**Supporting Statement A**

**Maternal and Child Health Bureau Performance Measures for Discretionary Grant Information System**

**OMB Control No. 0915-0298 - Revision**

**Terms of Clearance:** None

**A. Justification**

The Health Resources and Services Administration (HRSA) is proposing to continue using reporting requirements for grant programs administered by the Maternal and Child Health Bureau (MCHB), including national performance measures, previously approved by the Office of Management and Budget (OMB), and in accordance with the “Government Performance and Results Act (GPRA) of 1993” (Pub. L. 103-62). This Act requires the preparation of an annual performance plan covering each program activity set forth in the agency's budget, which includes establishment of measurable goals that may be reported in an annual financial statement to support the linkage of funding decisions with performance. Performance measures for MCHB discretionary grants were initially approved in January 2003, and have been approved several times subsequently, including significant revisions in 2016 and minor revisions in 2019. Continued approval from OMB is currently being sought to continue the use of performance measures with minor revisions. Most of these measures are specific to certain types of programs and are not required of all grantees. The measures are categorized by domain (Adolescent Health, Capacity Building, Child Health, Children with Special Health Care Needs, Lifecourse/Crosscutting, Maternal/Women’s Health, and Perinatal/Infant Health). Grant programs are assigned domains based on their activities. In addition, there are three core measures and financial/demographic forms that are utilized by all grantees. MCHB programs are authorized by Section 501 of Title V of the Social Security Act, PL 101-239 (see Attachment A) and are administered by HRSA’s MCHB. The Discretionary Grants Information System (DGIS) is used for grants related to program initiatives such as those listed above. The OMB number for this activity is 0915-0298 and the current expiration date is 6/23/2022.

Grant reporting forms and performance measures for MCHB discretionary grant programs have been designed and revised to capture information across the variety of grants. The attached common grant documents include the entire set of forms to address the range of information needed from different MCHB discretionary grant programs. However, each grantee is only required to complete forms in this package that are applicable to its activities. Specific measures and forms are assigned by the Project Officer when the grant competition is announced. HRSA is proposing to make changes to the DGIS to more closely align data collection forms with current program activities. Specifically, these revisions will facilitate more efficient and accurate reporting of information related to Capacity Building activities, Financial and Demographic data, and Training activities.

Requested changes to DGIS include removing 6 forms, adding 2 forms, revising 8 forms, and moving 1 form. A crosswalk that details these changes is included as Attachment B-1. Below is a summary:

Removing the following existing forms: Core 1 (Grant Impact), Capacity Building 2 (Technical Assistance), Capacity Building 7 (Direct Annual Access to Maternal and Child Health (MCH) Data), Training Form 13 (Diverse Adolescent Involvement (LEAH-specific)), Financial Form 2 (Project Funding Profile), and Financial Form 4 (Project Budget and Expenditures);

Adding the following new forms: Training Form 15 (Consultation and Training for Mental and Behavioral Health) and Leadership, Education, and Advancement in Undergraduate Pathways Training Program Trainee Information Form;

Revising the following existing forms: F2F (Family to Family Form 1), Financial Form 1 (MCHB Project Budget Details), Financial Form 4 (new name: Maternal & Child Health Discretionary Grant Project Abstract), MCH Training Program Data Forms, Core 3 (Health Equity), Financial Form 3 (Budget Details by Types of Individuals Served), Financial Form 5 (Number of Individuals Served (Unduplicated)), and Financial Form 6 (Project Abstract).

Moving the following form to a new category: Core 2 (Quality Improvement) will become Capacity Building 8 (Quality Improvement). Moving this form out of the Core category and into the Capacity Building category will allow HRSA to assign this form to only applicable grantees.

Non-substantive revisions also include updates to terminology, goals, benchmark data sources, and significance sections included in the measures’ detail sheets.

# History and Legislative Requirements

The Maternal and Child Health Bureau evolved from the Children’s Bureau established in 1912. The enactment of Title V of the Social Security Act of 1935, specifically Section 509, which states that “the Secretary shall designate an identifiable administrative unit with expertise in maternal and child health within the Department of Health and Human Services, which … shall be responsible for … promoting coordination at the Federal level of the activities authorized under this Title [V],” sanctioned the Maternal and Child Health program as well as provided the foundation and overall structure for the MCHB.[[1]](#footnote-1) Situated within HRSA, MCHB continues to administer Title V and leads the nation in efforts to improve and promote the health of mothers and children. With the establishment of Title V, many programs aimed at extending health and welfare services to mothers and children were enacted. These programs have evolved since 1935 with passage of several legislative amendments.

In 1981, the Omnibus Budget Reconciliation Act of 1981 (OBRA ’81), Public Law (PL) 97-35, amended Title V of “the Social Security Act to establish a [block grant] program for maternal and child health services…by consolidating specified [categorical] programs of Federal assistance to States.” This amendment resulted in the creation of the Maternal and Child Health (MCH) Block Grant. The categorical programs consolidated under the block grant program included: Maternal and Child Health and Children with Special Needs Services, Lead-Based Paint Poisoning Prevention Program, Genetic Disease Programs, Sudden Infant Death Syndrome Programs, Hemophilia Treatment Centers, and Adolescent Pregnancy Grants. Additionally OBRA ’81 authorized a set-aside of discretionary federal funds for Special Projects of Regional and National Significance (SPRANS) as part of the MCH Block Grant, “by setting forth provisions concerning: (1) the allotment of such funds; (2) payments to States; (3) use of grant money” in addition to other provisions. The set-aside of federal funds permits withholding of some of the MCH Block Grant appropriations each fiscal year to support certain categorical programs.

The Omnibus Budget Reconciliation Act of 1989 (OBRA ’89), Public Law (PL) 101-239 specifically defined two set-asides for discretionary programs, SPRANS and Community Integrated Service Systems (CISS), by amending Section 502 of Title V to state:

“[The] Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 501(a) (2)” and “[of] the amounts appropriated under section 501(a) for a fiscal year in excess of $600,000,000 the Secretary shall retain an amount equal to 12 ¾ percent thereof for the projects described in subparagraphs (A) through (F) of section 501(a) (3),” respectively.

The MCH Block Grant is the base on which SPRANS and CISS grants rest. The passage of OBRA ’81 provided more discretion to states in using federal funds. State governments (the recipients of the MCH Block Grants) have the discretion to self-direct Block Grant funds to areas they identify as needing funding. The SPRANS and CISS grants, under MCHB, complement the state MCH Block Grants. They also enable MCHB to fulfill its leadership mission to facilitate research, policy, programs, and practice.

The common performance measures used for the discretionary grant programs meet mandated reporting requirements. The attached forms and performance measures are intended to cover all discretionary grant programs managed by MCHB.

**Description of Reporting Forms**

DGIS electronically captures data from the approximately 700 discretionary grant awards made each year. Many of these grants are supported under the Title V MCH Block Grant Federal set-aside programs (SPRANS and CISS). The DGIS electronically captures performance measures, program-specific information, annual financial data, and abstract data for MCHB’s discretionary grants. These data help to demonstrate the impact of the discretionary grants, assess the effectiveness of these programs, inform programmatic planning, and ensure that quality health care is available to the nation’s MCH populations. Originally released in October 2004, the DGIS is a web-based system that allows grantees to report their data online to MCHB through HRSA’s Electronic Handbooks as part of grant application and performance reporting processes. The data captured in the performance measures and the financial forms are aggregated to display program data.

# MCHB Programs

Programs administered by MCHB fall into three major categories:

* **The State MCH Block Grant program**, which awards formula grants to 59 states and jurisdictions to address the health needs of mothers, infants, and children, as well as children with special health care needs in their state or jurisdiction;
* **Special Projects of Regional and National Significance (SPRANS)** that address national or regional needs, priorities, or emerging issues (such as opioids, maternal mortality, and COVID-19) and demonstrate methods for improving care and outcomes for mothers and children; and
* **Community Integrated Service Systems (CISS)** grants, which help increase local service delivery capacity and form state and local comprehensive care systems for mothers and children, including children with special health care needs.

**Other Categorical Programs:** Additional funding programs administered by MCHB include the Autism Education, Early Detection, and Intervention Program; the Sickle Cell Disease Treatment Demonstration Program; the Early Hearing Detection and Intervention Program; Emergency Medical Services for Children; the Healthy Start Program; Newborn and Child Screening for Heritable Disorders programs; Pediatric Mental Health Care Access Grants; Screening and Treatment for Maternal Depression; Family to Family Health Information Centers; the Maternal, Infant, and Early Childhood Home Visiting Program, and the Poison Control Program.

***Special Projects of Regional and National Significance******(SPRANS)***

HRSA awards SPRANS grants to:

1. Respond to legislative set-asides and directives, including:
	1. **Oral Health:** Projects to improve perinatal and oral infant health.
	2. **Epilepsy:** Projects to improve access to quality services for children and youth with epilepsy in underserved areas.
	3. **Sickle Cell Disease:** Projects to improve care coordination for children and families affected by sickle cell disease
	4. **Fetal Alcohol Syndrome:** Projects to decrease the prevalence of alcohol use during pregnancy through provider and consumer education.
2. Address critical and emerging issues of regional and national significance in MCH, such as maternal mortality and opioids.
	1. For example, SPRANS supports the Alliance for Innovation on Maternal Health, or AIM. AIM is a national data-driven maternal safety and quality improvement initiative that supports the implementation of evidence-based maternal safety bundles within birthing facilities to address the leading causes of maternal death, such as hemorrhage and hypertension. As of October 2021 44 states plus the District of Columbia are enrolled in AIM, and the program is improving care affecting a significant percentage of births across the country. For example, Louisiana is implementing the AIM Severe Hypertension bundle, and from 2016 to 2019, experienced a 23% decrease in the severe maternal morbidity rate among birthing persons.
3. Support collaborative and innovative learning across states so programs can utilize existing best practices and evidence.
	1. For example, SPRANS supports the National Survey of Children’s Health, which is the only annual comprehensive source of national and state-level data on key measures of child health and well-being. Findings from the Survey enable HRSA and its state and federal partners to develop policies and programs informed by recent, quality data that strengthen and support families. States use survey results to track and report on their National Performance and National Outcome Measures.

Other examples of grants funded through SPRANS include:

* **Genetics:** Projects to improve access to genetic counseling and services for those at-risk of having a genetic condition and their families.
* **Hemophilia:** Projects to improve the quality of care in hemophilia treatment centers serving patients with hemophilia and related blood disorders per year.
* **MCH Training:** Projects to support targeted interdisciplinary professional training in areas such as behavioral health, nutrition, public health, and adolescent health.
* **MCH Research and Data**: Projects to support 1) translational research to advance MCH science and practice; 2) capacity-building to use data to drive improvements in state Title V programs and outcomes.

 ***Community Integrated Services Systems (CISS)***

CISS grants are awarded on a competitive basis and support states and communities in building a comprehensive, integrated system of care to improve access and outcomes for all children, including children with special health care needs. For example, CISS funding supports the Early Childhood Comprehensive Systems (ECCS) program to enhance state-level capacity and infrastructure for integrated maternal and early childhood systems of care that lead to improved children’s developmental health, family well-being, and increased family-centered access to care for the prenatal-to-3-year-old population. The program provides direct support and technical assistance to 20 states to build leadership capacity in early childhood systems, improve cross-sector service coordination and alignment, improve policies and practices across sectors, and advance health equity and health system improvements in early childhood so that more children are thriving at age three and school-ready by age five. The program was re-competed in FY 2021.

 ***Other Categorical Funding***

MCHB also administers additional funding programs, which include:

* **Autism:** The Autism and Other Developmental Disabilities Program improves care and outcomes for children and adolescents with autism spectrum disorder and other developmental disabilities through training, advancing best practices, and service. The Autism and Other Developmental Disabilities Program began in 2008 as authorized by the Combating Autism Act of 2006. The Autism Collaboration, Accountability, Research, Education and Support Act of 2019, or Autism CARES Act, reauthorized the program in 2019. The program supports training programs, research, and state systems grants.
* Authorizing Legislation - Public Health Service Act, Sections 399BB-399DD, (42. U.S.C. 280i-1 through 280i-4), as most recently reauthorized and amended by the Autism Collaboration, Accountability, Research, Education and Support Act of 2019 (Public Law 116-60).
* **Sickle Cell:** The Sickle Cell Disease Treatment Demonstration Program improves access to care and health outcomes for individuals with sickle cell disease, a genetic condition that results in abnormal red blood cells that can block blood flow to organs and tissues, causing anemia, periodic pain episodes, damage to tissues and vital organs, and increased susceptibility to infections and early death.
* Authorizing Legislation - Public Health Service Act, Section 1106(b) (42 USC 300b-5) as most recently reauthorized and amended by the Sickle Cell Disease and Other Heritable Blood Disorders Research, Surveillance, Prevention, and Treatment Act of 2018 (Public Law 115-327).
* **Early Hearing Detection and Intervention:** The Early Hearing Detection and Intervention Program (formerly known as the James T. Walsh Universal Newborn Hearing Screening Program) supports the development of comprehensive and coordinated state and territory early hearing detection and intervention systems of care. The Early Hearing Detection and Intervention program assures that families with newborns, infants, and young children up to three years of age that are deaf or hard of hearing receive appropriate and timely services that include hearing screening, diagnosis, and early intervention. The Children’s Health Act of 2000 (P.L. 106-310) authorized the program in FY 2000. The Early Hearing Detection and Intervention Act of 2017 (P.L. 115-71) recently amended and reauthorized the program.
* Authorizing Legislation - Public Health Service Act, Section 399M (42 U.S.C. 280g-1), as most recently reauthorized and amended by the Early Hearing Detection and Intervention Act of 2017 (Public Law 115-71) Section 2.
* **Emergency Medical Services for Children:** The Emergency Medical Services for Children (EMSC) Program is the only federal grant program specifically focused on addressing the distinct needs of pediatric patients in emergency medical services. The EMSC Program, authorized under the EMSC Reauthorization Act of 2019, works to ensure that seriously sick or injured children have access to the same high-quality pediatric emergency care, no matter where they live in the United States.
* Authorizing Legislation – Public Health Service Act, Section 1910 (42 U.S.C. 300w-9), as most recently reauthorized and amended by the Emergency Medical Services for Children Reauthorization Act of 2019 (Public Law 116-49).
* **Healthy Start:** The Healthy Start program provides grants to support community-based strategies to reduce disparities in infant mortality and improve perinatal outcomes for women and children in high-risk communities throughout the nation. Major and persistent racial and ethnic disparities exist for infant mortality, maternal mortality, and other adverse outcomes such as preterm birth and low birth weight.
* Authorizing Legislation - Public Health Service Act, Section 330H (42 U.S.C. 254c-8), as most recently reauthorized and amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law 116-136) Section 3225.
* **Heritable Disorders:** The Heritable Disorders in Newborns and Children Program focuses on reducing the morbidity and mortality caused by heritable disorders in newborns and children by supporting state and local public health agencies’ ability to provide screening, counseling, and health care services. Four million newborns each year are screened for at least 30 of the 35 core conditions on the Recommended Uniform Screening Panel, a list of conditions recommended by the U.S. Secretary of Health and Human Services for state newborn screening programs. The Heritable Disorders in Newborns and Children Program was authorized in 2000 and was reauthorized by the Newborn Screening Saves Lives Reauthorization Act of 2014.
* Authorizing Legislation – Public Health Service Act, Section 1109-1112 and 1114 (42 U.S.C. 300b-8 -- 300b-11, 300b-13, and 300b-16), as most recently reauthorized and amended by the Newborn Screening Saves Lives Act of 2014 (Public Law 113-240).
* **Pediatric Mental Health Care Access:** The Pediatric Mental Health Care Access Program promotes behavioral health integration in pediatric primary care by supporting the development of new, or the improvement of existing, statewide or regional pediatric mental health care telehealth access programs. These programs provide tele-consultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat, and refer children with behavioral health conditions. The program works to address the shortages of psychiatrists, developmental-behavioral pediatricians, and other behavioral health clinicians who can identify behavioral disorders in children and adolescents and provide appropriate services through telehealth technologies that support and promote long-distance clinical health care, clinical consultation, patient and professional health-related education, public health and health administration.
* Authorizing Legislation – Public Health Service Act, Section 330M (42 U.S.C. Section 254c-19) as added by the 21st Century Cures Act, (Public Law 114-255) Section 10002.
* **Screening and Treatment for Maternal Depression and Related Behavioral Disorders:** The Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program expands health care providers’ capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal depression and related behavioral health disorders by providing training, real-time psychiatric consultation, and care coordination to front-line health care providers, including in rural and underserved areas. This program improves the mental health and well-being of pregnant and postpartum women and the social and emotional development of their infants.
* Authorizing Legislation – Public Health Service Act, Section 317L-1 (42 U.S.C. 247b-13a), as added by the 21st Century Cures Act, (Public Law 114-255) Section 10005.
* **Family-to-Family Health Information:** The Family-to-Family Health Information Centers (F2F HICs) Program assists families of children and youth with special health care needs (CYSHCN) to be partners in health care decision making. Staffed by family members who have first-hand experience using health care services and programs for CYSHCN, F2F HICs promote cost-effective, quality health care by providing patient-centered information, education, technical assistance, and peer support to families of CYSHCN and health professionals. Initially authorized by the Deficit Reduction Act of 2005, the program funded one health information center in each of the 50 states and the District of Columbia. Most recently, the Sustaining Excellence in Medicaid Act of 2019 reauthorized the program through FY 2024 at $6 million per year and added the requirement that F2F HICs be developed in all territories and at least one such center be developed for Indian tribes.
* Authorizing Legislation - Social Security Act, Section 501(c)(1)(A) (42 U.S.C. 701(c)(1)(A) as most recently reauthorized by the Sustaining Excellence in Medicaid Act of 2019 (Public Law 116-39) Section 5.
* **Maternal, Infant, and Early Childhood Home Visiting:** The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry. The MIECHV Program builds upon decades of scientific research showing that home visits by a nurse, social worker, or early childhood educator during pregnancy and in the first years of life have the potential to improve the lives of children and families by helping to prevent child abuse and neglect; encouraging positive parenting; improving maternal and child health; and promoting child development and school readiness.
* Authorizing Legislation – Social Security Act, Section 511 (j) (42 U.S.C. 711), most recently reauthorized by the Bipartisan Budget Act of 2018 (Public Law 115-123).
* **Poison Control:** The Poison Control Program was established in 2000 and is legislatively mandated to: fund poison centers; establish and maintain a single, national toll-free number (800-222-1222) to ensure universal access to poison center services; and implement a nationwide media campaign to educate the public and health care providers about poison prevention, poison center services, and the toll-free number. This grant program supports Poison Control Centers’ efforts to: 1) prevent and provide treatment recommendations for poisonings; 2) comply with operational requirements to sustain accreditation and/or achieve accreditation; and 3) improve and enhance communications and response capability and capacity. Funds may also be used to improve the quality of data uploaded from poison centers to the National Poison Data System in support of national toxic surveillance activities conducted by the Centers for Disease Control and Prevention (CDC).
* Authorizing Legislation – Public Health Service Act, Sections 1271-1274, as amended by Public Law 116-94.

**Domain Specific Measures and Program-Specific Measures (Attachment B):**

This is a central set of performance measures. The performance measures reflect MCHB’s strategic and priority areas. Collectively, they communicate the MCHB “story” to a broad range of stakeholders on the role of MCHB in addressing the needs of MCH populations. Individual grantees respond to only a limited number of performance measures that are specifically relevant to their program.

A performance measure detail sheet defines and describes each performance measure. The detail sheet includes: a performance measurement and goal statement, an operational definition including the tier structure for the performance measure, relevance to Healthy People 2030 Objectives, data source and issues surrounding data collection, and a statement on the significance of the performance measure in the MCH field. These detail sheets assure consistent understanding and reporting among all grantees and, when appropriate, allow for national data aggregation. In many cases, data forms are included as attachments to assist the grantee in reporting on the measure.

**Financial and Demographic Data Forms (Attachment C):**

These forms are completed by all grantees to report financial and demographic information. The forms capture grantee annual budget details, budget details by types of individuals served, number of individuals served by type of individual served, project budget and expenditures, number of individuals served, and project performance/outcome measure details. The forms consolidate and streamline this information and make data collection and reporting consistent across all of MCHB’s discretionary grant programs.

**Other Data Elements (Attachment D):**

This section includes other data requested by MCHB divisions and offices, and captures information that grantees are already reporting for program administration and management purposes for certain grant categories. The information highlights unique characteristics of discretionary grant projects that are not captured in Parts 1 or 2. Forms capture grantee technical assistance/collaboration; products, publications and submissions from programs; and additional workforce development information.

1. **Purpose and Use of Information Collection**

The performance data will serve several purposes including grantee monitoring, program planning, and performance reporting. In addition, these data will facilitate the ability to demonstrate alignment between MCHB discretionary programs and the MCH Title V Block Grant program to quantify outcomes across MCHB. The overall number of performance measures, and the design of the performance measures, are not significantly changing. Revisions are being proposed to facilitate more efficient and accurate reporting of information related to Capacity Building activities, Financial and Demographic data, and Training activities.

**Federal Uses of Information**

The data and attendant information that are collected from the discretionary grant recipients allow MCHB to monitor grantee performance and progress toward achieving both short-term and long-term goals. The information provides the Bureau with timely information on grantee progress toward achieving goals, and also serves as a mechanism to identify technical assistance needs needed by grantees to meet specified objectives. MCHB uses the information to monitor and assess grantee progress, report on Bureau activities, and support budget planning.

**Grantee Uses of Information**

States, local agencies, and other grantees use the data to respond to other Federal, State, and local performance requirements/requests; to set priorities for their MCH populations; and to develop and justify efforts to advance MCHB-related agendas within states and communities.

Due to the diversity of grant categories administered by MCHB, the grant reporting forms and set of performance measures forms appears extensive. However, each grantee only responds to certain applicable portions that are appropriate to their grant, as assigned by Project Officers. In addition, the performance measure format utilizes a tiered approach in which grantees are able to demonstrate the full breadth of the work that their programs are doing in increasing levels of detail, regardless of proximity to the final outcome.

The common set of measures preserves the ability of grantees to highlight their own program needs and characteristics by allowing them to choose performance measures that pertain to their specific program. It also allows for standardized accountability across all grantee sites in measuring program progress and impact toward stated goals. Furthermore, this consolidated effort collects consistent and comparable information across all sites and different program areas.

1. **Use of Improved Information Technology and Burden Reduction**

This activity is fully electronic. To accommodate the recognized need for better access to data, states’ demands for an electronic version of the forms, and in compliance with GPRA, grantees use an Electronic Reporting Package (ERP) to report data and to disseminate performance reports via the web. The (ERP) enables states to submit information and report data in a universal format. The ERP provides pre-formatted and interactive data entry that helps assure standardized data across states and greatly simplifies the data entry process. All calculations (e.g., ratios, rates, percentages, totals) are automated, tables are interlocked where data overlap, and historical data are preserved so that only the annual data for the year in question needs to be newly entered.

1. **Efforts to Identify Duplication and Use of Similar Information**

Efforts have been made to align with other data collection efforts of other Federal agencies, as required by Section 509(a) (5) of Title V of the Social Security Act. The data requested in these measures are unique to the discretionary programs, required by statute, and are not available elsewhere.

1. **Impact on Small Businesses or Other Small Entities**

No small businesses will be involved in this data collection.

1. **Consequences of Collecting the Information Less Frequently**

Annual submission of grant reporting requirements is required by law to entitle grantees to receive federal grant funds for each year of their grant award.

1. **Special Circumstances Relating to the Guidelines of 5 CFR 1320.5**

This data collection request is fully consistent with the guidelines in 5 CFR 1320.5(d)(2).

1. **Comments in Response to the Federal Register Notice/Outside Consultation**

The notice required in 5 CFR 1320.8(d) was published in the *Federal Register* on January 21, 2022, (87 FR 3313). A total of six (6) individual comments were received during the public comment period and were taken into account in the final preparation of these performance measures and forms. There were six (6) requests to view the proposed revisions.

One comment conveyed support for the proposed DGIS form updates and relayed that it will improve their organization’s ability to understand trainees with relation to gender diversity and also decrease the burden of completing DGIS reporting. The other comment also conveyed support for removing several forms to alleviate reporting burden, with which the Department agrees.

In addition, this same commenter supported the proposal to align the age ranges across DGIS measures, specifically between Form 5 and Form 3, with which the Department also agrees. This commenter also relayed concern over the administrative burden required to count and report specialty providers by specialty type for trainings and requested clearer guidance for how to accurately count provider types in Training Form 15 (referenced as Training Form 14 in the January 21, 2022 notice).

Finally, the commenter relayed concern that requiring providers to submit data to HRSA (for purposes of Training Form 15) could preclude providers from participating in the program given their limited resources. Similar comments regarding count of providers by specialty type were received by another commenter, with a focus on the difficulty to collect this data related to depression training and additional burden that is created when the count is required to be de-duplicated by provider type.

The Department acknowledges counting and reporting specialty providers by specialty type requires more effort than counting and reporting providers without specialty type. However, provider specialty type is crucial to HRSA's ability to measure programmatic reach and impact, which is used to inform programmatic and policy decision making. To provide better guidance, the form has been updated to include “non-specialty” to the applicable sections of the tables to assist with reporting and the Department will ensure Training Form 15 is programmed into DGIS in such a way that it is clearer to the grantee that any provider type not listed should be counted in an “Other” category. Additionally, grantees are not expected to de-duplicate training counts by provider type. If grantees do not have information on the type of providers who attended a training, it is acceptable to place counts under “Other.”

Additional comments received by a single commenter on Training Form 15 included feedback regarding the difficulty for their teleconsultation line staff to track and report the number of enrolled providers who may be eligible to call the line; the need for clarification on how a care coordinator/patient navigator is defined; the need for clarification on what “teleconsultation” specifically entails and what level of provider needs to provide this service; the need for clarification around specific terms, including: polysubstance use, disruptive, impulse-control, conduct disorders as well as co-occurring mental and substance use disorders; a request for HRSA to make the individuals served screening-level measure optional for Maternal Depression and Related Behavioral Disorders (MDRBD) grantees similar to Pediatric Mental Health Care Access program (PMHCA) grantees; feedback that depending on the specific modality used to obtain practice-level screening data, the numerator and denominator time frame may not fully align with the federal fiscal year; and a request for clarification regarding reporting the number of referrals given with a suggestion that HRSA define this measure not as the number of referrals provided, but rather as the number of referrals services/supports that could be offered.

In response to these comments, the Department has made the following updates to Training Form 15: “if applicable” has been added in the first table requesting the number of providers enrolled AND participating; consultation language has been clarified by changing “teleconsultation” to “consultation,” which includes both teleconsultation and in-person consultation. If a call/contact includes both consultation and care coordination support the contact should be reported in the “Both” category; polysubstance use and co-occurring mental and substance use disorders have been removed from the list of condition(s) to report why providers contact the program for consultation; and the individuals served screening-level measure now reflects as optional for MDRBD grantees similar to PMHCA grantees.

The Department wishes to clarify that family visitors and doulas should be reported as Care Coordinators/Patient Navigators if that is the role they are filling and reporting the number of referrals given is solely for referral and treatment recommendations for providers who contact the program. Grantees should be able to collect this information at the time the provider contacts the program and no updates have been made to the form regarding this question.

This commenter also provided feedback on the Core Health Equity Form, Women and Maternal Health (WMH) 1, 2, and 4, and Financial Forms 2, 3, and 5 (now Financial Forms 3, 5, and 7). While the commenter welcomes the revisions of the Core Health Equity form, they clarified that specific health equity goals and objectives being pursued may be overarching and aligned with organizational equity aims, and as such, progress toward achieving them may be hard to quantify and/or specify from a programmatic-level.

The Department recognizes there may be some overlap with larger organizational aims, however, health equity is a focus of MCHB programs and it is necessary to capture how grantees are advancing health equity. With regards to WMH 1 and 2, the commenter provided feedback that it remains difficult to specify/stratify training counts specific to pregnancy and postpartum care given that most training is specific to the perinatal period. As a result, grantees whose focus spans the entirety of the perinatal period like MDRBD grantees would benefit from additional reporting instruction on how best to fill out these forms and whether to include training counts only in Training Form 15 or in WMH 1 and 2 forms as well. The Department recognizes that some programs may span pregnancy and postpartum periods, however, there is a need to capture prenatal care (WMH 1) in the first trimester and timely postpartum visit (WMH 2) separately to demonstrate each of these measures are improving.

The Department wishes to clarify that for programs with trainings that may cover pregnancy and post-partum care, these trainings should be counted under both WMH 1 and WMH2. These trainings however should include content on timely prenatal and timely postpartum care.

Finally, the commenter requested HRSA consider making the Tier 4 measure for WMH 4 optional given reporting difficulty and the amount of time it would take to enact needed electronic medical record modifications and reporting protocols to obtain treatment/referral information; any immediate information provided in this area would require manual tracking. After further consideration, the Tier 4 measure for WMH 4 has been updated to reflect its optional status, bringing it into alignment with the updates made to Training Form 15. Additional comments received by a final commenter on Training Form 15 included requested clarification on the definition of “enrolled provider,” guidance for how to classify the reason for provider contact, requested clarification on how to count the number and types of providers trained, an example for what constitutes "treatment strategies,” and a specific definition for the term "treatment.”

As a result of this feedback, the form has been updated to include a footnote which clarifies that an “Enrolled” provider is one who is currently enrolled in the program even if initial enrollment occurred prior to the current reporting period. With regards to classifying the reason for a provider contact, The Department clarifies that the intent is to not limit responses to specific diagnoses for this question. If a specific diagnoses can be captured at the time of the call, it should be captured as such. If it cannot, and the reason(s) for the call are not included in the provided list, the grantee should capture the reason for the call under the response option titled, “Other (please specify).” In addition, the form has been updated to state “Treatment modality-focused trainings” instead of “Treatment strategies-related trainings.” Finally, recognizing each grantee may define “Treatment” differently, the Department clarifies that “Treatment” is broadly defined for both PMHCA and MDRBD programs as, “the provision, coordination, or management of health care and related services among health care providers.”

Two commenters provided feedback on the Family-to-Family (F2F) Form 1. The first commenter provided the following: a recommendation that parents of CYSHCN be specified in the definition of the numerator as they are in other related statements in the document; concern about the removal of the details “family centered, comprehensive, and coordinated system” in the benchmark data sources replaced with “a system of care,” with a recommendation of listing additional other benchmarks here, such as Healthy People 2030 MICH-19; language that states F2F services are either one-to-one or through group training and events, with a recommendation to replace “one-to-one” with “individual Total number of families receiving one-to-one services (including small group individualized assistance); use of a Likert scale when capturing the percentage of one-to-one services and trainings provided by topic, as well as when capturing the percentage of services and trainings to professionals/providers provided by topic; use of the term “American Indian or Alaska Native” instead of “tribal organization;” and concern about the removal of four subcategories that were previously used to report the types of services/trainings provided to families, and removal of references to the six core outcomes in the form.

As a result of the feedback, the measure’s numerator has been revised to state: “The total number of families of CYSHCN receiving one-to-one services and training total number of families with CSHCN in the State that have been provided information, education, and/or training from Family-To-Family Health Information Centers.” This language is consistent with the statutory activities. Question 1 has been revised to include the phrase, “small group individualized assistance.” After considering the commenter’s use of Likert scales when capturing the percentage of one-to-one services and trainings provided by topic, as well as when capturing the percentage of services and trainings to professionals/providers provided by topic, these questions have been removed from the form. After further consideration, the four subcategories that were previously used to report the types of services/trainings provided to families has been added back to the form. Finally, the form has been updated to reflect “American Indian or Alaska Native” instead of “tribal organization.”

With regards to the use of MICH-19 in addition to the benchmark data source of MICH-20, the Department intends to proceed with the use of MICH-20, as “systems of care” includes having a medical home. While the title of the objective has changed, the objective of receiving care in a system of care is still the same. Finally, with regards to the removal of references to the six core outcomes in the form: Despite removal from the form, the six (6) core outcomes remain foundational for all work to improve systems of care. The Department intends to proceed with removal and would like to reiterate that grantees can report on the six (6) core outcomes in their annual progress report.

The second commenter on the F2F form mirrored those of the first and no additional consideration was necessary.

The 30-day FRN was published in the *Federal Register* on June 9, 2022, (87 FR 35220), and received no public comments.

1. **Explanation of any Payment/Gift to Respondents**

Respondents will not receive any payments or gifts.

1. **Assurance of Confidentiality Provided to Respondents**

The information that is collected does not identify any individuals by name or collect any individual information.

1. **Justification for Sensitive Questions**

In support of the Department’s longstanding commitment to achieving health equity and the Executive Order *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government* (January 21, 2021), MCHB has a need to collect both race and ethnicity data in aggregate form. There are 3 DGIS forms which ask the respondent to provide this information for the populations they are serving. These forms are: Form 7 (Discretionary Grant Project Summary Data), the MCHB Faculty and Staff Training Form, and the MCHB Training Program Trainee Follow-up Survey Form. MCHB uses this information to better understand if certain populations, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality, are being served by MCHB programs.

**Estimates of Annualized Hour and Cost Burden**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Form | Number ofRespondents | Responses per Respondent | Total Responses | Burden hours per response | Total burden hours |
| Grant Report | 700 | 1 | 700 | 36 | 25,200 |
| Total | 700 | 1 | 700 | 36 | 25,200 |

1. **Estimates of other Total Annual Cost Burden to Respondents or Recordkeepers/Capital Costs**

Other than their time, there is no cost to respondents.

1. **Annualized Cost to Federal Government**

This activity requires approximately 1 FTE GS-14 at 10% time and 3 FTE GS-13 at 10% time for an average annual combined cost of $41,000. In addition, about $850,000 in contract costs is required annually for the operation of the system for automated reporting and analysis of data. On this basis, the estimated average annual cost to the Federal Government is $891,000.

1. **Explanation for Program Changes or Adjustments**

The current inventory for this activity is 25,200 hours. For this revision, there is not a change in burden hours as any additional information requested is offset by information no longer being requested. Most programs have a limited number of measures assigned (3 to 5 measures), with only Training programs, EMSC programs, Healthy Start programs, and Family-to-Family programs continuing to report additional program-specific measures as part of these discretionary grant performance measures.

1. **Plans for Tabulation, Publication, and Project Time Schedule**

This activity is an annual data collection. Submission of all documents by grantees will take place at different grant cycles throughout the year depending on the program for which the grantee is reporting. See <https://perf-data.hrsa.gov/MCHB/DGISReports/> for more information.

1. **Reason(s) Display of OMB Expiration Date is Inappropriate**

The OMB number and expiration date will be displayed on every page of every form/instrument.

1. **Exceptions to Certification for Paperwork Reduction Act Submissions**

There are no exceptions to the certification.This project meets all of the requirements in 5 CFR 1320.9. The certifications are included in this package.

**AttachmentS to Supporting Statement**

**Attachment A Section 501 of Title V of the Social Security Act**

**Attachment B-1 Crosswalk of Form Changes**

**Attachment B Domain-Specific Measures and Program-Specific Measures**

**Attachment C Financial and Demographic Data Forms**

**Attachment D Additional Data Elements**

**Attachment E Public Comments**

**Attachment F Summary of Public Comments**

1. Section 509, Title V: Maternal and Child Block Health Services Block Grant, Social Security Act (US Code

 §§701-710, subchapter V, chapter 7, Title 42) [↑](#footnote-ref-1)