United States Government Accountability Office

Report to Congressional Committees

March 2024

MATERNAL AND INFANT HEALTH

HHS Should Strengthen Processes for Measuring Program Performance

GAO-24-106605

March 2024

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HHS Should Strengthen Processes for Measuring Program Performance

GAO Highlights

Highlights of GAO-24-106605, a report to congressional committees

Why GAO Did This Study

The Healthy Start program awards funding to organizations in areas with high rates of infant death and other adverse maternal and infant health outcomes. In fiscal year 2022, the Healthy Start program received $131 million in appropriations.

The CARES Act included a provision for GAO to review and assess Healthy Start. This report: describes Healthy Start grantees and participants served, examines HHS's efforts to assess progress towards Healthy Start goals, examines the extent to which Healthy Start performance measures meet key attributes of effective measures, and examines HHS' efforts to align Healthy Start performance measures with those of related HHS programs.

GAO analyzed Healthy Start and other HHS program documentation and data for the most recent grant period (April 2019–March 2024) and the upcoming period (beginning April 2024), including performance measure information. GAO also interviewed HHS officials and six Healthy Start grantees, selected to vary by factors such as geography and years as a grantee.

What GAO Recommends

GAO is making two recommendations. HHS should implement documented processes to 1) review Healthy Start performance measures to ensure they are clear and allow for the collection of reliable data, and 2) coordinate the selection of performance measures across Healthy Start and related programs. HHS partially agreed with the first recommendation and agreed with the second. GAO maintains the recommendations are warranted, as discussed in the report.

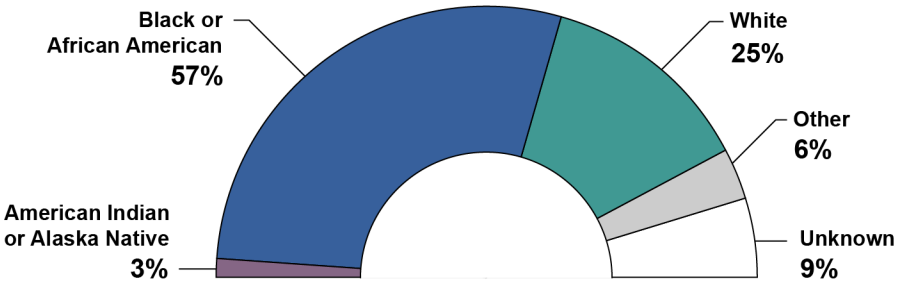
View GAO-24-106605. For more information, contact Mary Denigan-Macauley, (202) 512-7114 or deniganmacauleym@gao.gov.

What GAO Found

The U.S. has the highest rates of maternal and infant death of developed, high-income countries. The Healthy Start program, administered by the Department of Health and Human Services (HHS), has three goals: reduce rates of infant death, improve maternal health outcomes, and reduce racial and ethnic disparities.

HHS funded 101 Healthy Start grantees—e.g., health departments and not-for-profit organizations—in the 2019-2024 grant period. In 2022, grantees served nearly 85,000 participants, including pregnant women, partners, and children. Slightly more than half of participants were Black or African American. Grantees are expected to provide one-on-one consultation and health and parenting education classes, as well as connect participants with medical services.

Percentage of Healthy Start Participants by Race in 2022



Source: GAO analysis of Health Resources and Services Administration data. | GAO-24-106605

Note: "Other" includes Asian, Native Hawaiian or other Pacific Islander, and multiple races.

HHS uses performance data to assess progress toward the first two of Healthy Start's three goals. It has plans to begin stratifying these data by race and ethnicity in 2024 to assess progress toward the third goal: reducing racial and ethnic disparities. HHS is also conducting an evaluation, to be completed in 2025, to assess program progress toward all three goals.

Healthy Start data to measure program performance—known as performance measures—align with most GAO-identified key attributes of effective measures. However, the measures do not align with two attributes related to clarity and reliability. For example, HHS's updates to the measures during the 2019-2024 grant period made it challenging for grantees to collect consistent and therefore reliable data. This occurred because HHS lacks a documented process to review its performance measures before implementation. Such a process would help ensure HHS is using measures that are clear and allow for the collection of reliable data.

Also, HHS officials said they try to align performance measures across Healthy Start and two related programs. However, HHS lacks a documented process to coordinate the selection of measures used across the programs, and officials could not provide examples of coordination. Implementing a documented process could help ensure that HHS is using the most appropriate measures. Ultimately, this could help HHS gather the best evidence across the programs as they pursue the shared goal of improving health outcomes for mothers and infants.

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Abbreviations

CDC	Centers for Disease Control and Prevention
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
MIECHV	Maternal, Infant, and Early Childhood Home Visiting program
Title V	Title V Maternal and Child Health Services Block Grant program

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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March 27, 2024

The Honorable Bernard Sanders
Chair
The Honorable Bill Cassidy, M.D.
Ranking Member
Committee on Health, Education, Labor and Pensions
United States Senate

The Honorable Cathy McMorris Rodgers
Chair
The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

The U.S. has the highest rates of maternal death—death from complications related to pregnancy or childbirth—and infant mortality of developed, high-income countries. The U.S. faces a maternal mortality crisis. In 2021, 1,205 women died from complications related to pregnancy or childbirth in the U.S, according to data from the Centers for Disease Control and Prevention (CDC).[1] In 2022, about 20,000 babies died before their first birthday in the U.S., and the infant mortality rate rose for the first time in 20 years to 5.6 infant deaths per 1,000 live births, up from 5.4 in 2021.

Further, these adverse maternal and infant health outcomes are disproportionately higher among certain groups, such as people who identify as Black or African American and American Indian or Alaska

[1]Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2021*, Health E-Stats, (Hyattsville, Md.: National Center for Health Statistics, 2023.) https://doi.org/10.15620/cdc:124678. A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes, according to the World Health Organization.

Native.[2] We and others have previously reported on adverse maternal and infant health outcomes and disparities across racial and ethnic groups. For example, in 2022, we reported that preterm and low birthweight births—leading causes of infant deaths— increased during the COVID-19 pandemic. We also reported that there were persistent disparities in these adverse outcomes for people who identify as Black or African American.[3]

The Healthy Start program was originally established in 1991 and administered by the Health Resources and Services Administration (HRSA), within the Department of Health and Human Services (HHS), as a demonstration project to improve maternal and infant health outcomes.[4] The program has three goals: (1) reduce the rate of infant deaths; (2) improve maternal health outcomes before, during, and after pregnancy; and (3) reduce racial and ethnic disparities in rates of negative maternal and infant health outcomes.[5]

Healthy Start offers 5-year grants to organizations serving communities with infant mortality rates at least 1.5 times the national average and high rates of other adverse perinatal outcomes, such as low birthweight births,

[2]The maternal mortality rate for Black or African American women was 69.9 per 100,000 live births in 2021, significantly higher than the rates for White and Hispanic women (26.6 and 28.0 per 100,000 live births respectively), according to the CDC. See Hoyert, D.L., *Maternal Mortality Rates in the United States, 2021.* Infant mortality rates were higher among Black or African American and American Indian or Alaska Native people compared to people of other races and Hispanic people, according to provisional 2022 CDC data. Specifically, the infant mortality rates per 1,000 live births were as follows: American Indian or Alaska Natives, 9.06; Asians, 3.50; Black or African Americans, 10.86; Hispanic, 4.88; and White 4.52. Danielle M. Ely and Anne K. Driscoll. *Infant Mortality in the United States: Provisional Data from the 2022 Period Linked Birth/Infant Death File,* Vital Statistics Rapid Release, no 33 (Hyattsville, Md.: National Center for Health Statistics, 2023). https://doi.org/10.15620/cdc:133699.

[3]GAO, *Maternal Health: Outcomes Worsened and Disparities Persisted During the Pandemic*, GAO-23-105871 (Washington, D.C.: Oct. 19, 2022). The five leading causes of infant death in 2021 were birth defects, preterm birth and low birthweight, sudden infant death syndrome, unintentional injuries (e.g., suffocation), and maternal pregnancy complications, according to the CDC.

[4]A demonstration project is a small-scale project that tests the viability of implementing a project on a larger scale. Following the demonstration period, the Healthy Start program was authorized as part of the Children's Health Act of 2000. Pub. L. No. 106-310, § 1501, 114 Stat. 1101, 1146. It has been reauthorized in years since, with the most recent reauthorization in 2020 as part of the CARES Act. Pub. L. No. 116-136, § 3225, 134 Stat. 281, 381 (2020) (codified at 42 U.S.C. § 254c-8).

[5]HRSA officials said that these goals are based on the Healthy Start statute.

preterm births, and maternal mortality.[6] In the most recent grant period (2019-2024), HRSA funded 101 grantees. Grantees received about $1 million per year, or about $5 million over the 5-year period.[7]

Healthy Start grantees—which include local health departments and community-based organizations—serve women of reproductive age, pregnant women, fathers and partners, and children (up to 18 months).[8] In this report, we refer to these individuals as Healthy Start "participants." Grantees aim to tailor activities to their local communities' needs. Healthy Start grantees are required to collect and regularly submit program performance information to HRSA, including performance measure data. Performance measure data are data on concrete, objective, observable conditions that permit HRSA to assess progress towards program goals.

Healthy Start is one of several grant programs that aim to improve maternal and infant health outcomes and are funded by HRSA. The legislation reauthorizing Healthy Start in March 2020 also directs HHS to coordinate Healthy Start with other programs that aim to reduce infant mortality and improve perinatal and infant health outcomes.[9]

The CARES Act included a provision for GAO to review and assess the Healthy Start Program.[10] This report

1. describes Healthy Start grantees and the participants they serve,

[6]HRSA is charged with improving access to health care services for people in the U.S. who are geographically isolated, economically or medically vulnerable. Within HRSA, the Maternal and Child Health Bureau, which administers the Healthy Start program, aims to improve the health and well-being of mothers, children, and families.

[7]In fiscal year 2022, the Healthy Start program received $131 million in appropriations. The majority of this funding was used for the Healthy Start program grants which are the focus of this report. However, some funding was used for other activities per Congressional directive, according to HRSA officials. For example, in fiscal year 2022, HRSA made awards for the Catalyst for Infant Health Equity grant, which expects grantees to implement plans to reduce infant mortality in their communities.

[8]We use the term "women" in this report because HRSA uses it to describe the people served by Healthy Start and related programs, but acknowledge this term does not include all people who may become pregnant, such as people who do not identify as either male or female, and some transgender men.

[9]See Pub. L. No. 116-136, § 3225, 134 Stat. at 382 (codified at 42 U.S.C. § 254c-8(c)(2)).

[10]Pub. L. No. 116-136, § 3225, 134 Stat. at 382 (2020) (codified at 42 U.S.C. § 254c-8(f)).

2. describes the services Healthy Start grantees are expected to provide,
3. examines HRSA's efforts to assess progress towards Healthy Start program goals,
4. examines the extent to which Healthy Start performance measures meet key attributes of effective measures, and
5. examines HRSA's efforts to align Healthy Start performance measures with those of related HHS programs.

To describe Healthy Start grantees and the participants they serve, we analyzed HRSA Healthy Start program data and documentation and spoke with agency officials. Specifically, we analyzed program grantee data from the current grant period (April 2019-March 2024). We analyzed these data to examine the grantee organization types; length of time as a grantee; geographic area they reported serving (urban, rural, or tribal); and the race, ethnicity, and number of participants served. Our analysis of participants was limited to calendar year 2022, the most recent data available. To assess the reliability of the data we reviewed publicly available information on the data, such as HRSA's list of grantees; manually reviewed the data for data quality issues; and interviewed HRSA officials about the data. Based on these steps, we found these data to be reliable for reporting on Healthy Start grantees and the participants they serve.

To describe the services that Healthy Start grantees are expected to provide, we reviewed HRSA Healthy Start program documentation and spoke with selected grantees. Specifically, we reviewed the Healthy Start Notice of Funding Opportunities for the 2019-2024 and 2024-2029 grant periods, which discuss HRSA's expectations on the services grantees should provide in each grant period.[11] We interviewed HRSA officials on these topics. We also interviewed a non-generalizable sample of six grantees, which included two state or local health departments, three not-for-profit organizations, and one tribal organization. We selected these grantees to achieve variation in the following characteristics: geography; reported service of urban, rural, and tribal areas; number of years as a Healthy Start grantee; grantee progress on performance measures; and whether the grantee also received funding from a program related to Healthy Start. We interviewed officials, including project directors and

[11]A *Notice of Funding Opportunity* is a public document that outlines the requirements for grant applications and how applications will be evaluated.

evaluators, at these six grantee organizations. The perspectives offered by our selected grantees are not generalizable beyond those grantees.

To examine HRSA's efforts to assess progress towards Healthy Start program goals, we reviewed Healthy Start program performance documentation and data. Specifically, we reviewed birth outcome and performance measure data for calendar years 2019 through 2021—the most recent available data at the time of our review—as reported by HRSA. We also reviewed reports from 2020 and 2021, the most recently available reports at the time of our review, from the Healthy Start Technical Assistance and Support Center for grantee-level performance measure data.[12] We interviewed and obtained written responses from HRSA officials on the performance information the agency collects and how they use such information to assess overall program performance. We assessed HRSA's efforts against a GAO-identified key step for effective performance management. Specifically, our past work has defined performance management as a three-step process by which organizations (1) set goals to identify the results they seek to achieve, (2) collect performance information to measure progress, and (3) use that information to assess results and inform decisions to ensure further progress towards achieving those goals.[13]

To examine the extent to which Healthy Start performance measures meet key attributes of effective measures, we reviewed Healthy Start performance measure documentation. This documentation included the forms used to collect performance measure data from grantees and the data dictionary, which documents the methodology to calculate performance measures. We also reviewed the *Notice of Funding Opportunity* for the 2024-2029 grant period to understand HRSA's planned changes to performance measures from those used in the 2019-2024 grant period. We also reviewed HRSA's summary of grantee listening sessions the agency held in October 2022. We reviewed written comments about Healthy Start performance measures that HRSA received from grantees and other stakeholders in response to the agency's public request for comments in January 2023. We interviewed and obtained written responses from HRSA officials on changes made to

[12]The Healthy Start Technical Assistance and Support Center is operated by the National Institute for Children's Health Quality, a not-for-profit organization that receives funding from HRSA to provide training and support to Healthy Start grantees.

[13]See GAO, *Evidence-Based Policymaking: Practices to Help Manage and Assess the Results of Federal Efforts*, GAO-23-105460 (Washington, D.C.: July 12, 2023).

the Healthy Start performance measures for the 2024-2029 grant period. Additionally, we interviewed the six selected grantees to understand how grantees use the performance measure data to assess their program's performance and any challenges associated with this. We assessed the Healthy Start performance measures—including the description of the measures, associated data collection forms, and data dictionary—against select GAO-identified key attributes of effective performance measures. These key attributes are that performance measures should cover core program activities, align with program goals, be objective, have limited overlap, be clear, and be reliable.[14] We also compared HRSA's efforts to Federal Standards for Internal Control which state that management should document responsibilities through policies.[15]

To examine HRSA's efforts to align Healthy Start performance measures with those of related HHS programs, we first identified other maternal and child health programs in HHS related to Healthy Start. To do this, we reviewed the *White House Blueprint for Addressing the Maternal Health Crisis*, HRSA documentation, and previous GAO reports to identify HHS-administered programs for maternal and child health.[16] We reviewed HHS documentation on the goals, funding, and services of these programs. We considered a program "related" to Healthy Start if it had similar goals or aims and it offered direct services to people participating in the program. We confirmed with HRSA officials that these programs were related to Healthy Start, given our definition, and that we were not missing any other related programs. Once we identified related programs, we reviewed the programs' performance measure documentation, such as data dictionaries. We interviewed and obtained written responses from agency officials to understand their efforts to align the performance measures

[14]Our prior work identified nine key attributes of effective performance measures. In this report, we focus on these six, because we determined these attributes to be the most relevant to the Healthy Start program and achievement of program goals. The three others are measurable target, balance, and governmentwide priorities. For more information on the key attributes, see GAO, *Tax Administration: IRS Needs to Further Refine Its Tax Filing Season Performance Measures*, GAO-03-143 (Washington, D.C.: Nov. 22, 2002).

[15]According to federal internal control standards for control activities, management should document in policies for each unit its responsibility for an operational process's objectives and related risks, and control activity design, implementation, and operating effectiveness. See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

[16]The blueprint outlines various actions the federal government is undertaking or plans to undertake to improve maternal health, including several efforts from HHS and its component agencies. See The White House, *White House Blueprint for Addressing the Maternal Health Crisis* (Washington, D.C.: June 2022).

across programs. We assessed HRSA's efforts against our prior work and guidance from the Office of Management and Budget on evidence-based policymaking within and across agencies. Both of these emphasize the importance of coordinating evidence-building activities, such as selecting performance measures.[17] Such coordination is emphasized in the law reauthorizing Healthy Start, which directs HHS to coordinate Healthy Start with other programs that aim to reduce infant mortality and improve perinatal and infant health outcomes.[18] Further, our work on evidence-based policymaking, as well as our work on leading practices for enhanced collaboration, emphasize that documenting collaborative efforts can strengthen the commitment of coordinating parties, among other potential benefits.[19]

We conducted this performance audit from February 2023 to March 2024 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Maternal and Infant Health Disparities

Adverse maternal and infant health outcomes are disproportionately higher among certain groups, such as people who identify as Black or African American and those who identify as American Indian or Alaska Native. We and others have conducted work on health disparities and differences based on social determinants of health:

- **Health disparities.** These are preventable differences in the burden of disease, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other populations. We have previously reported on racial and ethnic disparities in health outcomes, and factors that contribute to such disparities, including for

[17]See GAO-23-105460 and Office of Management and Budget, *Evidence-Based Policymaking: Learning Agendas and Annual Evaluation Plans*, OMB-M-21-27 (Washington, D.C.: June 30, 2021).

[18]See Pub. L. No. 116-136, § 3225, 134 Stat. at 382 (2020) (codified at 42 U.S.C. § 254c-8(c)(2)).

[19]See GAO-23-105460 and GAO, *Government Performance Management: Leading Practices to Enhance Interagency Collaboration and Address Crosscutting Challenges*, GAO-23-105520 (Washington, D.C.: May 24, 2023).

maternal and infant health.[20] We have also reported that people who identify as Black or African American and American Indian or Alaska Native are at a greater risk of dying from chronic conditions, such as diabetes, that can be prevented compared to other Americans.[21]

- **Social determinants of health.** These are nonmedical factors that influence health outcomes. They are the conditions in the environments in which people are born, live, learn, work, play, worship, and age. Examples include access to housing and healthy food, educational and job opportunities, and exposure to pollution. These conditions affect a wide range of health outcomes and risks, according to HHS.[22] Further, social determinants of health are key drivers of health disparities and place communities of color at greater risk for poor health outcomes, according to CDC documentation.[23]

  Research has shown that social determinants of health are associated with adverse maternal health outcomes. For example, studies suggest that factors such as lower education or exposure to pollution are associated with a higher risk of maternal death and morbidity.[24] Similarly, we have reported that certain health system factors (such as lack of access to care), socioeconomic factors (such as being uninsured or having Medicaid coverage), and patient factors (such as chronic health conditions or older age) affect maternal health outcomes. Several of these disproportionately affect certain populations, including Black women and women in rural and underserved areas, leading to health disparities.[25]

Related Maternal and Child Health Programs

Our review identified, and HRSA officials confirmed, two programs related to Healthy Start: (1) the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV) and (2) the Title V Maternal and Child Health

[20]GAO-23-105871.

[21]GAO, *Chronic Health Conditions: Federal Strategy Needed to Coordinate Diet-Related Efforts*, GAO-21-593 (Washington, D.C.: Aug. 17, 2021).

[22]See Department of Health and Human Services, *Social Determinants of Health*, accessed November 7, 2023, https://health.gov/healthypeople/priority-areas/social-determinants-health.

[23]See Centers for Disease Control and Prevention, *Racism and Health,* accessed November 7, 2023, https://www.cdc.gov/minorityhealth/racism-disparities/index.html.

[24]For example, see Eileen Wang, et al., "Social Determinants of Pregnancy-Related Mortality and Morbidity in the United States: A Systematic Review," *Obstetrics & Gynecology*, vol. 135, no. 4 (April 2020): 896-915.

[25]GAO-23-105871.

Services Block Grant Program (Title V). Like Healthy Start, both programs fall within the Maternal and Child Health Bureau of HRSA.

- **MIECHV** provides grants to all 50 states and six other jurisdictions to provide home visits to families (pregnant people and parents with children up to kindergarten entry age) in the early childhood period.[26] It aims to improve maternal and child health, prevent child abuse and neglect, and promote children's development and school readiness. By law, MIECHV prioritizes serving low-income families, and families that have a history of substance abuse, child abuse or neglect, or have had interactions with child welfare services, among other factors.[27] In fiscal year 2023, MIECHV had a $500 million budget.
- **Title V** provides a block grant to all 50 states and nine other jurisdictions to fund public health systems and a variety of activities that support grantees' maternal and child health priorities.[28] Among other goals, Title V aims to improve rates of infant or maternal mortality. In fiscal year 2023, Title V had a $593 million budget.[29]

MIECHV and Title V have similar goals as Healthy Start: to improve maternal and infant health outcomes. They also deliver services to pregnant women and their families, some of which are similar to those

[26]The six other jurisdictions are the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. When a state declines funding, a MIECHV grant may be made competitively to a not-for-profit organization acting on behalf of the state, according to HRSA officials. Additionally, for fiscal year 2023 six percent of MIECHV's annual funding is used for cooperative agreements awarded to tribal organizations to provide home visits to American Indian and Alaska Native children and families. The Administration for Children and Families administers these tribal cooperative agreements.

[27]See 42 U.S.C. § 711(b).

[28]According to HRSA officials, this block grant supports the basic public health infrastructure for maternal and child health in each state and the nine other jurisdictions: American Samoa, District of Columbia, the Federated States of Micronesia, Guam, the Marshall Islands, the Northern Mariana Islands, Palau, Puerto Rico, and the U.S. Virgin Islands. As part of the grant, each grantee is required to conduct an extensive needs assessment and use that assessment to make decisions on their priorities for fund use. By law, grantees must devote at least 30 percent of the funding they receive to primary and preventive care for children, and another 30 percent to children with special health care needs. See 42 U.S.C. § 705(a)(3). Examples of activities that grantees use Title V funding for include conducting child death reviews and developing statewide programs to prevent child deaths; supporting statewide screenings to detect for genetic issues; and developing systems to identify (and then provide coordinated care for) children with special health needs, according to HRSA officials.

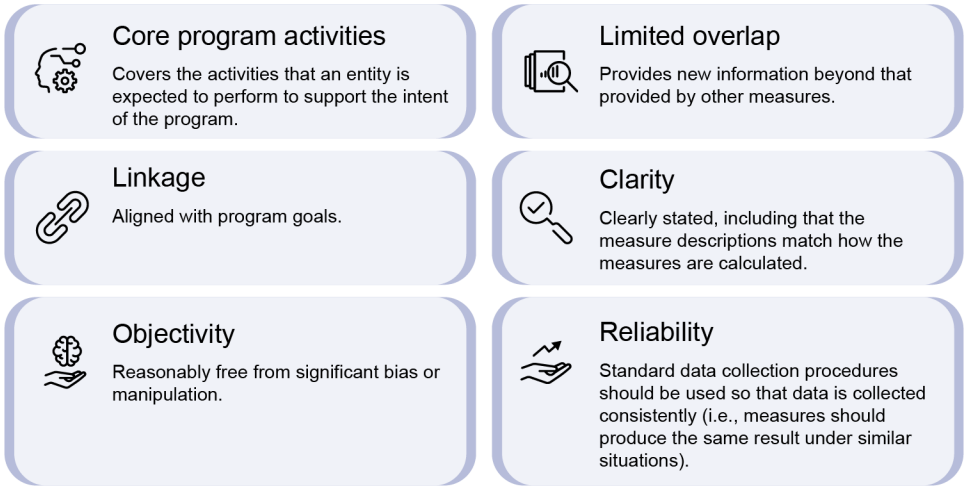
[29]Title V grants require grantees to match every $4 provided by the federal government by at least $3.

provided by Healthy Start. For example, all three programs' grantees may provide services, such as home visits, health education, and health screenings. Grantees may also have safe sleep and breastfeeding initiatives. For more on these programs and their goals, similarities and differences, please see appendix I.

Key Attributes of Effective Performance Measures

In our prior work, we found that measuring performance allows organizations to track the progress they are making toward their goals and gives managers critical information on which to base decisions for improving their programs. In that past work we identified key attributes for assessing performance measures, which include: core program activities, linkage, objectivity, limited overlap, clarity, and reliability.[30] (See Figure 1.)

Figure 1: Select GAO-Identified Key Attributes for Effective Performance Measures



Source: GAO; RaulAlmu/stock.adobe.com (illustrations). | GAO-24-106605

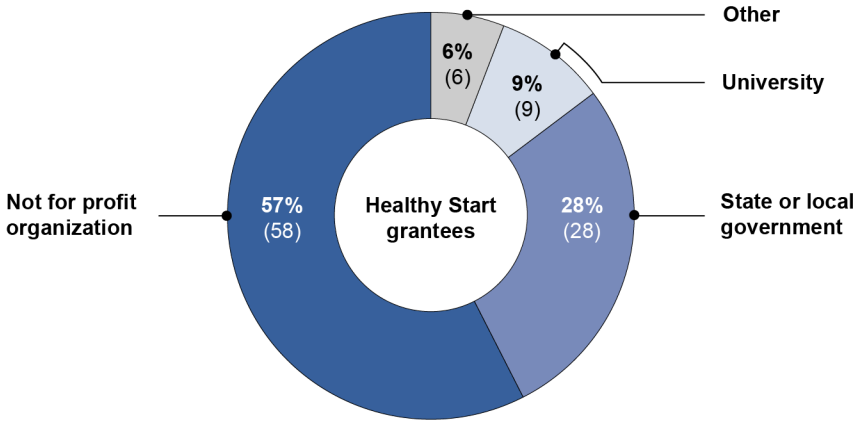
[30]Our prior work identified nine key attributes for assessing performance measures. In this report, we focus on these six. The three others are measurable target, balance, and governmentwide priorities. See GAO-03-143.

Healthy Start Grantees Vary by Organization Type, Location, Length of Time as Grantee, and Participants Served

HRSA data show the Healthy Start program's 101 grantees that received HHS funding in the 2019-2024 grant period varied across a number of characteristics including: organization type; geographic location (including whether they reported serving rural, urban, or tribal areas); length of time as a grantee; and the total number, as well as race and ethnicity, of participants they serve. These 101 grantees were selected from the 145 eligible applications HRSA received, using a multi-step process, according to agency officials. These steps include establishing that applications are complete, rating the applications, and making final award decisions. Additional details on the multi-step evaluation process are available in appendix II.

Organization type. A little more than half of grantees (57 percent) are not-for-profit organizations, though grantees also include state and local governments, and universities. (See figure 2.) The not-for-profit organizations include those that provide health care services, such as health centers and hospital systems, as well as organizations that focus on certain aspects of improving community health. For example, several not-for-profit grantees are organizations focused on improving maternal and infant health and one is a state rural health association. State or local governments, which make up 28 percent of grantees, include boards of health or health departments.

Figure 2: Healthy Start Grantees for 2019-2024 Grant Period (Number and Percentage of Total), by Organization Type



Source: GAO analysis of Health Resources and Services Administration program data. | GAO-24-106605

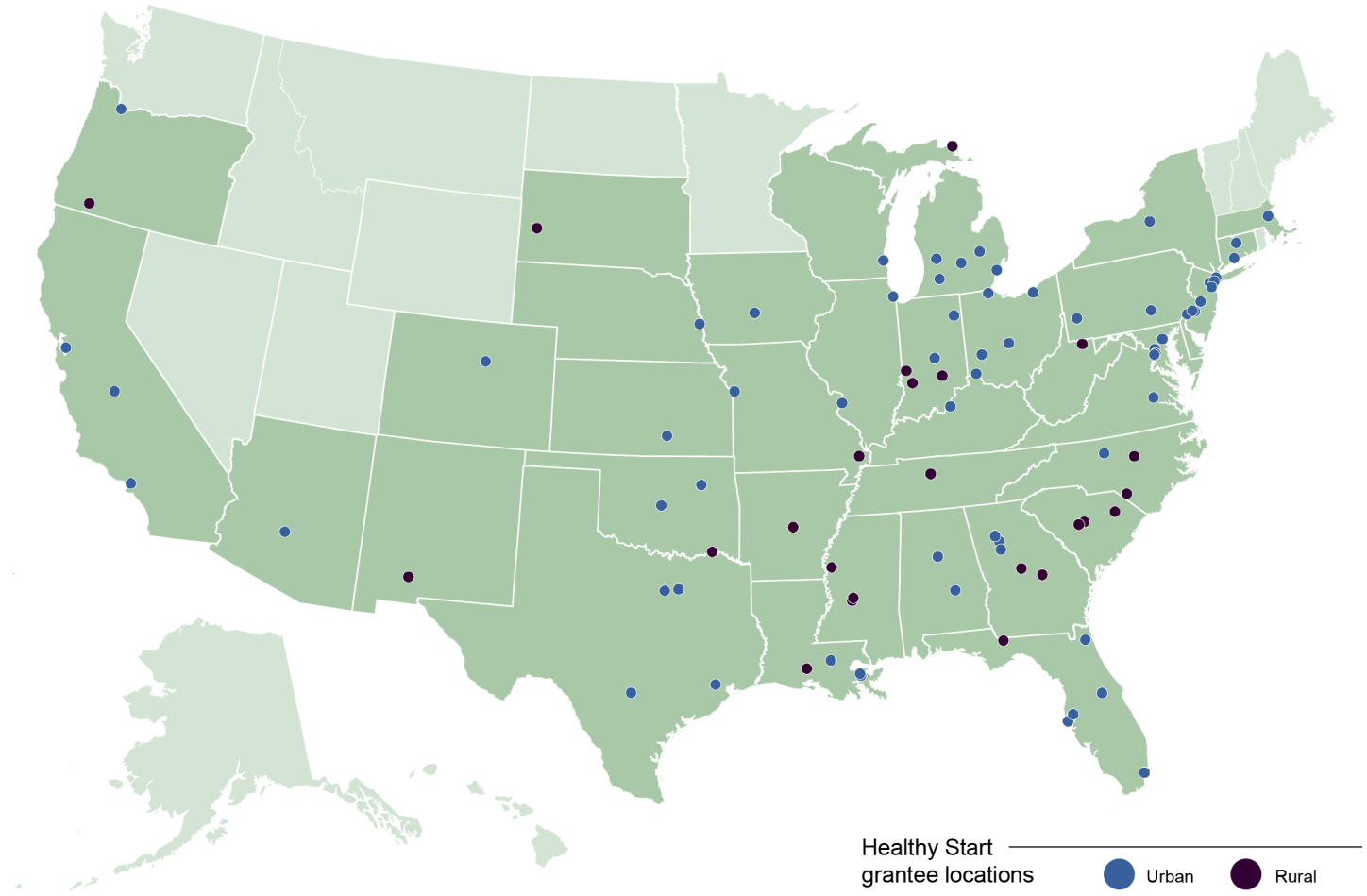
Note: Grantees can make sub-awards to other organizations, including for the purposes of providing services to Healthy Start participants, such as case management and education. As a result, the type of organization receiving the grant may not be the same as the type providing services. Health Resources and Services Administration (HRSA) officials told us they do not track sub-award recipients. "Other" is a category used by organizations to indicate not fitting into other categories.

Since Healthy Start grantees can make sub-awards to other organizations, the type of organization receiving the grant may not be the same type of organization providing direct services to Healthy Start participants.[31] For example, the government of the District of Columbia was awarded a Healthy Start grant in 2019 and made sub-awards to two not-for-profit health centers that provide services to Healthy Start participants.

Geographic location. Healthy Start grantees are located in 35 states and the District of Columbia. (See figure 3.) About one-third of states have one grantee, half of states have two to five grantees, and five states—Florida, Georgia, Michigan, New York, and Pennsylvania—have six grantees, the maximum number that HRSA awards per state. In addition, nearly one-quarter of grantees (24 of 101) reported primarily serving rural areas, including two that also serve tribal areas. The remaining grantees reported primarily serving urban areas.

[31]HRSA officials told us they do not track sub-award recipients. Because of this limitation, we were not able to report on sub-awards, such as the number and the amount of funding.

Figure 3: Locations of Healthy Start Grantees for 2019-2024 Grant Period, by Rurality



Source: GAO analysis of Health Resource and Services Administration (HRSA) program data. | GAO-24-106605

Note: Rurality (e.g, urban or rural) is reported by grantees as the primary type of location served. Additionally, three grantees serve people in different locations than where the grantee is located by making sub-grants to partner organizations that provide services. One grantee is located in Virginia but serves people in Puerto Rico; another grantee is located in Maryland but serves people in California. One grantee located in South Dakota and serves participants in three states: Nebraska, South Dakota, and North Dakota.

Length of time as grantee. Grantees are nearly split in terms of being either a long-time grantee or a more recent grantee. Specifically, as of 2023, nearly half of Healthy Start grantees (46 percent) had been grantees of the program for more than 20 years, including eight grantees

that took part in the program's first grant period.[32] In contrast, 42 percent of grantees had been grantees for 10 or fewer years, including 16 percent that were grantees for the first time. The remaining 13 percent have been grantees for 11 to 20 years.

Participants served. In 2022, the third full year of the 2019-2024 grant period and the most recent year of program data available at the time of our review, Healthy Start grantees served an average of 841 participants. However, individual grantees served anywhere from 90 to 2,512 participants. In total, the Healthy Start grantees reported cumulatively serving nearly 85,000 participants.

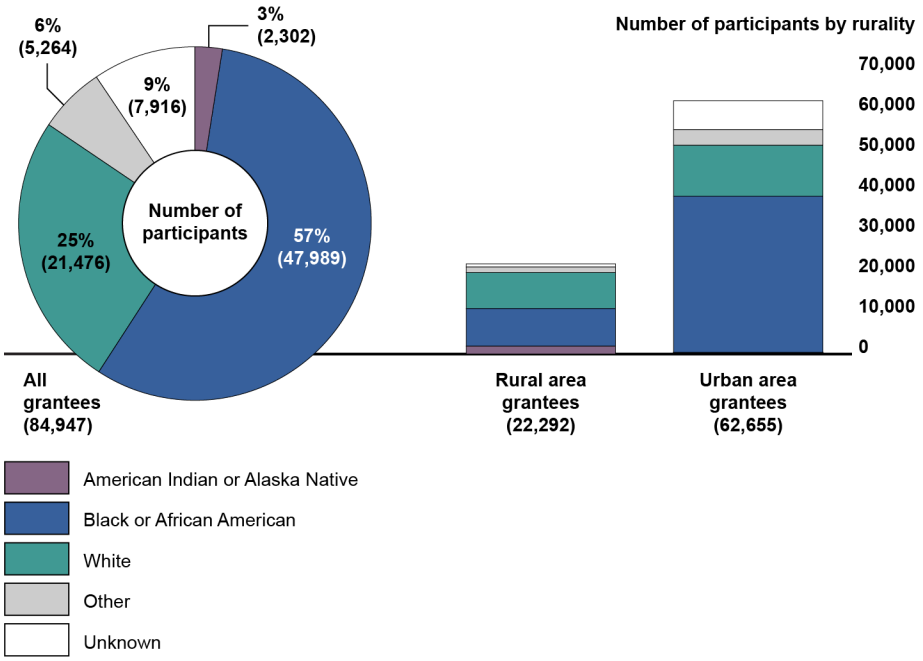
Of the total participants, slightly more than half were Black or African American (57 percent) and about one-quarter (26 percent) were Hispanic or Latino.[33] However, the races and ethnicities of participants in each grantee's program varied. For example, the percentage of participants who were Black or African American ranged from 0.2 percent to 100.0 percent across grantee programs. Additionally, two grantees served more than 75 percent of participants who were American Indian or Alaska Native, while a majority of other grantees' American Indian or Alaska Native participants comprised less than 1 percent of the participants served.

In addition, the 24 rural grantees as a group served an equal proportion of Black or African American and White participants (each approximately 40 percent), and a greater proportion of American Indian or Alaska Native participants than across all grantees in 2022. (See figure 4.)

[32]The Healthy Start program began in 1991 as a demonstration program with 15 grantees.

[33]HRSA collected race and ethnicity as two separate variables from grantees. As a result, we are reporting them separately. Also, the race and ethnicity of participants was sometimes unknown. For example, in 2022, over 9 percent of Healthy Start participants had an unknown race and 2 percent of participants had an unknown ethnicity. Additionally, due to a limitation in HRSA's data system, race and ethnicity category data on some participants was missing. Based on our analysis of several prior years of data, we estimate that these data are missing for less than 1 percent of participants.

Figure 4: Number of Healthy Start Participants by Race, for All Grantees and for Rural Compared to Urban Area Grantees, 2022



Source: GAO analysis of Health Resources and Services Administration program data. | GAO-24-106605

Note: HRSA collected race and ethnicity as separate variables. As a result, we are reporting them separately. Twenty-six (26) percent of Healthy Start participants of any race identified as Hispanic or Latino in 2022. Due to a limitation in HRSA's data system, race and ethnicity category data on some participants was missing. Based on our analysis of several prior years of data, we estimate that these data are missing for less than 1 percent of participants. The "Other" race category includes those participants who are Asian; Native Hawaiian or other Pacific Islander; and multiple races.

HRSA Expects Grantees to Provide Case Management and Education, among Other Services, and Allows Grantees Flexibility to Meet Participant Needs

Our review of agency documents shows that HRSA expects Healthy Start grantees to provide certain services. At the same time, HRSA allows grantees flexibility to meet the unique needs of their participants by customizing other aspects of the program, which selected grantees said they valued.

HRSA Expects Grantees to Provide Certain Services

HRSA expects grantees to provide the following services at a minimum:

- **Case management services.** Grantees are to offer one-on-one consultations, which could include home visits, in which staff assess participants' needs and connect them to services to meet health and related needs.[34]
- **Health and parenting education.** HRSA expects grantees to provide education to participants on a range of topics, including breastfeeding and nutrition.
- **Community action networks.** Grantees are to form and maintain community action networks that include both local partner organizations and individuals to collaborate on actions to improve maternal and child health in their community.[35]

Grantees may also provide additional services, including clinical services (e.g., prenatal care) and doula services. (See sidebar.)

While these expectations will generally still apply to grantees for the next grant period (2024-2029), HRSA has made modifications, per the *Notice of Funding Opportunity* released in September 2023 for the next grant period. For example, HRSA reduced the expected number of case-managed participants each grantee should serve from at least 700 to at least 450 participants.[36] HRSA also added a new expectation in the area of health and parenting education services to serve at least 250 non-case-managed participants through group education classes. See Table 1 for a summary of key Healthy Start service expectations for the 2019-2024 grant period and HRSA's revisions to these expectations for the 2024-2029 grant period.

Doula Services

Doulas are trained professionals who provide physical, educational, and emotional support and advocate for mothers before, during, and after childbirth. Access to their services in the U.S. has traditionally been limited to higher-income individuals, as services are often not paid for by health insurance plans. However, some state Medicaid insurance programs are beginning to pay for doula services. According to HHS, as of October 2022, nine Medicaid programs cover doula services and four were in the process of implementing coverage. Studies have found that doula services during labor reduced rates of cesarean deliveries and birth complications, and increased rates of breastfeeding.

Source: GAO summary of Department of Health and Human Services (HHS) information; AndreyPopov/stock.adobe.com (image). | GAO-24-106605

[34]As part of case management services, grantees conduct HRSA-required screenings, including for depression and intimate partner violence.

[35]These groups will be referred to as "community consortia" in the 2024-2029 grant period, according to the *Notice of Funding Opportunity*.

[36]While HRSA sets an expectation for grantees to serve a certain number of participants, officials told us that they anticipate that the number will vary across grantees. For the 2024-2029 grant period, HRSA established the minimum of 450 case-managed participants per year based on the number served by grantees in the 2014-2019 grant period, among other factors, officials said.

Table 1: Summary of Key Healthy Start Program Expectations, 2019-2029

Program expectations	2019-2024 grant period	2024-2029 grant period
Case management—provided by staff (social workers, community health workers, etc.) who meet with participants to assess medical needs and other factors affecting health, such as food, housing, and transportation. Connects participants to local service providers.	Grantees expected to provide case management services to a minimum of 700 program participants annually. Grantees also expected to promote access to clinical services, such as maternity care services or well-woman care.	Grantees expected to provide case management services to a minimum of 450 program participants annually.
Health and parenting education—health education and promotion for mothers and families on a range of topics, such as breastfeeding, safe sleep, and effective parenting practices.	Grantees expected to provide education to program participants.	Grantees expected to provide group education classes to a minimum of 250 other (non-case-managed) participants annually. Case-managed participants also may take part in these classes.
Community action network—convening a group that includes partner organizations and individuals, establishes common goals, and facilitates collaboration, information sharing and advocacy to improve maternal and child health in the community.[a] Aims to address barriers to medical care or other social determinants of health, such as access to housing or healthy food.[b]	Grantees expected to develop, implement, and evaluate a 5-year action plan to achieve a common goal.	Grantees expected to finalize the network's action plan by October 2024, which should include at least 5 performance measures that relate to the plan's activities. The network should advise the grantee on planning and implementing other types of Healthy Start services.
Other services—other services grantees may offer to meet participant needs.	Grantees could apply for and receive supplemental Healthy Start funding to provide clinical services and doula services.[c]	Grantees expected to provide clinical services and/or have partnership or referral procedures to ensure participants receive clinical care. They are expected to use 10 percent of their grant funds to support clinical staff and encouraged to include doulas as staff and connect participants to doula services.

Source: GAO analysis of Health Resources and Services Administration (HRSA) documentation. | GAO-24-106605

[a]These groups will be referred to as "community consortia" in the 2024-2029 grant period, according to the *Notice of Funding Opportunity*.

[b]Social determinants of health are nonmedical factors that influence health outcomes. They are the conditions in the environments in which people are born, live, learn, work, play, worship, and age; examples include access to housing and healthy food, educational and job opportunities, and exposure to pollution.

[c]Ninety-two grantees received supplemental funding for clinical services and 44 grantees received supplemental funding for doula services, according to HRSA officials.

HRSA made these revisions for several reasons, including grantee feedback and research in the field of maternal health, HRSA officials told us. For example, HRSA officials said they had feedback from a grantee that it was challenging to provide case management services to 700 participants given the rising costs of staff wages while grant funding remained level. Serving some participants through group education will

result in lowering the average cost of services per participant, according to HRSA officials. Officials also stated that this change aligns with evidence that group education classes have several potential benefits for participants, including increased social support.

HRSA Also Allows Grantees Flexibilities to Customize Services to Meet Participant Needs

In addition to its expectations that Healthy Start grantees will offer the services discussed above, the agency encourages grantees to customize their programs to meet the unique needs of their participants. For example, grantees may choose whether they deliver case management services in their offices, participants' homes, or virtually. Grantees may also tailor health and parenting education services to emphasize topics that meet the unique needs of their communities. Five of the six selected grantees we spoke with identified safe sleep practices and three of the six identified breastfeeding as topics that needed emphasis in their communities.

Access to Obstetrical Care in Healthy Start Communities

We spoke to a nongeneralizable sample of representatives of six Healthy Start grantees from the 2019-2024 grant period, and officials from two reported that their communities face challenges related to the availability and accessibility of hospital-based obstetrical care.

One grantee primarily serving an urban area said that the city it serves used to have three hospitals where participants could deliver their babies, but now has none. This is due to one hospital closing its obstetrics unit, one hospital closing entirely, and one relocating outside the city.

Another grantee primarily serving a rural area said that all of the counties to its north were maternity care "deserts" that lacked obstetric services, even if they had a hospital. GAO previously reported that the number of hospitals providing obstetric services in rural areas declined from 2004 to 2018, particularly in low-income areas, and may contribute to adverse health outcomes, such as premature births. For more information, see GAO-23-105515.

Source: GAO-23-105515 and GAO interviews with select grantees. | GAO-24-106605

Three of the six grantees we interviewed said they value the flexibility of the Healthy Start program. It allows them to help address social determinants of health by assisting with challenges many of their participants face in housing, transportation, and food insecurity, they said. For example, because participants commonly face transportation-related barriers when attempting to access health care, three of six selected grantees said they use Healthy Start funding to support transportation. Officials from one grantee said it offers an hourly van service to a community hospital where participants receive medical care; another offers participants bus tokens. By addressing these transportation challenges, grantees can help improve participants' access to medical care—an important factor for improving maternal and infant health.

Further, Healthy Start allows grantees to spend funds on nominal incentives to retain participants. Representatives of one grantee told us its program markets such incentives to participants as "earn as you learn;" its participants receive small but important items, such as diapers or diaper wipes, during their time in the program.

HRSA Assesses Performance Towards Two of Three Program Goals and Has Plans to Assess Performance Towards Third Goal

HRSA uses performance data to assess the Healthy Start program's progress towards two of its goals: (1) reducing the rate of infant deaths, and (2) improving maternal health outcomes. HRSA officials said that, beginning in 2024, the agency has plans to use performance data to assess performance towards the program's third goal—to reduce racial and ethnic disparities in rates of negative maternal and infant health outcomes.[37]

HRSA Uses Performance Data to Assess Program's Progress in Reducing Infant Deaths and Improving Pregnancy Outcomes

HRSA uses performance data—specifically birth outcomes data and performance measures—to assess Healthy Start's progress towards two of its program goals: (1) reducing the rate of infant deaths and (2) improving maternal health outcomes before, during, and after pregnancy. These efforts are consistent with a GAO-identified key step for effective performance management, which states that agencies should use performance data to assess results and inform decisions to ensure progress towards achieving program goals.[38]

Birth outcomes data. For the 2019-2024 grant period, HRSA uses data on birth outcomes, which include rates of infant mortality, low birthweight births, and preterm births, to assess overall program performance toward the goal of reducing the rate of infant deaths. Low birthweight and preterm births were one of the leading causes of infant mortality in 2022, according to the CDC.[39]

Grantees are required to submit birth outcomes data to HRSA on a monthly basis, and HRSA uses these data to track and monitor overall program performance. According to HRSA documentation, higher rates in

[37]According to HRSA officials, since the Healthy Start program was established in statute, the purpose of the program has been to (1) reduce the rate of infant mortality and (2) improve perinatal outcomes. See 42 U.S.C. § 254c-8(a)(2). In both the original legislation and subsequent reauthorizations, Congress directed HRSA to address racial or ethnic differences in infant mortality by conducting evaluations that determine whether the program has been effective in reducing disparities in health, so HRSA includes this as one of the program's goals. See 42 U.S.C. §254c–8(e)(2)(B).

[38]GAO-23-105460.

[39]D. M. Ely and A. K. Driscoll, *Infant Mortality in the United States: Provisional Data from the 2022 Period Linked Birth/Infant Death File*, National Center for Health Statistics. Vital Statistics Rapid Release; no 33. (Hyattsville, Md.: National Center for Health Statistics, 2023.) https://doi.org/10.15620/cdc:133699.

adverse birth outcomes among Healthy Start participants compared to the U.S. general population likely reflect the high-risk populations targeted by the program. (See table 2.)

Table 2: Birth Outcomes of Healthy Start Participants Compared to the U.S. General Population, 2019-2021

	2019		2020		2021	
Birth outcome	**Healthy Start**	**General population**	**Healthy Start**	**General population**	**Healthy Start**	**General population**
Infant mortality rate (per 1,000 live births)[a]	7.98	5.68	7.06	5.56	7.17	5.48
Low birthweight (Less than 2,500 grams)[b]	N/A	N/A	10.3%	6.7%	12.2%	6.9%
Preterm birth (Live births before 37 weeks gestation)[b]	N/A	N/A	9.4%	8.4%	10.4%	8.8%

Source: GAO summary of Health Resources and Services Administration's (HRSA) Healthy Start data. | GAO-24-106605

Note: Data from 2021 were the most recently available set of data at the time of our review.

[a]The infant mortality rates shown here are 3-year rates of the indicated year and 2 prior years. For example, the rate reported for 2019 is calculated by combining the number of infant deaths and live births from 2017, 2018, and 2019. These 3-year rates allow HRSA to track infant mortality for the Healthy Start program while taking into consideration that infant death is a rare event, according to HRSA documentation. When calculated for small populations, such as the Healthy Start program population, infant mortality rates can appear to change substantially with even a small change in the number of deaths in a single year. Such changes may be due to normal variation and are not necessarily caused by actual change in the underlying risk.

[b]Beginning in 2020, HRSA started tracking low birthweight and preterm birth statistics to only include singleton (one fetus) births to focus on these outcomes independent of the effects of multiples (two or more fetuses), which are more likely to be born preterm or of low birthweight, according to HRSA officials. Since 2019 data is not comparable, we did not include it in this table.

While HRSA hopes to see improvements in birth outcomes within the 5-year grant period, officials noted that birth outcomes are influenced by a complex interaction of social and environmental factors, many of which are beyond the control of the grantees' services. (See textbox.)

Examples of grantee reports of participant needs

- A director of a Healthy Start grantee program was asked by a participant to attend her baby's birth because she lacked alternative support—the participant's partner and mother were both in prison.
- One grantee said 20 percent of their participants are homeless, 40 percent have a clinical diagnosis of depression, and 67 percent have multiple chronic medical conditions.

Source: GAO interview and written comments the Health Resources and Services Administration received in response to a public request for information. | GAO-24-106605

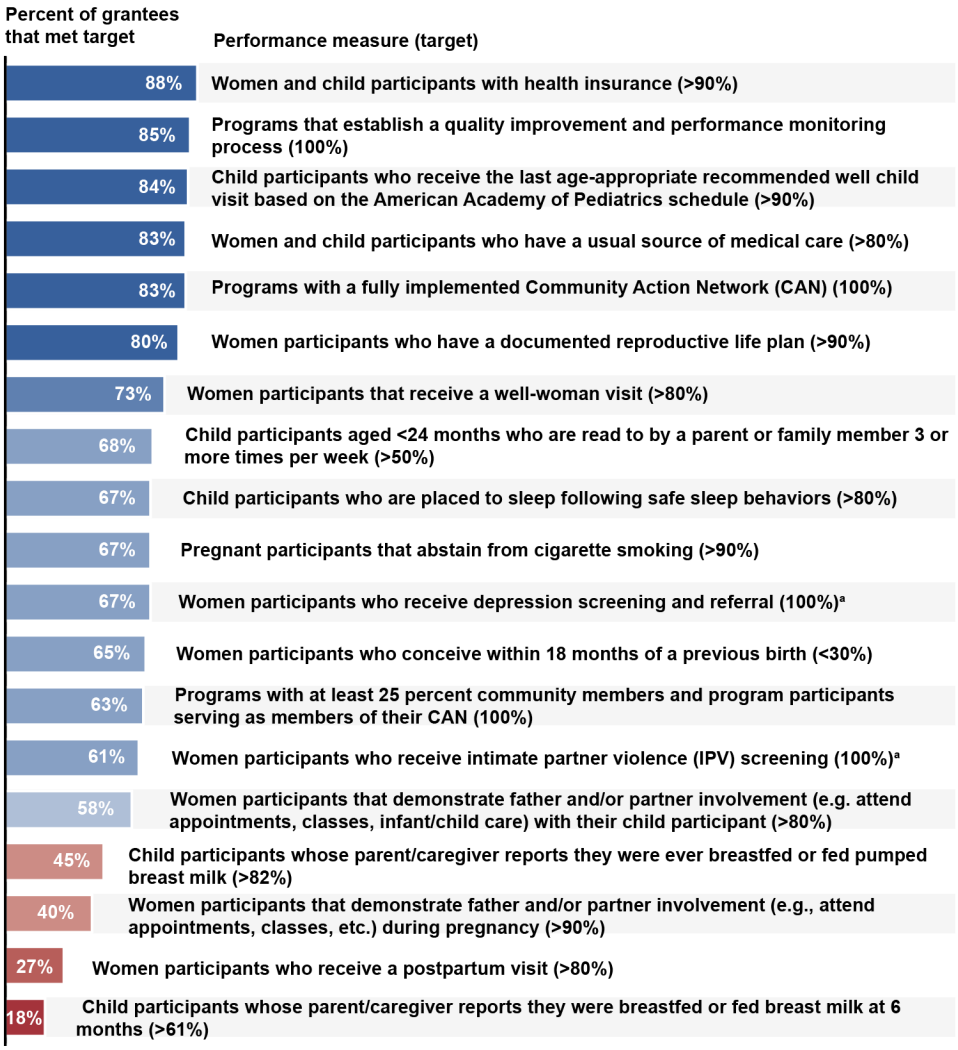
Performance measures. For the 2019-2024 grant period, HRSA uses 19 performance measures with targets to assess individual grantee performance and, in turn, overall program performance towards two

program goals: (1) reduce the rate of infant deaths and (2) improve maternal health outcomes before, during, and after pregnancy.[40] For example, HRSA uses a performance measure on safe sleep practices because research has shown that babies put to sleep using these practices can prevent some infant deaths.

Grantees are required to submit performance measure data annually to HRSA. HRSA officials said they use these data to inform programmatic direction, including adjustments to future grant funding opportunities. See Figure 5 for the 19 performance measures with the percentage of grantees that met performance measure targets in 2021, the most recently available performance measure information at the time of our review.

[40]Targets are numerical goals that HRSA establishes for each performance measure.

Figure 5: Percentage of Healthy Start Grantees That Reported They Met Performance Measure Targets, 2021



Source: GAO analysis of Health Resources and Services Administration (HRSA) information and data from the Healthy Start Technical Assistance and Support Center. | GAO-24-106605.

Notes: This figure uses the term “women participants,” as HRSA does to describe program participants. Data reflect achievement at the grantee level, not at the Healthy Start participant level. Targets are numerical goals established by HRSA for grantees to reach for each performance measure.

[a]According to HRSA officials, HRSA revised the target for this measure for the 2024-2029 grant period to better align with CDC guidance that objectives should be attainable within a given time frame and with available resources. See, for example, Centers for Disease Control and Prevention, *Writing SMART Objectives*, Evaluation Briefs No. 3b (updated Aug. 2018).

In addition to performance measures, HRSA uses other performance information to assess individual grantees, such as information grantees report in annual progress reports. See appendix III for other performance information that HRSA uses.

HRSA Has Plans to Measure Performance Toward Reducing Racial and Ethnic Disparities in Negative Maternal and Infant Health Outcomes

HRSA has not yet regularly used performance measure or birth outcomes data to assess program performance toward its third goal of reducing racial and ethnic disparities in rates of negative maternal and infant health outcomes, but officials said it plans to do so beginning in 2024. The national Healthy Start evaluation for the 2014-2019 grant period analyzed performance measure and birth outcomes data from 2017 stratified by race and ethnicity. (See text box.) However, HRSA officials said they did not regularly use and analyze performance measure or birth outcome data stratified by race and ethnicity to assess the program's progress in reducing disparities throughout the 2019-2024 grant period.

Stratifying performance measure data by race and ethnicity is important when monitoring disparities and analyzing progress toward reducing such disparities, according to an expert workgroup on maternal and infant health.[41] HRSA officials told us that conducting such an analysis to assess progress toward this goal—which has been a program goal since 2000—had not previously been a priority. However, they said that it has become a priority for the agency. To implement this priority, HRSA needed to first upgrade their data system to be able to conduct this analysis, according to officials. As of October 2023, HRSA officials said they had recently completed the upgrade. As of December 2023, agency officials were developing a data analysis plan, which includes steps to examine birth outcome disparities and performance measure data by race and ethnicity, using the updated system. According to HRSA officials, the plan is expected to be completed in February 2024 with results from the first analysis to be completed by April 2024 and annually thereafter. Officials also told us that the national evaluation for the 2019-2024 grant period, expected to be reported in 2025, also will analyze birth outcomes and performance measure data by race and ethnicity.

By conducting these analyses, HRSA efforts will be consistent with a GAO-identified key step for effective performance management, as it will be using performance information to assess progress towards achieving

[41]Bigby, J., et al, *Recommendations for Maternal Health and Infant Health Quality Improvement in Medicaid and the Children's Health Insurance Program,* a report prepared at the request of the Centers for Medicare and Medicaid Services, Dec. 18, 2020.

the Healthy Start program goal of reducing racial and ethnic disparities in the rates of negative maternal and infant health outcomes.

National Healthy Start Evaluation

About once per 5-year grant period, an independent evaluator conducts a national evaluation of the overall Healthy Start program to determine how the program has improved maternal and infant health outcomes. The most recently completed national evaluation report was released in February 2020 by Abt Associates on the 2014-2019 grant period.

According to this evaluation, Healthy Start participants had earlier initiation and more frequent prenatal care visits than non-Healthy-Start participants. In addition, Healthy Start participants had fewer low birthweight births and higher rates of following safe sleep practices than non-Healthy-Start participants. The evaluation also found that White participants were more likely to follow infant safe sleep practices but were more likely to smoke during pregnancy than Black or African American participants.

The evaluation also noted limitations in the data, including the lack of baseline data for Healthy Start participants and challenges matching participant data to state vital records data, which resulted in a smaller than expected sample size. HRSA officials noted that the evaluation for the 2014-2019 grant period was innovative and well-constructed, but the complexity of the evaluation design was too difficult for the community-based Healthy Start grantees to implement.

Currently, Westat is conducting a national evaluation for the 2019-2024 grant period to assess Healthy Start program progress towards the goals of reducing infant mortality, improving maternal health, and reducing racial and ethnic disparities. This evaluation will measure program effects on participant outcomes using the duration of time participants receive services, which will provide a substitute for baseline data, according to the evaluation design plan. The final report is expected in 2025.

Source: GAO summary of information from the Health Resources and Services Administration, Abt Associates, and Westat. | GAO-24-106605

HRSA's Performance Measures Align with Most, but Not All, Key Attributes of Effective Measures

HRSA's Healthy Start performance measures align with four of six key attributes of effective measures. Our prior work has identified key attributes of effective performance measures that enable agencies to track program progress towards goals and provide decision makers with critical information on which to base decisions for improving the program.[42]

[42]GAO-03-143.

Updates to Healthy Start Performance Measures for the 2024-2029 Grant Period

The Health Resources and Services Administration (HRSA) used 19 performance measures for the Healthy Start program's 2019-2024 grant period, but reduced the measures to 10 for the 2024-2029 grant period. HRSA also made other changes, including reducing targets for certain measures and revising definitions. HRSA officials told us that they made these changes in response to grantee feedback, and to align performance measures more closely to program goals, reduce grantee burden, and use measures with clearer definitions.

Source: GAO summary of HRSA information. | GAO-24-106605

We assessed the Healthy Start performance measures from the 2019-2024 grant period and changes to the measures for the upcoming 2024-2029 grant period. (See sidebar.) Our assessment of the performance measures included the performance measure description, the forms used to collect data for the measure, and the methodology used to calculate the measure as described in the data dictionary. (See text box for a description of these performance measure elements.)

We found that HRSA's upcoming changes to the performance measures for the 2024-2029 grant period resulted in alignment with four of six key attributes, but the measures do not align with the remaining two. Our findings were supported by grantee feedback from listening sessions that HRSA conducted in October 2022 and our interviews with the selected grantees.

The four key attributes of effective performance measures for which HRSA's changes led to alignment were: core program activities, linkage, objectivity, and limited overlap.

Elements of Healthy Start Performance Measures

A performance measure is made up of several parts, including a description of the measure, a collection tool to obtain data for the measure, and a methodology to calculate the measure.

Healthy Start grantees use the following documents to collect performance measure data:

- **Healthy Start data collection forms.** Used by grantees to collect standardized information from participants.
- **Healthy Start data dictionary.** A manual that includes the description and methodology for each measure. Grantees use the data dictionary to understand how to calculate performance measures from responses obtained in the data collection forms.

Source: GAO analysis of information from the Healthy Start Technical Assistance and Support Center, which is funded by Health Resources and Services Administration, and Centers for Medicare and Medicaid Services. | GAO-24-106605

Core program activities: measures should cover the activities that grantees are expected to perform to support the intent of the program. Our analysis found that HRSA's performance measures for the upcoming grant period satisfy the attribute of core program activities in that they cover the core program activities of case management and health and parent education. For example, the measure on depression screening and referral is one of multiple measures that cover case management activities to assess participants' medical needs.

In addition, HRSA added a measure for the 2024-2029 grant period to determine the extent to which participants received prenatal care in the

first trimester of pregnancy. This performance measure is important, because grantees are expected to provide prenatal care or access to prenatal care as part of their case management activities. Early prenatal care is important in identifying maternal disease and risks for complications of pregnancy and birth. We previously reported that fewer American Indian or Alaska Native and Black or African American women initiated early prenatal care and attended the recommended number of prenatal visits, as compared with White and Asian women.[43] HRSA officials said that grantees annually submitted information on prenatal visits to HRSA during the 2019-2024 grant period, but it was not one of the 19 performance measures.

HRSA also reduced the number of performance measures from 19 to 10 measures for the 2024-2029 grant period to focus on core areas of concern, according to HRSA officials. One grantee noted that the number of Healthy Start performance measures can make it challenging to hone in on the most important ones. We have previously reported that limiting the number of performance measures to the core program activities helps identify performance that contributes to achievement of program goals.[44]

As part of this reduction, HRSA removed performance measures that primarily relate to the core activity of convening a community action network. HRSA officials told us they did this because these measures were really program requirements rather than a performance target to be achieved. Instead, the agency officials stated that they track this core activity using other means, such as through grantees' annual submissions of their progress reports.

Linkage: measures should align with program goals. Our analysis found that HRSA's performance measures for the upcoming grant period satisfy the linkage attribute, because the measures link to the program's goals to (1) reduce the rate of infant deaths and (2) improve maternal health outcomes before, during, and after pregnancy. HRSA officials told us they removed performance measures that were less closely linked to these program goals. For example, officials said that they determined that the measure on reading to a child did not demonstrate progress towards

[43]GAO, *Maternal Health: HHS Should Improve Assessment of Efforts to Address Worsening Outcomes,* GAO-24-106271 (Washington, D.C.: Feb. 21, 2024).

[44]GAO-03-143.

the program goals and thus removed this measure for the 2024-2029 grant period.

As mentioned above, HRSA is working to stratify performance measure data by race and ethnicity to address the third program goal of reducing racial and ethnic disparities in negative maternal and infant health outcomes. Once HRSA regularly stratifies these data, then the performance measures will fully link to the program's goals.

Objectivity: measures should be reasonably free from significant bias or manipulation. Our analysis found that HRSA's performance measures for the upcoming grant period satisfy the attribute of objectivity and are free from significant bias. In particular, HRSA removed the two performance measures used in the 2019-2024 grant period that asked the participant to report their perception of the father's or partner's involvement. These measures were dependent on subjective judgement.

Limited overlap: measures should provide new information beyond that provided by other measures. Our analysis found that HRSA's performance measures for the upcoming grant period satisfy the attribute of limited overlap and provide new information. HRSA officials told us that they removed measures used in the 2019-2024 grant period to reduce overlap in performance measures. For example, HRSA removed the measure on "usual source of care." This measure aimed to show whether participants have access to and receive preventive services, such as for routine preventive and sick care. However, HRSA has other measures for the Healthy Start program that also demonstrate access to and receipt of preventive services. These include whether participants have health insurance and have completed certain medical visits, such as well-child or well-woman visits.

(For additional details on the changes HRSA made to the performance measures for the 2024-2029 grant period, see appendix IV.)

While HRSA's performance measures align with four of our key attributes, they do not align with two others: attributes related to clarity and reliability.

Clarity: measures should be clearly stated, including that the measure descriptions match how the measures are calculated. We found, and grantees also noted in listening sessions, that two

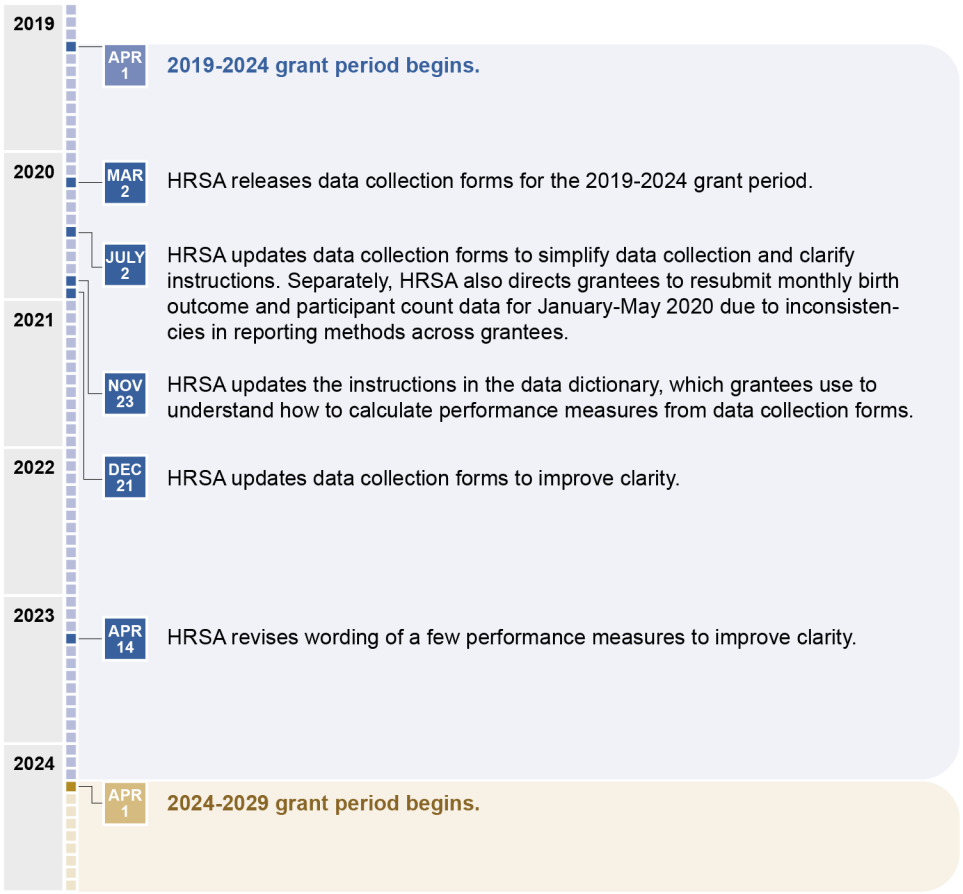
performance measures in the 2019-2024 grant period lacked clarity.[45] Specifically, the performance measure description, the forms used to collect data for the measure, and the methodology used to calculate the measure as described in the data dictionary did not match. For example, we found, and one grantee pointed out, that in the data dictionary the measure on well-woman or preventative visit includes prenatal and postpartum visits. However, one of the forms used to collect the data for this measure specifically excluded prenatal visits from being used to calculate performance. These differences may make it confusing for staff calculating performance and for decision-makers interpreting the data.[46]

Reliability: Standard data collection procedures should be used so that data is collected consistently (i.e., measures should produce the same result under similar situations). In an effort to address grantee feedback, among other reasons, HRSA has made updates to performance measure elements, including the data dictionary and data collection forms, at several points during the 2019-2024 grant period. Specifically, HRSA updated the data collection forms four times during the grant period and the instructions in the data dictionary once. (See figure 6.) However, these updates potentially affect the data's reliability.

[45]We found that for the performance measures on well-woman visits and cigarette smoking, the measure descriptions do not match the data collection forms. We also reviewed HRSA's summary from the Healthy Start grantee listening sessions, in which grantees noted inconsistent language between the data collection forms or between data collection forms and the wording for the performance measures in the data dictionary. Specifically, grantees pointed to the two measures we identified, along with the measure on reading to the child participant and the two measures on father or partner involvement as being unclear. HRSA removed the reading measure and the two father or partner involvement measures for the 2024-2029 grant period.

[46]Our analysis is based on the data dictionary and forms used in the 2019-2024 grant period, though our findings may apply to performance measures that will be used in the upcoming 2024-2029 grant period. This is because, as of March 2024, HRSA had not yet released the updated data dictionary and data collection forms for the 2024-2029 performance measures, so we were not able to review those documents. The 2024-2029 grant period begins on April 1, 2024.

Figure 6: Timeline of Events Related to HRSA Updates to the Healthy Start Program Performance Measures and Related Documentation



Source: GAO analysis of written responses from Health Resources and Services Administration (HRSA) officials. | GAO-24-106605

HRSA officials told us the agency updated performance measures and data collection forms in the middle of the grant period to address several challenges. First, HRSA made updates to address inconsistencies in how grantees were reporting certain data. Officials said they spent a lot of time going back to grantees to ask them to correct data they had submitted. Second, the agency made updates to streamline reporting in response to grantee feedback.

However, the updates to the data collection forms and instructions in the data dictionary made it challenging for grantees to ensure that staff were properly trained to collect and report the data reliably, according to HRSA's listening sessions and our interviews with two grantees. For

example, HRSA updated the instructions in the data dictionary to explain that the definition of a program participant is someone receiving ongoing case management services. The previous version of the data dictionary did not specify this detail. One selected grantee told us that this change in the participant definition affected how their organization calculated its performance measures and that it is important for the Healthy Start program to maintain consistent definitions throughout the grant period.

Another selected grantee told us that when HRSA makes changes, the data the grantee tracks is no longer accurate, so they then have to recalculate performance measure data by hand. According to a 2021 survey of grantees by the Healthy Start Technical Assistance and Support Center, 30 percent of grantees reported that the data collection forms hindered the collection and submission of data for 2021.[47] In addition, multiple updates within a grant period limit HRSA and grantees' ability to track trends in performance over time; because the data is not consistently collected, it is not comparable year over year.

When asked about the clarity and reliability issues we and grantees identified, HRSA officials told us that the agency has had a goal to have the data collection forms and data dictionary set at the beginning of the grant period to minimize changes throughout the period. However, the issues we identified demonstrate that this goal has not been met.

Further, these issues may persist in the next grant period (2024-2029). For example, at the time of our review, HRSA had not released its corresponding data collection forms or data dictionary for the measures that will be used for the 2024-2029 grant period, which begins on April 1, 2024.

In commenting on a draft of this report, HRSA officials said the data collection forms had been approved for use on March 1, 2024. As such, agency officials said the forms would be ready by the start of the grant period and the data collection system would incorporate these changes for the first reporting period in the summer of 2024. However, as of March 14, 2024, the forms had not been posted on the Healthy Start website and the agency did not provide us copies.

[47]The survey was conducted from October 29, 2021 to January 6, 2022 and had a 92.1 percent response rate. See National Institute for Children's Health Quality, Healthy Start Technical Assistance and Support Center. *Supporting Health Start Performance Project: 2021 Annual Assessment Report,* a report prepared at the request of HRSA, 2022.

Due to this timing, we could not assess the forms to know whether HRSA's updates will fully address the clarity issues or if any updates will introduce new clarity issues. Further, HRSA officials did not provide any information on when the data dictionary for the 2024-2029 grant period would be released.

Ultimately, the issues we found related to HRSA's performance measure descriptions, data collection forms, and data dictionary are because the agency lacks a documented process to review its performance measures before implementing them. Federal standards for internal control call for agencies to document in policies the responsibilities for operational processes.[48]

In written responses, HRSA officials outlined a general process they use to review Healthy Start performance measures. This includes identifying and developing draft performance measures, selecting final measures, and developing and/or updating associated data collection forms and the applicable data dictionary. However, when asked if this process was documented anywhere for program staff to implement, officials said it was not. For example, officials could not provide documentation demonstrating whether or how this process is followed by program officials—such as memos summarizing decisions around why certain performance measures were selected or eliminated.

Further, HRSA officials did not have documentation indicating that officials reviewed performance measure descriptions to ensure they were clear to grantees and matched across data collection forms and the data dictionary. Also, the evidence we reviewed indicated that HRSA does not have a documented process in place to ensure that, moving forward, data collection forms and the data dictionary are finalized before a grant period begins, which could minimize changes throughout a grant period and disruptions to the collection of reliable data.

By implementing a documented process to review the performance measures (including their descriptions, associated data collection forms, and data dictionary) before a grant period begins, HRSA could better ensure the measures they implement are clear and allow for the collection of reliable data. This will allow grantees to report reliable and accurate

[48]According to federal internal control standards for control activities, management should document in policies for each unit its responsibility for an operational process's objectives and related risks, and control activity design, implementation, and operating effectiveness. See GAO-14-704G.

information on their performance, which will in turn, enable HRSA to better interpret grantee performance data and assess overall program performance. It will also better enable HRSA and grantees to assess changes in participant outcomes over the course of the grant period. Further, developing a pre-defined process will allow HRSA to include steps in that process to pretest the performance measure data dictionary and data collection forms with grantees to learn about any potential issues or points of confusion and make improvements, before releasing them for official use.

Ultimately, clear and reliable performance measures will allow HRSA to use those measures to accurately assess whether Healthy Start is achieving the intended goals of the program: to (1) reduce the rate of infant deaths, (2) improve maternal health outcomes before, during, and after pregnancy, and (3) reduce racial and ethnic disparities in rates of negative maternal and infant health outcomes.

HRSA Lacks a Documented Process to Coordinate Measure Selection Across Related Programs

We found that HRSA lacks a documented process to coordinate the selection of performance measures used across Healthy Start and related programs—MIECHV and Title V. According to HRSA officials, these three programs are designed to be separate and complementary, they have similar goals, deliver some similar services to pregnant women and their families, and have similar performance measures. (See sidebar.)

HRSA officials said the agency tries to align measures across its programs in several scenarios, including to align measures with: (1) a generally accepted definition; (2) a clinical guideline; or (3) a widely used data source, such as vital statistics. HRSA officials also noted that performance measures cannot always be aligned. However, they were unable to provide specific examples of such coordination. The officials explained that differences exist for several reasons: (1) differences in the laws authorizing the programs, (2) differences in program design and population served, (3) measures drawn from different sources, and (4) misaligned timing of the start of program grant periods. For example, the Healthy Start 5-year grant period does not align with the MIECHV 2-year grant period.

However, we found HRSA lacks a documented process for coordinating the selection of performance measures across these three programs. The law reauthorizing Healthy Start directs HHS to coordinate Healthy Start with other programs supported by HHS that aim to reduce infant mortality

and improve perinatal and infant health outcomes, such as Title V and MIECHV.[49] Moreover, our prior work on evidence-based policymaking and leading practices for collaboration indicates that documenting a collaborative process can strengthen the commitment of coordinating parties, among other potential benefits.[50] Further, both our prior work and guidance from the Office of Management and Budget highlight the importance of coordinating evidence-building activities, such as the selection of performance measures, across an agency.[51]

For HRSA, coordination activities between the three programs would help the agency identify and select the most appropriate evidence-based measure for a particular topic to use across all three programs, where feasible, and to ensure that any differences between these three programs' measures were made purposefully.

We observed a number of differences across the performance measures used by these three programs that suggest that opportunities exist to improve coordination. Specifically, Healthy Start and MIECHV have nine performance measures on the same topics, and Healthy Start and Title V

HRSA Programs Offer Complementary Care for Mothers and Children

According to Health Resources and Services Administration (HRSA) officials, three programs are designed and administered to be separate and complementary, to represent a continuum of care for mothers, children, and families: 1) the Healthy Start program, 2) the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV), and 3) the Title V Maternal and Child Health Block Grant Program (Title V).

We spoke to a nongeneralizable sample of representatives of six Healthy Start grantees from the 2019-2024 grant period, and officials from four noted that the Healthy Start program reached a different population than the MIECHV program, in some cases. For example, an official from one of these grantees commented that the grantee's staff often work to transfer families that participated in Healthy Start to MIECHV once the participants' children reach 18 months of age and no longer qualify for Healthy Start.

Source: GAO summary of information from HRSA and select grantees and Halfpoint/stock.adobe.com (image). | GAO-23-106605

[49]Pub. L. No. 116-136, § 3225, 134 Stat. at 382 (2020) (codified at 42 U.S.C. § 254c-8(c)(2)).

[50]GAO-23-105460 and GAO-23-105520.

[51]GAO-23-105460 and Office of Management and Budget, *Evidence-Based Policymaking: Learning Agendas and Annual Evaluation Plans*, M-21-27 (Washington, D.C.: June 30, 2021).

have eight.[52] However, in most cases, these measures differ in aspects such as time frame of the measured activity, the frequency of a measured behavior, the population included in the measure, and the specificity of the topic.

For example, all three programs have similar but distinct performance measures related to smoking or tobacco usage. The Healthy Start and MIECHV measures ask whether participants use of any type of tobacco products, while the Title V measure only asks about smoking. A coordinated review of these performance measures by HRSA could indicate whether one of the three measures has the strongest evidence in determining maternal and infant health, and therefore, would be best to use across all three programs.

In addition, Healthy Start and MIECHV both have performance measures on the percentage of participants that had postpartum medical visits, but the measures have different definitions for the acceptable time frames for those visits. Healthy Start measures whether participating mothers have postpartum visits 4 to 6 weeks after delivery, while MIECHV measures visits that occurred within 8 weeks of delivery. The Healthy Start data dictionary states that the program's measure was chosen to align with clinical guidelines, but it is not clear why HRSA selected a different time frame for the MIECHV measure on this topic. In response to our inquiry about the difference in definitions between these two programs, officials told us in October 2023, that they are considering aligning the Healthy Start and MIECHV postpartum visits measures with clinical guidelines when each program begins its new grant period.

See table 3 for a comparison of selected measures on similar topics across the three programs and identified differences in definitions and terminology. A complete comparison of all the differences in the performance measures is available in appendix V.

[52]In its upcoming 2024-2029 grant cycle, the Healthy Start program will remove its measure on reading to infants. After this change, Healthy Start and MIECHV will have eight performance measures on the same topics.

Table 3: Comparison of Selected Performance Measures for the Healthy Start, MIECHV, and Title V Programs (Underlined Text Indicates Differences)

Healthy Start Program	Maternal Infant and Child Home Visiting Program (MIECHV)	Maternal and Child Health Services Block Grant Program (Title V)
Women participants who enrolled prenatally or within 30 days after delivery and received a postpartum visit between 4-6 weeks after delivery	Mothers who enrolled prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery	*No equivalent measure*.
Prenatal participants that abstain from using any tobacco products during the last 3 months of pregnancy	Primary caregivers who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment	Women who report smoking during pregnancy

Source: GAO analysis of Health Resources and Services Administration documentation. | GAO-24-106605

Note: For the performance measures above, we incorporated information from data dictionaries when necessary, as the measure names and descriptions did not always include relevant details needed to compare across measures.

When we discussed coordinating the selection of performance measures across the three programs with HRSA officials in December 2023, they stated that implementing a process for coordination would be helpful in future grant periods. In written responses in January 2024, officials stated that they were working to develop such a process to implement in that calendar year. Specifically, officials stated that they plan to utilize two existing groups within the Maternal and Child Health Bureau for the process: (1) the Performance Measurement and Evaluation Council, which serves as a resource for the Bureau's programs and provides a forum for collaboration on performance measures; and (2) the Office of Epidemiology and Research, which conducts and funds research that scientists, medical professionals, and policy makers use to advance the health and well-being of maternal and child health populations. Officials plan to have these groups work with Healthy Start, MIECHV, and Title V program staff to conduct reviews of performance measures across the programs, aiming to align them when feasible and scientifically appropriate, according to their January 2024 written responses.

While HRSA's plans to develop a coordination process are promising, the plans have not yet been formalized, according to officials. Further, during our review, we found that the role of the Performance Measurement and Evaluation Council is not well defined or documented. For example, in prior written responses, when asked about the Council's role in performance measure selection, HRSA officials broadly stated that the Council aimed to enhance performance measurement. It was not formally involved in making updates to Healthy Start's performance measures for

the 2024-2029 grant period. Since the Council's inception in 2020, officials said it has developed a general framework used across the Bureau to guide performance measurement, but they could not provide any other work products, detail, or documentation on its activities, responsibilities, or role. Creating such detail and documentation will be an important component of HRSA's plans to use this group as part of its new coordination process.

Without such detail and documentation, Congress and other stakeholders lack assurance that HHS is fulfilling its duty to coordinate Healthy Start with other programs that aim to reduce infant mortality and improve perinatal and infant health outcomes.[53] Further, HRSA's plans are not consistent with our prior work on evidence-based policymaking and leading practices for collaboration, which both emphasize that documenting a collaborative process can strengthen the commitment of coordinating parties.[54] For example, in HRSA's case, in defining plans to coordinate measure selection across three programs, such operational documentation could outline coordination roles, as well as processes and procedures (and related time frames), to be followed by all parties involved in these plans. Additionally, as HRSA moves forward, the agency could consider using or modifying an already established process, such as the process it established for regularly exchanging information and discussing relevant maternal and health program efforts and outcomes across HHS.[55]

By implementing a documented process for program officials to coordinate the selection of performance measures across Healthy Start, MIECHV, and Title V—which could include the plans for a process that HRSA officials described to us—HRSA could realize a number of benefits. Specifically, an enhanced, documented collaborative process for

[53]See 42 U.S.C. § 254c-8(c)(2).

[54]GAO-23-105460 and GAO-23-105520.

[55]In April 2021, we recommended that the Secretary of Health and Human Services direct HHS's Healthy People Maternal, Infant, and Child Health Workgroup and the Maternal Health Working Group to establish a formal coordinated approach for monitoring maternal health efforts across HHS, including in rural and underserved areas. See GAO, *Maternal Mortality and Morbidity: Additional Efforts Needed to Assess Program Data for Rural and Underserved Areas,* GAO-21-283 (Washington, D.C.: April 8, 2021). HHS agreed with this recommendation and took action to address this recommendation in November 2021. Specifically, HHS established a process for regularly exchanging information and data and discussing relevant program efforts and progress on a quarterly basis. This recommendation is now closed as implemented.

coordinating the selection of performance measures across these three programs—all attempting to improve maternal and infant health—could help HRSA: (1) strengthen the commitment of its programs to coordinate; (2) ensure that all three programs are using the most appropriate or best performance measures based on available evidence and, (3) know that any differences among the measures are purposeful.

Conclusions

The U.S. has the highest rates of maternal death—death from complications related to pregnancy or childbirth—and infant mortality of developed, high-income countries. HRSA administers Healthy Start to reduce the rate of infant deaths; improve maternal outcomes before, during, and after pregnancy; and reduce racial and ethnic disparities in the rates of negative maternal and infant health outcomes. To ensure HRSA is meeting these program goals, HRSA needs effective performance measures. While HRSA's Healthy Start performance measures align with most key attributes of effective performance measures, issues related to the key attributes of clarity and reliability remain.

By implementing a documented process to review its performance measures (including their definitions, associated data collection forms, and data dictionary) before a grant period begins, HRSA could better ensure the measures they implement are clear and will allow for the collection of reliable data. Ultimately, this will enable HRSA to more accurately assess Healthy Start's progress toward goal achievement.

Additionally, by implementing a documented process for program officials to coordinate the selection of performance measures across the Healthy Start, MIECHV, and Title V programs, HRSA has an opportunity to ensure the most appropriate measures are used across these programs, which have shared goals of improving maternal and infant health outcomes, and that any differences among measures are purposeful. Moreover, this new process has the potential to strengthen the body of evidence that HRSA gathers about its work to improve maternal and infant health outcomes. It could lead HRSA to align performance measures and simplify HRSA's evidence from its maternal and infant health programs so the agency can more easily gauge the outcomes of program participants, which are already complex, given they can be affected by many external factors. This documented process could leverage existing coordination efforts planned within the Maternal and Child Health Bureau.

Overall, taking these actions will help the agency ensure that the Healthy Start program is meeting the critical mandate of saving the lives of mothers and their infants.

Recommendations for Executive Action

We are making the following two recommendations:

The Administrator of HRSA should implement a documented process to review Healthy Start performance measures (including their definitions, associated data collection forms, and data dictionary), before a grant period begins, to ensure they are clear and allow for the collection of reliable data. (Recommendation 1)

The Administrator of HRSA should implement a documented process for program officials to coordinate the selection of performance measures across its related programs—Healthy Start; the Maternal, Infant, and Early Childhood Home Visiting; and the Title V Maternal and Child Health Services Block Grant. (Recommendation 2)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review and comment. HHS's comments are reprinted in appendix VI. HHS also provided technical comments, which we incorporated as appropriate.

HHS partially concurred with our first recommendation that HRSA implement a documented process to review Healthy Start performance measures before a grant period begins. In its comments, HHS stated that it has already implemented a process utilizing a standard approach for reviewing and updating performance measures prior to the start of Healthy Start program grant periods.

HHS also stated that it is working to formally document this process in greater detail as we recommended, a positive step. As our report notes, HRSA outlined a general process it uses to review Healthy Start performance measures. However, the documents HRSA provided did not outline how the agency reviewed definitions, nor did they include associated data collection forms and the data dictionary. These steps would help ensure the documents are clear to grantees and allow them to collect reliable data. Additionally, while HHS stated in its comments that it provided data collection forms and a data dictionary in January 2024, it had not provided these documents for the 2024-2029 grant period. We did receive from HHS and report on these documents for the 2019-2024 grant period.

Implementing such a documented process before a grant period begins will allow HRSA officials and other stakeholders to confidently assess the Healthy Start program's progress towards meeting its goals.

HHS concurred with our second recommendation that HRSA implement a documented process for program officials to coordinate the selection of performance measures across Healthy Start and related programs. HHS noted that the programs are statutorily distinct and that performance measures must reflect these distinctions. Nonetheless, HHS officials said the agency is implementing a process to enhance coordination where possible and will document this process. Implementing this coordination process has the potential to strengthen the body of evidence to improve maternal and infant health outcomes.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on GAO's website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or DeniganMacauleyM@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix VII.

Mary Denigan-Macauley
Director, Health Care

Appendix I: Characteristics of Healthy Start and Related Programs

Our review identified, and Health Resources and Services Administration officials confirmed, two programs related to Healthy Start: the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and the Title V Maternal and Child Health Services Block Grant (Title V) program. These programs have similar goals to Healthy Start of improving maternal and infant health and provide some similar services to participants. Like Healthy Start, both of these other related programs are administered by the Maternal and Child Health Bureau within the Health Resources and Services Administration. See table 4 for information about the goals, target populations served, selected services, funding, and number of grants for each program.

Table 4: Characteristics of Healthy Start, MIECHV, and Title V Programs

Program	Healthy Start	Maternal, Infant, and Early Childhood Home Visiting (MIECHV)	Title V Maternal and Child Health Services Block Grant (Title V)
Program summary	Supports organizations that provide community-based services to improve infant mortality and maternal health and eliminate health disparities.	Supports evidence-based home visiting programs that support expectant and new parents during the early childhood period.[a]	Funds public health systems and a variety of activities that support grantees' maternal and child health priorities.
Goals	• Reduce the rate of infant deaths • Improve maternal health outcomes before, during, and after pregnancy • Reduce racial and ethnic disparities in rates of negative maternal and infant health outcomes	• Improve maternal and child health • Prevent child abuse and neglect • Reduce crime and domestic violence • Increase family education level and earning potential • Promote child development and school readiness • Connect families to needed community resources and supports	• Increase access to quality maternal and child health services (in particular those with low income or with limited availability of health services) • Reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children • Support blind and disabled individuals under the age of 16 • Support provision of community-based, coordinated care
Target population	Women of reproductive age, pregnant women, fathers and partners, and children up to 18 months of age. Operates in communities with high rates of infant mortality or other poor perinatal outcomes like low birth weight.	Pregnant people and parents of children up to kindergarten entry age. Prioritizes low-income families, families with a history of substance use, child abuse or neglect, and families that have had interactions with the child welfare system, among other factors.	Mothers, infants, and children (through 21 years of age), including children with special health care needs.

Program	Healthy Start	Maternal, Infant, and Early Childhood Home Visiting (MIECHV)	Title V Maternal and Child Health Services Block Grant (Title V)
Examples of services provided	• case management services, including referrals to community services and resources • health and parenting education (including breastfeeding, infant injury prevention, tobacco cessation) • community action networks that aim to improve maternal and child health throughout the community served[b] • screening for mental health and domestic abuse • well-woman and doula services • transportation assistance	• home visits using a MIECHV-approved evidence-based home visiting model, including referrals to community services and resources[a] • health and parenting education (including breastfeeding nutrition, injury prevention) • screening for mental health, domestic violence, and child development delays	Services vary by state. They include direct and enabling services, as well as public health services.[c] Examples of direct and enabling services include: • maternal and child health care services, including regular screenings • toll-free hotlines and assistance with applying for services to pregnant women and children eligible for Medicaid • home visiting services • safe sleep and breastfeeding education initiatives • home safety assessments • transportation assistance • doula services • training and leadership development classes for children with special health care needs Examples of public health services include workforce development and health promotion campaigns, among others
Funding and number of grants	• Funding: $145 M, fiscal year 2023 enacted • Grants allocated: 101 grantees across 35 states and the District of Columbia	• Funding: $500 M, fiscal year 2023 enacted[d] • Grants allocated: 56 grants across 50 states and six jurisdictions[e]	• Funding: $593 M, fiscal year 2023 enacted[f] • Grants allocated: 50 states and nine jurisdictions[g]

Sources: GAO summary of Health Resources and Services Administration (HRSA) documentation. | GAO-24-106605

Notes: We considered programs "related" to the Healthy Start program if they were administered by the Department of Health and Human Services, had similar goals to the Healthy Start program, and offered similar direct services to people participating in the programs. HRSA administers all three of the programs in this table.

We use the term "women" in this report because HRSA uses it to describe the people served by Healthy Start and related programs, but acknowledge this term does not include all people who may become pregnant, such as people who do not identify as either male or female, and some transgender men.

[a]There are 24 evidence-based home visiting models that are eligible for MIECHV program funding based on a review of studies demonstrating for evidence of their effectiveness towards meeting MIECVH program goals. Models vary in characteristic such as the duration and intensity of home visits, and who provides services.

[b]Community action networks will be referred to as "community consortia" in Healthy Start's 2024-2029 grant period, according to the *Notice of Funding Opportunity*.

[c]Title V is a block grant that allows grantees discretion on how to use the funds. By law, grantees must devote at least 30 percent of the funding they receive to preventive and primary care for children, and another 30 percent to children with special health care needs. See 42 U.S.C. §

705(a)(3). Grantees explain how their use of the funds contributes towards their specific maternal and child health priorities in an annual report to HRSA.

[d]According to the Department of Health and Human Services' Fiscal Year 2024 Congressional Budget Justification, six percent of MIECHV's budget is reserved for the tribal home visiting program, which awards cooperative agreements to tribal organizations to provide home visits to American Indian and Alaska Native children and families. The tribal home visiting program is administered by the Administration for Children and Families.

[e]The six jurisdictions are the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. When a state declines funding, a MIECHV grant may be made competitively to a not-for-profit organization acting on behalf of the state, according to HRSA officials. One such example is Prevent Child Abuse North Dakota.

[f]Title V grants require grantees to match every $4 provided by the federal government by at least $3.

[g]The nine jurisdictions are American Samoa, District of Columbia, the Federated States of Micronesia, Guam, the Marshall Islands, the Northern Mariana Islands, Palau, Puerto Rico, and the U.S. Virgin Islands.

Appendix II: Health Resources and Services Administration's Process to Evaluate Healthy Start Applications

The Health Resources and Services Administration (HRSA) uses a multi-step process to evaluate Healthy Start grant applications and make grant award decisions. Specifically, HRSA takes three steps:

1. **Establish that each application is complete.** This means the application contains all the required information, and the applicant is eligible for the grant, HRSA officials told us.
2. **Assign ratings.** Ratings are primarily determined by a panel of external subject matter experts that reviews each of the complete and eligible applications, according to HRSA officials, and assigns point ratings based on six criteria established by HRSA.
3. **Make final award decisions.** HRSA makes final award decisions by taking into account the ratings each application was assigned and other considerations. For example, HRSA allows a maximum of six Healthy Start grant awards in a single state.

HRSA explains its multi-step process in the program's *Notice of Funding Opportunity*, so applicants understand how HRSA will evaluate their applications.[1]

For the 2024-2029 grant period, HRSA slightly changed its process to evaluate Healthy Start grant applications from the process used for the 2019-2024 grant period. For example, for the 2019 grant application, grantees had to complete all required application fields and demonstrate certain infant health outcomes in the communities they serve.[2] HRSA would then deem the application complete and eligible and move it on to step two in the evaluation process. For 2024 grant applications, HRSA plans to review the infant health outcome data as part of its second step in the evaluation process. As a result, to meet step one, the 2024 grant applications only have to demonstrate that all required fields of the application are complete. See table 5 for more details on the grant application evaluation steps and differences between these steps for the grant cycles beginning in 2019 and 2024.

[1]A *Notice of Funding Opportunity* is a public document that outlines the requirements for grant applications and how applications will be evaluated.

[2]Applicants were required to provide vital statistics data from a 3-year period (calendar years 2013-2015). Proposed project areas with 20 or more total infant deaths during the 3-year period needed an infant mortality rate that was 1.5 times the national average. Proposed project areas with fewer than 20 infant deaths during the 3-year period needed at least 100 low birthweight births or 100 preterm births and a corresponding low birthweight or preterm birth rate that was at least 1.5 times the national average.

Table 5: Process HRSA Used to Evaluate Healthy Start Grant Applications in 2019 and 2024

General evaluation steps	Key details for step in 2019	Changes to step for 2024
(1) Establish completeness and eligibility. HRSA reviews Healthy Start grant applications to ensure they are complete and eligible for the grant.	HRSA ensures all required fields of the application are complete.	No changes.
	The eligibility definition said that the applicant plans to serve an eligible community, which was defined as having rates of infant mortality, preterm birth, or low birthweight births that were 1.5 times the national average.[a]	This was removed as an eligibility requirement; instead it is included as part of the step 2 of the application evaluation process—assign scores.
(2) Assign scores. Complete and eligible applications are reviewed by a panel of subject matter experts who assign scores based on criteria.	Subject matter experts assigned each application a score up to 100 points based on six criteria: need, response, evaluative measures, impact, resources/capabilities; and support requested.	Subject matter experts will assign each application a score up to 85 points based on the same six criteria. HRSA can assign an additional 15 points to each application's score based on rates of adverse health outcomes such as infant mortality, preterm birth, and low birthweight for the community the applicant serves, which should exceed 1.5 times the national average.[b] (In 2019, this was an eligibility criteria.)
	HRSA assigned up to three additional points for applicants that were grantees in the prior 5-year grant period and served the required number of participants or met 14 of 19 performance measure targets.[c]	HRSA can assign up to two additional points for applicants serving communities in counties with an average of 20 or more infant deaths per year or with rates of poor maternal health, such as pre-pregnancy obesity, that were in the top 20 percent nationally.
(3) Make final award decisions. HRSA makes final award decisions taking into account the ratings assigned to each application and other considerations.	HRSA allowed maximum of 6 awarded grants per state.	No changes.
	HRSA allowed a maximum of 25 grant awards to applicants serving rural areas.	HRSA plans to award a minimum of 10 percent of grants to applicants serving rural areas.
	If two applicants plan to serve areas that overlap, HRSA would only award a grant to the highest scoring application.	If two applicants plan to serve areas that overlap, HRSA will consider awarding grants to both in limited circumstances, such as if one but not both applicants is serving tribes.
	With expected annual program funding of $95 million, the agency estimated it would fund approximately 100 applications.	With expected annual program funding of nearly $114 million, the agency estimated it would fund up to 103 applications.

Source: GAO analysis of Health Resources and Services Administration (HRSA) documentation. | GAO-24-106605

[a]Applicants were required to provide vital statistics data from a 3-year period (calendar years 2013-2015). Proposed project areas with 20 or more total infant deaths during the 3-year period needed an infant mortality rate that was 1.5 times the national average. Proposed project areas with fewer than 20 infant deaths during the 3-year period needed at least 100 low birthweight births or 100 preterm births and a corresponding low birthweight or preterm birth rate that was at least 1.5 times the national average.

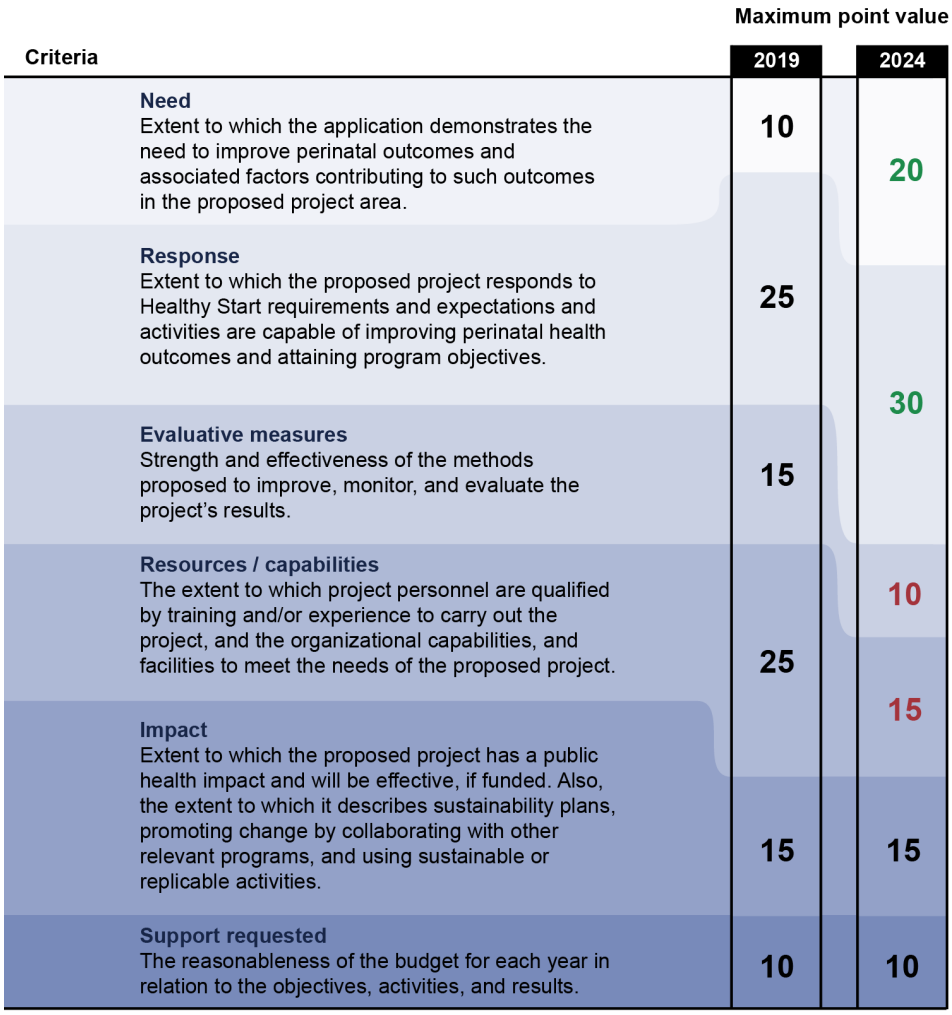
[b]Similar to applicants in 2019, applicants in 2024 are required to provide vital statistics data from a 3-year period (calendar years 2019-2021), but requirements were slightly different. Applicants planning to serve a population with 30 or more total infant deaths during the 3-year period needed an infant mortality rate that was 1.5 times the national average. Applicants planning to serve a population with fewer than 30 infant deaths during the 3-year period needed at least 90 low birthweight births or 90 preterm births and a corresponding low birthweight or preterm birth rate that was at least 1.5 times the national average.

[c]In the prior Healthy Start grant period (2014-2019), the program offered three levels of grant funding, each with slightly different expectations, including the number of participants to be served. Depending

on the level of funding received, grantees were expected to serve a minimum of 500, 800, or 1,000 participants per year; at least half of the participants for all grantees were expected to be pregnant.

See figure 7 for changes in step two of the Healthy Start grant application evaluation process—assign scores to applications—between the 2019 and 2024 application periods.

Figure 7: Healthy Start Grant Application Scoring Criteria in 2019 and 2024



Source: GAO analysis of Healthy Start Notice of Funding Opportunities for Fiscal Years 2019 and 2024. | GAO-24-106605

Appendix III: Additional Details on Information the Health Resources and Services Administration Collects from Healthy Start Grantees

The Health Resources and Services Administration (HRSA) uses birth outcomes data and performance measures to assess the progress of the Healthy Start program towards the goals of (1) reducing the rates of infant deaths and (2) improving maternal health outcomes before, during, and after pregnancy. HRSA also collects additional information from grantees on a regular basis to assess grantee performance. Table 6 provides details on this additional information collected from grantees.

Table 6: Summary of Additional Information HRSA Collects from Healthy Start Grantees

Information source	Description	Frequency	How HRSA uses information
Progress reports	Narrative reports that include any accomplishments and challenges.	Annually	Identify grantee strengths and challenges to connect them to appropriate technical assistance. This information may also be used to inform programmatic direction.
Monitoring calls	HRSA project officer conducts calls with the grantee.[a] Grantees provide written information on participants served, birth outcomes, project accomplishments, barriers, and any questions ahead of the call.	Monthly or quarterly	Identify grantee strengths and challenges to connect them to appropriate technical assistance. This information may also be used to inform programmatic direction.
Site visits	HRSA project officer conducts an on-site visits of the grantee project location.[a]	Once per grant period or more frequent, if needed	Substantiate sound financial management, program progress, and compliance with laws, regulations, and policies. Site visits may be conducted in response to a perceived problem or concern (e.g., delay in program start up).
Impact Report	Narrative report which includes descriptions of the implementation of the grant, accomplishments, and effect on the community.	Once at the end of the grant period	Identify promising practices and barriers. This information may also be used to inform programmatic direction in future grant periods.
Local evaluations	Each grantee works with an independent evaluator to conduct a local evaluation of grantee activities. The evaluation could be on a variety of aspects of the program. For example, for one grant cycle a grantee evaluated their breastfeeding program, while for another grant cycle they are conducting a longitudinal analysis of the effectiveness of their program on infant mortality.	Once at the end of the grant period	Determine whether the goals of the local program have been met and how the programs' activities have influenced the community.

Source: GAO summary of Health Resources and Services Administration (HRSA) documentation and Westat documentation and written responses from HRSA officials. | GAO-24-106605

[a]Healthy Start project officers provide assistance to grantees and monitor project performance, according to HRSA officials.

Appendix IV: Details of Healthy Start Performance Measures Changes between the 2019-2024 and 2024-2029 Grant Periods

The Health Resources and Services Administration (HRSA) uses performance measures with targets to assess individual Healthy Start grantee performance and, in turn, according to HRSA officials, overall program performance towards program goals. Table 7 details the differences between performance measures for the Healthy Start program's 2019-2024 and 2024-2029 grant periods.

Table 7: Comparison of Healthy Start Performance Measures for the 2019-2024 and 2024-2029 Grant Periods

2019-2024 performance measures *(and target[a])*	2024-2029 performance measures (*and target[a]*)
No equivalent performance measure, but grantees submitted data on prenatal care to HRSA annually.	Pregnant participants who receive prenatal care in the first trimester *(>80%)*
1. Women and child participants with health insurance *(>90%)*	Women and child participants with health insurance *(>90%)*
2. Women participants who have a documented reproductive life plan *(>90%)*	Removed
3. Women participants who receive a postpartum visit *(>80%)* Women participants who enrolled prenatally or within 30 days after delivery and received a postpartum visit between 4-6 weeks after delivery.	Women participants who receive a postpartum visit *(>80%)* Pregnant/newly postpartum participants, who had enrolled prenatally or within 30 days after delivery and received a comprehensive postpartum visit within 12 weeks of delivery.
4. Women and child participants who have a usual source of medical care *(>80%)*	Removed
5. Women participants that receive a well-woman visit *(>80%)*	Women participants who receive a well-woman/preventive visit in the past year *(>80%)*
6. Women participants who engage in safe sleep practices *(>80%)*	Infants placed to sleep following safe sleep practices *(>80%)*
7. Child participants whose parent/caregiver reports they were ever breastfed or pumped breast milk *(>82%)*	Infant participants who were: A. ever breastfed or fed breast milk *(>82%)*
8. Child participants whose parent/caregiver reports they were breastfed or fed breast milk at 6 months *(>61%)*	B. breastfed or fed pumped breast milk at 6 months *(>50%)*
9. Pregnant participants that abstain from cigarette smoking *(>90%)*	Pregnant participants that abstain from cigarette smoking, or using any tobacco products *(>90%)*
10. Women participants who conceive within 18 months of a previous birth *(<30%)*	Removed
11. Child participants who receive the last age-appropriate recommended well child visit based on the American Academy of Pediatrics schedule *(>90%)*	Child participants who receive the last age-appropriate recommended well child visit based on the American Academy of Pediatrics schedule *(>90%)*
12. Women participants who receive depression screening and referral *(100%)*	Women participants who receive depression screening *(>90%);* Of those who screen positive for depression, women participants who receive referral *(>95%)*
13. Women participants who receive intimate partner violence screening *(100%)*	Women participants who receive interpersonal violence screening *(>90%);* Of those who screen positive for interpersonal violence, women participants who receive referral *(>95%)*.

2019-2024 performance measures *(and target[a])*	2024-2029 performance measures (*and target[a]*)
14. Women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) during pregnancy *(>90%)*	Removed
15. Women participants that demonstrate father and/or partner involvement (e.g. attend appointments, classes, infant/child care) with their child participant *(>80%)*	Removed
16. Child participants aged <24 months who are read to by a parent or family member 3 or more times per week *(>50%)*	Removed
17. Programs with a fully implemented Community Action Network (CAN) *(100%)*	Removed
18. Programs with at least 25 percent community members and program participants serving as members of their CAN *(100%)*	Removed
19. Programs who establish a quality improvement and performance monitoring process *(100%)*	Removed

Source: GAO summary of Health Resources and Services Administration (HRSA) documentation. | GAO-24-106605

[a] HRSA establishes targets, or numerical goals, for grantees to reach for each performance measure.

Appendix V: Comparison of Performance Measures for the Healthy Start, MIECHV, and Title V Programs

The Healthy Start; the Maternal, Infant, and Early Childhood Home Visiting (MIECHV); and the Title V Maternal and Child Health Services Block Grant (Title V) programs, all administered by the Health Resources and Services Administration (HRSA), share certain similar performance measures. Specifically, Healthy Start and MIECHV have nine performance measures on the same topics. Healthy Start and Title V share eight performance measures on the same topics. However, in most cases, these measures did not use common definitions and terminology. Table 8 details the differences between the performance measures on the same topics for the Healthy Start, MIECHV, and Title V programs respectively.

Table 8: Comparison of Performance Measures for the Healthy Start, MIECHV, and Title V Programs

Healthy Start	Maternal Infant and Child Home Visiting Program (MIECHV)	State and Maternal Health Block Grant Program (Title V)
Women and child participants with health insurance as of the last assessment in the reporting period	Primary caregivers enrolled for at least 6 months who had continuous health insurance coverage for the most recent 6 consecutive months	Children, ages 0 through 17, who are reported by a parent to not be currently covered by any private or public health insurance
Women participants who enrolled prenatally or within 30 days after delivery and received a postpartum visit between 4-6 weeks after delivery	Mothers who enrolled prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery	*No equivalent measure.*
Women participants who received a well-woman or preventive (including prenatal or postpartum) visit in the 12 months prior to last assessment within the reporting period	*No equivalent measure*.	Women, ages 18 through 44, who report visiting a doctor for a routine checkup in the past year
Child participants who are ‘always’ or ‘most often’ 1) placed to sleep on their back, 2) always or often sleeps alone in his or her own crib or bed with no bed sharing, and 3) sleeps on a firm sleep surface (crib, bassinet, pack and play, etc.) with no soft objects or loose bedding	Infants that are always placed to sleep on their backs, without bed-sharing and without soft bedding	Mothers who report that they most often place their baby to sleep on their back only
		Mothers who report that their baby always/often slept alone, usually in a crib, bassinet, or pack and play, and not usually in a standard bed, couch, sofa, armchair, car seat, or swing in the past two weeks
		Mothers who report that their baby did not usually sleep with blankets, toys, cushions, pillows, or crib bumper pads in the past two weeks
Child participants that are ever breastfed or fed pumped breast milk, even for a short period of time	*No equivalent measure*.	Infants who are reported by a parent to have ever been breastfed
Participants that breastfeed or pumped breast milk to feed their new baby at 6 months	Infants (among mothers who enrolled prenatally) who were breastfed any amount at 6 months of age	Infants who are reported by a parent to have been breastfed exclusively through 6 months

Healthy Start	Maternal Infant and Child Home Visiting Program (MIECHV)	State and Maternal Health Block Grant Program (Title V)
Prenatal participants that abstain from using any tobacco products during the last 3 months of pregnancy	Primary caregivers who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment	Women who report smoking during pregnancy
Child participants who receive the last recommended well child visit based on the American Academy of Pediatrics (AAP) schedule	Children who received the last recommended visit based on the AAP schedule	*No equivalent measure.*
Women participants screened for clinical depression using an age appropriate standardized tool and, if screened positive for depression, received a referral for follow-up services	Primary caregivers screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally)	Women who report postpartum depressive symptoms following a recent live birth (defined as reporting always/often feeling down, depressed, hopeless or always/often having little interest or little pleasure in doing things)
	Primary caregivers referred to services for a positive screen for depression who receive one or more service contacts	
Women participants who receive intimate partner violence (IPV) screening using a standardized screening tool during the reporting period	Primary caregivers who are screened for IPV within 6 months of enrollment using a validated tool	*No equivalent measure.*
	Primary caregivers with positive screens for IPV (measured using a validated tool) who receive referral information for IPV resources	*No equivalent measure.*
Women and child participants who have a usual source of medical care[a]	*No equivalent measure.*	Children with and without special health care needs, ages 0 through 17, who are reported by a parent to meet the criteria for having a medical home (personal doctor or nurse, usual source for care, family-centered care, referrals if needed, and care coordination if needed)
Child participants aged 6 through 23 months who are read to 3 or more times per week, on average[a]	Children with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily, every day	*No equivalent measure.*

Source: GAO summary of Health Resources and Services Administration documentation. | GAO-24-106605

Notes: For the performance measures above, we incorporated information from data dictionaries when necessary, as the measure names and descriptions did not always include relevant details needed to compare across measures.

[a]Healthy Start will not use this performance measure in the upcoming 2024-2029 grant period.

Appendix VI: Comment from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

March 12, 2024

Mary Denigan-Macauley
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Denigan-Macauley:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, **"MATERNAL AND INFANT HEALTH: HHS Should Strengthen Processes for Measuring Program Performance" (GAO-24-106605).**

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — MATERNAL AND INFANT HEALTH: HHS SHOULD STRENGTHEN PROCESSES FOR MEASURING PROGRAM PERFORMANCE MEASURES (GAO-24-106605)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

Recommendation 1
The Administrator of HRSA should implement a documented process to review Healthy Start performance measures (including their definitions, associated data collection forms, and data dictionary), before a grant period begins, to ensure they are clear and allow for the collection of reliable data.

HHS Response
HHS partially concurs with GAO's recommendation. HHS already has an implemented process utilizing a standard approach for reviewing and updating performance measures prior to the start of Healthy Start program grant periods.

In January 2024, HHS provided GAO a detailed description of its implemented process supported by documentation including:

- A Foundational Program Summary to guide program planning;
- A Logic Model used to select and update performance measures;
- Notices of Funding Opportunities, which include final performance measures; and
- Information collection forms and data dictionary.

Consistent with this recommendation, HHS is actively working to formally document this process in greater detail.

Recommendation 2
The Administrator of HRSA should implement a documented process for program officials to coordinate the selection of performance measure across its related programs – Healthy Start; the Maternal, Infant, and Early Childhood Home Visiting; and the Title V Maternal and Child Health Services Block Grant.

HHS Response
HHS concurs with GAO's recommendation. Healthy Start; the Maternal, Infant, and Early Childhood Home Visiting; and the Title V Maternal and Child Health Services Block Grant are three statutorily distinct programs with distinct purposes. Performance measures must reflect these statutory distinctions. Nonetheless, HHS has been implementing a process to coordinate the selection of performance measure across its related programs where possible and is currently taking steps to document this process.

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Mary Denigan-Macauley, (202) 512-7114, deniganmacauleym@gao.gov

Staff Acknowledgments

In addition to the individual named above, Deirdre Brown (Assistant Director), Jennifer Lucado (Analyst-in-Charge), Laurie Chin, and John (Mac) Emery made key contributions to this report. Also contributing were Jennie Apter, Sonia Chakrabarty, Jeanne Murphy-Stone, Eric Peterson, and Ethiene Salgado-Rodriguez.

Related GAO Products

Maternal Health: HHS Should Improve Assessment of Efforts to Address Worsening Outcomes. GAO-24-106271. Washington, D.C.: Feb. 21, 2024.

Midwives: Information on Births, Workforce, and Midwifery Education. GAO-23-105861. Washington, D.C.: Apr. 26, 2023.

Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas. GAO-23-105515. Washington, D.C.: Oct. 19, 2022.

Maternal Health: Outcomes Worsened and Disparities Persisted During the Pandemic. GAO-23-105871. Washington, D.C.: Oct. 19, 2022.

Health Care Capsule: Racial and Ethnic Health Disparities. GAO-21-105354. Washington, D.C.: Sept. 23, 2021.

Maternal Mortality and Morbidity: Additional Efforts Needed to Assess Program Data for Rural and Underserved Areas. GAO-21-283. Washington, D.C.: Apr. 8, 2021.

Maternal Mortality: Trends in Pregnancy-Related Deaths and Federal Efforts to Reduce Them. GAO-20-248. Washington, D.C.: Mar. 12, 2020.

Maternal and Child Home Visiting Program: HHS Determined That States Generally Met the Maintenance of Effort Requirement. GAO-19-645. Washington, D.C.: Sept. 17, 2019.

Healthy Start: Preliminary Results from National Evaluation Are Not Conclusive. GAO/HEHS-98-167. Washington, D.C.: June 15, 1998.

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