

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

1. Justification

The Health Resources and Services Administration (HRSA) is proposing to continue use of 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 and 2022. Approval from OMB is currently being sought to continue the use of performance measures with substantive revisions. Most of these measures are specific to certain types of programs and are not required of all grantees. Currently, 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. The proposed substantive revision is meant to align data collection forms more closely with current program activities. The goals of the redesigned performance measures are to: (1) improve clarity and validity of DGIS forms, (2) increase alignment with the MCHB Strategic Plan and other performance measurement efforts, (3) produce timely, actionable data for program management, (4) support communications about the range of HRSA’s maternal and child health programs (5) reduce the number and complexity of data collection forms, and (6) improve data quality.

The proposed forms are under two general groupings: central measures and program specific measures. Redesigned forms associated with central measures fall into four categories: basic forms, topical forms, activity forms, and outcome forms. Certain programs also complete relevant program-specific forms. 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 to collect performance

measurement information 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 08/31/2025.

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.

Requested changes to the DGIS include eliminating 52 forms, adding 25 forms, and revising 23 forms. Many of the requested changes are a result of the redesigned categorization of measures. For example, the proposed set of activity forms capture common types of activities conducted across MCHB investments and replace the set of Population Domain forms (Adolescent Health, Capacity Building, Child Health, Children with Special Health Care Needs, Lifecourse/Crosscutting, Maternal/Women Health, and Perinatal/Infant Health). The proposed set of basic forms consolidate and simplify the set of Financial forms (Form 1, 3, 5, 7, and 8). Other changes reflect efforts to reduce burden or the need to relocate measures from the Population Domain forms to program-specific forms (i.e., Healthy Start). A crosswalk that details these changes is included as Attachment B-1. Below is a summary:

Removing the following 52 existing forms: Capacity Building (CB) 1 (State Capacity for Advancing the Health of MCH Populations), CB 3 (Impact Measurement), CB 4 (Sustainability), CB 5 (Scientific Publications), CB 6 (Products), CB 8 (Quality Improvement), Women's/Maternal Health (WMH) 1 (Prenatal Care), WMH 2 (Perinatal/Postpartum Care), WMH 3 (Well Woman Visit/Preventive Health Care), WMH 4 (Depression Screening), Perinatal Infant Health (PIH) 1 (Safe Sleep), PIH 2 (Breast Feeding), PIH 3 (Newborn Screening), Child Health (CH) 1 (Well Child Visit), CH 2 (Quality of Well Child Visit), CH 3 (Developmental Screening), CH 4 (Injury Prevention), Children with Special Health Care Needs (CSHCN) 1 (Family Engagement), CSHCN 2 (Access to and Use of Medical Home), CSHCN 3 (Transition to Adult Health Care), Adolescent Health (AH) 1 (Adolescent Well Visit), AH 2 (Injury Prevention), AH 3 (Screening for Major Depressive Disorder), Life Course/Cross Cutting (LC) 1 (Adequate Health Insurance Coverage), LC 2 (Tobacco and eCigarette Cessation), LC 3 (Oral Health), Division of Workforce Development (Training) 01 (MCH Training Program and Healthy Tomorrows Family Member/Youth/Community Member Participation), Training 05 (Policy), Training 06 (Diversity of Long-Term Trainees), Training 10 (Leadership), Training 11 (Work with MCH Populations), Training 12 (Interdisciplinary Practice), Emergency Medical Services for Children (EMSC) 01 (Using NEMSIS Data to Identify Pediatric Patient Care Needs), EMSC 02 (Pediatric Emergency Care Coordination), EMSC 03 (Use of Pediatric-Specific Equipment), EMSC 05 (Pediatric Traumatic Emergencies), EMSC 06 (Written Inter-facility Transfer Guidelines that Contain All the Components as per the Implementation Manual), EMSC 07 (Written Inter-facility Transfer Agreements That Covers Pediatric Patients), Healthy Start (HS) 01 (Reproductive Life Plan), HS 02 (Usual Source of Care), HS 03 (Interconception Planning), HS 05 (Father/Partner Involvement during Pregnancy), HS 06 (Father and/or Partner Involvement with Child 0-24 Months), HS 07 (Daily Reading), HS 08 (CAN Implementation), HS 09 (CAN Participation), Form 3 (Budget Details by Types of Individuals Served), Form 5 (Number of Individuals Served (Unduplicated)), Form 7

(Discretionary Grant Project Summary Data and Demographics), Form 9 (Program-Specific Project Performance/Outcome Measures), Technical Assistance/Collaboration Form, and Continuing Education Form.

Adding the following 25 new forms: Direct and Enabling Services, Training and Workforce Development, Partnerships and Collaboration, Engagement of Persons with Lived Experience, Technical Assistance, Outreach and Education, Research, Guidelines and Policy, Data and Information Systems, Quality Improvement and Evaluation, Knowledge Change, Behavior Change, EMSC 10 (Prehospital Emergency Medical Services Pediatric Readiness Recognition Program), HS 10 (Prenatal Care), HS 11 (Perinatal/Postpartum Care), HS 12 (Well Woman Visit/Preventive Health Care), HS 13 (Depression Screening), HS 14 (Safe Sleep), HS 15 (Breastfeeding), HS 16 (Well Child Visit), HS 17 (Adequate Health Insurance Coverage), HS 18 (Prenatal Tobacco and eCigarette Use), HS 19 (Low Birthweight), HS 20 (Preterm Birth), and HS 21 (Infant Mortality).

Revising the following 23 existing forms: Health Equity, Healthy Start Site Form, Family to Family Form (F2F) 1, Financial Form (MCHB Project Budget Details), Project Abstract (Maternal & Child Health Discretionary Grant Project Abstract), Project Abstract-Research Projects Only, Form 10 (Program-Specific and Project Developed Measures), Products, Publications, and Submissions Data Collection Form, Faculty and Staff Information, Short-Term Trainees, Medium-Term Trainees, Long-Term Trainees, Former Long-Term Trainees, LEAP Trainee Information, Training 02 (MCH Training Program and Healthy Tomorrows Cultural Competence), Training 03 (Healthy Tomorrows Title V Collaboration), Training 04 (Title V Collaboration), Training 07 (MCH Pipeline Program-Work with MCH Populations), Training 08 (MCH Pipeline Program-Work with underserved or vulnerable populations), Training 09 (MCH Pipeline-Graduate Program Enrollment), Training 15 (Consultation and Training for Mental and Behavioral Health), HS 04 (Intimate Partner Violence Screening), and EMSC 04 (Pediatric Medical Emergencies).

In addition, the following 3 forms are included with no substantive changes from the prior approved OMB package: Training 14 (Medium-Term Trainees Skill and Knowledge), EMSC 08 (Established Permanence of EMSC), and EMSC 09 (Established Permanence of EMSC by Integrating EMSC Priorities Into Statutes/Regulations).

Additional non-substantive revisions 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 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 discretionary grant programs meet mandated reporting requirements. The attached forms and performance measures are intended to cover all discretionary grant programs managed by MCHB.

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)

MCHB Programs

Programs administered by MCHB under the Title V Block Grant 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 programs administered by MCHB under authorities outlined in the Public Health Service Act include the:

- Autism Education, Early Detection, and Intervention Program;
- Sickle Cell Disease Treatment Demonstration Program;
- Early Hearing Detection and Intervention Program;
- Emergency Medical Services for Children;
- Healthy Start Program;
- Newborn and Child Screening for Heritable Disorders Program;
- Pediatric Mental Health Care Access Grants;
- Screening and Treatment for Maternal Mental Health and Substance Use Disorders;
- Integrated Services for Pregnant and Postpartum Women;
- Family-to-Family Health Information Centers;
- Maternal, Infant, and Early Childhood Home Visiting Program; and
- 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:
 - a. **Oral Health:** Projects to improve perinatal and oral infant health.
 - b. **Epilepsy:** Projects to improve access to quality services for children and youth with epilepsy in underserved areas.
 - c. **Sickle Cell Disease:** Projects to improve care coordination for children and families affected by sickle cell disease.
 - d. **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.
 - a. **Maternal Mortality:** HRSA supports a number of investments with SPRANS funding that are integral to HRSA’s efforts to promote maternal health and reduce maternal mortality and morbidity. In FY 2023, HRSA continued support for the State Maternal Health Innovation Program, which supports state-specific actions that address disparities in maternal health and improve maternal health outcomes, including the prevention and reduction of maternal mortality and severe maternal morbidity.
 - b. **Reducing Health Disparities:** SPRANS funding has been vital to support efforts to reduce health disparities in communities across the country. The National MCH Workforce Development Center launched a new effort to help states implement, evaluate, sustain and advance practices designed to reduce health disparities within their state/jurisdiction. SPRANS also supports a new investment to establish a research network that is comprised of and supports minority-serving institutions to study health disparities in maternal health outcomes.
 - c. **COVID-19:** SPRANS funding has been instrumental in addressing emerging public health issues that impact the MCH population, including COVID-19. The SPRANS-funded 2021 National Survey of Children’s Health (NSCH) is an annual, cross-sectional, address-based survey that collects information on the health and well-being of approximately 30,000 children ages 0-17 and related health care, family, and community-level factors. The NSCH produced actionable data, which has been made publicly available, on COVID-related issues, such as missed preventive care visits due to the coronavirus pandemic and reasons for missed care (past 12 months) and interruptions in childcare arrangements (past 12 months).
- 3) Support collaborative and innovative learning across states so programs can utilize existing best practices and evidence.
 - a. For example, SPRANS supports the National Survey of Children’s Health, which is the largest 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 that strengthen and support families informed by recent, quality data. States also use survey results to track and report on their Title V 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 treatment centers serving patients with hemophilia and related blood disorders.
- **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 translational research to advance MCH science and practice, as well as 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.

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 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 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) initially authorized 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 2022 (Public Law 117-241).
- **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 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).
- **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 initially authorized in 2000.
 - Authorizing Legislation – Public Health Service Act, Section 1109-1112, 1114, and 1117 (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, and most recently reauthorized and amended by Section 11005 of the Bipartisan Safer Communities Act (Public Law 117-159).
- **Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD)** (formerly the Screening and Treatment for Maternal Depression and Related Behavioral Disorders (MDRBD)): This 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, and most recently reauthorized in December 2022 by the Consolidated Appropriations Act of 2023 (Public Law 117-328).
- **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 and amended by the Sustaining Excellence in Medicaid Act of 2019 (Public Law 116-39).
- **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 and amended by the Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022 as included in (Section 6101 of the Consolidated Appropriations Act, 2023 (P.L. 117-73).
- **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.

- Authorizing Legislation – Public Health Service Act, Sections 1271-1274, as most recently authorized and amended by the Consolidated Appropriations Act of 2020 (Public Law 116-94).

Description of Reporting Forms

DGIS electronically captures data from the approximately 800 discretionary grant awards 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 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 the performance reporting processes. The data captured in the performance measures and the financial forms are aggregated to display program data. Additionally, applicants have the ability to see the performance measures that they will be responsible for reporting performance on through a DGIS program manual link provided in the Notice of Funding Opportunity (NOFO).

Central Forms (Attachment B)

These forms collect data to report on a central set of performance measures. Forms are grouped into five categories: Basic Forms, Topical Forms, Activity Forms, Outcome Forms, and Form 10. These performance measures reflect MCHB's strategic priority areas. Collectively, they support communications about the range of HRSA's maternal and child health programs to a broad range of stakeholders. Individual grantees respond to a limited number of forms and performance measures that are relevant to their program.

Program-Specific Forms (Attachment C)

These forms are used to collect data requested by MCHB divisions and offices that are specific to Training and Workforce, Healthy Start, Emergency Medical Services for Children, and Family to Family programs.

A performance measure detail sheet defines and describes each performance measure. The detail

sheet includes: a performance measurement and goal statement, an operational definition for the performance measure, relevance to Healthy People Objectives, data source and potential 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 collection forms are included as attachments to assist the grantee in reporting on the measure. Individual grantees respond to a limited number of forms and performance measures that are relevant to their program.

Additional 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. Forms capture additional Healthy Start and workforce development information.

2. 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 proposed substantive revision is meant to align data collection forms more closely with current program activities. The goals of the redesigned performance measures are to: (1) improve clarity and validity of DGIS forms, (2) increase alignment with the MCHB Strategic Plan and other performance measurement efforts, (3) produce timely, actionable data for program management, (4) support communications about the range of HRSA's maternal and child health programs, (5) reduce the number and complexity of data collection forms, and (6) improve data quality.

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 serves as a mechanism to identify grantee technical assistance needs 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 the forms that are applicable to their grant. In addition, the revised forms include skip patterns

and auto-filled fields to reduce grantee burden.

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

3. Use of Improved Information Technology and Burden Reduction

This activity is fully electronic. 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.

4. 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.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

6. 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.

7. 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).

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

A 60-day Federal Register Notice was published in the Federal Register on May 4, 2023: Vol. 88, No. 86, pp. 28566-28567. No public comments were received during the 60 Day comment period.

From October to December 2022, James Bell Associates worked with the Contracting Officer's Representative (COR) and Maternal and Child Health Bureau (MCHB) program contacts to identify MCHB grantees to pilot test new and revised DGIS forms. Eighty-two grantees were asked to pilot test revised DGIS forms, and 72 of the invited grantees (88 percent) completed a phone call or a survey to provide an estimated time burden and general feedback for each DGIS form they pilot tested. Due to the Paperwork Reduction Act, each form was pilot tested by a maximum of nine grantees.

Grantees were asked to pilot test assigned DGIS forms and provide feedback on each form's clarity, flow, definitions, and response options. Grantees provided thoughtful and detailed feedback on the DGIS forms. Most of the feedback was minor and focused on issues related to formatting, spelling, or grammar. Other feedback focused on providing additional explanations or definitions for terms, categories, or response options on the DGIS forms.

9. Explanation of any Payment/Gift to Respondents

Respondents will not receive any payments or gifts.

10. Assurance of Confidentiality Provided to Respondents

The following forms collect limited non-sensitive personally identifiable information (PII) to allow programs to conduct longitudinal individual-level analysis (e.g., first name, last name, email address, work address).

- Faculty and Staff Information Form
- Long-Term Trainee Form
- Former Long-Term Trainee Form

Personally identifiable grantee-level DGIS data can only be accessed by HRSA employees using two factor authentication, and a Security Impact Analysis is conducted by an organizational official to determine the extent to which changes to the information system have affected the security state of the system. As part of the HHS Enterprise Performance Life Cycle gate review, the security impact analysis for this release shows no impact to the HRSA Electronic Handbook platform on which DGIS resides.

11. 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 both aggregate and individual-level form. There are 9 DGIS forms that ask the respondent to provide this information for the populations they are serving. These forms are Faculty and Staff Information (individual-level); Medium-Term Trainees; Long-Term Trainees (individual-level); Former Long-Term Trainees (individual-level); LEAP Trainee Information; Direct and Enabling Services; Engagement of Persons with Lived Experience; Research; and Family to Family. 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.

12. Estimates of Annualized Hour and Cost Burden

The estimated total annual cost to respondents is approximately \$549,411.80 (see burden table below). This cost to respondents is based on the average wage of healthcare practitioners and technical workers (occupation code 29-9099). Estimates come from the 2021 Bureau of Labor

Statistics report on Wage Estimates (retrieved from <https://www.bls.gov/oes/current/oes299099.htm>).

Form Name	Number of Respondents	Responses per Respondent	Total Responses	Burden Hours per Response	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Project Abstract-Attachment A	817	1	817	1.33	1,087	\$31.19	\$33,903.53
Project Abstract (Research Projects Only)-Attachment A	58	1	58	0.66	38	\$31.19	\$1,185.22
Financial Form-Attachment A	817	1	817	0.87	711	\$31.19	\$22,176.09
Health Equity-Attachment A	817	1	817	0.47	384	\$31.19	\$11,976.96
Direct and Enabling Services-Attachment A	476	1	476	1.89	900	\$31.19	\$28,071.00
Training and Workforce Development-Attachment A	250	1	250	2.42	605	\$31.19	\$18,869.95
Partnerships and Collaboration)-Attachment A	380	1	380	1.04	395	\$31.19	\$12,320.05
Engagement of Persons with Lived Experience-Attachment A	416	1	416	1.58	657	\$31.19	\$20,491.83
Technical Assistance-Attachment A	300	1	300	2.24	672	\$31.19	\$20,959.68
Outreach and Education-Attachment A	500	1	500	0.61	305	\$31.19	\$9,512.95
Research-Attachment A	65	1	65	3.11	202	\$31.19	\$6,300.38
Guidelines and Policy-Attachment A	78	1	78	0.70	55	\$31.19	\$1,715.45
Data and Information Systems-Attachment B	50	1	50	0.67	34	\$31.19	\$1,060.46
Quality Improvement and Evaluation-Attachment B	346	1	346	0.29	100	\$31.19	\$3,119.00
Knowledge Change-Attachment B	200	1	200	1.64	328	\$31.19	\$10,230.32
Behavior Change-Attachment B	200	1	200	1.56	312	\$31.19	\$9,731.28

Form Name	Number of Respondents	Responses per Respondent	Total Responses	Burden Hours per Response	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Products and Publications-Attachment B	672	1	672	4.23	2,843	\$31.19	\$88,673.17
Training Form 2-Attachment C	168	1	168	0.69	116	\$31.19	\$3,618.04
Training Form 3-Attachment C	41	1	41	0.99	41	\$31.19	\$1,278.79
Training Form 4-Attachment C	130	1	130	1.52	198	\$31.19	\$6,175.62
Training Form 7-Attachment C	6	1	6	0.83	5	\$31.19	\$155.95
Training Form 8-Attachment C	6	1	6	0.75	5	\$31.19	\$155.95
Training Form 9-Attachment C	6	1	6	0.92	6	\$31.19	\$187.14
Training Form 14-Attachment C	6	1	6	3.64	22	\$31.19	\$686.18
Training Form 15-Attachment C	52	1	52	3.17	165	\$31.19	\$5,146.35
Faculty and Staff Information-Attachment D	124	1	124	1.92	238	\$31.19	\$7,423.22
Short-Term Trainees-Attachment D	8	1	8	0.67	5	\$31.19	\$155.95
Medium-Term Trainees-Attachment D	121	1	121	2.49	301	\$31.19	\$9,388.19
Long-Term Trainees-Attachment D	112	1	112	6.37	713	\$31.19	\$22,238.47
Former Long-Term Trainees-Attachment D	106	1	106	1.60	170	\$31.19	\$5,302.30
LEAP Trainee Information-Attachment D	6	1	6	0.65	4	\$31.19	\$124.76
HS 4-Attachment C	101	1	101	0.57	58	\$31.19	\$1,809.02
HS 10-Attachment C	101	1	101	0.31	31	\$31.19	\$966.89
HS 11-Attachment C	101	1	101	0.61	62	\$31.19	\$1,933.78
HS 12-Attachment C	101	1	101	0.33	33	\$31.19	\$1,029.27
HS 13-Attachment C	101	1	101	0.50	51	\$31.19	\$1,590.69
HS 14-Attachment C	101	1	101	0.43	43	\$31.19	\$1,341.17
HS 15-Attachment C	101	1	101	0.45	45	\$31.19	\$1,403.55
HS 16-Attachment C	101	1	101	0.39	39	\$31.19	\$1,216.41

Form Name	Number of Respondents	Responses per Respondent	Total Responses	Burden Hours per Response	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
HS 17-Attachment C	101	1	101	0.40	40	\$31.19	\$1,247.60
HS 18-Attachment C	101	1	101	0.33	33	\$31.19	\$1,029.27
HS 19-Attachment C	101	1	101	0.38	38	\$31.19	\$1,185.22
HS 20-Attachment C	101	1	101	0.37	37	\$31.19	\$1,154.03
HS 21-Attachment C	101	1	101	0.36	36	\$31.19	\$1,122.84
Healthy Start Site Form- Attachment D	101	1	101	0.32	32	\$31.19	\$998.08
EMSC 4-Attachment C	58	1	58	0.92	53	\$31.19	\$1,653.07
EMSC 8-Attachment C	58	1	58	0.09	5	\$31.19	\$155.95
EMSC 9-Attachment C	58	1	58	0.42	24	\$31.19	\$748.56
EMSC 10-Attachment C	58	1	58	0.46	27	\$31.19	\$842.13
F2F 1-Attachment C	59	1	59	2.76	163	\$31.19	\$5,083.97
Form 10-Attachment B	200	2	400	12.87	5,148	\$31.19	\$160,566.12
TOTAL	817		817		17,615		\$549,411.85

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

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

14. Annualized Cost to Federal Government

This activity requires approximately 2 FTE GS-14 at 40% time and 2 FTE GS-13 at 20% time for an average annual combined cost of \$132,512. In addition, about \$1,000,000 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 \$1,132,512.

15. Explanation for Program Changes or Adjustments

The current inventory for this activity is 17,616 hours, a reduction of 7,584 burden hours compared to the estimate in the previous *Federal Register* notice (87 FR 3313) published on January 21, 2022. Most programs have a limited number of forms assigned (5 to 7), with only Workforce and Training, EMSC, Healthy Start, and Family-to-Family programs reporting additional program-specific measures as part of these discretionary grant performance measures.

16. 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.

17. 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.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

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

ATTACHMENTS TO SUPPORTING STATEMENT
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Attachment A	Section 501 of Title V of the Social Security Act
Attachment B-1	Crosswalk of Form Changes
Attachment B	Central Forms
Attachment C	Program-Specific Forms
Attachment D	Additional Data Elements