DOMAIN: Children with Special Health Care Needs PRIORITY: Provide a medical home for children identified as Children with Special Health Care Needs. NOM: Children with Special Health Care Needs receiving care in a well-functioning system (%) Children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations (%)			
NPM #11: Increase Children with Special Health Care Needs with a medical home.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**
		-Work with CHCC, Private Clinics, and partner agencies, such as the Public School System-Special Education Program and the Community Guidance Center, to develop/ or adopt a position statement regarding ensuring that all identified CSHCN are provided with a medical home with the use of a state-wide comprehensive care plan.	MOU developed by all entities stating a shared position statement across agencies and use of universal comprehensive care plan for all identified CSHCN.
		-Maintain partnerships with governmental, advocacy and community organizations to assure the availability of quality patient and public education materials, campaigns, and programs on providing medical homes for identified CSHCN.	MOUs developed with partners; number of statewide resources identified.

DOMAIN: Children with Special Health Care Needs PRIORITY: Improve identification of Children with Special Health Care Needs through screening for developmental delay. NOM: Children with Special Health Care Needs receiving care in a well-functioning system (%) Children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations (%)			
Improve identification of Children with Special Health Care Needs through screening for developmental delays. To be accomplished through NPM #6: Increase children receiving developmental screening.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**

By 2020, increase the proportion of CSHCN who are screened, evaluated, and enrolled in special services in a timely manner from baseline to 25%, 5% each year.	Implement the Ages and Stages (ASQ) Questionnaire tools at all CHCC satellite clinics.	- Implement ASQ SOPs for each clinic site which includes the agreed upon quality components for each of the following essential roles: surveillance, screening, referral, evaluation, parent education, and support. - Evaluate capacity of the Electronic Health Record (EHR) Well Child Module to be used as a mechanism for electronic data capture, validation, analysis and reporting of ASQ results.	Number of children screened early and continuously for special health care needs. Evaluation report of EHR and its suitability in managing developmental screening data completed.
	CNMI Birth Defects Registry reimplementation	-Work with SSDI Program and CSHCN Program on the updated development of the Birth Defects Registry. -Work with CHCC, including its Laboratory, CSHCN Program and the CNMI CoIIN Team, to assure a continuous system of conducting newborn screening testing, shipping of specimens, ordering of kits, use of Birth Defects registry, sustainable funding, etc. - Partner with CHCC Nursery and Laboratory to offer Newborn Screening and referral for positive results.	Database developed with modules conformed to the requirements of Oregon State Public Health Laboratory/Northwest Regional Newborn Screening Program MOU developed upholding the vital role of the Birth Defects Registry in supporting child-find efforts for CSHCN. Number of newborns screened, identified, and referred timely to specialized services.
	Enhance partnerships with community by developing a partnership document that outlines function and partner roles and responsibilitiesto ensure increased screenings for developmental delays (i.e.	- Meet with ECCS partners to identify roles, responsibilities, and strategies towards a coordinated approach in integrating program services to ensure screenings, referrals, evaluations, and connecting those in need to services they are eligible for. - Develop data and benchmark monitoring report to be	MOU developed detailing roles, responsibilities, and strategies of all partners involved.

DOMAIN: Children with Special Health Care Needs PRIORITY: Improve identification of Children with Special Health Care Needs through screening for developmental delay. NOM: Children with Special Health Care Needs receiving care in a well-functioning system (%) Children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations (%)			
Improve identification of Children with Special Health Care Needs through screening for developmental delays. To be accomplished through NPM #6: Increase children receiving developmental screening.			
Objectives	**Strategies**	**Key Activities**	**Evaluation**
	how often will the Steering Committee will meet, minutes, partnership assessment tool discussed and agreed upon)	assessed as part of regular partnership meetings.	Data plan completed detailing identified measures and frequency of reporting.

Cross Cutting

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

Furthermore, with the priority to improve insurance status of children and pregnant mothers, the MCHB recently updated its Memorandum of Understanding (MOU) between the State Medicaid Office and the Division of Public Health Services (DPHS) – MCHB to include amongst other data sharing services, the allowance of MCHB to receive, review, and submit MCH client's Medicaid application for processing, and furthermore, to expedite the processing of MCH such applications. MCHB anticipates that the provision of the updated MOU will allow children, pregnant mothers, and families, who qualify for Medicaid or are current Medicaid recipients, be able to acquire and or remain coverage, with the end goal of establishing a medical home. Topics for such strategies include

addressing the high cost of premiums associated with private insurance, in which insured families do not seek medical care altogether due to high costs. For this, MCHB intends to all seek guidance and work collaboratively with the CNMI government.

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

DOMAIN: Cross Cutting

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

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

Percent of children without health insurance.

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

Objectives	Strategies	Key Activities	Evaluation
By 2020, increase the rate of pregnant women who had a dental visit by 10%.	Integrate components of oral health care into existing services/standard of care for pregnant women.	-Maintain and strengthen partnerships with the Dental Clinic to develop comprehensive systems of care for pregnant women.	MOUs developed detailing responsibilities.
		- Include oral health care education in the WIC Group Prenatal Care curriculum.	Number of patients receiving oral health care education/information.
		-Enhance administrative services such as improving scheduling and care coordination of pregnant women.	Scheduling and care coordination policies developed.
		-Maintain partnership with the CHCC Women's Clinic, with a focus on improving access to and quality of primary care	Documentation of integrated/improved

DOMAIN: Cross Cutting

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

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

Percent of children without health insurance.

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

Objectives	Strategies	Key Activities	Evaluation
		(i.e. oral health screening and follow-up)	efforts; oral health care included in standard of care.
		-Maintain partnership with CHCC Women's Clinic to review existing screening policies and procedures and amend if necessary.	Policies reviewed annually and amended as necessary.
		-Maintain partnership with all public and private clinics to include as a part of prenatal visits, oral health assessments and education and health promotion counseling for oral health during pregnancy.	Number of visits of pregnant women with oral health education and promotion counseling included.
		-Evaluate the capacity of ICare case management software to measure the impact of oral health services for pregnant women.	Software fully implemented and measures identified.
	Increase public awareness on the importance of oral	-Review existing educational materials and ensure they are culturally and linguistically appropriate.	Number of educational materials reviewed/developed.

DOMAIN: Cross Cutting

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

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

Percent of children without health insurance.

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

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

DOMAIN: Cross Cutting

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

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

Percent of children without health insurance.

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

Objectives	Strategies	Key Activities	Evaluation
		-Refer children enrolled in the HOME Visiting Program to dental providers.	Number of children enrolled in the HOME Visiting Program that had preventative dental visits.
		-Maintain partnership with all public and private clinics to include as a part of well child visits, oral health assessments, education and oral health promotion counseling.	Number of well child visits with oral health education and promotion counseling included.
		-Maintain partnership with CHCC Children's Clinic and increase referrals for preventative dental visits.	Number of children referred by the CHCC Children's Clinic to a dental provider.
		-Maintain partnership with the CHCC Children's Clinic and private providers, with a focus on improving access to preventative dental care.	Oral health assessments included in standard of care.
		-Develop reporting systems for referrals.	Fully functional referral and tracking system.
	Establish a dental home for	-Maintain and strengthen partnerships to develop	MOUs developed detailing responsibilities.

DOMAIN: Cross Cutting

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

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

Percent of children without health insurance.

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

Objectives	Strategies	Key Activities	Evaluation
	Children and Youth with Special Health Care Needs.	comprehensive systems of care for CYSHCN.	
		- Collaborate with the Public School System's Early Intervention (EIS) and Special Education (SPED) programs to include oral health as a component within their programs.	Inclusion of an oral health component into the EIS and SPED programs.
		- Partner with the EIS and SPED programs to increase referrals to the CHCC Dental Clinic.	Number of referrals received from EIS and SPED programs.
		-Meet with CHCC management to discuss the establishment of a dental home for CYSHCN at the CHCC Dental Clinic.	Policy or MOU completed establishing the CHCC Dental Clinic as a dental home for CYSHCN.
		-Maintain partnership with public and private providers to facilitate referrals to the CHCC Dental Clinic for CYSHCN.	MOUs developed detailing responsibilities. Number of referrals of CYSHCN to the CHCC Dental Clinic.
		-Develop reporting systems for referrals.	Fully functional referral and tracking system.

DOMAIN: Cross Cutting

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

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

Percent of children without health insurance.

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

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

DOMAIN: Cross Cutting

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

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

Percent of children without health insurance.

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

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