



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.4 Overview of the State

The Commonwealth of the Northern Mariana Islands (CNMI) is located 200 miles north of Guam, 1,800 miles south of Japan and 5,000 west of Hawaii. There are 14 islands in the Commonwealth; the three inhabited islands are Saipan, Tinian, and Rota. These 3 islands are separated by ocean. Nearly 90% of the population live on Saipan (Table1).

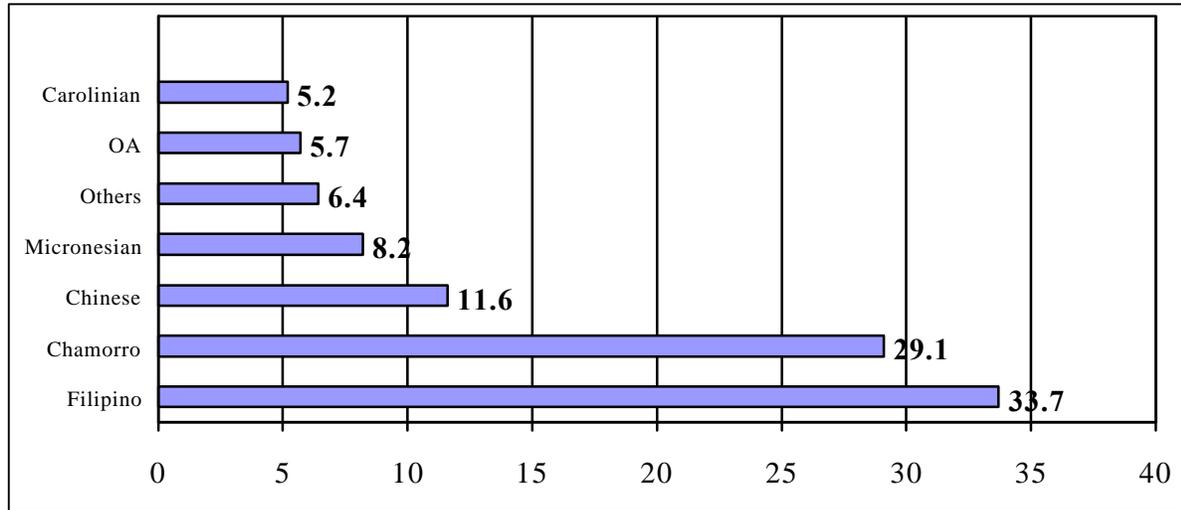
Table 1. Population by Island in the CNMI

	1980	1990	1995
Saipan	14,549	38,896	52,698
Rota	1,261	2,295	3,509
Tinian	866	2,118	2,631
Northern Islands	104	36	8
Total CNMI	16,780	43,346	58,846

CNMI Census, Division of Central Statistics

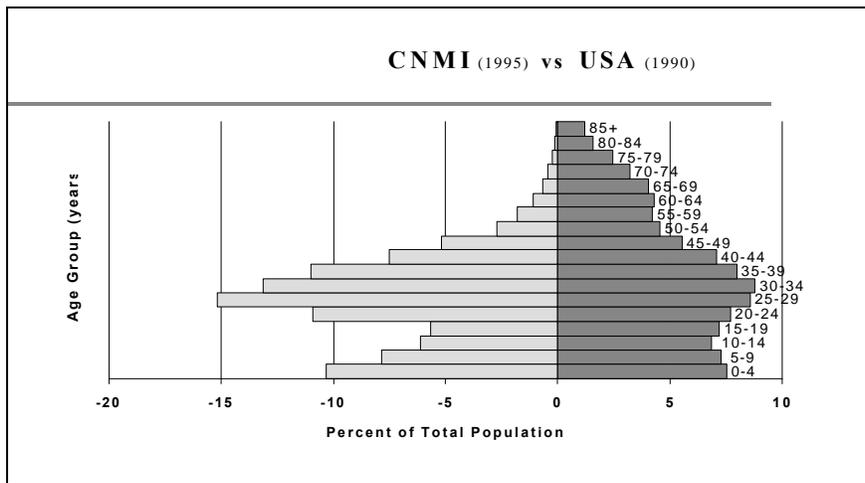
The annual population growth rate of the CNMI of 5.6% is amongst the highest in the world. According to the National Vital Statistics Reports, births in the United States increased 2% in 1998 (the first increase since 1990). The 1998 population of the CNMI, currently estimated at 66,616 (58,846 at 1995 Census), has more than tripled since the 1980 estimated population of 18,780. It includes an indigenous population of Chamorro and Carolinian. Other groups residing in the CNMI include Micronesians from the Federated States of Micronesia, Palau, and the Marshall Islands; Americans from the US mainland; Koreans; and Japanese (Figure 1). The total population figure also includes an estimate of about 35,000 contract workers from the Philippines, China, Thailand, and other Asian countries. Most of these workers are between 18 and 44 years of age, as seen by the disproportionate size of this segment of the population (Figure 2). The two largest group of contract workers are from China and the Republic of the Philippines. During CY 1999 approximately 32,881 contract workers received alien health screening. Out of this number 15,859 are from China and 13,422 are from the Philippines. One hundred and forty-five referrals went to the Chest Clinic and thirty-nine referrals were made to the STD Clinic.

Figure 1. Percent Population by Ethnicity in the CNMI, 1995



Total Population = 58,846
 OA= Other Asians
 CNMI Division of Central Statistics

Figure 2. Population of the CNMI by Age



CNMI 1995 Census, Division of Central Statistics

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 preventive (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 median age of the CNMI population is 27.4 years. The average life expectancy at birth in the CNMI is for 1999 is 72.90 years for males and 79.21 years for females (Table 2) while the United States' 1997 life expectancy rate at birth reached an all-time high of 76.5 years.

Table 2. Life Expectancy in Years, CNMI 1990-1999

	<i>1990</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>
TOTAL	71.93	71.53	71.08	72.39	74.65	72.77	75.47	75.61	75.79	75.96
Male	68.57	68.17	68.72	68.98	71.53	69.51	72.42	72.56	72.73	72.90
Female	75.49	75.10	75.64	76.01	72.95	76.23	78.72	78.85	79.03	79.21

Source: CNMI Division of Central Statistics
CNMI Office of Health Planning & Statistics, Division of Public Health

The CNMI has a Crude Mortality Rate (CMR) of 2.7/1000 population in 1997 and 2.3/1000 population in 1998 (Table 3). The CNMI 1998 Infant Mortality Rate was 8.4/1000 live births compared to the US rate of 7.3/1000 live births in 1997.

Table 3. Vital Statistics for CNMI

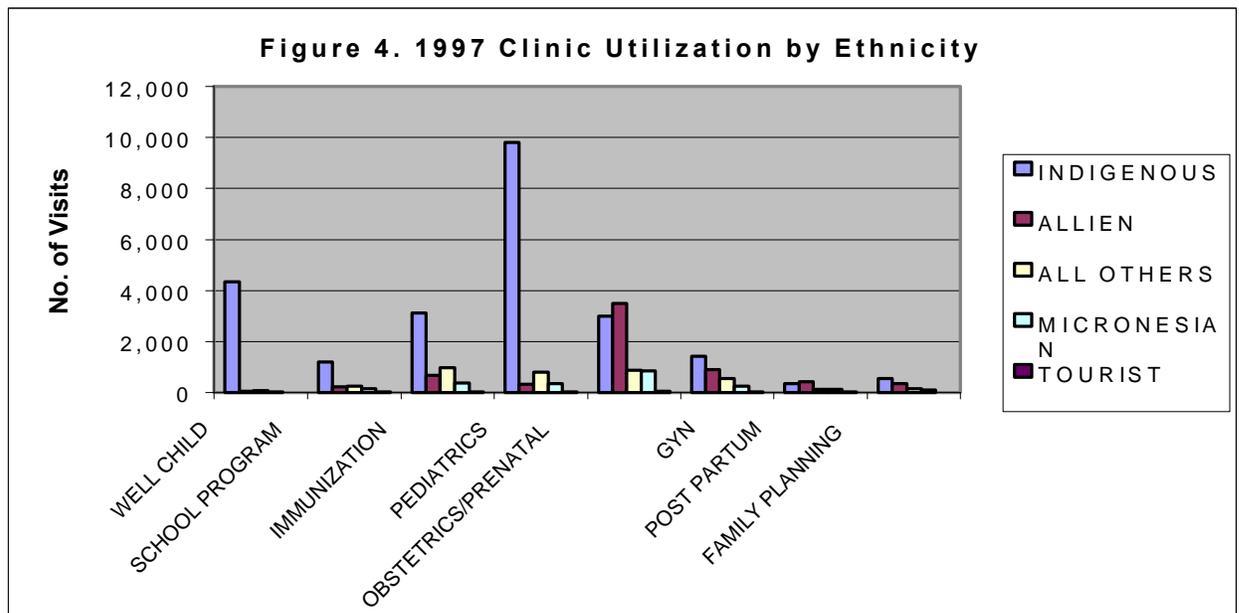
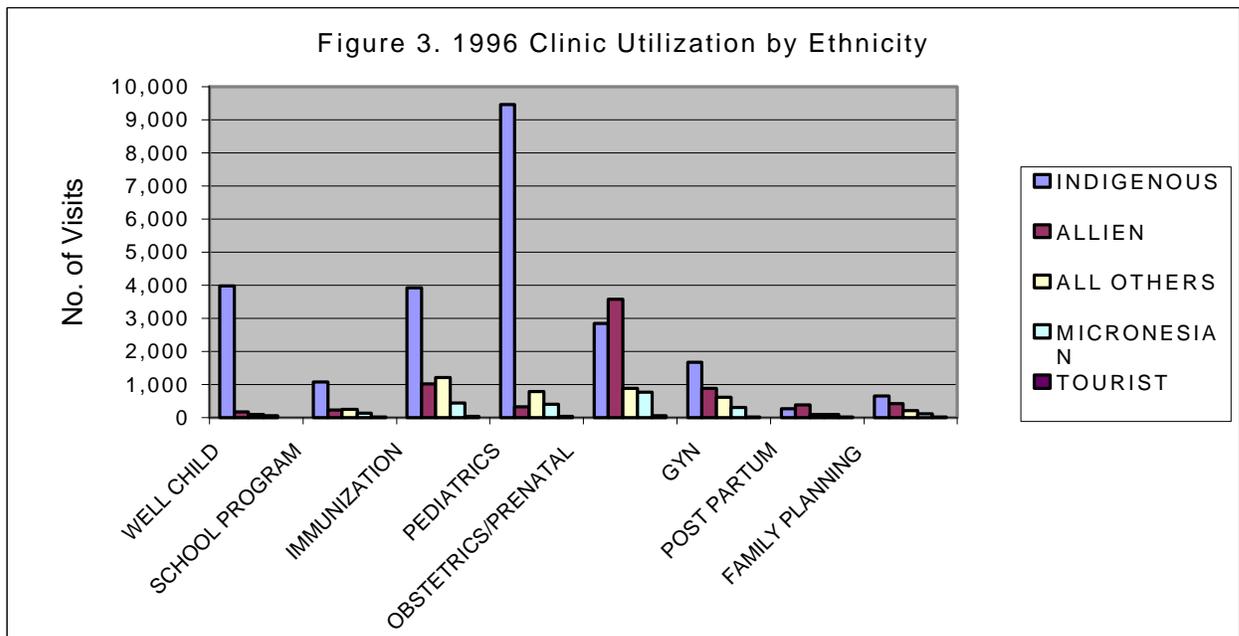
Year	Crude Birth Rate ¹		Crude Mortality Rate ²		Infant Mortality Rate ³		Life Expectancy (years)	
	'97	'98	'97	'98	'97	'98	'97	'98
CNMI	25.6	21.6	2.7	2.3	8.8	8.4	75.61	75.79

Five-year means
1 Births/1000 population
2 Deaths/1000 population
3 Infant deaths/1000 live births

The ethnic make-up of live births continues to shift, with a decreasing proportion of indigenous live births and an increasing number of births to mothers from Asian countries. The CNMI 1995 census reported 6,754 Filipino women of childbearing age; for the Chamorro and Carolinian the total is 7,665. These ethnic and cultural diversity makes the delivery of health care a very challenging endeavor. Majority of these Asian mothers are non-resident contract workers but there is an increasing number who are married to U.S. citizens and citizens from other compact states. These women and their infants traditionally do not seek prenatal care until time of delivery, thus having an impact on the increasing rates of high risks mothers and infants. Table 3 and Table 4 illustrates service utilization per ethnic group.

1996 CLINIC	INDIGENOUS (BORN IN CNMI)	MICRONESIAN	ALIEN	TOURIST	ALL OTHERS	TOTAL
WELL CHILD	3,984	47	169	1	94	4,295
SCHOOL PROGRAM	1,064	124	228	21	247	1,684
IMMUNIZATION	3,920	447	1,017	28	1,216	6,628
PEDIATRICS	9,473	408	318	34	783	11,016
OBSTETRICS/PRENATAL	2,855	756	3,577	53	881	8,122
GYN	1,672	304	884	17	614	3,491
POST PARTUM	262	89	376	9	88	824
FAMILY PLANNING	658	115	418	5	201	1397

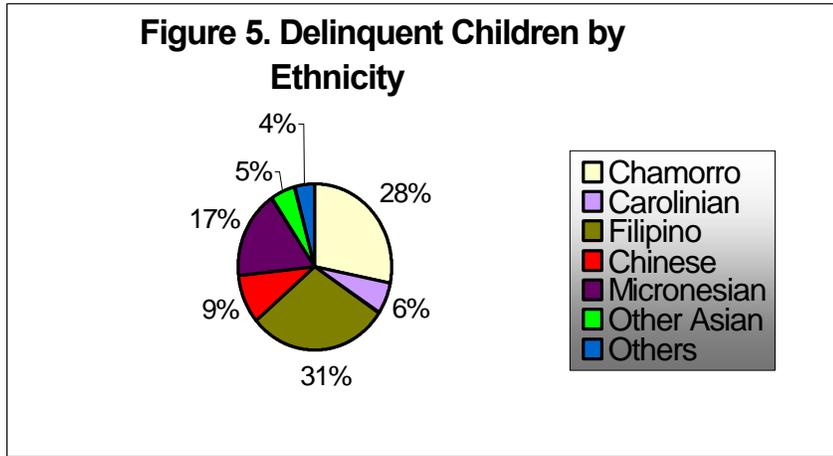
1997 CLINIC UTILIZATION						
1997 CLINIC	INDIGENOUS (BORN IN CNMI)	MICRONESIAN	ALIEN	TOURIST	ALL OTHERS	TOTAL
WELL CHILD	4,350	29	48	6	81	4,514
SCHOOL PROGRAM	1,183	137	224	12	240	1,796
IMMUNIZATION	3,104	371	677	30	963	5,145
PEDIATRICS	9,812	333	318	26	803	11,292
OBSTETRICS/PRENATAL	3,003	849	3,498	56	861	8,267
GYN	1,423	244	890	13	540	3,110
POST PARTUM	351	120	413	10	128	1022
FAMILY PLANNING	555	91	350	3	139	1138



Another program that is affected by people moving in and out of the islands is the Immunization Program. The program is not linked to a system that identifies children who exited the islands. (Table 6 illustrates immunization delinquency by ethnicity)

Table6. FY 1999 Delinquent Children by Ethnicity

Ethnicity	Total No.
Chamorro	98
Carolinian	21
Filipino	104
Chinese	33
Micronesian	60
Other Asian	18
Others	15
TOTAL:	349



A critical issue currently facing Department of Public Health (DPH), that has added a tremendous burden to the manpower shortage, is that nurses are required to pass the nursing examination (NCLEX) or be demoted; some would opt to resign than be demoted as it affects the salary. This only applies to government health facilities. One solution addressing the shortage of medical professionals is Senate Legislative Initiative No. 10-4. It was passed to amend Article III, Section 20 of the Commonwealth Constitution “to permit legislation allowing retirees to reenter the work force as doctors, nurses, and other medical professionals without losing their retirement

benefits and to help reduce reliance on nonresident labor to fill these positions”. Currently the nursing staff for Public Health Clinic is:

Nursing Staff	# working at Public Health Clinic
Retirees	8 (5 are NCLEX certified)
Manpower Agency	9 (all are NCLEX certified)
Local Hire	6 (4 are NCLEX certified)
Nursing Assistant	3

The Southern Community Health Center, located in San Antonio, has recently reopened servicing the most southern residents and others in need of prenatal care, immunization, family planning, as well as routine blood pressure and sugar level screening. The Center reopened on March 29 of this year. The staff includes one OB/GYN, two family planning nurses, one registered nurse, and a nurse from the Breast and Cervical Cancer Screening Program. Well baby care is provided on Wednesdays and Thursdays afternoons. There has been an increase in the utilization of family planning services and prenatal care services for adolescents. The monthly logbook show about 6 more adolescents per month are seeking family planning services than this time last year. The Center will be opening from 12:00 p.m. to 8:00 p.m. on Thursdays. The Breast and Cervical Cancer Screening Program will also provide services at this day and time.

There are five private health clinics on the island of Saipan. Of the five private health clinics, FHP is one that can be classified as a managed care facility. Patients who are enrolled under the FHP program still get referred to the Public Health Clinic, i.e., for GYN services. At the private clinics there are four Family Practitioners, three Internists, two OB/GYNs, one Pediatrician, and three Physician Assistants. Three of the five clinics render immunization services per MOA with the Department. Vaccines and staff training are provided to the private clinics. Medicaid clients seek health care at DPH because it is the only facility that accepts Medicaid. Uninsured patients are also seen at the Public Health Clinic.

1.5 The State Title V Agency

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. The authorized representative is the Secretary of Health, who is appointed by the Governor. The Governor also appoints the Deputy Secretary for Public Health Administration.

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

A Secretary of Health who is appointed by the Governor and serves as a Cabinet Member heads the Department of Public Health (DPH). The organization of DPH affects how services are delivered, and to an extent, which services are provided. DPH consists of three Divisions: the Hospital Division (Commonwealth Health Center), Public Health Division, and the Division of Mental Health and Social Services. There are two Program Offices: Medicaid Program and the Medical Referral Program. The mission of the Department is *“To improve the quality of life through encouraging and empowering the community to achieve its highest possible level of wellness and ensuring 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, §2 gives 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.

(Please refer to attachment #1 - Organizational Structure Chart and Functional Chart)

1.5.1.2 Program Capacity

The MCH Program is administered through the Division of Public Health, Department of Public Health. Currently the MCH program addresses teenage pregnancy intervention, prenatal and postpartum care, family planning, breast and cervical cancer screening, childhood immunizations, well childcare, children with special health care needs, and primary care for women and children.

The mission of the Maternal and Child Health Program is *“to improve the quality of life of all mothers and children by providing preventive and primary health care services”*.

Most of the clinical services are provided at the Public Health Clinic (Women's and Children's Clinic), located at the Commonwealth Health Center, with the assistance of pediatricians and obstetricians from the Hospital Division.

The CNMI was granted a waiver to allow anyone with low income and minimal resources access to Medicaid; not just the aged, blind, and poor. During FY 1998 there were of 3,711 children on the Medicaid Program. Of this total 3,443 are children without third party liability insurance. During FY 1998 there were a total of 172 pregnant women on Medicaid. The program services more than the indigenous population of the CNMI (Table 10). Because Medicaid takes into account property value, most do not qualify for benefits due to owning homestead property.

Table 7. Medicaid Recipients by Ethnicity FY1999

Chamorro	3,752
Carolinian	1,101
Filipino	719
Chinese	17
Other Micronesian	989
Other Asian	34
Others	53

Medicaid Office

The CNMI is eligible for participation in the Child Health Insurance Program (CHIP) of Title XXI and has applied for such entitlement. The amount of the entitlement set by Congress for the CNMI is \$118,113. The CNMI's CHIP funds will be used primarily to expand eligibility for children under their Medicaid Program. This will provide child health assistance to targeted Medicaid eligible children. The MCH Program and the Medicaid Program will work together to identify and enroll these children. All uninsured children come to the Public Health Clinic for their health care needs. Public awareness of CHIP will be actively promoted via dissemination of brochures at the Clinic and interviews of clients who are uninsured. Rota and Tinian clients will also benefit from such entitlement. According to the Director of the Medicaid Program the CNMI has not drawn on CHIPS funds because it has not met the required matching funds for Medicaid. Sliding fee scale is in effect and income sources determine amount to be paid. Eliminating barriers to the access of health care and promotion of family-centered and community-based settings are priorities of DPH.

Preventive and primary care services for pregnant women, mothers, and infants:

- Prenatal Care: Prenatal care is provided at the Women's Clinic located at the Commonwealth Health Center, Rota Health Center, Tinian Health Center and Southern Community Health Center. A physician evaluation, routine screening tests, prenatal counseling and education, and monitoring the baby's growth and the mother's condition are part of the prenatal care visit. Staffing include four OB/GYNs, two Midwives, seven registered nurses, one nursing assistant, and two licensed practical nurses. 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 priority goal of the program. Another goal is 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. Voluntary testing for HIV is also available at the clinic. Prenatal Education classes are also provided every Thursday. A high-risk clinic is also available for pregnant women with diabetes, heart problems, or with a special health care need. Gynecological services – pap smears and consultations, are also provided at the Clinic. During 1999 3,566 patients received gynecological services and 8,268 came for prenatal first visits and revisits. The encounter forms for prenatal visits are revised to promote a user-friendly environment.
- Postpartum Care: This clinic is held twice a week on Tuesdays and Thursdays at the Public Health Clinic. 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. The six weeks follow up visit for infants is incorporated into this appointment. Basic

immunization series along with the second dose of the Hepatitis B vaccine is initiated.

A health care provider also conducts routine well baby examination.

- 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. Names and numbers of the members of the breastfeeding support group are also given out. The Clinic is held on Thursdays.
- Family Planning: The primary focus of the Family Planning Program is the prevention of teen pregnancy. Many of the teenage pregnancies are out of wedlock and do not have the family environment that is optimal for the raising of children. Teenage mothers are more likely to have subsequent pregnancies and are at higher risk of not completing their education.

TABLE 8. TEENAGE DELIVERIES BY AGE AND ETHNICITY OF MOTHER CY 1998

ETHNIC	12 Yrs	13 Yrs	14 Yrs	15 Yrs	16 Yrs	17 Yrs	18 Yrs	19 Yrs	TOTAL
CHAMORRO	1		3	8	15	28	36	27	118
CAROLINIAN			1	3	2		1	5	12
FILIPINO							2	2	4
CAUCASIAN								2	2
PALAUAN					1	2	2	3	8
CHUUKESE	1				1	2	4		8
POHNPEAN				1		1	1	2	5
MARSHALLESE								1	1
YAPESE								1	1
OTHERS									
TOTAL	2		4	12	19	33	46	43	159

TABLE 9. TEENAGE DELIVERIES BY AGE AND ETHNICITY OF MOTHER, CY 1999

ETHNIC	12 Yrs	13 Yrs	14 Yrs	15 Yrs	16 Yrs	17 Yrs	18 Yrs	19 Yrs	TOTAL
CHAMORRO				3	6	19	31	27	86
CAROLINIAN				1	1	5	4	2	13
FILIPINO					1	1	2	1	4
CAUCASIAN								1	1
PALAUAN						1	1	3	5
CHUUKESE							1	3	4
POHNPEAN									
MARSHALLESE					1				1
YAPESE									
OTHERS						1			1
TOTAL				4	8	27	39	37	115

Table 10. TEENAGE DELIVERIES BY YEAR: 1995-99

1995	1996	1997	1998	1999	TOT	5YA
135	137	171	159	115	717	143

Total Live Births for 1999 = 116, with 1 fetal demise to an 18 year old mother.

Three sets of twins were born to a 16, 17 & 18 year old mothers; all chamorros.

Source: Certificates filed at the Office of Health Planning and Statistics, DPH

In 1999 teenage live births dropped 3.4% from 1998 with a five-year average of 143.

The teen pregnancy rate for FY 1998 27.8%. The objective was to decrease it from 30% in 1997 to 28%. Table 11 illustrates planned and unplanned pregnancies.

Table 11. CNMI Deliveries by Status: Planned/Unplanned 1998-99

Age	Planned	Unplanned
12-19 years old	71	150
20 years old and above	818	658
Total	889	808

Source: Prenatal Log Book, 1998-1999

STD/HIV: Services include STD counseling and education, HIV pre and post counseling, partner identification and notification, treatment, and follow up. There have been a total of thirty- three (33) persons with known HIV infection residing in the CNMI since 1983 (Table 12). Twenty-five of the 33 tested positive in CNMI, however one of these was discovered at autopsy. The remaining eight were tested positive off island. Prior to 1995, all of the cases (10) were men who have had sex with men (MSM), 7 of the 10 were Chamorro. Since 1995, the epidemiology has been changing to include women and teenagers starting in 1997 and

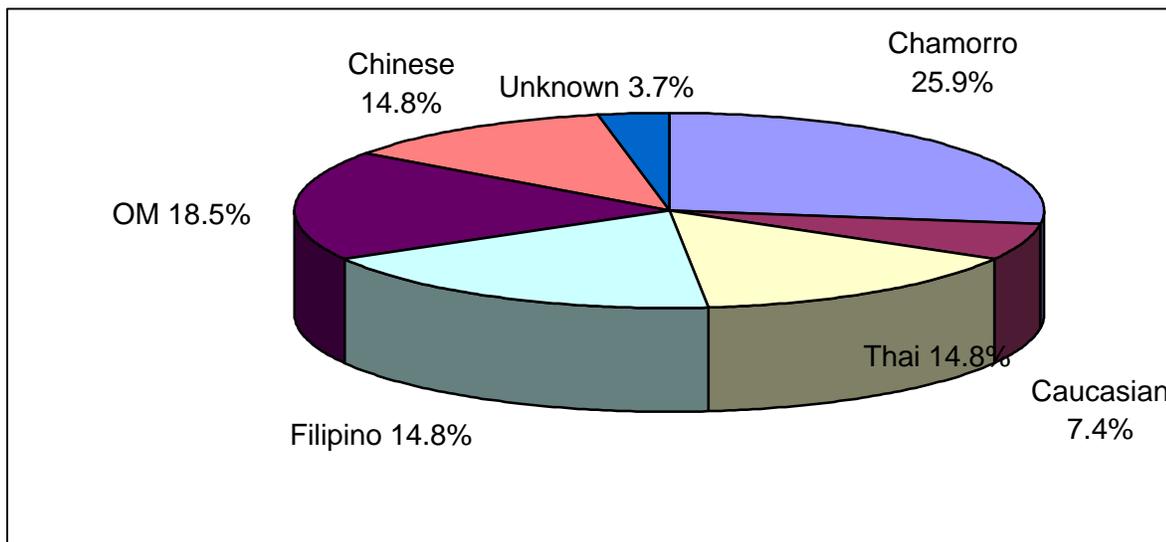
newborn babies.

Twenty-five of the 33 resided on Saipan; 7 on Tinian; and one on Rota. The mean age at the time of HIV sero-positivity was 34.6 years (range 4 months –53yrs.). The year-end prevalence of HIV infected individuals for 1998 was 22 per 100,000.

Table 12. Profile of HIV/AIDS Cases in CNMI, 1999 (Source:CNMI DPH)

Characteristic	Number of Cases (% of Total)
Sexual Preference	
Perinatal Transmission	2(6.06%)
Gay or Bisexual Men	11 (33%)
Heterosexual Men	10 (30.3%)
Heterosexual Women	9 (27.3%)
Unknown (men)	1(3.0%)
Ethnicity	
Chamorro	9 (27.27%)
Thai	5 (15.15%)
Caucasian	2 (6.06%)
Filipino	6 (18.2%)
Other Micronesian	6 (18.2%)
Chinese	4 (12.12%)
Unknown	1 (3.0%)
Island of Residence	
Saipan	25 (70.3%)
Tinian	7 (25.9%)
Rota	1 (3.7%)
Progression to AIDS	9 (42.9%)
Died of AIDS	7 (33.3%)
Mean Age at Diagnosis	34.6 years
Mean Age at Death	34.7 years

Figure 6. Known HIV Infected Individuals by Ethnicity, 1999



OM = Other Micronesian
 CNMI Department of Public Health

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.

- Immunization: The Immunization Program continues to prove successful because of the commitment and effort of the Program and Tracking Coordinators. The walk-in clinic at WCC and the Saturday morning clinic has enhanced efforts to reach the 90% immunization rate for two-year olds. The immunization coverage rate for the Head Start Program for 1998-99 enrollees is 95%. Nurses have gone to Head Start, and Kindergarten schools, Hopwood Junior High School and Marianas High School for immunization of delinquent students. 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) (see attachment #2). (Table 13 illustrates vaccine-preventable morbidity)

Table 13. Vaccine Preventable Disease Morbidity, CNMI 1996-1999

Disease	1996	1997	1998	1999
Diphtheria	0	0	0	0
Tetanus	1	0	0	0
Pertussis	0	0	0	0
Measles	0	4	0	0
Mumps	1	0	0	0
Rubella	0	0	0	0
Polio	0	0	0	0
HiB	0	0	0	0
Hep B	32	70	76	78

A school health certificate is issued upon completion of immunization. By law, all children are required to be up-to-date on their immunizations before they can enter school (see attachment #3). Currently, the Program is working on a policy for adult immunization.

Another concern is the tracking and follow-up of families for mothers who test positive for Hepatitis B.

- Well Baby/Child Clinic: The Well Baby/Child Clinic functions as a component of the pediatric section of the Women's and Children's Clinic (WCC). Immunizations, health education and counseling including nutrition, assessment and monitoring for growth and development and other underlying health problems, and physical exams are some of the services provided. The promotion of breastfeeding is actively done during prenatal care visits and well baby visits. EPDST is also incorporated into the Well Baby/Child Clinic visits in order not to duplicate services and because of manpower issues. The staffing include four pediatricians, one Nurse Practitioner, seven RNs, two LPNs, and two Nursing Assistants. There were 3,431 well baby visits for 1999.
- 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. A day's log for home visits would show more than 35 patients per day.

Preventive and primary services for children:

School Health Program: Routine physical examination (including hearing and vision screening) is provided to all children entering school for the first time. School health certificates are issued to children who have completed the required vaccinations for that age group. Children are routinely bussed in from the schools for dental examinations. The challenge for the school health program is to have parents schedule physical examinations

early and not wait until July and August. For 1999 1,260 children received physical examinations.

- Dental Fluoride and Sealant Program: There are two parts to this program: The first one is school-based in which classroom presentations and hands on activities are provided to the students on dental care and hygiene. Teachers are also trained on the administration of the fluoride tablets to students from Kindergarten to sixth grade. The second part of the Program is clinical-based. Students in the first, second, fifth, and sixth grades are bussed to the clinic for dental sealant, oral health instructions, and are assessed for caries and periodontal diseases. These children are given report cards on dental finding so parents can make necessary appointments for further dental procedures.

Services include general dentistry such as sealant application, fluoride tablets, education/counseling, community outreach activities, cleaning, extraction, fillings, prophylaxis, and dentures. The Head Start Program buys the fluoride varnish and the Clinic applies the varnish. This procedure prevents early childhood caries. Baby bottle tooth decay is addressed at the prenatal education class. The staff works closely with the legislature on implementing preventive regiments such as bottled water fluoridation. The upgrading of equipment is one priority of the program.

Staff includes four Dentists (*last year there were three Dentists*), two Lab Technicians and two Dental Assistants. Recruitment for a dental hygienist is still pending. During school year 1999, 2,142 students received sealant. The total number of student participation is 4,933. These students are from both private and public schools, including Tinian and Rota. The clinic provides services to about 75 patients per day.

TABLE 14. CNMI DENTAL HEALTH SEALANT PROGRAM 1st, 2nd, 5th & 6th, 1996 - 1997						
	TOTAL	TOTAL	% PARTICIPATION	TOTAL NUMBER	CARIES	% ASSESSED

SCHOOL NAME	ENROLLED	ASSESSED		TEETH SEALED		W/CARIES
KOBLERVILLE	222	186	186/222=84%	411	186	186/186=100%
SAN ANTONIO	186	131	131/186=71%	259	123	123/131=94%
WSR	455	350	350/455=77%	924	304	304/350=87%
OLEAI	287	238	238/287=83%	719	202	202/238=85%
GARAPAN	481	384	384/481=80%	1158	343	343/384=90%
TANAPAG	231	175	175/231=76%	600	156	156/175=90%
GRACE CHRISTIAN	214	149	149/214=70%	422	128	128/149=86%
MT. CARMEL	231	139	139/231=61%	334	91	91/139=66%
GTC	194	131	131/194=68%	571	120	120/131=92%
SAN VICENTE	467	467	467/467=100%	1608	376	376/467=81%
TOTAL	2968	2350	2350/2968=80%	7006	2029	2029/2350=87%

TABLE 15. CNMI DENTAL HEALTH SEALANT PROGRAM 1st, 2nd, 5th & 6th, 1997 - 1998

	TOTAL	TOTAL	% PARTICIPATION	TOTAL NUMBER	CARIES	% ASSESSED
SCHOOL NAME	ENROLLED	ASSESSED		TEETH SEALED		W/CARIES
KOBLERVILLE	249	210	210/249=84%	553	183	183/210=87%
SAN ANTONIO	200	114	114/200=57%	224	100	100/114=88%
WSR	485	279	279/485=57%	1037	255	255/279=91%
OLEAI	299	233	233/299=78%	548	198	198/233=85%
GARAPAN	517	436	436/517=84%	1125	386	386/436=89%
TANAPAG	231	164	164/231=71%	578	161	161/164=98%
GRACE CHRISTIAN	228	114	114/228=50%	520	80	80/114=70%
MT. CARMEL	250	180	180/250=72%	686	162	162/180=90%
GTC	201	157	157/201=78%	518	149	149/157=95%
SAN VICENTE	633	470	470/633=74%	1721	377	377/470=80%
TOTAL	2968	2350	2350/2968=80%	7006	2029	2029/2350=86%

Table 16. CNMI DENTAL HEALTH SEALANT PRORAM 1st, 2nd 1998 – 1999

School Name	Total	Total	% participation	Total Number	Caries	% Assessed
	Enrolled	Assessed		Teeth Sealed		With caries
GTC	124	90	90/124=73%	155	86	86/90=96%
Tanapag	124	93	93/124=75%	167	91	91/93=98%
Garapan	293	284	284/293=97%	551	258	258/284=91%
Oleai	156	140	140/156=90%	310	123	123/140=88%
WSR	289	209	209/289=72%	434	195	195/209=93%
San Antonio	100	98	98/100=98%	234	93	93/98=95%
Koblerville	127	109	109/127=86%	208	104	104/109=95%
Mt. Carmel	155	114	114/155=74%	334	78	78/114=68%
GCA	109	90	90/109=83%	183	74	74/90=82%
San Vicente	322	274	274/322=85%	521	240	240/274=88%
Rota Private School	24	16	16/24=67%	61	14	14/16=88%
Rota Elementary	94	70	70/94=74%	159	69	69/70=99%
Tinian Elementary	110	107	107/110=97%	316	97	97/170=91%
Tinian GCA	40	32	32/40=80%	79	29	29/32=91%
TOTAL	2067	1726	1726/2067=84%	3702	1551	1551/1726=90%

Mental Health and Social Services: School counselors and other service providers work closely with the staff of the Division of Mental 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.

- Well Baby/Child Clinic: Screening for vision and hearing are done for 5 years and up, dental, anemia, tuberculosis, and physical conditions are done on a regular basis. The promotion of breastfeeding is actively done during well baby visits. EPDST is also incorporated into the Well Baby/Child Clinic visits in order not to duplicate services and because of manpower issues. There are currently four full-time pediatricians at the clinic.

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. The program, in its efforts to promote family and community-based center, is located at the Children's Developmental Assistance Center. 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. One priority of the program is to identify, monitor, and track CSHCN. Specialty clinics, such as Pediatric Cardiology, and Shriners, are conducted throughout the year. Some activities include a training workshop for care coordinators in assistive technology, CSHCN Registry; computer class on Word and Excel; Open House;

CSHCN Registry, and activities such as Easter egg hunt and weekly play group. 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

1.5.1.3 Other Capacity

The MCH Program is administered through the Division of Public Health, Department of Public Health. Key personnel involved in MCH activities include the:

Secretary of Health: Mr. Joseph K.P. Villagomez has the overall responsibility for all activities within the Department of Public Health. Mr. Villagomez was the Director of the Division of Mental Health and Social Services from 1995-97. Prior to that he was the Substance Abuse Treatment/Prevention Coordinator for that Division. Mr. Villagomez graduated with a B.S. in Psychology from Washington State University and a Masters of Art Degree from Antioch/New England Graduate School.

Deputy Secretary for Public Health Administration: Mr. Ned S. Arriola was appointed by the Governor to oversee the Division of Public Health. He received his MPH from the University of Hawaii. His expertise in the health field includes holding the position of Special Assistant to Public Health, Deputy Director, and Assistant Hospital Administrator.

Public Health Adviser: Mr. David B. Rosario comes to us from Guam. He graduated with a BA Degree in Political Science & Public Administration and a Master Degree in Public Health specializing in Health Services Administration and Health Education. Mr. Rosario worked with the Guam Department of Public Health & Social Services for 8 years as a Health Educator and Health Education Administrator. He joined the South Pacific Commission based in Noumea, New Caledonia, for six years as the

Health Education Specialist and worked with 22 Pacific Island Countries and Territories. He then worked for the United Nations Funds for Population Activities (UNFPA) as the Population Communication Coordinator for IEC in the South Pacific Region for 2 years. In May 1996, Mr. Rosario moved to the CNMI and worked in the Department of Public Health as the Health Education Trainer/Advisor for two years. Mr. Rosario's expertise include program planning and evaluation.

Public Health Medical Director: This position has been vacant since July 1999. One is actively being recruited.

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.

Children with Special Health Care Needs Specialist: Ms. Joanne Camacho was recruited in December last year. Ms. Camacho was working as a care coordinator for the Early Intervention Program, C*DAC since its inception in 1986. She received numerous training in areas such as physical therapy, occupation therapy, NICU observations, and home visit procedures. Some of these training took place in Honolulu, Hawaii at Kapiolani Children's Hospital, Shriners, etc.

Epidemiologist: Mr. Edward Diaz, newly graduated with a Masters of Public Health Degree in Epidemiology from the University of Hawaii, joined the 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.

Manager, Health Planning and Statistics Office: Ms. Maggie T. Sablan holds this position.

She has the responsibility of providing all data to the entire DPH programs.

She is the AMCHP's State Data Contact person for the CNMI.

Computer Specialist II: Mr. Michael Pitts was recruited June of this year. He was on active duty with the U.S. Navy from 1971 to 1991. He worked at the Dona Ana County Detention Center in Los Cruces, New Mexico as the Medical Services Coordinator and Finance Advisor. He is currently working with the Immunization Program on their forms and database.

Other Public Health Program include the Communicable Diseases Program such as the Chest Clinic; Pediatric Clinic (Children's Clinic); Specialty Clinics (Shriners, Pediatric Cardiology, etc.); Saturday Walk-in Immunization Clinic; and the Non-Communicable Diseases Program such as Diabetes Clinic. The Health Promotion and Wellness Coordinator collaborates with the Nutritionist on outreach activities, i.e., Food and Nutrition Council, school nutrition survey, dental health study, etc. to address healthy lifestyle choices for the community.

Current administrative staff provides support in data input, collection, analysis and dissemination, clerical, and budgetary issues. The MCH Coordinator works in collaboration with the Family Planning Coordinator, Immunization Coordinator, Breast and Cervical Cancers Screening Program Manager, STD/HIV/AIDS Program Manager, Health Promotion and Wellness Coordinator, Nutritionist, etc., to promote health prevention and education to the people of the CNMI.

Parents of CSHCN have been active since the creation of the Parent-to-Parent group. These parents have children ranging in the age of 0-21. These parents were part of a panel for people with disability held by the Developmental Disability Council. A group of them also attended training on assistive technology. The Program provided transportation for the parents. A meeting with service providers and agencies such as Medicaid, SSI, Public School System, Hospital Division, MCH Program, etc. was conducted for CSHNC parents. These parents have been instrumental in getting other CSHCN parents to be members of advisory boards, interagency committees, and especially in being more vocal in the decision process in the areas of medical and related services that are needed for their children.

1.5.2 State Agency Coordination

The Department of Public Health includes the Division of Public Health, Division of Mental Health and Social Services, Bureau of Environmental Health, and Dental Health. 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 CNMI government including the Public School System, Division of Youth Services, Developmental Disabilities Council, Medicaid, and Office of Vocational Rehabilitation.

Because the Department of Public Health is the only government-run facility here in the CNMI, collaboration and partnership with other agencies, both public and private, is important to ensure the delivery of services to the people of the CNMI. Collaborative

efforts in prevention 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 recently recruited Community Outreach Worker will assist all programs in outreach educational activities at the schools, private agencies, conferences, fairs, etc. The staff will also be actively promoting services available not just with MCH but other programs at the Division of Public Health. Another activity in educating the public is that each month a theme is showcased in regards to preventive activities. For example, for the month of June the theme is on STD/HIV/AIDS prevention. Part of the showcase includes posters, data on STD/HIV and condoms. Showcases are displayed at the Clinic and at the hospital.

Staff from the Family Planning Program and the MCH Program work closely together in outreach activities for adolescents. Presentations include teen pregnancy, family planning issues, and reproductive health. The two programs together with staff from the Community Guidance Health Center have collaborated in doing radio spots on teen pregnancy. For the past four years the Pacific Basin Annual Family Planning Conference have been a joint effort with the MCH Institute. Family Planning portion of the conference presents contraceptive methods, clinical issues of family planning, counseling, etc., while the MCH Institute give presentations on data collection, analysis, etc.

The CNMI Breast and Cervical Cancer Screening Program provides free screening services to eligible women. Funding for the program is from the CDC National Breast and Cervical Cancer Early Detection Program. The criteria for eligibility are: ❶ one year of residence in the CNMI (for non-residents a passport entry date); ❷ 50 years and over for screening mammogram, 40-49 with high risk factors for screening

mammogram; ③ 18 years and over for pap smears; ④ family and income size; ⑤ insurance status. Transportation for appointments is also available. Clinical screening services are offered everyday. On Tuesdays it is provided up to 8:00 p.m. and on Thursdays up to 7:00 p.m. To date the Program has approximately 800 clients enrolled in the Program. The Program works closely with MCH not only in screening but also in tracking and follow-up of cases. The staff works together in outreach activities, i.e., the MCH Coordinator chaired the Breast and Cervical Cancer Awareness Month Committee for three years.

A collaborative effort that is currently ongoing between the staff from the AIDS Program and MCH is to encourage more pregnant women to take the HIV test. MCH staff will be trained for pre and post counseling and taking the blood. Out of 1, 509 pregnancies last year, only 170 were tested for HIV. Again, outreach activities, especially for adolescents, on STD/HIV/AIDS are ongoing activities between the two programs.

The Immunization Program not only collaborates with MCH in ensuring that delinquent children are identified and immunized. The Program works with the Public School System in tracking of delinquent children. These children are bussed to the Clinic for their required immunization. The Program also work closely with the day care centers on-island for identifying delinquent children. Other collaborations include assisting in grant management, outreach activities, and support staff. Parents are reminded to bring their babies for their six-week check-up. The home-visit nurses assist in tracking of delinquent children and in administering of vaccinations at home when necessary. The Program is currently in the process of updating MOAs with three private clinics for immunization services.

The MCH Program has been a tremendous support in the success of the Dental Sealant and Fluoride Program. Aside from working together in doing outreach and educational activities in dental caries and enhancement of skills and staff training funds are provided for purchase of sealant and fluoride. Bussing the children to the Clinic for application is a joint effort with the Public School System.

The Health Promotion and Wellness Coordinator, from the Health Education and Nutrition Office, actively works in raising awareness of services available and in preventive activities in the community. It works with MCH staff in the planning and organizing of conferences or health fairs.

Referrals to the Community Guidance Health Center, formerly the Division of Mental Health and Social Services, for counseling is another ongoing activity. One project among different agencies was Project Hope. Project Hope provided an 8 week drug education to 10 students at Hopwood Junior High School. The Center provides substance abuse education at the schools.

Collaboration and partnership with other service providers, both public and private, is vital in the delivery of services for Children with Special Health Care Needs. The program links with the Public School System's Early Intervention Program, Head Start, and Special Education Program in the provision of related services in the areas of speech therapy, physical therapy, and occupational therapy. The Program collaborates with the Assistive Technology Unit at the Developmental Disabilities Council Office and Medicaid to ensure that children with disabilities lead a more independent life. One pediatrician from a private clinic is a member of the interagency committee on CSHCN. He also volunteers in the screening and evaluation process of clients at C*DAC.

The Medical Referral Program at the Department has provided off-island 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 outside the CNMI.

The collaboration between Public Health and Karidat continues to be a success.

Karidat is a non-profit agency with programs aimed at adolescents. Summer camps are held twice a month and Public Health staff provides educational presentations on teen pregnancy, reproductive health, abstinence education, life-building skills, STD/HIV, etc. Counseling on an individual basis, as requested, is also provided.

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, Monitoring, Systems of Care and Information System. Funds have been used for training of care coordinators, nurses, staff from the Office of Health Planning and Statistics, administrative support staff in the areas of computer, Outreach Program, nursing home care, measurement and production of vital statistics, 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 Office of Health Planning and Statistics, Medicaid Program, CSHCN Program, Women's and Children's Clinic. Last year's most successful collaboration is the CSHCN Registry. This year it is the recruitment of the Computer Specialist. He will be assisting each program with data needs and requirements.

Among the Department's most successful community-based collaboration are the CNMI Food and Nutrition Council and the First Lady's Vision Foundation. The

Council is formed because two former Nutritionists believed that the only way to bring about a healthier CNMI was to bring together a community based partnership of non-medical people. The primary task of the Council is to design interagency partnership programs that would address nutrition and food related issues and concerns affecting the indigenous community. The First Lady's Vision Foundation hold annual conferences focusing on healthy families – strong community. The Department has been a major sponsor of the Foundation and in the planning and organizing of the conferences.

II. REQUIREMENTS FOR THE ANNUAL REPORT

The mission of the Maternal and Child Health Program is “*to improve the quality of life of all mothers, infants, and children, by providing comprehensive health care services*”. Programs in MCH continue to be a priority for the Division of Public Health. The program provides preventive and primary care that includes prenatal and postpartum care, immunization, well child care, children with special health care needs, health education and awareness, family planning, etc.

The general MCH population includes women of childbearing age (15-49 years), infants less than 1 year of age, and children, including children with special health care needs. Large portions of the overall population in the age range 20 to 34 years are alien female contract workers. The largest ethnic group for women in this age group is Asian (Filipino and other Asians), reflecting the number of women in the garment and service industries. A breakdown by age and ethnicity is shown in Tables 17 and 18

Table 17. Females in the CNMI by age

Age Group	CNMI	Saipan	Rota	Tinian
15 to 19 years	1719	1537	99	83
20 to 29 years	9491	8888	340	261
30 to 44 years	8443	7716	389	338
45 to 64 years	2404	2149	156	98
65 years +	487	418	46	23
Total	22,544	20708	1030	803

CNMI 1995 Mid-Decade Census, Division of Central Statistics

Table 18. Females in the CNMI by Ethnicity

Age Group	Chamorro	Carolinian	OM	Filipino	Chinese	OA	Others
15-19 years	774	163	204	169	216	101	92
20-29 years	1300	264	544	2643	3775	708	257
30-44 years	1442	294	607	3842	1174	736	348
45-64 years	810	172	187	836	34	190	175
65 years +	291	43	38	41	9	37	28
Total	4617	936	1580	7531	5208	1772	900

OM = Other Micronesians OA = Other Asians
 CNMI 1995 Mid-Decade Census, Division of Central Statistics

The annual population growth rate of 5.6% has been classified as the highest in the world. The population has more than tripled since 1980 (58,846 – 1995 Census). Children in the CNMI come from diverse background. The ethnicity of these children is much more difficult to define given the amount of mixing, especially among Asians and the indigenous population (Chamorro and Carolinian).

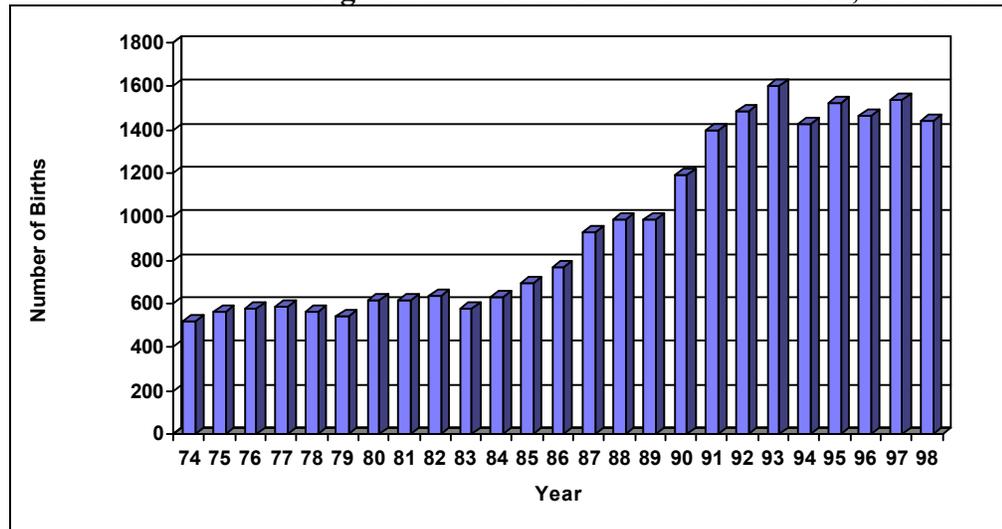
The median age of the CNMI population is 28.0 years. The average life expectancy at birth in the CNMI is 75.5 years. The CNMI has a crude death rate of 2.3/1000 population. The CNMI 1998 infant mortality rate was 8.4/1000 live births compared to the U.S. rate of 7.2/1000 live births in 1997. The number of live births has been stable over the past 5 years (Table 19, Figure 7).

Table 19. Birth Statistics for CNMI 1995-1998

	1995	1996	1997	1998
Total Population*	58,846	61,946	63,763	66,559
Live Births	1,525	1467	1,536	1,438
Crude Birth Rate	25.9	23.7	24.1	21.6

*1990 Census, 1992 CNMI Household survey, 1995 Census, Estimates from CNMI Division of Central Statistics
CNMI Dept. of Public Health

Figure 7. Total Births in the CNMI, 1974-1998



CNMI Dept. of Public Health

The prevention of teen pregnancy is one primary focus and this will be addressed specifically with the CNMI Abstinence Education Grant application. Tables 20 and 21 shows the ethnic breakdown of teen pregnancies for 1997 and 1998 in CNMI. During 1998 8% of total live births are born to teen mothers aged 15-19 years. The 1997 birth rate for Chamorro females

aged 15-19 years at 130 is twice as high as the U.S. 1997 birth rate for teenagers of 52.3/1,000 women aged 15-19 years.

Table 20. Ethnic Distribution of Births in the CNMI by Age of Mother for 1997

Ethnicity	Under 13	13	14	15	16	17	18	19	Total
Carolinian	-	-	-	2	3	2	3	5	15
Chamorro	-	-	2	11	12	19	29	30	103
Chinese	-	-	-	-	-	-	-	-	-
Filipino	-	-	-	-	-	1	2	4	7
Other Micronesian	-	-	-	5	4	4	2	8	23
Other Asians	-	-	-	-	-	1	-	-	1
Others	-	-	-	-	-	-	-	2	2
Total	-	-	2	18	19	27	36	49	151

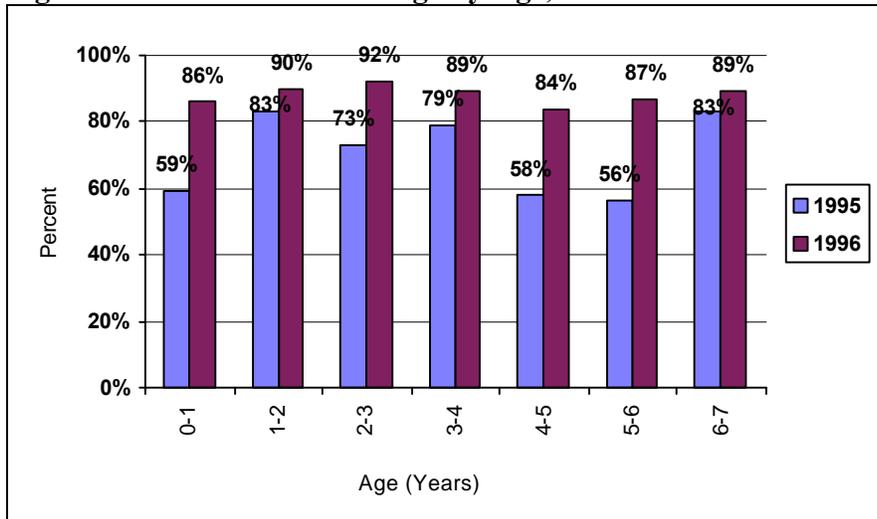
Table 21. Ethnic Distribution of Births in the CNMI by Age of Mother for 1998

Ethnicity	Under 13	13	14	15	16	17	18	19	Total
Carolinian	-	-	1	3	2	-	1	5	12
Chamorro	-	-	3	8	15	28	36	27	117
Chinese	-	-	-	-	-	-	-	-	-
Filipino	-	-	-	-	-	-	2	2	4
Micronesian	1	-	-	1	2	5	7	7	23
Other Asians	-	-	-	-	-	-	-	-	-
Others	-	-	-	-	-	-	-	2	2
Total	1	-	4	12	19	33	46	43	158

The CNMI immunization rate for 2-year-olds for 1998 is 88.2%. Figures 8 and 9 illustrates vaccine coverage for 1995-96 and 1997-98. The staff works diligently in tracking delinquent

children and works closely with all schools in the CNMI, including daycare centers, and the private clinics.

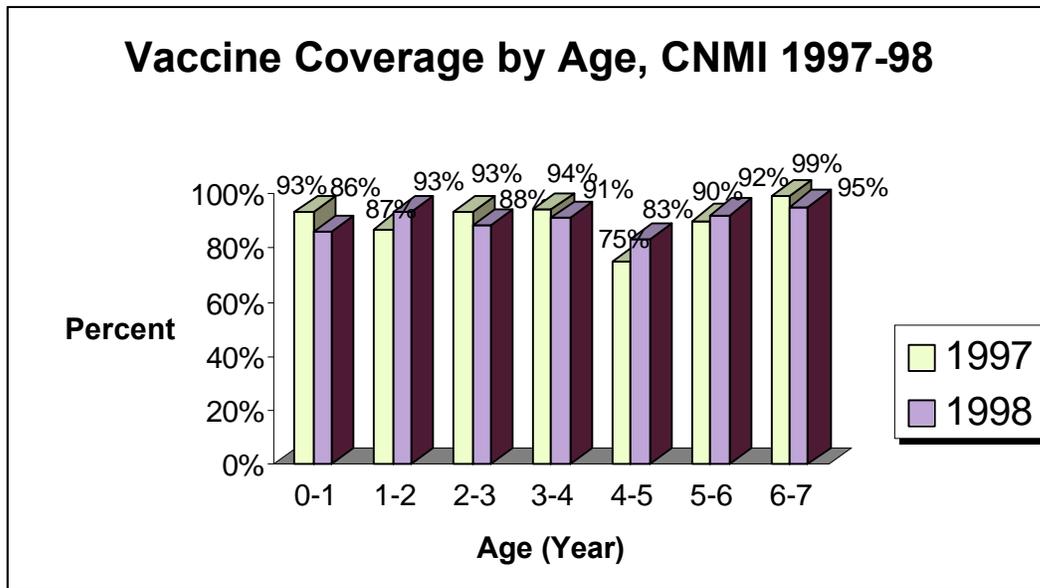
Figure 8. Vaccine Coverage by Age, CNMI 1995-1996



CNMI Dept. of Public Health

0-12 months DPTx3, TOPVx3, HepBx3, HIBx3 (3:3:3:3)
 2-3 years DPTx4, TOPVx3, MMRx1, HepBx3, HIBx4 (4:3:1:3:4)
 4-7 years DPTx5, TOPVx4, MMRx2, HepBx3, HIBx4or1 (4:3:1:3:4or1)

Figure 9. CNMI Vaccine Coverage by Age, 1997-98



The Children with Special Health Care Needs (CSHCN) Program is a component of the Maternal and Child Health Program. The program is set up to promote an integrated service delivery system for CSHCN from birth to twenty-one years of age and their families. The

program, in its efforts to promote family and community based center, is located at the Children’s Developmental Assistance Center (C*DAC). The CNMI definition of eligibility for program services for “at-risk” children includes children with a diagnosed physical, mental, metabolic or other chromosomal abnormality that has a high probability of impairing normal development. The CSHCN Program works collaboratively and cooperatively with other agencies and departments in the CNMI to provide CSHCN appropriate education and support services needed to meet their social, emotional, physical and medical needs. The Interagency Committee is a group of service providers that work together to ensure a seamless delivery of services for CSHCN. The CSHCN Program is responsible for identifying, monitoring, tracking and taking care of all CSHCN. The transdisciplinary model has proven to be effective for it allows each discipline to combine their assessments into one and also allows the formulation of a team for implementation and smooth transition into a setting acceptable by the families. The model ensures that the family is a part of the team. Currently, the CSHCN program is actively participating in child find activities. The Social Worker goes to Labor and Delivery every morning and works with staff in the area of referral. Referral forms are picked up daily at the Children’s Clinic. The CSHCN Registry has also increased child find activities. Specialty Clinics are provided for CSHCN. Specialists from off-island, i.e., Hawaii, are brought to Saipan to provide specialized medical care (Table 22).

Table 22 Specialty Clinic, 1999

Specialty Clinic	Total # of Clients
Shriners	308
Pediatric Cardiology	150
Plastic Surgery	43
Genetics	40
Neurology	10
ENT	

Total

A primary physician is assigned to each child during Specialty Clinic visits.

There is a great need for the CSHCN program. Each agency and individual involved is highly motivated and dedicated to the program. The program's primary focus is on the well being of the child and the needs of the family. The program is dedicated to ensuring the overall care coordination for CSHCN.

Program Activities:

- Maternal and Child Health Conference focused on childhood obesity, immunization, prenatal care, postpartum care, and breastfeeding,.
- First Lady's Vision Foundation 3rd Annual Conference: The foundation's theme is Healthy Women-Healthy Families – Strong Communities. This year's conference theme was "Bridging the Gap: Culture to Health. Getting information to the community was a theme for each presentation. Speakers included health professionals and consumers and parents. Health screenings were done and exhibits were on display.
- Prenatal Education Classes: To bring about a more supportive and preventive prenatal care program, the prenatal education classes pilot project began in May of this year. The classes are offered every Thursday from 10:00 a.m. to 11:00 a.m. The classes are divided into four sessions: Class 1 – Nutrition and Exercise During Pregnancy; Class 2: - What is a normal pregnancy, Common complaints of pregnancy, Dental care for you and your baby, and STD/HIV/AIDS education; Class 3 – Labor and Delivery; and Class 4 – Postpartum Care, Newborn Care, Breastfeeding, and Family Planning. Classes will be repeated every 4 weeks and are free of charge.

- Breastfeeding Clinic: Newborn assessments are done and breastfeeding education and techniques are reinforced. The Clinic is held every Tuesday. There are forty mothers who come to this Clinic with their infants per month.
- MOU with PSS was signed August of 1999.
- The Early Childhood Conference educated parents about physical and emotional development, correct eating habits, immunization, signs of substance abuse, and betel nut chewing and dental problems (oral cancer).
- Assistive Technology Workshop focused on various types of assistive technology devices available to the disabled population. Procedures for IFSP/IEP process and Federal laws and regulations were discussed.
- Part II of the transdisciplinary/transagency/transcultural training was conducted in January of this year. The training centered on evaluation and assessment process, IFSP/IEP process, and integrating families in the team.
- Dental Education/Outreach: Team of staff from the Dental Office went to neighboring islands of Tinian and Rota to assess children's caries rates in grades 1-6 who are enrolled in the public school. The staff provided training on dental health education, application of pit and fissure sealant, and implementation of fluoride chewable tablets for the school-based program; and performed pit and fissure sealant to 352 children grade 1-6.
- World Aids Day Conference: The purpose of the conference was to present preventative education to a panel of students ranging from the ages of 9-17 years, including Rota and Tinian students. The students presented a variety of skits pertaining to HIV preventative education
- Food and Nutrition Conference: The purpose of this conference was to provide knowledge and skills on food and nutrition issues; secure support from community leaders and decision makers; ensure council sustainability and its activities; inform the community on Food and Nutrition

activities such as the School-Based Nutrition and Physical Activity Partnership Program; define food security in a cultural context thus ensuring access by CNMI residents to wholesome foods.

- C*DAC Open House: As part of our Public Awareness efforts brochures, posters, news releases, etc. were used to campaign for this activity. The Center provided the general public the opportunity to meet the staff and ask questions regarding Early Intervention Program and CSHCN Program. In addition, secondary consumers were able to communicate with primary service providers. As was planned last year a documentary video on the program was available.
- Staff Development Training: Training were conducted for MCH nursing staff on fetal growth and perinatal trauma, neonatal cardiac disease, perinatal infections, extremities of the newborn, etc.
- CSHCN Registry: maintains information about children – demographic, patient care, evaluation, follow-up, etc. The registry can generate report on child information, assessments pending, high-risk list, referral condition, and a CSHCN summary report. The Registry is currently installed in Tinian and Rota.

2.1 Annual Expenditures

No one is denied health care service in the CNMI regardless of ability or inability to pay. Because the Department of Public Health is the only government run health care facility in the CNMI the cost of providing health care services is ingrained. The demand for health care services has tripled along with the population growth. Along with this is the situation of people being referred off-island for medical services. During FY 1999, the CNMI requested for \$512,718 but was awarded the amount of \$489,573. The reason for this was that the CNMI government restructured the pay scale for nurses thus increasing their annual salary.

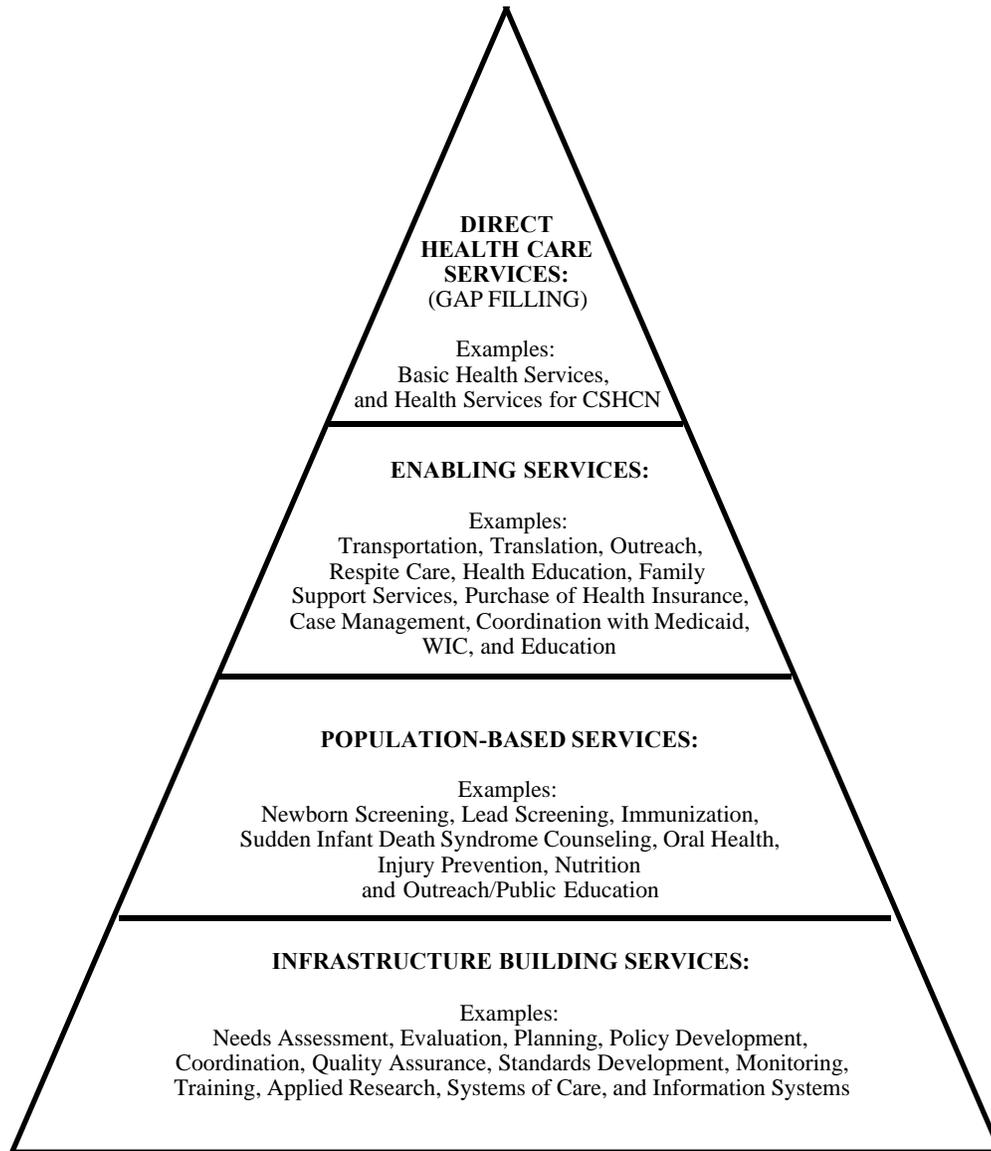
The unobligated balance normally results from a vacant position or a staff is recruited months into the fiscal year. The Accountant and the MCH Coordinator are

working closely to ensure that all funds are expended. For example, for FY 1999 funds earmarked for recruitment of personnel (Direct Health Care Services) were reallocated to other areas such as transportation (Enabling Services) and training (Infrastructure Building Services). Please note that the expended column for FY 1999 is not the final amount for FY 1999 expires on September 30, 2000.

The Division of Public Health is requesting for funds for the recruitment of a physician (OB/GYN) to provide services at the Women's Clinic. All physicians at the Public Health Clinic are paid under Hospital accounts and reports to the Deputy Secretary for Hospital Administration.

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



2.2 Annual Number of Individuals Served

A pregnant woman may receive her prenatal care at a private clinic but all deliveries are done at the Commonwealth Health Center (CHC), including Tinian and Rota. All pregnant women are screened for Hepatitis B, cervical cancer, and sexually transmitted diseases. HIV testing is voluntary. Medicaid and uninsured receive their health care needs at CHC.

Access to the telephone numbers of each respective health clinics may be easily obtained through telephone books, operators, flyers and posters, community outreach activities, and home visit nurses and other staff. There is a direct line for Immunization Program and Communicable Disease Program

2.3 State Summary Profile

The only change for form 10 is that Title V funds are also used for direct health care, enabling, and population-based services at the Southern Community Health Center.

2.4 Progress on Annual Performance Measures

Performance Measures #4 (newborn screening), #10 (hearing screening), and #17 (high-risk deliveries) are not applicable to the CNMI. As of February 2000, PKU screening is being done at CHC.

Preventive and primary care services for pregnant women, mothers, and infants:

Direct Health Care Services: The main focus for this level of the pyramid is to ensure that personnel are recruited on a timely manner. The recruitment process is a slow, lengthy, and costly process. The CNMI Department of Public Health has join forces with the Hawaii Job Fair and has done a video on the benefits of coming to the CNMI to work in the health field. As previously mentioned Senate Legislative Initiative No. 10-4 allows for retirees in the health and educational field to reenter the work force without losing their

retirement benefits. One registered nurse will continue working after her contract expires in July thus losing her retirement benefits.

Enabling Services: The CNMI's CHIP funds will be used as a Medicaid Expansion Program. The MCH Program will continue to assist in identifying and enrolling uninsured children.

Population-Based: Some activities include the new encounter forms for prenatal first visit (see attachment #4); Immunization, prenatal care, breast and cervical cancer screening services will be provided at the Southern Community Health Center (Thursdays the Center will be opened up to 8:00 p.m.); a staff from the Communicable Diseases Program will be at the Center to provide counseling for pregnant women on taking the HIV test and will be drawing the blood. Last year out of 1509 pregnant women, only 170 took the HIV test.

Infrastructure Building: The task force that was formed to address problems with the prenatal clinic (i.e., low prenatal care rate for first trimester) last year continues to work to improve access and utilization to prenatal services. Newly revised ambulatory and billing encounter forms for the prenatal clinic was completed. The members of the task forces are currently working on the prenatal package – educational materials are selected and the bags in which the materials will be put in and distributed are already ordered. The prenatal education classes are still on-going. One nurse from Rota and one from Tinian successfully completed the Nurse Practitioner's training from Harbor, UCLA. There are both back in their respective island. We currently have two nurses from Saipan attending a 16 weeks Women's Health Care Nurse Practitioner Program at the University of Texas, Southern Medical Center. The two nurses will come back to Saipan to do a five months practicum at the Commonwealth Health Center. The training is sponsored by the family planning program.

Preventive and primary care services for children:

Direct Health Care Services: The Saturday walk-in Clinic that was closed due to staff shortage from October 1999 to April 2000 has started again; MOA with three private clinics continue to enhance immunization services. The recruitment of professional nurses and physicians (one being a local pediatrician) for the Children's Clinic are some accomplishments.

Enabling Services: Some accomplishments include ①printing and translation of educational materials; ②CHIP application; ③ collaboration with government and non-government agencies in conducting health education outreach activities; ④ applied for Abstinence Education grant.

Population-Based Services: The provision of fluoride and sealant to 1st and 2nd grade students in the public and private schools, including Rota and Tinian continues with funds from Title V; MCH staff and PSS staff are currently organizing a Teen/Parent Symposium for students at Hopwood Junior High School and their parents – the symposium will be held on July 23 and 24; and collaboration with Department of Public Safety on child safety awareness including injury prevention continues.

Infrastructure Building: MCH nursing staff received training such as extremities of the newborn, fetal growth and perinatal trauma, neonatal cardiac disease, perinatal infections, etc.

Services for children with special health care needs:

Direct Health Care: Other than services for well and pediatric care the Specialty Clinics continue to provide the specialized care that is lacking on island for these children. The Department brings in specialist in different health areas such as the pediatric cardiologist

from Hawaii. The primary physician works with the visiting physicians for continuity of care and referral process. A Care Coordinator III was recruited last month.

Enabling: One barrier to access to health care is the lack of transportation. The Program currently provides transportation that includes not just home visits but transporting of patients to the Clinic/Hospital, to other agencies, and to conferences/meetings, etc. At the Assistive Technology training the Program provided transportation to the training sit for families of CSHCN. Other on-going activities include Child find, referrals to other agencies or programs within Public Health, etc. The care coordinators works with home visit nurses on medical evaluation.

Population-Based: The Audiologist comes to C*DAC every Wednesday afternoon for hearing screening. One nurse attended training sponsored by the PSS Special Education Program on home visits for CSHCN. She will be the primary team member for IFSP.

Infrastructure Building: The CSCHN Registry has been installed at both Rota and Tinian Health Centers. The Programs have received computer equipment and training for data needs. The MOU with PSS, was signed (see attachment #5).

2.5 Progress on Outcome Measures

CNMI and MCHB have negotiated and agreed that Outcome Measure #2 is not applicable to the CNMI. As recommended at last year's grant review the State Negotiated Outcome Measure is changed from maternal mortality to fetal death. In 1998 there were 28 fetal deaths (stillbirths) in the CNMI; the highest since 1988.

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

The interagency coordinating committee, a group of service providers for people with disabilities, has volunteered to be the MCH Advisory Committee. The MCH Coordinator did a presentation on Title V and the MCH Program and other public health programs here in the CNMI. Presentations include data on prenatal care, CSHCN, immunization, teen pregnancy, morbidity, mortality, national and negotiated performance and outcome measures, priority needs from 1997 needs assessment, etc. The core health status indicators were presented also. From these health indicators were selected.

Statistics were obtained from a variety of sources and used to calculate incidence, prevalence, and mortality rates where applicable. The Division of Central Statistics, Department of Commerce provided DPH with up-dated population estimates. Census reports for 1990 and 1995 population estimates, including ethnicity breakdowns were also used. Data was obtained from other sources – hospital records, birth and death certificates, immunization records, MUMPS, chart reviews, monthly reports, logbooks, etc. All reportable diseases are gathered from physicians, including private clinics. CHC laboratory also reports all diseases to the Communicable Disease Program. The Laboratory provided data on PKU. Data for other diseases were obtained by review of the central computer database system (MUMPS) at DPH and logbooks. Surveys were conducted to obtain information on access to health care and health care providers, barriers to health care, patient satisfaction, etc.

Two pending reports that would have been very instrumental in baseline data and in the overview of the MCH population are the Behavior Risk Factor Surveillance Survey and the Annual Public Health Progress Report for 1997-1998. The Behavior Risk Factor Surveillance Survey for adults was conducted in collaboration with the Division of Central Statistics' Labor Force Survey. Results have been coded and input. A database has been developed and the analysis of the survey will be included with next year's block grant application.

Weaknesses in doing the needs assessment: The absence of a Medical Director was one weakness in doing the needs assessment. The involvement of the former Medical Director in previous projects in the different programs was an asset especially in getting the involvement and support of other medical staff. Also, it was hard to solicit physician involvement in task force such as the Breastfeeding Task Force, because of patient load and they need to get the approval of Deputy Secretary for Hospital Administration.

Another weakness in the collection of data was that some agencies do not collect certain data that was required. For example, the Medicaid Program does not collect the health status indicator on prenatal care for women. The Manager for Health Planning and Statistics Office and the MCH Coordinator will meet with each Program so that collection of required data would commence. Forms are also going to be developed to be included in daily census of the clinic by the Computer Specialist.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

The general MCH population includes women of childbearing years (15-44 years) and children from birth to 15 years. The Program also serves children with special health care

needs. Large portions of the overall population in the age range of 20 to 34 years are alien women contract workers. The MCH population comprises of more than half of the entire population. According to the 1995 census, infants, children less than 20 years of age, and women through age 44 comprise 60% of the population. About 33% of the population are women of childbearing years (15-44 years). Many of these women are giving birth to children in the CNMI because of citizenship status; thus the MCH population is greatly affected by the current labor arrangements in the CNMI. The largest ethnic group for women in this age group is from China and the Republic of the Philippines and other Asian countries (Table 23 and 24). This reflects the number of women in the garment and service industries.

Table 23. CNMI Births by Ethnicity and Age of Mother; 1998

ETHNIC	12-14	15-19	20-24	25-29	30-34	35-39	40-44	45+	TOTAL
CHAM	2	60	131	103	72	18	7	0	393
CARO	1	9	38	22	21	4	1	1	97
Filipino	0	1	31	138	211	138	32	3	554
MICRO	0	10	44	75	44	19	6	0	198
CHIN	0	0	5	34	21	9	2	0	71
OA	0	1	0	16	22	14	5	0	58
OTHER	0	3	7	11	10	14	5	0	50
TOTAL	3	84	256	399	401	216	58	4	1421

*

Table 24. CNMI Births by Ethnicity and Age of Mother; 1999

ETHNIC	12-14	15-19	20-24	25-29	30-34	35-39	40-44	45+	TOTAL
CHAM	0	87	153	97	79	18	9	0	443
CARO	0	13	25	27	19	13	1	1	99
Filipino	0	5	55	143	205	114	43	3	568
MICRO	0	10	48	61	39	14	6	0	178
CHIN	0	0	13	37	27	6	0	0	83
OA	0	1	2	21	20	3	1	0	48
OTHER	0	1	6	16	18	12	3	0	56
TOTAL	0	117	302	402	407	180	63	4	1475

Abbreviation: CHAM = Chamorro; CARO = Carolinian; MICRO = Micronesian; CHIN = Chinese; OA =Other Asians; OTHER = Others

Children in the CNMI come from a diverse background including Chamorro, Carolinian, other Micronesians, Filipino, Chinese, Japanese, Koreans, Thai, other Pacific Islanders, and

Americans from the mainland U.S. The ethnicity of these children is much more difficult to define given the amount of mixing, especially among Asians and the indigenous population – Chamorro and Carolinian. The Department has a policy in which the ethnicity of a child is determined by the mother’s ethnicity. For reporting purposes the categories for ethnicity is as follows: ①Chamorro; ②Carolinian; ③Filipinos; ④Chinese; ⑤Other Micronesian; ⑥Other Asians; and ⑦Others. The ethnic make-up of live births continues to shift, with a decreasing proportion of indigenous live births and an increasing number and proportion of births among non-resident aliens.

Table 25. Children in the CNMI by Age and Island Residence

Age Group	CNMI	Saipan	Rota	Tinian
Under 5 years	6,084	5,312	393	379
5 to 9 years old	4,619	4,004	312	303
10 to 14 years	3,600	3,128	262	210
Total	14,303	12,444	967	892

CNMI 1995 Census, Division of Central Statistics

Live births for 1998 total 1,421 while the total for 1999 is 1,475. Although most of the population growth over the past 15 years is a result of immigration of contract workers, the crude birth rate of 21.6 for 1998 remains high.

Table 26. CNMI Vital Statistics Compared to Guam and U.S.

	Crude Birth Rate ¹	Crude Mortality Rate ²	Infant Mortality Rate ³	Life Expectancy (years)
CNMI	21.6 (1998)	2.3 (1998)	8.4 (1998)	75.79 (1998)
Guam**	27.5 (1997)	4.4 (1997)	8.6 (1997)	N/A
US***	14.5 (1997)	864.7 (1997)	7.2 (1997)	76.5 (1997)

1. Births/1000 population
 2. Deaths/1000 population
 3. Infants deaths/1000 live births
- **Guam 1997 Annual Statistical Report
 ***CDC National Center for Health Statistics

There are differences among the various ethnic groups in regards to adequate prenatal care rate. Adequate prenatal care is defined as 7 or more visits with presentation during first and second trimester. The percent of mothers who received adequate prenatal care in 1998 was only 22.73% (323/1421). There are differences among the various ethnic groups with “Other” (i.e., Caucasians) having the highest rate of 61.1 (1998) and “Other Micronesians” with the lowest rate of 35.5 (1998). During 1998 210 infants were admitted to Neonatal Intensive Care Unit (NICU) out of 1421 live births. The number of infants admitted to the NICU for 1999 was 175 out of 1480 live births. There are several factors affecting the accessibility of care for prenatal services in the CNMI: availability of public health clinics, scheduling at the public health clinics, availability of private providers, and cost of prenatal care services.

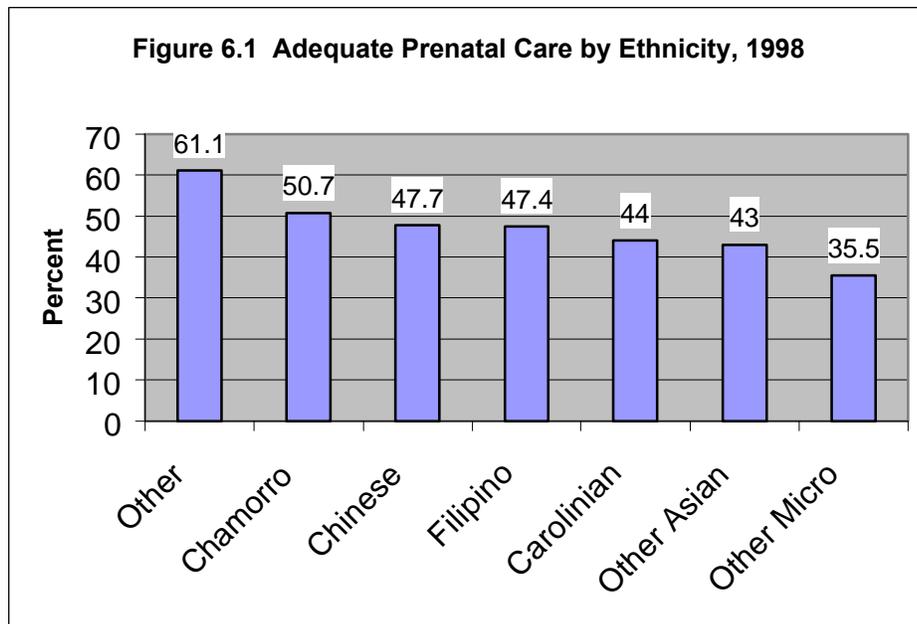
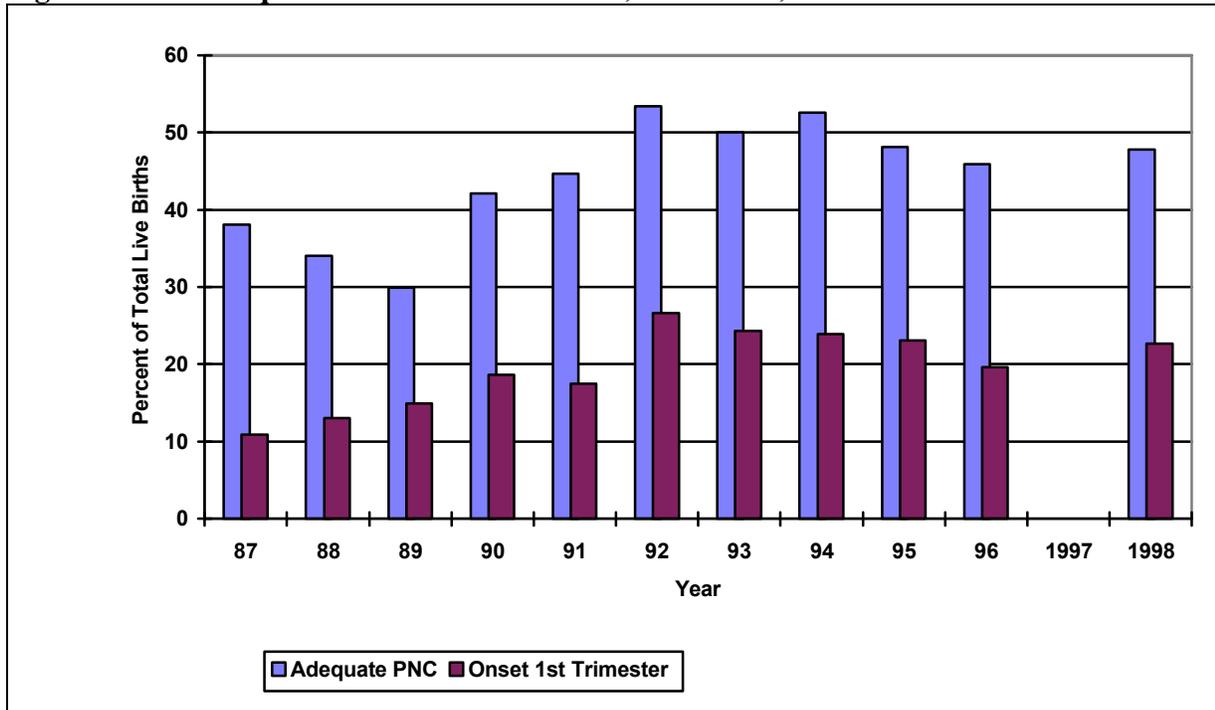


Figure 7. Adequate Prenatal Care CNMI, 1987-1996, 1998



Dept. of Public Health

The 1998 CNMI Fertility rate was 2.443 live births/1000 women 15-49 years of age (Table 27). In 1999 the CNMI teenage pregnancy rate (aged 15-19 years) of 3.5 is lower than Guam’s rate (all races combined) of 11.3. However, the 1999 teenage pregnancy rate for *Chamorro* females aged 15-19 years is higher than the U.S. 1997 birth rate for teenagers, all races combined, of 52.3 (Table 28).

Table 27. CNMI Fertility Rate Compared to Guam and U.S.

	15-49 years
CNMI	2.443 (1998)

Guam	N/A
US	65.0 (1997)

Live Births/1000 women aged 15-44 years

Table 28. CNMI Teen Pregnancy Rate Compared to Guam and U.S.

	Chamorro only	Teen Pregnancy Rate
CNMI	65.5 (1999)	5.11 (1999)
Guam		11.3 (1997)
US		52.3 (1997)

Live Births/1000 women aged 15-19 years

The Immunization Program has recently recruited two more staff. They will be assisting with the tracking of children and working with the schools. The Saturday walk-in clinic was closed for about six months due to shortage of nursing staff. The immunization rate for 2 year-olds increased from 86.3 (1998) to 88.2% (1999). Immunization services are also provided at the Southern Community Health Center.

Table 29. CNMI Survey of Immunization coverage of 2 year olds, 1998

Category	Number of Children
Total Number Registered	1,599
Migrated out of CNMI	240
No contact number or address	32
No record of visit	36
Tourist	63
Other (Double entries, Deceased, etc.)	11
Total Inactive	382
Total Active	1,217
Total Delinquent	143
Total Up-to-date (%)	(88.2%) 1,074

0-24 months DPTx4, TOPVx3, MMRx1, HepBx3, Hibx4 (4:3:1:3:4)

CNMI Department of Public Health

Tables 30, 31 and 32 illustrated the top ten purposes of visits to the Public Health Clinic for 1999. Child Health Exam ranks high due to well baby visits. Dental exams are also high due to the Sealant and Fluoride Programs.

Table 30. Top Ten Visits for Infants less than 1, 1999

<i>Purpose of Visits(POV)</i>	Number of visits
<i>Routine Child Health Exam</i>	<i>766</i>
<i>Acute URI NOS</i>	<i>133</i>
<i>Follow-up Exam</i>	<i>44</i>
<i>Fetal/Newnatal Jaundice NOS</i>	<i>39</i>
<i>Non Infect. Gastroenteritis NEC</i>	<i>23</i>
<i>Acute Bronchiolitis Infect</i>	<i>19</i>
<i>Otitis Media</i>	<i>16</i>
<i>Constipation</i>	<i>15</i>
<i>Referral No Exam/Treat.</i>	<i>13</i>
<i>Person with feared complaints</i>	<i>11</i>

Source: MUMPS System

Table 31. Top Ten Visits for Children Aged 1-22 years, 1999

<i>Purpose of Visits(POV)</i>	Number of Visits
<i>Dental</i>	<i>5,592</i>
<i>Acute URI NOS</i>	<i>3,462</i>
<i>Routine Child Health Exam</i>	<i>3,351</i>
<i>Otitis Media</i>	<i>2,113</i>
<i>Vaccine for Polio</i>	<i>1,227</i>
<i>Non Infect. Gastroenteritis NEC</i>	<i>1,147</i>
<i>Medical Exam NEC Admin. Purpose</i>	<i>1,036</i>
<i>Supervision Normal 1st Pregnancy</i>	<i>929</i>
<i>Screening for TB</i>	<i>894</i>
<i>Asthma</i>	<i>775</i>

Source: MUMPS System

Table 32. Top Ten Visits for Females Age 23+, 1999

<i>Purpose of Visits(POV)</i>	Number of Visits
<i>Supervision, other Normal Pregnancy</i>	4,691
<i>Dental Exam</i>	2,837
<i>Supervision Normal 1st Pregnancy</i>	1,825
<i>Physical Therapy</i>	1,471
<i>Diabetes Mellitus</i>	1,286
<i>Hypertension</i>	1,027
<i>GYN Exam</i>	832
<i>Abdominal Pain</i>	593
<i>Acute URI NOS</i>	561
<i>Asthma w/o Status</i>	507

Source: MUMPS System

Emerging infectious diseases include a rise in tuberculosis, continued high rates of dysentery and other bacterial diarrhea diseases, sexually transmitted diseases, HIV/AIDS, Hepatitis B, vaccine preventable diseases, and infections with resistant bacteria. The Department of Public Health has dealt with recent outbreaks of measles, mumps, and food borne outbreaks involving salmonella, shigella, and cholera. The rapid influx of poorly screened and monitored contract workers has contributed to these problems. Over half of all tuberculosis cases are among contract workers and the number of cases is increasing. The threat of HIV and other communicable diseases are currently being evaluated. There have been two HIV perinatal transmissions in the CNMI.

<i>Ten Leading Causes of Morbidity</i>	<i>No. of Cases</i>	<i>Rate per 100,000 population</i>	<i>Year</i>	<i>Source of Data</i>
Bacterial Food Poisoning	1219	1758	1999	1-cdc
Chlamydia	206	297	1999	1-cdc
Syphilis	97	140	1999	1-cdc
Hepatitis B	76	110	1999	1-cdc
Tuberculosis	58	84	1999	1-cdc
Salmonellosis	31	45	1999	1-cdc
Gonorrhea	29	42	1999	1-cdc
Shigellosis	29	42	1999	1-cdc
Cigautera	15	22	1999	1-cdc
HIV	4	6	1999	1-cdc

<i>Ten Leading Causes of Mortality</i>	<i>No. of Deaths</i>	<i>Rate per 100,000 population</i>	<i>Year</i>	<i>Source of Data</i>
Diseases of the Heart	33	54.08	1998	1
Neoplasms	26	39.06	1998	1
Cerebrovascular Diseases	14	21.03	1998	1
Perinatal Conditions	13	19.53	1998	1
Motor Vehicle Accidents	7	10.51	1998	1
Pneumonia	6	9.01	1998	1
All Other Accidents	5	7.51	1998	1
Chronic Liver Disease & Cirrhosis	5	7.51	1998	1
Suicide	5	7.51	1998	1
Diabetes Mellitus	4	6.00	1998	1

Obesity, diabetes, hypertension, and atherosclerotic vascular disease are among the major concerns facing the CNMI with an increasing median age. Diabetes is another major health concern and is ranked in the top ten primary causes of mortality. Diabetes is almost exclusively adult onset of Type II diabetes, however the onset is often very young, leading to early complications and mortality. Prevention and education will need to become a priority for the entire CNMI community.

3.1.2.2 Direct Health Care Services

One of the major barriers to access to health care services is financial. Patients, especially the uninsured, teenagers, and illegal contract workers, are reluctant to seek health care services because of inability to pay. Since the pharmacy has been privatized, some patients do not get medications until they have money. We also have the problem of patients not doing required laboratory tests because of finances. But, regardless of ability or inability to pay, a commonwealth constitutional provision state that no individual may be denied medical care because of inability to pay. Local and Federal government monies fund MCH services.

Currently the staffing for the Public Health Clinic is as follows:

Women's Clinic:
4 Ob/Gyn
1 Mid-wife
4 Registered Nurses
1 LPN

Children's Clinic:
4 Pediatricians
8 Registered Nurses
2 LPNs
1 Nurse Assistant

There are actually 2 other Pediatricians who are also Internists. They provide walk-in services at the Children's Clinic when needed. Because they are mainly providing services at the Hospital, they are classified as Internists.

Other support staff includes 5 Clinical Attendants, 1 Nutrition Technician, 1 Community Outreach Worker, 2 Health Educators, and administrative and clerical support staff. Social Workers from the Division of Mental Health and Social Services assist in counseling. There is one Social Worker for the CSHCN Program. The Nutritionist will come on board next month after being vacant for one year. The Clinic gets assistance from the Hospital Dietician on a physician/nurse request basis. About one thousand six hundred (1,600) patients are seen per month at the Children's Clinic. These visits range from school physical examinations, immunizations, well baby, pediatric, and treatment and procedures. The pediatricians alternate for on-call duty thus leaving three pediatricians at the Clinic. When one goes on leave only two pediatricians are at the Clinic providing services. About two thousand (2,000) patients are seen per month at the Women's Clinic. These visits range from prenatal first visits, revisits, postpartum, and gynecology.

An audiologist from the Public School System is stationed at the PH Clinic to do hearing screening to children, especially for the School-Health Program.

Referrals to the home visit program totals about 50 a month. There is only one vehicle available for home visits.

The CNMI was granted a waiver to allow anyone with low income and minimal resources access to Medicaid; not just the aged, blind and poor. The Medicaid Program provides assistance not only to the indigenous population. More than half of the Medicaid population is children. The CNMI Medical Program was implemented in 1979. Public Law 100-203 §4116 authorizes the Secretary of Health to waive or modify any Title XIX program requirements for the CNMI. The basis for the proposed waiver is due to issues that include ①the nature of the single government-operated health care system; ②growing health plan coverage; and ③cultural diversity.

The availability of specialty care services is brought on island to address the lack of these specific services. The Shriners (Honolulu Unit) Outreach Clinic is conducted twice a year for children with orthopedic conditions. There are 308 children on the list; Rota – 17; Tinian – 12. The clinic for Plastic Surgery is conducted every 6 month. Physician comes from Canada for about 10 days to provide the service. There are 125 patients on the waiting list. Patients are also referred off-island (to Honolulu, Hawaii, Guam, or the Philippines) to receive care.

3.1.2.3 Enabling Services

The availability of preventive, primary, and specialty care services is always identified as one of the barriers in the CNMI's health care system because of manpower shortage. Recruitment is a lengthy process and the costs - repatriation, housing, household shipping/storage - are high. A factor that has also contributed to staff shortage is that nurses are required to pass the National Council Licensing Examination (NCLEX). The disadvantage of this

requirement is twofold in that the ones who do not pass the NCLEX resign or gets send back to their countries and the ones that pass the NCLEX move to the United States.

The lack of public transportation within the CNMI present problems for patients coming for MCH services. Limited translation materials have also been a problem. The purchase of a vehicle for the CSHCN Program has enhanced outreach activities to these children.

The government sponsored Medical Referral Program (MRP) was established to provide residents of the CNMI with a means of receiving medical care and treatment that is not available on-island. By sending patients approved for extended medical care and treatment, the MRP can expand the range of medical specialties and procedures attainable for enhanced patient care. The medical referral policy has been revised to reflect the usage of private insurance and it follows U.S. poverty guidelines to select those eligible for government-subsidized referrals to off-island health facilities.

CHIP funds are to be used for children eligible under the Medicaid Program. MCH Program will assist in identifying and enrolling uninsured children. DPH runs special clinics once or twice a year by contracting off-island specialist, i.e., ENT, Cardiologist, Dermatologist. MCH works in collaboration with the Public School System for the provision of related services for CSHCN such as occupational therapy and speech therapy.

3.1.2.4 Population-Based Services

DPH administers a population-based immunization program targeting 100% of children 0-21 years of age in the CNMI. The School Health Program provides

TB skin testing, anemia screening, vision and hearing screening for all children entering Head Start, Kindergarten, and first grade. All pregnant women who come to the clinic for prenatal care are screened for the following: Hepatitis B, Gonorrhea, Chlamydia, rubella, Diabetes, Hypertension, Cervical Cancer, and Group B Stretococcus. In addition, all mothers are offered voluntary HIV testing. Hemophilia Management training was conducted not only to providers but also to children diagnosed with this disease and their families. Issues and concern especially around safety issues and pain management were addressed. Nutrition awareness for adolescents is provided. Mammography screening is offered free to women 40 years and older during Breast Cancer Awareness Month. Since 1995, DPH has been hosting a Breast Cancer Symposium, (MCH Coordinator has chaired the committee), and one issue that is always addressed is the non-coverage of preventive care, specifically Pap smear and mammography, by health insurance. As of January 1998, the government health insurance plan has extended coverage to include preventive services such as Pap smear and mammography and well baby visits.

The newly established Breast and Cervical Cancer Detection Program targets women 50 years and older for mammogram and women 20 years and older for Pap smear testing. These services are offered free to low income women. The Tracker would determine the eligibility of these women. Women who are not eligible financially will be assist in a referral process to Medicaid, Medicare, and other health financing mechanisms. This program addresses the high mortality of these diseases among indigenous women and increases the awareness of the importance of regular screening examinations. To promote and educate women

on breast and cervical cancer screenings, the program have participated in health fairs, conferences, etc. and will be going to do presentations at some of the work sites next month.

3.1.2.5 Infrastructure Building Services

The Department of Public Health is the sole provider of comprehensive health services in the CNMI. Health services include preventive, emergency, primary, secondary, and, in some cases, tertiary health care, as well as mental health, oral health, and health financing mechanisms (Medicaid).

The current health care system, including preventive services and the services at the Commonwealth Health Center were developed to meet the demands of a CNMI population of estimated at 20,000 (1984). Long term planning did not anticipate for the rapid population growth. Moreover, strategic planning is hampered because of insufficient funds and manpower. 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. There has been no expansion of the health care infrastructure to accommodate the rapid population growth. Thus the rapid population growth has been a major contributing factor for the inadequate health care system.

The Commonwealth Health Center is inspected once a year by HCFA and must meet Medicaid/Medicare standards. The health care professionals at CHC must, by law, hold a valid license to engage in the practice of medicine, dentistry, or any other health professions issued by Canada, U.S. Possessions, the Commonwealth, Province, State or Territory of the United States [Public

Law 3-30, 3 CMC, Div. 2, § 2227 (a)]. This is problematic, as recruitment is difficult given the remoteness of these islands.

The move to privatization is perceived as negative by patients. Laboratory services were privatized in 1995 but has reverted back to the CNMI government since 1997. The pharmacy has been privatized since 1995.

The Rota and Tinian Health Centers are both Hill-Burton facilities and are overseen by the Secretary of Health. Day-to-day activities are under the supervision of Resident Directors, one at each site. Both Centers provide basic primary health care services.

Data collection and analysis is still weak. Program Managers strongly emphasized the need for training in this area. The move for new program software to compliment existing system – MUMPS - is highly recommended. With the success of the CSHCN registry, other programs are looking into the feasibility of developing other data system thus ensuring easier access to gathering data needs for their programs. The importance of networking/linking to other programs or agencies is necessary but the issue of confidentiality needs to be considered.

Some issues that we are currently working on include the need to do quality assurance of nurse's documentation on immunization given; development of adult immunization policy; needs assessment; and enhancement of health information system.

3.2 Health Status Indicators

The Maternal and Child Health Program, under the Division of Public Health, collaborates with the other units in offering family planning, school health, CSHCN services, nutrition services, health

education, and other preventive health services for the MCH population. Services are provided at the Women's and Children's Clinic. Located within the Commonwealth Health Center, the clinic promotes the coordination and continuity of medical care and incorporates the numerous clinics and programs related to MCH. Services are also provided at the Southern Community Health Center. There are five villages within the proximity of the Southern Community Health Center with an estimate population of 23,442.

Services provided include immunization, family planning, well-baby, prenatal, and allied support services such as audiology and nutrition counseling. Overall, the program is dedicated to improving the quality of life of all mothers and children in the CNMI by providing comprehensive health care services. It also addresses the improvement and expansion of information management, prevention and education, manpower and training, planning and evaluation, and case management services.

Pregnant Women:

In addressing the health care needs of this target population some of the strengths identified are the capable staff, adequate supplies and equipment, and the opening of the clinic at the southern end of the island. The following barriers were identified:

- Access and utilization of health care services: barriers include limited number health care providers, especially women; hours of operation; and limited space available.
- Logistical barriers include the lack of public transportation and the lack of available care sitters.
- Organization and delivery of services: Barriers include the impact of additional needs, i.e., public health staff were detailed to the Tanapag Clinic that opened in May 2000 to screen and assess level of PCB with the residents of that village.

Issues that still need to be addressed is the need for a nutritionist and the low numbers of pregnant women seeking prenatal care during 1st trimester. A survey questionnaire was developed by the Nursing Manager and the MCH Coordinator on access and utilization of health care services for pregnant women but was put on hold so the questions will be compared to PRAMS. The Nursing Manager, MCH Coordinator, and an OB/GYN will be working on this activity.

Infants < 1 year of age:

A strength that is identified is the complete range of well baby/child services that is offered at the clinic. The Children's Clinic provides a wide range of health care including immunization, health education and counseling, growth monitoring and screening, physical exams, pediatric care, treatment, vision and hearing screening, etc. The dental clinic is located next door. Laboratory, radiology, and pharmacy services are located upstairs at the Hospital.

A weakness is the shortage of health care providers thus long waiting periods. There are four pediatricians at the clinic. When one is on-call that leaves three physicians at the Clinic.

Issues that need to be addressed include the inadequate space available.

Children (1-14 years of age):

The major strength is the wide range of comprehensive services available at the Children's Clinic.

The same issues that need to be addressed are the limited numbers of health care providers available and the inadequate space available. The turnover rate for physicians is also high. There are three newly recruited pediatricians since last year's grant application. The obvious need to recruit a tracker to assist in efforts to decrease rates of DMF teeth has been stated in the Dental Clinic's 5-year plan. When a child is seen in January and that child requires additional dental procedures the next available appointment is about six weeks from that time. The appointment slip

is given to the parents but by the time the six weeks come around the child will miss the appointment. There is about a 50% missed appointment rate.

Adolescents (15-19 years of age):

Again the strength in health care services for this target population is the dedication, competency, and commitment of the staff. The collaboration of the programs within the Division of Public Health in the areas of outreach, education, and counseling have enhanced efforts in improving the health status of this population. There were 115 deliveries to teenage mothers in 1999 – the lowest ever in the CNMI. Confidentiality in addressing teen issues is very important and is emphasized with all the programs.

Children with Special Health Care Needs (CSHCN):

Once identified, CSHCN are eligible for the full range of well-child services, including case management. There is a formal memorandum of agreement with the Public School System for provision of health care services and related specialized services in accordance to the overall care of children with special health care needs. The Dental Clinic has put a priority in making appointments available for CSHCN at any given time.

The commitment of the limited number of staff (see Application on CSHCN) and the involvement of families in the case management of CSHCN are some strength for this population. Transportation and referral services are also provided for CSHCN and their families. Home visits are done on a daily basis and home visits by nurses are done as requested. Referrals to off-island facilities are also provided for additional medical care.

Parents have brought up the need for respite care and faster referral process for off-island care. In the area of off-island referral the parents of CSHCN who are not U.S. citizens or residents of the CNMI are normally turned down for a visa request to be escorts.

In summary, some of the key indicators for health such as infant mortality rate, life expectancy, and crude mortality rate are very encouraging for the CNMI. Although these key indicators are encouraging, there are some alarming trends for non-communicable diseases in the CNMI, especially among the indigenous population. There must be serious effort by the Department of Public Health, but also the Legislature, community, families, and individuals to begin a campaign to prevent diabetes, heart disease, stroke, hypertension, and obesity in the Chamorro and Carolinian population. These diseases are preventable and are beginning to consume a larger amount of health care resources, not to mention a decrease in the quality of life. The committee strongly recommends that the high number of fetal deaths for 1998 be reviewed. Also, there is a need to collect current rate/data for DMFT (latest is 1987) to illustrate the priority need in addressing DMFT.

3.2.1 Priority Needs

The State's priority needs are all interrelated with the outcome of ensuring a higher standard of living for an improved quality of life. The rate of sexually transmitted disease, especially chlamydia, is high amongst the teenagers. Teenagers are a vulnerable group for acquiring AIDS (there are currently three teenagers who tested positive for HIV). Chlamydia cases amongst pregnant women are also high. The three are priorities for direct health care: (1) *reduce the rate of sexually transmitted diseases for teenagers aged 13-19;* (2) *decrease the percent of chlamydia cases in pregnant women;* and (3) *increase the percent of infants born to pregnant teenagers receiving prenatal care beginning in the first trimester.*

Because diabetes is a major health concern in the CNMI and is ranked in the top ten primary causes of mortality there is a need to provide nutrition education at a very young age. Thus, the priority area for enabling service is *to improve and continue providing nutrition education information to students.*

The priority needs in the area of population-based are (1) *to increase the percentage of mothers who breastfeed at 4 months*; and (2) *to reduce the percent of overweight school-aged children*.

The priority in the area of infrastructure building is *to improve collaborative partnership with other service providers for CSHCN in formulation of policies, needs assessment, data collection and analysis, and financing of services*.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

3.3.2 Other Requirements

Forms 3, 4, and 5 illustrate budget documentation for the maternal and child health population. The Department of Finance and Accounting ensures that funds are expended accordingly. The Department works closely with the Federal Accountant at Public Health to ensure that all funds are expended to services aimed at improving the quality of lives of the target population.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

Figure 3 TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM

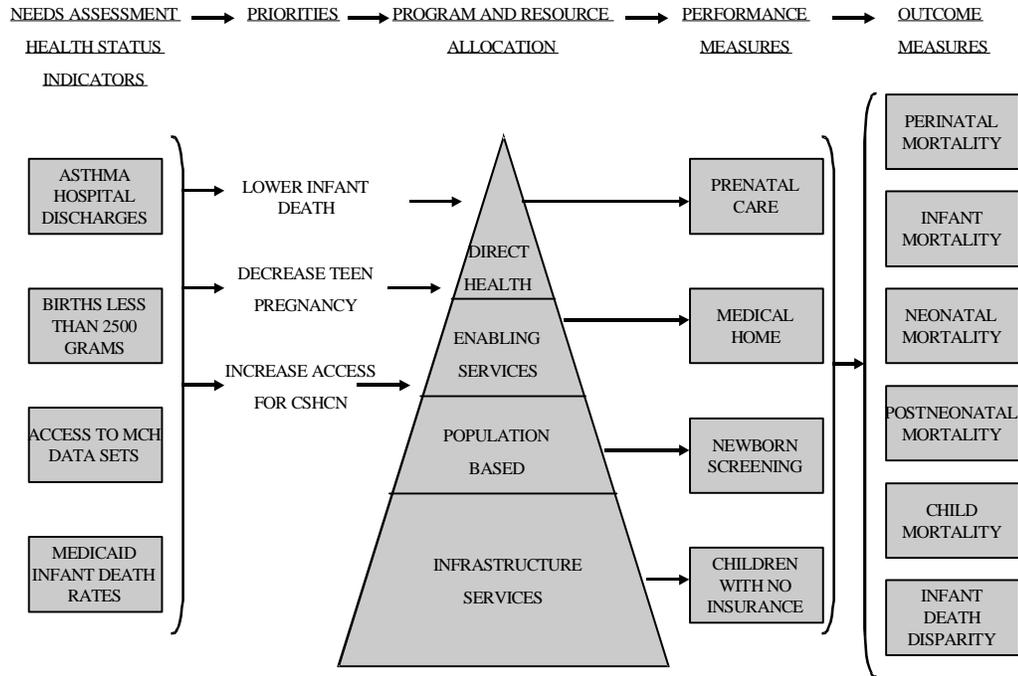


Figure 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) 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.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
SP1) Percentage of mothers who breastfed at 4 months.			X				X
SP2) Percent of overweight school-aged children			X				X
SP3) The rate of sexually transmitted disease for teenagers aged 13-19.	X						X
SP4) Percent of infants born to pregnant teenagers receiving prenatal care in the first trimester	X						X
SP5) The degree to which the State MCH Program provides nutrition education information		X				X	
SP6) Percent of chlamydia cases in pregnant women.	X						X
SP7) The State Title V Program formed a collaborative partnership with other service providers for CSHCN in formulation of policies, assessment, data collection and analysis, and financing mechanisms.				X	X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.1.1 Five Year Performance Objectives

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

The development of the State Performance Measures were selected for the following reasons:

- The recommendation of the committee to keep the same priority needs for it addresses efforts for a change in lifestyle.
- The need for prevention awareness and education was emphasized.
- A review of data and health status indicators.

The goal is to improve the quality of life for all pregnant women, mothers, infants, children, and children with special health care needs. Intervention in the core and negotiated performance measures and core and negotiated outcome measures will result in a much healthier CNMI population.

3.4.2.2 Discussion of State Performance Measures

Below are discussions of each state performance measure. These state performance measures are all seen as priorities and are not prioritized in number.

1. Percentage of mothers who breastfeed their infants at 4 months.

The Breastfeeding Clinic began in February with the recruitment of a nurse. The Clinic is held once a week and has enhanced our efforts in promoting breastfeeding. The new prenatal education class is another activity to assist us in our efforts to promote breastfeeding. A study of women delivering in 1997 showed that breastfeeding is initiated in 85% of all infants. The general public is educated on benefits of breastfeeding for both mother and infant, but only 17% of the infants were reported to be exclusively breastfed and 31% are predominantly breastfed up to four months. 90% of the 400 women who had terminated breastfeeding had reported initiating breastfeeding at birth. Agencies are also being educated on breastfeeding to encourage them to establish policies that promote breastfeeding. Almost half of the women are in the work force.

2. Percent of overweight in school-aged children.

CNMI has identified childhood obesity as a major nutrition problem. A study of two Saipan schools in 1996-97 showed that 33% of all 5-11 year children were overweight by Body Mass Index (BMI). During the same year 351 Head Start children were assessed. Of those assessed, 35% of all 3-6 year old children were diagnosed as being overweight by BMI. Data collection on obesity would be gathered from surveys and studies. The School

Based Nutrition and Activity Program and the Healthy Eating policy at the schools are ongoing activities to address this measure.

3. The rate of sexually transmitted diseases (gonorrhea) for teenager aged 13 through 19.

Sexual activity among CNMI teenagers is lower than U.S., but remains above 50% for high school students and nearly 30% of junior high school students. Only 33% are using condoms. Activities to address this measure is the application for Abstinence Education Grant and outreach activity every Friday during the school year. The Communicable Disease Program or MCH nurse will go to one public high school to do education, counseling, referral for STD testing and voluntary HIV testing

4. Percent of chlamydia cases in pregnant women.

Chlamydia screening was put as part of the mandatory lab screening tests for pregnant women January 1995. In 1995, 1,295 pregnant women had Chlamydia testing and 127 (10%) were positive. The monthly screening rate for chlamydia positive pregnant women has been as high as 19.7%. Many cases of non-gonococcal urethritis, non-gonococcal cervicitis, and pelvis inflammatory disease suggest that chlamydia rates may be even higher. 90% of all chlamydia cases are pregnant women.

5. Percent of infants born to pregnant teenagers aged 12 through 19 receiving prenatal care beginning in the first trimester.

Teenage mothers are more likely to deliver infants that require NICU admission. Teenage mothers comprised 18.4% of the mothers who had infants admitted to the NICU. Of the teenage mothers whose infants were admitted to the NICU, 44.4% had adequate prenatal care.

6. The degree to which the State MCH Program provides nutrition education information.

Because obesity has been identified as a major nutrition problem, nutrition education information so that the children can use it in practical situations is emphasized. Teaching children to eat the right kinds of food; helping students make choices about snacks and meals; and helping kids stay fit were reasons given for the importance of nutrition information by the schools. Collaboration between the schools and DPH can be effective in lessening health/nutrition risks and in bringing about a healthier CNMI student population, including special needs students.

7. The State Title V agency formed a collaborative partnership with other service providers for CSHCN in formulation of policies, needs assessment, data collection and analysis, and financing of services.

One of the weaknesses in collaborative partnership among agencies is that each agency would put emphasis on individual program grant need. Program needs are presented in the interagency committee. Needs assessment for CSHCN has been identifies as one project for the interagency committee.

3.4.2.3 Five Year Performance Objectives

See Form 11

3.4.2.4 Review of State Performance Measures

3.4.3 Outcome Measures

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

4.1 Program Activities Related to Performance Measures

Direct Health Care: The Department of Public Health is the sole provider of comprehensive health care in the CNMI. The Department includes hospital (Commonwealth Health Center), Public Health, dental, ancillary, and environmental health. The CSHCN works closely with the Physical Therapy Unit at the Commonwealth Health Center (CHC) for

children needing such services. On January 6-8, 2000 Care Coordinators were trained to assess movement of children who are non-ambulatory and the different therapy techniques by the CHC Physical Therapy Unit. The Care Coordinator works with the Physical Therapist on the rehabilitative needs of the child and reinforces therapy techniques to the parents/families through home visits and at the Center. The Care Coordinator will also bring the children to CHC for appointments. Recommendations/evaluations from Special Clinics such as Shriners are also followed through. Other services include speech and occupational therapy. A plan is done for all children needing services in consultation with parents and staff and representatives of appropriate community agencies. Parents are trained on provision of these services. DPH collaborates with PSS in the provision of rehabilitative services. It also works closely with Assistive Technology Project Coordinator at Developmental Disabilities Council and Medicaid Office for needed device or equipment. Specialty Clinics ensures that these children receive needed health care. Activities to help achieve negotiated state measures include mandatory STD testing during prenatal care visits; in-service training for nurses on STD/HIV/AIDS. In the past some nurses do not even mention that HIV testing is available to clients. Information on STD is included in the new prenatal education class and prenatal package. A staff from the Communicable Disease Program conducts outreach activities (education, counseling, voluntary HIV testing) at Marianas Senior High School twice a month. Referrals for STD testing are actively done. STD testing fees are waived through the Program. MCH Program has identified funds to waive fees for pharmaceuticals and laboratory for teenagers during first prenatal care visit. Fees for family planning counseling and contraceptive are waived for teenagers through the Program. For low-income women

(50+) screening for cervical and breast cancers fees are waived under the Breast and Cervical Cancers Detection Program. All immunizations are administered for free.

Enabling Services: In its efforts to promote community-based, family-centered, culturally competent program, the CSHCN Program is located at C*DAC. Transportation to the Center is available. The Center is located away from CHC. The Open House conducted earlier this year gave the public the opportunity to come and learn about the Center and Program. The Center houses both the Early Intervention Program and the CSHCN Program.

Massive campaign to educate the community in nutrition has been effective in raising awareness nutrition and diseases. PH has formed partnerships with community programs, such as the CNMI Food and Nutrition Council, to ensure that the CNMI population lives a healthier life through their diet. PH has also formed a partnership with the schools in the development of the School-Based Nutrition and Activity Program. Some schools have also adopted a “Healthy Snack” policy in which children bring only healthy food to school. According to reports from the schools, a lot more families are also eating healthy snacks at the home. Nutrition counseling is also available at the clinic. Child Nutrition was a topic addressed at the MCH Conference. Nutrition education is also conducted during PTA meetings.

Population-Based: Some activities that have been done in this area are:

- Mass immunization for Kindergarten, Head Start, Junior and Senior High Schools
- Saturday Walk-in Clinic (Immunization)
- Tracking of Children for Immunization
- CHIP
- Outreach activities at the schools and community

- Applied for Abstinence Education grant
- Dental Sealant and Fluoride Program
- Breastfeeding Clinic
- Prenatal Education Classes
- Collaborates with other agencies on child safety issues
- Screening of low income women for breast and cervical cancers under the Breast and Cervical Cancer Early Detection Program
- HIV counseling and voluntary testing at the public high school
- HIV testing for pregnant women
- PKU screening
- Telemedicine efforts for CSHCN
- Playgroup for CSHCN

Infrastructure Building: Some activities include the CSHCN registry, signing of MOU with PSS, CHIP, newly developed Prenatal Encounter form, and recruitment of personnel.

4.2 Other Program Activities

Accomplishments that encompasses all collaborative efforts with other agencies and community groups with DPH:

- Teen/Parent Symposium to be held on Saipan on July 24-25.
- Healthy Aging Partnership Program – Held annually in celebration of “Mes Man Amko” during May
- Community Health Fair – PH set up booths promoting all programs and handing out brochures. Staff was available to answer questions. Blood pressure and glucose screening were provided.

- STD counseling every Friday during school year at one of the Public High School – referrals for STD testing and voluntary HIV testing are available.
- Continuous Outreach activities with schools and other agencies.
- Tracking of abnormal pap smear in collaboration with the Breast and Cervical Cancer Screening Program (B&CCSP)
- Breast & Cervical Cancer Awareness Month – mammogram and Pap smear were available through the B&CCSP.
- Immunization Awareness Month – held a contest for the school to encourage parents to bring children for immunization and the school with the best immunization rate wins a prize as an incentive.

4.3 Public Input [Section 505(a)(5)(F)]

The CNMI Legislature hold annual Public Hearings on both the Maternal and Child Health Block Grant and the Preventive Health and Health Services Block Grant. All hearings are publicized through local newspapers. The toll free number for MCH services is published in these hearings. These hearings are held in either July or August of any particular year, depending on scheduling.

The CNMI maintains a State Point of Contact (Office of Management and Budget) for grants, which enables all government agencies to review applications and offer comments for public input.

The Interagency Coordinating Committee serves as the MCH Program advisory committee to ensure public input. Public Health staff, other agencies, and consumers will be on the committee.

4.4 Technical Assistance [Section 509 (a)(4)]

Technical Assistance are needed for the following:

- Program planning, monitoring, and evaluation - assist program managers in effectively managing the MCH Programs considering the shortages of manpower and limited resources.
- Development of policies for programs is needed – i.e., a policy for adult immunization.
- Tools and techniques for conducting needs assessment on adolescent health, CSHCN, and other MCH programs.
- Tools and techniques for conducting a needs assessment on the current health information system to improve/enhance data collection and analysis.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [*Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. (*Title V Sec. 501(b)(4)*)

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (*For budgetary purposes*) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. (*For planning and systems development*) - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. **State Program Collaboration with Other State Agencies and Private Organizations.** States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.
2. **State Support for Communities.** State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.
3. **Coordination of Health Components of Community-Based Systems.** A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.
4. **Coordination of Health Services with Other Services at the Community Level.** A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual’s or family’s health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, “Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?”

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State’s MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, “Why should the State address this risk factor (i.e., what health outcome will this result support)?”

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State’s required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State’s Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State’s Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-

- (1) The dangers of drug abuse in the workplace;
- (2) The grantee's policy of maintaining a drug-free workplace,
- (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
- (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
 Office of Management and Acquisition
 Department of Health and Human Services
 Room 517-D
 200 Independence Avenue, S.W.
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may

result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

- 5.3 Other Supporting Documents
- 5.4 Core Health Status Indicator Forms
- 5.5 Core Health Status Indicator Detail Sheets
- 5.6 Developmental Health Status Indicator Forms
- 5.7 Developmental Health Status Indicator Detail Sheets
- 5.8 All Other Forms
- 5.9 National “Core” Performance Measure Detail Sheets
- 5.10 State "Negotiated" Performance Measure Detail Sheets
- 5.11 Outcome Measure Detail Sheets