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

1. Circumstances Making the Collection of Information Necessary

This is a request for OMB approval for a revision to the information collection activities for the Health Resources and Services Administration (HRSA) 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 2023. Non-substantive revisions were made in 2025 and 2026.

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. Grant programs are assigned data collection forms based on their activities. In addition, there are two central forms that are utilized by all grantees. The proposed revision is meant to remove 2 forms and update terminology in 5 forms.

The forms proposed for revision are under two general groupings: central measures and program specific measures. Forms associated with central measures fall into three categories: basic forms, activity forms, and outcome forms. Certain programs also complete relevant program-specific forms. MCHB Special Projects of Regional and National Significance (SPRANS) grant programs that report data using this information collection are authorized by 42 U.S.C § 701(a)(2) (Title V, § 501(a)(2) of the Social Security Act). DGIS collects data across other Legislative Authorities as noted in the History and Legislative Requirements section of this SS-A. 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 12/31/2026.

Grant reporting forms and performance measures for MCHB discretionary grant programs have been designed to capture information across a 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 removing 2 forms and revising 5 forms. A crosswalk that details these changes is included as Attachment A. Below is a summary:

Removing the following 2 existing forms: Training 03 (Healthy Tomorrows) and Training 04 (MCH Training Program).

Updating terminology on the following 5 existing forms: Engaging Families and Other Individuals (formerly Engagement of Persons With Lived Experience), Training 07, Training 08, Training 09, and Former Long-Term Trainees.

The following 42 forms are included with no changes from the prior approved OMB package: Project Abstract, Project Abstract-Research Programs Only, Financial Form, Direct and Enabling Services, Training and Workforce Development, Partnerships and Collaboration, Technical Assistance, Outreach and Education, Research, Guidelines and Policy, Data and Information Systems, Quality Improvement and Evaluation, Knowledge Change, Behavior Change, Products and Publications, Form 10 (Program-Specific and Project Developed Measures), Training 14 (Medium-Term Trainees Skill and Knowledge), Training 15 (Consultation and Training for Mental and Behavioral Health), EMSC 04 (Emergency Department Pediatric Readiness Recognition Program), EMSC 08 (Established Permanence of EMSC), EMSC 09 (Established Permanence of EMSC by Integrating EMSC Priorities Into Statutes/Regulations), EMSC 10 (Prehospital Emergency Medical Services Pediatric Readiness Recognition Program), HS 04 (Intimate Partner Violence Screening), 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), HS 21 (Infant Mortality), Family to Family Form (F2F) 1, Faculty and Staff Information, Short-Term Trainees, Medium-Term Trainees, Long-Term Trainees, LEAP Trainee Information, and Healthy Start Site Form.

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.

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[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)

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.

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 maternal health, children's mental health, and supporting the MCH workforce) and demonstrate methods for improving care and outcomes for mothers and children; and
- **Community Integrated Service Systems (CISS)** grants that help states and communities build comprehensive, integrated systems of care to improve access and outcomes for all children, including children with special health care needs.

Special Projects of Regional and National Significance (SPRANS)

HRSA administers SPRANS programs to:

1) Respond to legislative set-asides and directives, including:
    a. **Oral Health:** Projects to improve access to integrated preventive oral health care for the MCH population.
    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 health, children's mental health and supporting the MCH workforce.
    a. **Maternal Health:** SPRANS funding is integral to reducing maternal mortality and morbidity and severe maternal morbidity by enabling states to implement high-impact, data-driven strategies through the State Maternal Health Innovation (State MHI) program. The State MHI program strengthens maternal health systems across the full continuum of care by improving access to high-quality healthcare services; enhancing maternal health data and surveillance to identify and address preventable deaths; and supporting innovative, evidence-informed interventions such as improving rural hospital readiness and standardizing safety practices for labor and delivery.

b. **Children's Mental Health:** SPRANS funding supports the mental health of children and youth in communities across the country through the Children's Safety Network (CSN), a national center that helps states and jurisdictions prevent suicide, self-harm, and other fatal or serious injuries among children and youth. CSN strengthens state capacity to identify emerging risks, implement evidence-based prevention strategies, and integrate mental health and injury prevention approaches across systems such as public health, education, and child welfare.
c. **Supporting the Maternal and Child Health (MCH) Workforce:** SPRANS funding plays a vital role in enhancing and expanding the MCH workforce in communities across the country. The National MCH Workforce Development Center, for example, partners with states and jurisdictions to tackle complex challenges through training, collaborative learning, coaching, and consultation. The Center has helped address challenges such as helping states develop connected and coordinated care for children and youth with special health care needs (CYSHCN) and creating models of multi-stakeholder collaboration to support perinatal women with substance use disorder.

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 only national and state level data source for key measures of health, well-being, and health care needs of American children 0-17 years old. 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.
- **Maternal and Child Health Training:** Projects to support targeted interdisciplinary professional training in areas such as behavioral health, nutrition, public health, and adolescent health.
- **Maternal and Child Health Research and Data**: Projects to support translational research to advance maternal and child health 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 help states and communities build comprehensive, integrated systems 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, which helps states improve access to, and quality of, preventive health and support services for women who are pregnant or families with young children.

Other Categorical Funding

Additional programs administered by MCHB under authorities outlined in the Public Health Service Act and the Social Security Act include:

- **Autism:** The Autism Education, Early Detection, and Intervention Program improves care and outcomes for children, adolescents, and young adults with autism and other developmental disabilities. HRSA does this primarily by: training health care professionals to screen, diagnose, refer, and provide services for children with autism and other developmental disabilities (DDs); using findings from our research investments to help people with autism and other DDs; and making sure that states use best practices to help youth with autism transition to adult services.
    - 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 2024 (Public Law 118-180).
- **Sickle Cell:** The Sickle Cell Disease Treatment Demonstration Program (SCDTDP) helps individuals with sickle cell disease (SCD) access quality, coordinated, and comprehensive care by building sickle cell disease care teams that extend specialty care from centrally based SCD experts in hospitals, clinics, or university health centers to the communities where people live.
    - Authorizing Legislation - Public Health Service Act, Section 1106 (42 USC 300b-5) as most recently reauthorized and amended by the Consolidated Appropriations Act of 2026 (P.L. 119-75).
- **Early Hearing Detection and Intervention:** The Early Hearing Detection and Intervention (EHDI) Program supports the development of comprehensive and coordinated state and territory early hearing detection and intervention systems of care. EHDI 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.
    - 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 works to save the lives of children by expanding access to, and improving the quality of, pediatric emergency medical care. This program helps emergency medical services (EMS) agencies and emergency departments (EDs) be optimally prepared to provide life-saving emergency medical care for children.

- 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 2024 (Public Law 118-178).

Healthy Start: The Healthy Start Program provides grants to support community-based strategies to reduce the rate of infant mortality and improve perinatal outcomes for women and children in high-risk communities throughout the nation.

- 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 portfolio works to reduce the morbidity and mortality in newborns and children caused by genetic disorders passed from parent to child. The portfolio supports state newborn screening systems (NBS) and local public health agencies so that birthing facilities and providers screening newborns can quickly identify, diagnose, and treat newborns with serious health conditions. Newborn screening saves or improves the lives of nearly 13,000 babies in the United States each year.
    - 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 (PMHCA) program promotes behavioral health integration in pediatric primary care by developing new, or expanding, statewide or regional pediatric mental health care access programs. Tele-consultation strategies, like the ones the PMHCA program supports, connect primary care providers with specialty behavioral health care providers. Participating providers also gain knowledge and increase their capacity/capability to address some behavioral concerns on their own, which over time will decrease the need for consultation. PMHCA increases access to behavioral health care by addressing the shortage of psychiatrists, developmental-behavioral pediatricians, psychologists, and other behavioral health clinicians who provide care to children and adolescents with behavioral concerns.
    - Authorizing Legislation – Public Health Service Act, Section 330M (42 U.S.C. Section 254c-19) as added by the 21st Century Cures Act, Section 10002 (Public Law 114-255), 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):** The Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD) program expands health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal mental health and substance use disorders. The program aims to improve the mental health and well-being of women who are pregnant, postpartum, or have given birth within the preceding 12 months.

    - Authorizing Legislation – Public Health Service Act, Section 317L-1 (42 U.S.C. 247b-13a), as added by the 21st Century Cures Act, Section 10005 (Public Law 114-255), and most recently reauthorized by the Consolidated Appropriations Act of 2023 (Public Law 117-328).

- **National Maternal Mental Health Hotline:** The National Maternal Mental Health Hotline program supports a national hotline (1-833-TLCMAMA) that provides 24/7 free, confidential, emotional support, resources, and referrals to pregnant and postpartum women facing mental health challenges and their loved ones.
    - Authorizing Legislation – Public Health Service Act, Section 399V-7 (42 USC 280g-18), as added by the Consolidated Appropriations Act of 2023 (P.L. 117-328).
- **Innovation for Maternal Health:** The Alliance for Innovation on Maternal Health (AIM) program improves maternal health and safety in the United States by increasing access to safe, reliable, and quality care, particularly through the implementation of patient safety bundles. These bundles are replicable sets of evidence-informed practices designed to address specific maternal health conditions and improve health outcomes.
    - Authorizing Legislation – Public Health Service Act, Section 330O (42 USC 254c-21), as added by the Consolidated Appropriations Act of 2022 (P.L. 117-103).
- **Integrated Services for Pregnant and Postpartum Women:** The Integrated Services for Pregnant and Postpartum Women program funds demonstration projects that coordinate services across providers to improve maternal health outcomes.

  Authorizing Legislation – Public Health Service Act, Section 330P (42 USC 254c-22), as added by the Consolidated Appropriations Act of 2022 (P.L. 117-103).
- **Family-to-Family Health Information:** The Family-to-Family Health Information Centers (F2F HICs) program offers families of children and youth with special health care needs (CYSHCN) peer support and information on accessing care and coverage for their children's complex needs. Staffed by family members of CYSHCN with first-hand experience navigating health care and other needed services and supports for their children, F2F HICs also advise health care professionals on developing more effective partnerships with families. The program aims to empower families of CYSHCN to be active partners in health care decision making.
    - 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), as extended by the Consolidated Appropriations Act of 2026 (P.L. 119-75).
- **Maternal, Infant, and Early Childhood Home Visiting:** The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports pregnant women and parents with young children who live in communities that face greater risk and barriers to achieving positive maternal and child health outcomes. The MIECHV Program builds upon decades of gold-standard scientific research showing that voluntary home visits by a nurse, social worker, or other trained professional during pregnancy and in the first years of life can improve the lives of children and families by helping to prevent

childhood and adult chronic disease and behavioral health conditions; supporting families to prevent child abuse and neglect; promoting child development and school readiness; and boosting families' economic self-sufficiency.

- Authorizing Legislation – Social Security Act, Section 511 (42 U.S.C. 711), most recently reauthorized and amended by Section 6101 of the Consolidated Appropriations Act of 2023 (P.L. 117-328).

Poison Control: The Poison Control program ensures that individuals can call a national toll-free Poison Help line (1-800-222-1222) to connect to a local poison control center (PCC) in an emergency. The program supports the national toll-free number to ensure access to poison control services; implements a national media campaign to educate and support outreach to the public and health care providers; and supports PCCs to help prevent and manage poisonings and toxic exposures and comply with accreditation requirements.

- Authorizing Legislation – Public Health Service Act, Sections 1271-1274, as most recently authorized and amended by the Poison Control Centers (PCC) Reauthorization Act of 2024 (P.L. 118-86).

Description of Reporting Forms

DGIS electronically captures data from 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 maternal and child health 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 produce 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 four categories: Basic 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 maternal and child health field. These detail sheets assure consistent understanding and reporting among all grantees and, when appropriate, allow for national data aggregation. In some cases, suggested 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)

These forms include other data requested by MCHB divisions and offices and capture 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 revisions are meant to remove 2 forms that are no longer needed, and update terminology in 5 of the existing forms.

Federal Uses of Information

The data and accompanying qualitative 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 maternal and child health populations; and to develop and justify efforts to advance MCHB-related agendas within states and communities.

Due to the breadth of grant categories administered by MCHB, the grant reporting forms and set of performance measures forms appear extensive. However, each grantee only responds to the forms that are applicable to their grant. In addition, the 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 and 508-compliant. 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. HRSA MCHB aligns demographic categories with Census Bureau, and Healthy Start measures align where possible with other national data collection efforts (e.g. Healthy People 2030 objectives and underlying data sources) to allow HRSA MCHB to understand how HRSA MCHB programs are performing against national averages. Benchmarking and relevant data sources are noted in the detail sheets provided with this package. 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

A limited number of small entities will complete this data collection each year. To reduce burden on grantees, pre-population between reports and the ability to download past reports is built into the DGIS module. In addition, when grantees complete their report, a validation checker enables them to easily identify what portions of the report need further attention before it can be submitted successfully to HRSA.

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

Section 8A:

A 60-day Federal Register Notice was published in the Federal Register on July 13, 2026, vol. 91, No. 132; pp. 42967-69. HRSA received one out-of-scope comment regarding drug testing, which this information collection does not cover.

A 30-day Federal Register Notice was published in the Federal Register on October 21, 2026, vol. 91, No. 202; pp. 66565-66.

Section 8B:

In 2025, HRSA MCHB conducted consultations with current MCHB discretionary grant recipients to obtain feedback on proposed revisions to selected DGIS forms. The pilot testing was designed to assess the clarity and usability of several proposed revisions, the appropriateness of response options and definitions, and the estimated burden associated with preparing, collecting, and reporting the requested information. Pilot testing began in October 2025 and concluded in December 2025. Fifty-five grantees representing multiple MCHB programs were invited to participate; 29 agreed to participate and 22 completed pilot testing. Consistent with Paperwork Reduction Act requirements, no more than nine grantees were recruited to pilot test any individual form. The consultation identified several recurring issues. Grantees requested additional clarification regarding reporting periods and certain definitions, raised questions about age-group categories and the potential for double counting, and identified challenges associated with reporting on services provided to families.

MCHB reviewed the feedback and identified recommended revisions. Straightforward issues, such as spelling, grammar, formatting, and certain requests for clarification, were addressed where feasible in the non-substantive change request approved by OMB on March 25, 2026. Some issues identified by grantees were not addressed in the current package because they are addressed through the DGIS reporting system or program-specific guidance. Other comments requiring broader policy or programmatic consideration were documented for MCHB reconsideration in a future OMB package. These included certain requests for extensive revisions to definitions and age-group categories.

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 (i.e., name, email address):

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

- Former Long-Term Trainee Form

This personally identifiable DGIS data is collected inside the HRSA EHB ecosystem and can only be accessed by HRSA employees using two factor authentication. A Privacy Impact Assessment and Security Impact Analysis for the EHB ecosystem is conducted by the HRSA Information Systems Security Officer (ISSO) to determine the extent to which changes to the information system have affected the security state of the system. The current EHB Privacy Impact Assessment ID is 1445978 and expires 11/19/2028.

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. Data are kept private to the extent allowed by law.

11. Justification for Sensitive Questions

MCHB has a programmatic need to collect demographic data in both aggregate and individual-level form. There are 9 DGIS forms that ask the respondent to provide this information. 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; Engaging Families and Other Individuals (formerly named Engagement of Persons with Lived Experience), Research; and Family to Family. While demographic data is not legislatively required by the programs that utilize these forms, it is needed to understand and show the impact of MCHB programs. Demographic data helps MCHB assess whom its programs serve, understand program outcomes and workforce impacts, including the career trajectories of Maternal and Child Health (MCH) trainees, and evaluate how programs are addressing the needs of MCH populations.

12. Estimates of Annualized Hour and Cost Burden

12A. Estimated Annualized Burden Hours

HRSA MCHB used past piloting of these forms conducted by contractual support in 2023 and 2025. The pilot testing ensured that a range of programs were assigned each form. The average burden per response was tested for each form using a group of nine or fewer grantees. This renewal package requests minor revisions to terminology within 5 forms, therefore will not impact the burden already calculated for each form. DGIS is expected to include approximately 817 unique grantees annually. Because each grantee completes only the forms applicable to its grant activities, a grantee may submit responses to multiple forms during the year.

Form Name	Location of Form	Number of Respondents	Responses per Respondent	Total Responses	Burden Hours per Response (in hours)	Total Burden Hours
Project Abstract	Attachment B, Central	817	1	817	1.33	1,087

Form Name	Location of Form	Number of Respondents	Responses per Respondent	Total Responses	Burden Hours per Response (in hours)	Total Burden Hours
	Forms					
Project Abstract (Research Programs Only)	Attachment B, Central Forms	58	1	58	0.66	38
Financial Form	Attachment B, Central Forms	817	1	817	0.87	711
Direct and Enabling Services	Attachment B, Central Forms	476	1	476	1.89	900
Training and Workforce Development	Attachment B, Central Forms	250	1	250	2.42	605
Partnerships and Collaboration	Attachment B, Central Forms	380	1	380	1.04	395
Engaging Families and Other Individuals	Attachment B, Central Forms	416	1	416	1.58	657
Technical Assistance	Attachment B, Central Forms	300	1	300	2.24	672
Outreach and Education	Attachment B, Central Forms	500	1	500	0.61	305
Research	Attachment B, Central Forms	65	1	65	3.11	202
Guidelines and Policy	Attachment B, Central Forms	78	1	78	0.70	55
Data and Information Systems	Attachment B, Central Forms	50	1	50	0.67	34
Quality Improvement and Evaluation	Attachment B, Central Forms	346	1	346	0.29	100
Knowledge Change	Attachment B, Central Forms	200	1	200	1.64	328

Form Name	Location of Form	Number of Respondents	Responses per Respondent	Total Responses	Burden Hours per Response (in hours)	Total Burden Hours
Behavior Change	Attachment B, Central Forms	200	1	200	1.56	312
Products and Publications	Attachment B, Central Forms	672	1	672	4.23	2,843
Training Form 07	Attachment C, Program Specific Forms	6	1	6	0.83	5
Training Form 08	Attachment C, Program Specific Forms	6	1	6	0.75	5
Training Form 09	Attachment C, Program Specific Forms	6	1	6	0.92	6
Training Form 14	Attachment C, Program Specific Forms	6	1	6	3.64	22
Training Form 15	Attachment C, Program Specific Forms	52	1	52	3.17	165
Faculty and Staff Information	Attachment D, Additional Data Elements	124	1	124	1.92	238
Short-Term Trainees	Attachment D, Additional Data Elements	8	1	8	0.67	5
Medium-Term Trainees	Attachment D, Additional Data Elements	121	1	121	2.49	301
Long-Term Trainees	Attachment D, Additional Data Elements	112	1	112	6.37	713

Form Name	Location of Form	Number of Respondents	Responses per Respondent	Total Responses	Burden Hours per Response (in hours)	Total Burden Hours
Former Long-Term Trainees	Attachment D, Additional Data Elements	106	1	106	1.60	170
LEAP Trainee Information	Attachment D, Additional Data Elements	6	1	6	0.65	4
HS 04	Attachment C, Program Specific Forms	101	1	101	0.57	58
HS 10	Attachment C, Program Specific Forms	101	1	101	0.31	31
HS 11	Attachment C, Program Specific Forms	101	1	101	0.61	62
HS 12	Attachment C, Program Specific Forms	101	1	101	0.33	33
HS 13	Attachment C, Program Specific Forms	101	1	101	0.50	51
HS 14	Attachment C, Program Specific Forms	101	1	101	0.43	43
HS 15	Attachment C, Program Specific Forms	101	1	101	0.45	45
HS 16	Attachment C, Program Specific Forms	101	1	101	0.39	39
HS 17	Attachment C, Program Specific Forms	101	1	101	0.40	40

Form Name	Location of Form	Number of Respondents	Responses per Respondent	Total Responses	Burden Hours per Response (in hours)	Total Burden Hours
HS 18	Attachment C, Program Specific Forms	101	1	101	0.33	33
HS 19	Attachment C, Program Specific Forms	101	1	101	0.38	38
HS 20	Attachment C, Program Specific Forms	101	1	101	0.37	37
HS 21	Attachment C, Program Specific Forms	101	1	101	0.36	36
Healthy Start Site Form	Attachment D, Additional Data Elements	101	1	101	0.32	32
EMSC 04	Attachment C, Program Specific Forms	58	1	58	0.92	53
EMSC 08	Attachment C, Program Specific Forms	58	1	58	0.09	5
EMSC 09	Attachment C, Program Specific Forms	58	1	58	0.42	24
EMSC 10	Attachment C, Program Specific Forms	58	1	58	0.46	27
Family to Family 1	Attachment C, Program Specific Forms	59	1	59	2.76	163
Form 10	Attachment B, Central Forms	200	2	400	12.87	5,148
TOTAL		**817***		**8,283**		**16,876**

* The 817 respondents represent the estimated unduplicated number of grantees in the respondent universe. Individual grantees may be assigned multiple DGIS forms based on their program activities; therefore, form-level respondent counts are not additive. Total annual responses across all forms are 8,283.

** Total burden hours are rounded to the nearest whole number.

12B. Estimated Annualized Burden Costs

The estimated total annual cost to respondents is approximately $1,067,575.76. This cost to respondents is based on the median wage of healthcare practitioners and technical workers (occupation code 29-9099), multiplied by 2 to account for overhead costs (for a total adjusted median wage of $63.26 per hour). Estimates come from the May 2025 Bureau of Labor Statistics report on Wage Estimates (retrieved from https://data.bls.gov/oesprofile/?major_group=290000&occupation=299099&measure=01&areas=INDUSTRY,STATE,MSA).

Type of Respondent	Total Burden Hours	Hourly Median Wage Rate	Adjusted Median Wage Rate	Total Respondent Costs
Healthcare Practitioners and Technical Workers	16,876	$31.63	$63.26	$1,067,575.76

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 $153,170.01. 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 $1,153,170.01.

15. Explanation for Program Changes or Adjustments

The current inventory for this activity is 17,615. The proposed revisions will result in 16,876 annual burden hours, a reduction of 739 burden hours compared to the currently approved collection. The reduction in burden hours is due to the Health Equity and Training 02 forms being removed in previous non-substantive packages to align with administration priorities and Training 03 (Healthy Tomorrows) and Training 04 (MCH Training Program) forms being removed in this package. Most programs continue to

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 times throughout the year depending on the program for which the grantee is reporting. DGIS data are summarized by program and may be used to inform programmatic decision making and public dissemination of information about program impact. Currently, tabulated DGIS data are not public. When the need arises to provide aggregate DGIS data to HRSA MCHB evaluation contractors, a Data Use/Sharing Agreement is required which ensures use of DGIS data is for intended purposes only and used with appropriate data protections. PII is never provided outside of HRSA MCHB. HRSA MCHB plans to develop a Public Use File (PUF) containing select DGIS data beginning in 2027 (once complete fiscal year 2025 data have been fully reported by grantees). Once complete, the PUF will be posted to the HRSA Data Warehouse at data.hrsa.gov. Prior to posting, the HRSA Data Disclosure Review Board (DDRB) will review and approve the file's release. Subsequently, HRSA MCHB plans to release a PUF annually to reflect the most recent year of data.

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

Attachment A **Crosswalk of Form Changes**

Attachment B **Central Forms**

Attachment C **Program-Specific Forms**

Attachment D **Additional Data Elements**