

**Early Childhood Interagency Coordinating  
Council  
Strategic Report to the Governor on the Status  
of Early Childhood  
2012**



This report was prepared with the assistance of staff from the  
Nebraska Department of Education  
Head Start State Collaboration Office  
Nebraska Department of Health and Human Services

For more information about the ECICC see: <http://www.education.ne.gov/ecicc/>

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## I. Executive Summary and 2012 Recommendations

The Early Childhood Interagency Coordinating Council (ECICC) was established in state statute to advise the state agencies around issues of early childhood care and education. State statutes require that the Council “report biennially to the Governor and the Legislature on the status of early intervention and early childhood care and education in the state.” *Nebraska Revised Statutes, Chapter 43, Section 43-3401 to 43-3403.*

In 2008 Governor Heineman designated the ECICC as the State Advisory Council as required by the 2007 federal Improving Head Start for School Readiness Act (*Public Law 110-134, Statutes 1411-1413, Section 11, Section 642 B*). This report also includes information that is required according to those federal statutes.

The 2012 Strategic Report on the Status of Early Childhood is organized according to the Together for Kids and Families Strategic Plan (Nebraska’s Early Childhood Comprehensive Systems’ Grant). The ECICC approved the Together for Kids and Families Strategic Plan as its strategic plan in 2006 and continues to approve revisions to the plan and serve as its advisory committee. The Together for Kids and Families Strategic Plan has four critical component areas. The report will first address the status of the four critical component areas of the strategic plan including 1) parent education and family support; 2) social-emotional development and mental health; 3) early care and education; 4) medical and dental home and health services. The report will then address the infrastructure that exists to address early care and education in the state.



The Gaps and Barriers Identified throughout the 2012 Strategic Report to the Governor on the Status of Early Childhood are summarized in the table below.

<b>Focus Area</b>	<b>Gaps and Barriers Identified</b>
<b>Parent Education and Family Support</b>	<ul style="list-style-type: none"> <li>● Parents have difficulty locating information and resources when needed</li> <li>● Lack of support systems for parents struggling with a specific issue</li> <li>● Parents are delaying the age when children enter school</li> </ul>
<b>Social Emotional Development/Family Support</b>	<ul style="list-style-type: none"> <li>● More resources are needed to address the social and emotional needs of young children</li> <li>● Need for more mental health professionals prepared to work with young children</li> </ul>
<b>Early Care and Education</b>	<ul style="list-style-type: none"> <li>● Challenges of getting services to children and families throughout the state due to geographic distances</li> <li>● Finding available and qualified interpreters when working with families whose first language is other than English or for families who have members who are deaf or hearing impaired</li> <li>● Challenges in working to integrate and align all early childhood data systems among Head Start and state data systems</li> <li>● Limited availability of high quality services for children from birth to age 3</li> <li>● Need to access professional development other than through face to face training</li> </ul>
<b>Medical and Dental Home and Health Services</b>	<ul style="list-style-type: none"> <li>● There is a shortage of health and dental professionals in many Nebraska counties</li> </ul>

The ECICC developed and approved the following recommendations to forward on to the Governor and the state agencies based upon their knowledge of the status of early childhood in Nebraska and the information contained in this report.

### **Parent Education and Family Support**

1. Fund and support community capacity building for parent education and family support.
2. Promote increased resources and coordination to provide information and support to all families with young children to assist parents in their role as a child's first teacher.
3. Fully fund the child care subsidy system to support families in the workforce by moving the income eligibility rate to 185% of poverty.

### **Social-Emotional Development/Mental Health**

4. Ensure that all children from birth through age 8 are screened for social-emotional development delays.
5. Provide support that promotes young children's positive social and emotional development in all early childhood settings.
6. Increase the number of trained professionals available to support young children's social and emotional development.
7. Support Mental Health Consultation for children birth through age 8 by targeting prevention funds and expanded partnerships with regional behavioral health systems.

### **Early Care and Education**

8. Sustain and expand the availability of quality early childhood care and education settings through Nebraska's Early Childhood Education Grant Program and Early Childhood Education Endowment Fund Program (Sixpence Programs) in collaboration and coordination with community programs including Head Start and Early Head Start.
9. Promote physical activity and healthy nutrition practices in all early care and education settings.
10. Develop increased accountability for early care and education programs that receive federal/state funding in early care and education.
11. Continue to promote inclusive practices for children with special needs in all early childhood care and education programs, school districts, and before and after school programs.

### **Medical and Dental Home and Health Services**

12. Increase the number of dentists serving young children and families in a dental health care home that provides regular routine dental care and education and recommendations for any special dental health care the child might need.
13. Support, promote and expand a medical home approach to ensure continuity of health services for all young children and their families.
14. Focus outreach to eligible families and health providers to improve EPSDT (Early Periodic Screening and Diagnostic Testing) utilization rates.



## II. Overview of the Early Childhood Interagency Coordinating Council

The Early Childhood Interagency Coordinating Council (ECICC) was established in state statute in 2000. All members of the Council are appointed by the Governor and serve up to two three-year terms. Representation on the council includes: parents of children with disabilities, early care and education providers and programs, Head Start programs, state agency representatives, and other health professionals as designated in statute. The Council is chaired by a governor-designated chairperson. The Council is responsible to:

- 1) Promote the policies set forth in the Early Intervention Act, the Quality Child Care Act, and section 79-1101 to 79-1104;
- 2) Facilitate collaboration with the federally administered Head Start program;
- 3) Make recommendations to the Department of Health and Human Services, the State Department of Education, and other state agencies responsible for the regulation or provision of early childhood care and education programs on the needs, priorities, and policies relating to such programs throughout the state;
- 4) Make recommendations to the lead agency or agencies which prepare and submit applications for federal funding;
- 5) Review new or proposed revisions to rules and regulations governing the registration or licensing of early childhood care and education programs;
- 6) Study and recommend additional resources for early childhood care and education programs; and
- 7) Report biennially to the Governor and the Legislature on the status of early intervention and early childhood care and education in the state.

In 2007 the federal Improving Head Start for School Readiness Act passed and required governors to designate a state advisory council for early care and education. Governor Heineman designated the ECICC as the state advisory council for Nebraska. The state advisory council had additional responsibilities as pertains to the federal Improving Head Start for School Readiness Act. The responsibilities define in the Act include:

- 1) Conduct a periodic statewide needs assessment concerning the quality and availability of early childhood education and development programs and services for children from birth to school entry, including an assessment of the availability of high-quality pre-kindergarten services for low-income children in the state.
- 2) Identify opportunities for, and barriers to, collaboration and coordination among Federally-funded and State-funded child development, child care, and early childhood education programs and services, including collaboration and coordination among State agencies responsible for administering such programs.
- 3) Develop recommendations for increasing the overall participation of children in existing Federal, State and local child care and early childhood education programs, including outreach to underrepresented and special populations;
- 4) Develop recommendations regarding the establishment of a unified data collection system for public early childhood education and development programs and services throughout the state;

- 5) Develop recommendations regarding statewide professional development and career advancement plans for early childhood educators in the State;
- 6) Assess the capacity of 2-year and 4-year public and private institutions of higher education in the State toward supporting the development of early childhood educators, including the extent to which such institutions have in place articulation agreements, professional development and career advancement plans, and practice or internships for students to spend time in a Head Start or prekindergarten program; and
- 7) Make recommendations for improvement in State early learning standards and undertake efforts to develop high-quality comprehensive early learning standards as appropriate.

In addition the Council is required to hold a public hearing and provide an opportunity for public comment on the responsibilities described above. All strategic reports will be available for public hearing and comment. Additionally, the ECICC does allow time for public comment during all Council meetings.

### **Committees of the ECICC:**

The Early Childhood Interagency Coordinating Council has five committees. The five committees are the Family Leadership Team, Regulations and Standards, Professional Development and Workforce, Family Actions Matter Everyday (FAME), and the Early Childhood Services and Systems Committee. The purpose of each committee is:

**Family Leadership Team:** Promotes and makes recommendations to the ECICC on issues directly related to families with infants, toddlers and young children, in particular families participating in the Early Development Network (EDN) and the Individuals with Disabilities Education Act (IDEA) Part B 619 Services. Establishes communication methods to identify prioritized issues by local Planning Region Teams, families and early childhood professionals, and make recommendations to the ECICC in accordance with the Early Intervention Act.

**Regulations and Standards:** Reviews proposed legislation, regulations and standards. Helps make the full Council aware of legislation that might impact early childhood care and education and takes recommendations to the full Council regarding revisions to regulations and standards.

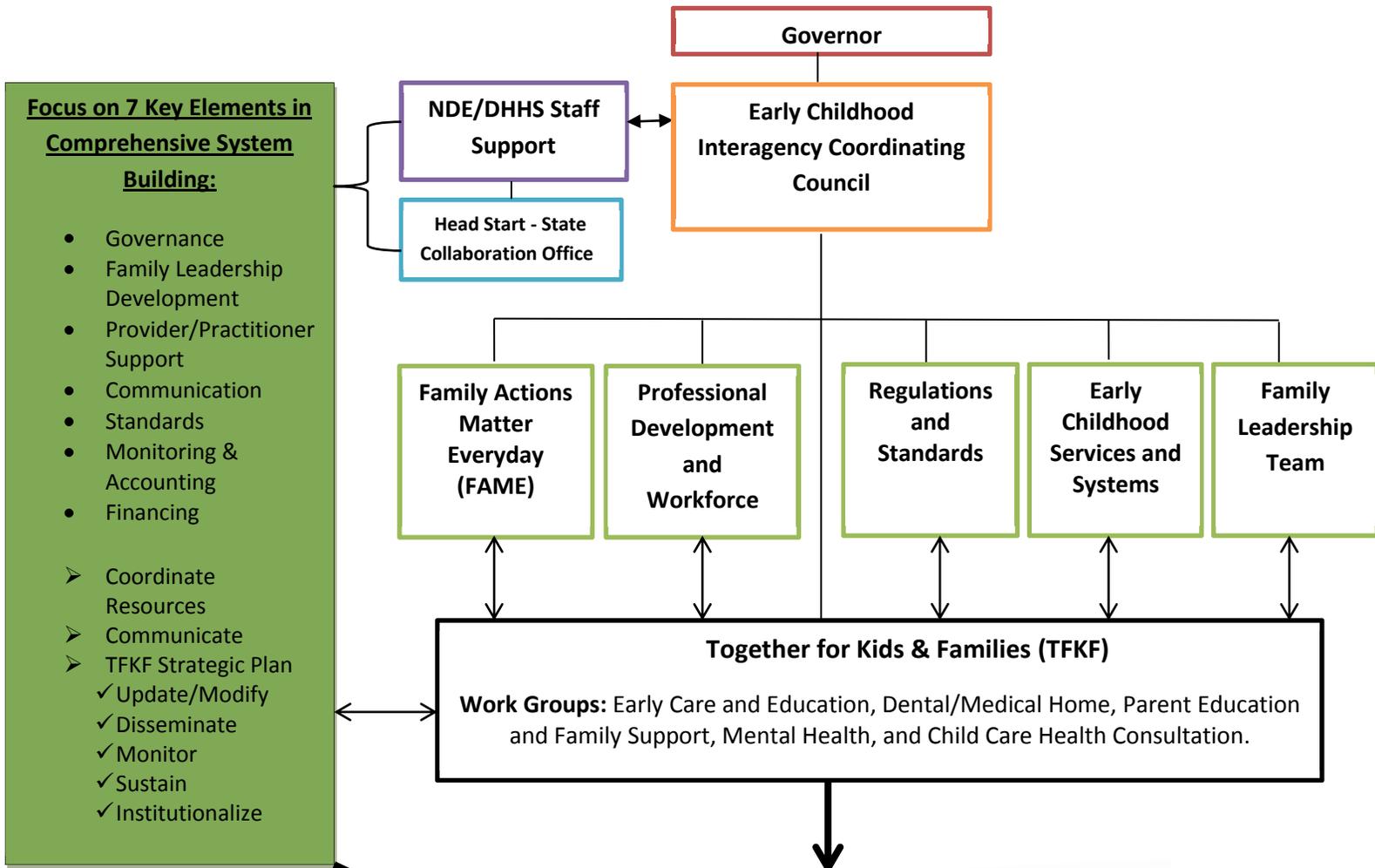
**Professional Development and Workforce:** Addresses early childhood professionals' credentials, workforce data, scholarship programs, and turnover and retention issues in the early childhood field, professional shortages, the professional development system, and the 2-year and 4-year higher education preparation programs for early childhood professionals.

**Family Actions Matter Everyday (FAME):** Examines ways to further engage families in the care and education of young children. Reviews ways the family voice can be further developed in schools and services. Examines the supports available for families through the Answers 4 Families website; and resource and referral resources to assist families in finding and understanding the early childhood care and education services available.

**Early Childhood Services and Systems:** Reviews the array of early care and education services available throughout the state. Reviews whether the services system is meeting the needs of young children across the state, and reviews data to ensure that services are meeting their intended goals.

The following chart displays the various committees and their relationship to the ECICC. The ECICC also serves as the advisory committee for the Together for Kids and Families Strategic Plan and their respective work groups. Additional ad hoc committees of the ECICC have been established over the years to complete a specific set of work for the Council and are usually time limited.





**Together For Kids and Families (TFKF) Organizational Chart**

### III. The Together for Kids and Families Strategic Plan

#### Together for Kids and Families Strategic Plan

The Early Childhood Interagency Coordinating Council became the advisory committee for the Early Childhood Comprehensive Systems (ECCS) Grant which led to the development of the Together for Kids and Families Strategic Plan. The strategic plan is a shared document that is utilized across the Department of Health and Human Services, the Department of Education, and the Head Start State Collaboration Office to guide work and new developments in the early childhood field. The following section describes the history of the Strategic Plan development and the critical component areas addressed in the plan and in this report.

#### **Together For Kids and Families Organizational Structure: Elements of an Early Childhood System**

##### *History and the Critical Component Areas:*

Together for Kids and Families (TFKF) began as a two-year strategic planning grant awarded to Nebraska Department of Health and Human Services in 2003 to address comprehensive early childhood systems, including at a minimum:

- medical home
- social-emotional development/mental health
- early care and education
- parent education
- family support

Funded through the State Early Childhood Comprehensive Systems (ECCS) Grant Program administered by the Maternal and Child Health Bureau, US Health and Human Services the comprehensive strategic plan was required to include:

- A needs assessment/environmental scan
- A clear vision and mission statement, priority areas of focus, and specific goals/objectives
- A set of indicators to track early childhood outcomes and a plan for collecting data
- Identification of best practice, evidence-based models and how they will be implemented
- Identification and involvement of key partners and the role each will play in carrying out the strategic plan
- Demonstration of how the plan links to and leverages other initiatives
- Evidence that the planning process is positioned to maximize the greatest policy impact
- A sustainability plan

### *Development of the Strategic Plan*

#### 2003-2006: Strategic Planning

- The Early Childhood Interagency Coordinating Council (ECICC) agreed to serve as overall advisory body.
- Leadership Team and eight work groups formed, consisting of early childhood (EC) stakeholders from across Nebraska
- Result of stakeholder driven planning was a strategic plan that consisted of 19 topic area strategies and 2 data strategies which was approved by the ECICC and federal project officers to begin implementation Spring of 2006

#### 2006-2009: Strategic Plan Implementation

- The ECICC continued to serve as the advisory body and an Implementation Team was formed
- The 19 topic area strategies and 2 data strategies that were chosen during planning were divided among the eight work groups whose members formed the Implementation Team
- The data group completed an indicator report included in the ECICC Report to the Governor on the Status of Early Childhood in 2008.

#### 2009-2012: Strategic Plan revised and implementation ensues

- Federal ECCS Guidance for 2009-2012 ECCS program development set new priorities that re-emphasized:
  - The ECCS Critical Components
  - Key Elements in Comprehensive System Building
  - Strengthening Collaborations and Partnerships
- An updated work plan that consists of 12 strategies was completed in 2010. The strategies and documents of the Together for Kids and Families Strategic Plan can be viewed on the Together for Kids and Families webpage [www.dhhs.ne.gov/TogetherKidsFamilies](http://www.dhhs.ne.gov/TogetherKidsFamilies)

### *Goals and Strategies of the Strategic Plan*

The strategic plan is organized around four goals developed from the ECCS critical component areas:

- Parent Education/Family Support Services [two component areas combined into one goal]
- Mental Health/Social and Emotional Behavioral Health
- Early Care and Education
- Access to Health Care/Medical and Dental Home

The chart on the following page describes the goals and strategies for implementing the Strategic Plan. It also shows how the plan aligns with the priorities of the Head Start State Collaboration Office (HSSCO).

## **The Goals and Strategies of Together For Kids and Families (TFKF)**

*Aligned with the priorities of the Head Start State Collaboration Office (HSSCO)*

<b>TFKF GOALS</b>			
Early care and education in Nebraska is high quality, developmentally appropriate and accessible to all children.	All Nebraska children have access to a dental/medical home, and receive high quality health services.	The early childhood social, emotional and behavioral health needs of Nebraska's children are met.	Nebraska families support their children's optimal development by providing safe, healthy & nurturing environments.
<i>Infrastructure Building Through Development of a Network of Child Care Health Consultants*</i>			
<i>Access to Medical Homes and Health Insurance Through Early Care and Education Providers*</i>			
<i>Quality Through Standards*</i>	<i>* Healthy Child Care America (HCCA) Goals</i>		<i>12-17-12</i>
<b>Head Start-State Collaboration Office Priorities</b>			
<p><i>Facilitate collaboration among Head Start agencies and State and local entities to emphasize: school transitions and school readiness, interoperability of data systems, professional development (i.e., partnerships with higher education) and quality child care and early childhood systems. Other priorities as determined by the Federal Offices, Region VII Head Start, include: health and disabilities, oral health, mental health, child welfare, family literacy, community services, and access to quality programs and services for military families.</i></p>			
<b>TFKF STRATEGIES<sup>1</sup></b>			
<b>Dental/Medical Home</b>			
<ol style="list-style-type: none"> <li>1. Implement and sustain the dental/medical home as a standard of care.</li> <li>2. Establish the infrastructure to support a comprehensive system promoting access to oral health services including preventive oral health care.</li> </ol>			
<b>Parent Education/Family Support</b>			
<ol style="list-style-type: none"> <li>3. Promote and support evidence-based home visitation services for families with young children.</li> <li>4. Promote integration of parent-to-parent peer support systems, when appropriate, into programs and services for families.</li> <li>5. Increase access to respite services to meet the needs of families.</li> <li>6. Coordinate statewide systems for sharing comprehensive information with families.</li> </ol>			
<b>Early Care &amp; Education</b>			
<ol style="list-style-type: none"> <li>7. Through a mixed delivery system, provide access to voluntary, high quality, early childhood education and care programs and services that meet the needs of all young children and their families.</li> <li>8. Develop and refine a system of support to improve the quality and effectiveness of early childhood education and care programs and services.</li> </ol>			
<b>Child Care Health Consultation</b>			
<ol style="list-style-type: none"> <li>9. Develop early childhood health &amp; safety communication network(s).</li> <li>10. Disseminate data-driven and evidence-based training and material resources to improve health and safety in child care.</li> </ol>			
<b>Mental Health</b>			
<ol style="list-style-type: none"> <li>11. Assist communities to develop/enhance an effective system of care to support the social, emotional and behavioral health needs of Nebraska's young children.</li> <li>12. Build the capacity of individuals who interact with young children to support social, emotional and behavioral health.</li> </ol>			

## IV. Statewide Needs Assessments

The Department of Health and Human Services and Department of Education conduct or fund a variety of needs assessments to better determine where needs and gaps and services exist within the state.

Over the last two years a variety of needs assessments have been conducted. A few of the needs assessment conducted are:

- a. The Title V Needs Assessment
- b. The Head Start Needs Assessment
- c. Parent-to-Parent Survey conducted by the University of Nebraska Medical Center

Key findings from each of the needs assessments conducted were:

### a. Title V Needs Assessment-

The Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA) provide detailed guidance for states receiving Title V Maternal and Child Health (MCH) Block Grant funds. The Nebraska Department of Health and Human Services (NDHHS), Division of Public Health is a recipient of the Title V Block Grant. Within the Division of Public Health the Lifespan Health Services Unit is responsible for administrating the Block Grant in coordination with the Division of Medicaid and Long-Term Care, Long-Term Care Section. One requirement of the Title V statute (Title V of the Social Security Act) is to conduct a statewide needs assessment every five (5) years that shall identify the need for:

- Preventative and primary care services for pregnant women, mothers, and infants
- Preventive and primary care services for children; and
- Services for Children with Special Health Care Needs (CSHCN)

The most recent Needs Assessment was conducted during the period of spring of 2009 through July, 2010. This Needs Assessment addresses the Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) populations in Nebraska and establishes priorities for the years 2010-2014.

Nebraska's MCH/CSHCN identified priorities are:

- Increase the prevalence of the MCH/CSHCN population who are physically active, eating healthy, and are at a healthy weight.
- Improve the reproductive health of youth and women by decreasing the rates of STDs and unintended pregnancies.
- Reduce the impact of poverty on infants/children including food insecurity.
- Reduce the health disparities gap in infant health status and outcomes.
- Increase access to oral health care for children and CSHCN.
- Reduce the rates of abuse and neglect of infants and CSHCN.
- Reduce alcohol use and binge drinking among youth.
- Increase quality of and access to perinatal health services, including pre/inter-conception health care, prenatal care, labor and delivery services, and postpartum care.

- Increase the prevalence of infants who breastfeed exclusively through 6 months old.
- Increase access to Medical Homes for CSHCN particularly for those with functional limitations.

The full report may be found at

<http://dhhs.ne.gov/publichealth/Documents/NeedsAssessmen2010FINAL.pdf>

## **b. Head Start-State Collaboration Office Needs Assessment**

The Nebraska Head Start-State Collaboration Office (HSSCO) finished its twentieth year of operation at the close of 2009. That also coincided with preparation of a new five-year grant cycle and the HSSCO is in its third year of that cycle. An initial comprehensive needs assessment was conducted in 2008 and updates annually inform the development of the work plan. A second comprehensive needs assessment was conducted in 2012 of Head Start and Early Head Start grantees, including American Indian and Migrant grantees to determine their capacity of coordination, cooperation, and collaboration in priority areas. The needs assessment survey questionnaire was organized around the eight national priority areas for the HSSCOs. These priority areas are:

- Health Services
- Services for Children Experiencing Homelessness
- Welfare/Child Welfare
- Family Literacy
- Services for Children with Disabilities
- Community Services
- Education (School Readiness, Head Start-Pre-K Partnership Development)
- Child Care

In addition, sections were included to cover these additional Federal Goals:

- Head Start Transition and Alignment with K-12
- Professional Development
- Early Childhood Systems

Based upon the results of the needs assessment survey, the following areas are in need of additional collaboration planning:

- Mental health services;
- Tribal agencies
- Early childhood systems

*August 2012 Nebraska Head Start State Collaboration Office 2011-2012 Needs Assessment*

### **c. Parent to Parent Support Survey Project**

*(Together for Kids and Families)*

The purpose of the Parent to Parent Support Survey Project is to gather valid information in order to inform early childhood advocates and stakeholders about:

- The efficacy of parent-to-parent peer support models as a method of service delivery
- The extent to which this type of service delivery is occurring in Nebraska
- Barriers and limitations to implementing such services

The Together for Kids and Families Parent Education-Family Support Work group worked with UNMC-College of Nursing to gather information from parents. Findings to date include:

- Participant awareness of parent support groups is primarily from medical agencies (pediatrician/doctors) followed by the internet and other parents.
- Majority of the participants belonged to the parent support groups 2 years or less and there is no monetary incentive provided for attending. A formal leader or facilitator such as an experienced parent or professional (social worker) leads the groups.
- Majority of participants noted the need for childcare services during the parent groups.
- Majority of participants noted transportation was NOT provided to support groups;
- Spanish-speaking participants noted transportation as a concern and need.
- All participants felt that the parent support group they attended was helpful. The most helpful model among participants was having a combination of both parents and a group facilitator.
- A majority of participants were interested in formal options such as courses or classes on the topics that were of interest to them.

Follow up on the Parent to Parent Support Survey Report will include further data analysis and focus groups. A final report will be developed by UNL-Extension with recommendations. The final report should be done by January 2014.



## V. Status Report on the Critical Component Areas of Together for Kids and Families Strategic Plan

The Status Report section of this report will be organized to include the Goal for each specific Critical Component area from the Together for Kids and Families Strategic Plan, the specific data indicators that are currently monitored related to that goal and Critical Component Areas by Together for Kids and Families and the Early Childhood Interagency Coordinating Council, other relevant data that informs the Critical Component areas, and then a brief discussion of what is working well related to these initiatives and where there might be gaps and barriers in services.

### a. Parent Education/Family Support Services

#### Goal, Indicators and Relevant Data

**Parent Education and Family Support Goal: Nebraska families support their children’s optimal development by providing safe, healthy, and nurturing environments.**

Indicator 1. Percent of mothers who participated in parenting classes during their most recent pregnancy<sup>1</sup>:

This indicator measures the estimated number of new mothers who report attending a parenting class during their pregnancy. It is based on the assumption that parents who participate in parenting classes are more likely to “support their children’s healthy development.” Data indicate that women who attend classes are more likely to be older, college educated and married. There has been a statistically significant decline in participation from a high of 18.3% in 2002 to 13.8% in 2010. It is unknown if the availability of classes has declined.

Indicator 2. Percentage of Nebraska children (birth through age 8) with family incomes less than 100% of the federal poverty threshold

Children raised in poverty are more likely to experience poor health, diminished personal and social development and have decreased educational attainment and earning potential. Poverty status is determined by comparing annual income to a set of dollar values called thresholds that vary by family size, number of children, and age of householder. If a family’s before-tax monetary income is less than the dollar value of their threshold, then that family and every individual in it are considered to be in poverty. The poverty thresholds are updated annually to allow for changes in the cost of living using the Consumer Price Index (CPI-U). They do not vary geographically.

In 2011, the poverty threshold for a single parent with one related child under the age of 18 was \$15,504; for a family of four with two parents and two related children under the age of 18 the poverty

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<sup>1</sup>Nebraska Department of Health and Human Services, Pregnancy Risk Assessment Monitoring System (PRAMS), 2002-2010

threshold was \$23,581<sup>2</sup>. In 2011, 17.5% of Nebraska's children less than 9 years old lived in poverty<sup>3</sup>. While this figure has ranged, from a high of 21.5% in 2008 to a low of 12.9 % (2006), the average over the ten years was 15.8%, with no significant linear trend.

Indicator 3: Rate of substantiated child protective services cases per 1,000 Nebraska children (birth through age 8)

Abuse and neglect can disrupt growth and development, lower self-esteem, perpetuate a cycle of violence and cause or exacerbate mental health problems. According to the Centers for Disease Control and Prevention's National Center for Injury Prevention and Control, children younger than 4 years old are at the greatest risk for severe injury or death due to abuse or maltreatment<sup>4</sup>. This is often due to lack of parent education regarding typical development and minimal coping skills.

The rate of abuse for children birth through age 8 in Nebraska averaged 14.0/1,000 from 2004-2011 and ranged from a low of 12.3/1,000 in 2006 to a high of 15.3/1,000 in 2011, with no significant linear trend.<sup>5</sup>

Indicator 4: Number of Nebraska children (1-8 years) who die of an unintentional injury, per 100,000

Unintentional injuries are the leading cause of death and hospitalizations among children ages 1-8, in Nebraska and nationally. Unintentional injuries are preventable and include incidents such as motor vehicle crashes, falls, firearms discharge, drowning, and exposure to smoke, fire, and poisoning.

In 2010, a rate of 7.2/100,000 deaths were reported, down from 14.6 in 2003.<sup>6</sup> This represents a statistically significant decrease. This decrease is part of a larger trend (as seen on the following page) for childhood death overall.

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<sup>2</sup> U. S. Census Bureau, Poverty Thresholds 2010: Poverty Thresholds for 2010 by Size of Family and Number of Related Children Under 18 Years (Dollars).

<http://www.census.gov/hhes/www/poverty/data/threshld/index.html>

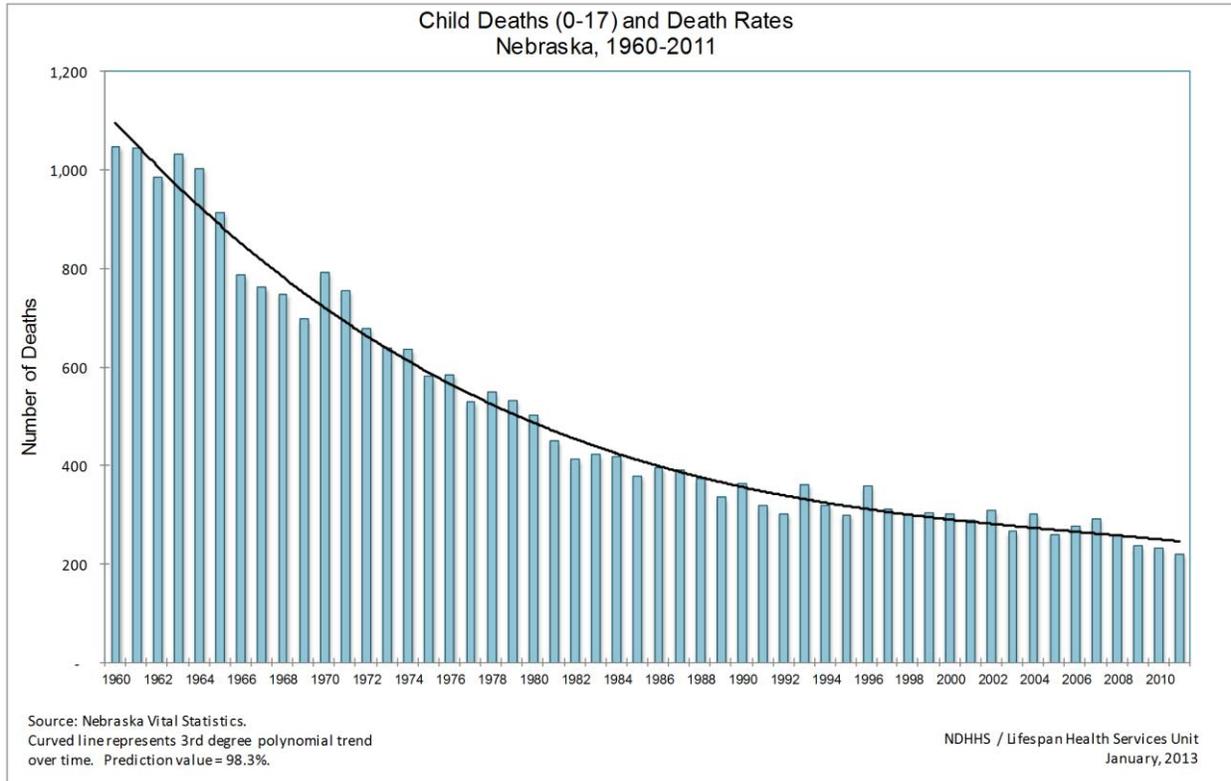
<sup>3</sup> US Census Bureau, Current Population survey, Annual Social and Economic Supplement, 2010, 2010.

<http://www.census.gov/cps/>

<sup>4</sup> Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Child Maltreatment: Fact Sheet, 2008. <http://www.cdc.gov/ncipc/dvp/CMP/default.htm>

<sup>5</sup> Nebraska Department of Health and Human Services, Child Abuse and Neglect Reports 2004-2011.

<sup>6</sup> Nebraska Department of Health and Human Services, Vital Statistics 2003-2010. Unpublished



## Other State-level Data: Parent Education and Family Support

### Child Welfare Data

Overall reports for child abuse and neglect in Nebraska for calendar year 2011:

**Investigations:** There were 15,175 cases assessed in 2011 compared to 14,161 cases in 2010. This is an increase of 1014 (6.6%). Compared to the 14,039 cases assessed in 2009, this is an increase of 1136 (7.4 %) reports of child abuse or neglect assessed by the Department of Health and Human Services (DHHS).

**Substantiated Cases:** 3,410 reports were substantiated in 2011 compared to 3,396 reports that were substantiated in 2010. This is an increase of 14 (.41%).

**Number of Children Involved:** There were 5,074 children that were involved or identified as a victim in at least one of the substantiated reports in 2011. This is a decrease of 95 compared to the 5169 children identified in 2010.

- Statewide, physical and emotional neglect together with neglect of medically handicapped infants was the most frequently substantiated form of child abuse or neglect and accounted for 4586 (90.38%) of all substantiated allegations in 2011.

- Physical and emotional abuse was the second most frequent substantiated form of child abuse or neglect and accounted for 660 (13.01%) of all substantiated allegations in 2011.
- Sexual abuse, the third major category of child abuse or neglect, had 386 (7.61%) substantiated allegations in 2011.

The average age for the involved children was 6.59 years. The median age of the involved children was 6.00 years. The following table shows the numbers of substantiated reports of abuse and neglect by age and gender.

<b>SUBSTANTIATED VICTIMS BY AGE AND GENDER</b>					
AGE IN YEARS	2011				
	GENDER		Total	%	Cumulative
	Female	Male			
<2	462	499	961	18.9%	
2	204	237	441	8.7%	27.63%
3	190	218	408	8.0%	35.67%
4	197	166	363	7.2%	42.83%
5	158	166	324	6.4%	49.21%
6	164	177	341	6.7%	55.93%
7	139	141	280	5.5%	61.45%
8	119	133	252	5.0%	66.42%
9	126	125	251	4.9%	71.36%
10	111	126	237	4.7%	76.03%
11	101	111	212	4.2%	80.21%
12	101	88	189	3.7%	83.94%
13	101	88	189	3.7%	87.66%
14	117	69	186	3.7%	91.33%
15	112	69	181	3.6%	94.90%
16	95	46	141	2.8%	97.67%
17	59	42	101	2.0%	99.66%
>17	9	8	17	0.3%	100.00%
<b>Total</b>	2,565	2,509	5,074		

## Highlights Parent Education and Support Services in Nebraska

### Child Line-Resource and Referral Services

Nebraska has a toll-free information line that provides assistance to both early care and education providers and to families looking for child care. The Child Line may be reached Monday-Friday, 8 am-5pm Central Time by calling **1-800-89-CHILD** outside the Omaha area or **402-557-6889** in the Omaha

area. Visitors are always welcome to visit the Early Childhood Training Center during business hours, or leave a message after hours.

### **Nebraska Resource and Referral Website**

The Nebraska Resource and Referral System website provides Nebraskans a user-friendly system for locating a wide array of services in Nebraska. Providers are able to search by town and zip code for services including child care, counseling and support services, health professionals, interpreters, mediation centers, medical/health, out of home placement for children and respite services.

<https://nrns.ne.gov>

### **Answers 4 Families**

The Answers4Families website connects families with information and resources to better understand when there is someone in the family with special needs. Families can be assisted with children's mental health issues, diabetes, foster care and adoption information, special needs, traumatic brain injury, etc.

[www.answers4families.org](http://www.answers4families.org)

### **Head Start and Family Engagement**

Head Start and Early Head Start requires a strong family engagement approach in order to help prepare parents and caregivers of young children in many areas that support their child's comprehensive development. Parents learn about social-emotional and physical health, and how to access dental and other health services, developing economic and financial literacy, employment and adult educational opportunities, and how to prepare themselves and their young children for entrance into kindergarten. A fifty-one (51%) parent representation is required for each Head Start grantee's "Policy Council", the program management and governance body.

The Head Start-State Collaboration Office facilitates the involvement of Head Start program staff and parent stakeholders in state level planning, policies, and initiatives, including potential membership on the ECICC.

### **PTI Nebraska**

PTI Nebraska is a statewide resource for families of children with disabilities and special health care needs. The Mission of PTI Nebraska is to provide training, information and support to Nebraska parents and others who have an interest in children from birth through twenty-six and who receive or who might need special education or related services. Enable parents to have the capacity to improve educational outcomes for all children.

- PTI Nebraska's staff are parent/professionals and are available to talk to parents and professionals about special education, other services and disability specific information.
- PTI Nebraska conducts relevant, no cost workshops statewide.
- PTI Nebraska provides printed and electronic resources.

- PTI Nebraska encourages and supports parents in leadership roles.

For more information <http://www.pti-nebraska.org/>

### **Parent Information Resources**

The Nebraska Department of Health and Human Services is committed to helping parents find the best information on locating quality child care and resources for child care in their community. DHHS, in partnership with the Nebraska Department of Education, work together to build consumer awareness and support families in making good choices for the care and education of their children.

Choosing quality child care is one of the most important decisions parents make, but much too often, parents have little information on which to base their decisions. DHHS has developed a guide in cooperation with Child Care Aware™ entitled “***The Right Place***”, which assists parents in making informed decisions on choosing child care environments. The production of this guide was paid for with Child Care and Development funds.

The guide contains the following sections:

- Five steps to finding good child care
- Five steps to choose safe and healthy child care
- Finding help paying for child care
- Early Learning topics and resources
- Matching your child’s style to the right child care setting
- Responsive care
- Selecting a quality after-school program
- Five steps to choosing summer child care
- Additional helpful resources and web sites
- “The Right Place” checklist of questions to ask and things to look for in quality child care settings

It was printed as a small spiral-bound booklet which can easily fit into a pocket or purse for parents to bring with them and refer to as they visit potential child care facilities. The guides have been updated and distributed statewide to DHHS office and human service organizations, have been made available at various conferences and workshops, and are also mailed directly to parents requesting help with locating child care in their communities. They are also available in Spanish, and have been widely distributed to offices and organizations in communities across the state for Spanish-speaking families.

### **The Munroe-Meyer Institute (MMI)**

Resource and Family Support Coordination staff at the Munroe-Meyer Institute provide informational supports through training and direct support to families with infants and toddlers with disabilities in identifying needed services and supports. This can involve service provided at MMI, specialized services in the community or generic community services as appropriate. MMI Resource Coordinators provide this service to families as initial contacts with the Institute as well as families already receiving services

in MMI programs. MMI Support Coordinators also facilitate presentations and trainings for caregivers and professionals on a variety of topics in addition to providing resource materials with information on caring for infants and toddlers with special needs. In addition, MMI Resource Coordinators work with MMI professional Trainees, Fellows and Medical Residents on insuring new professionals have a clear understanding of the family perspective in Early Intervention.

For more information, go to <http://www.unmc.edu/mmi>

### **Early Childhood Community Link (ECCL)**

The purpose of the Early Childhood Community Link (ECCL) is to create an interactive web based platform that early childhood professionals can easily access. ECCL will contain information in one place describing regional boundaries for early childhood programs and services, projects/initiatives and resources located in the state as well as community work completed, such as assessments. ECCL will serve as a resource center for state agencies and local communities to improve communication, implement best practices, and identify gaps and barriers in an effort to strengthen early childhood systems. Creating this system will assist in avoiding duplication in project efforts, technical assistance, and training and connecting people with resources that they can utilize for early childhood planning. ECCL will be developed and maintained by Answers4Families with a completion date projected of January 31, 2014. The platform will be developed with the ability to be built upon.

### **Ready for Success**

The Nebraska Department of Education as part of the State Advisory Council identified a goal to increase school readiness across the state. As part of that effort presentations have been held across the state in geographic regions to help early childhood caregivers and educators better understanding what being ready for school requires. A brochure was also developed in 2012 to assist parents. The brochure, *Ready for Success: What Families Want to Know about Starting School in Nebraska* has been printed and distributed widely across the state. The brochure was designed to answer many of the questions parents have about making sure their children are ready for starting school.

For a copy of the brochure go to:

[http://www.education.ne.gov/OEC/pdfs/Ready\\_for\\_Success\\_Booklet.pdf](http://www.education.ne.gov/OEC/pdfs/Ready_for_Success_Booklet.pdf)

## **Gaps and Barriers in Parent Education and Support**

### **Parents have difficulty locating information and resources when needed**

Finding consistent parent supports continues to remain a challenge for the early childhood care and education system. Parents continue to be challenged to find the information they need to support their young children. State agencies continue to supply many information sources, but parent representatives on the Early Childhood Interagency Coordinating Council indicate parents are struggling to find the right place to access the information at the right time.

### **Lack of support systems for parents struggling with specific issues**

Due to the geographic distances a family with a child with special needs may be the only person within a 100-200 mile radius with a child with that specific condition. Finding a support network that can help parents wade through the challenges of getting good care for their child's specific needs can be difficult. There are opportunities to utilize technology to connect parents across the state in finding other parents who could help them problem solve and navigate through the system.

### **Parents are delaying the age when children enter school**

School districts continue to report that parents are holding children out of school for one year to allow them time to develop more physically or socially. Parents indicate that they want their child to be successful in sports later in life and don't want them to be one of the youngest or smallest in their peer group. Some of these children have been enrolled and been successful in school district operated preschool programs and then parents pull them out for a year rather than have the child enter kindergarten on schedule. Teachers are indicating that these children are developmentally on target for transitioning into kindergarten, but parents are not always agreeable to having children move on. More information is needed to help parents understand the benefits of keeping children growing with their same age peers and learning by keeping them in programs based upon their school-age eligibility. More information on school readiness and ready schools can allay parent's fears about children's school entrance age.



## b. Mental Health/Social and Emotional Behavioral Health

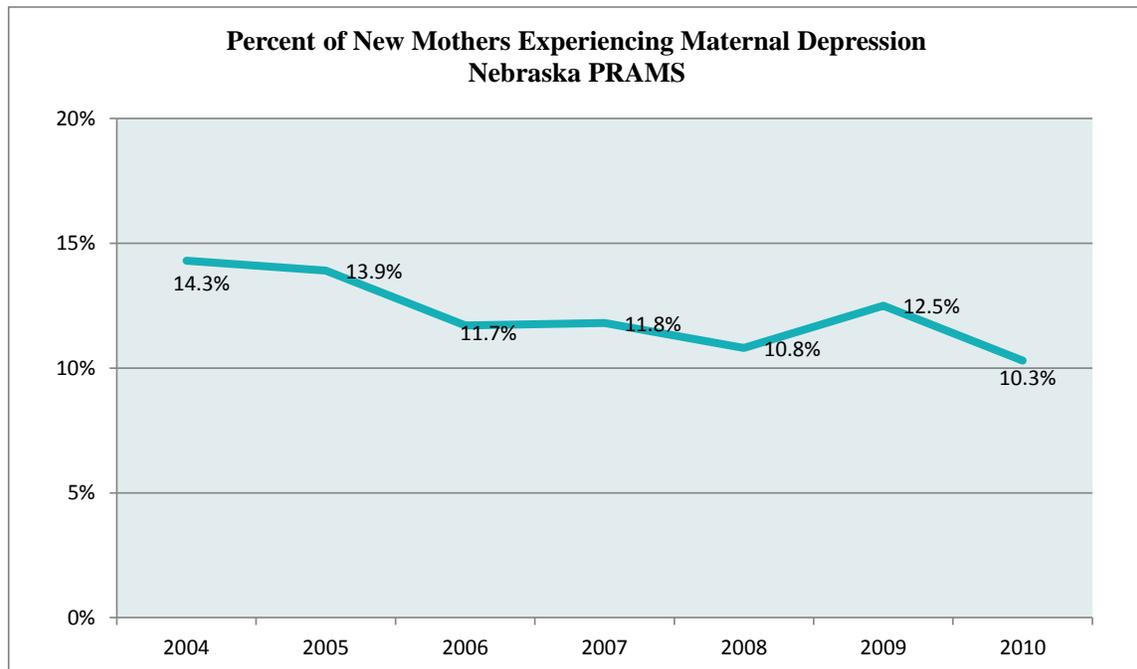
**Mental Health Goal:** The early childhood social, emotional and behavioral health needs of Nebraska's children are met.

### Mental Health Data Indicators

Indicator 5: Prevalence of new mothers who experienced maternal depression related to their most recent pregnancy:

Depression can interfere with a mother's ability to care for herself and her baby and have a long-term effect on the development of her child. According to Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS)<sup>7</sup>, a mother is considered at risk of postpartum depression if she reported that she always or often felt down, depressed or hopeless, OR if she reported always or often having little interest or pleasure in doing things.

Over the seven years (2004-2010) these data have been collected, the average rate was 12.2% with a high of 14.3% in 2004 and a low of 10.3% in 2010. These numbers represent a significant linear decline. This decline may be due to raised awareness of depression and its risks leading to earlier intervention.

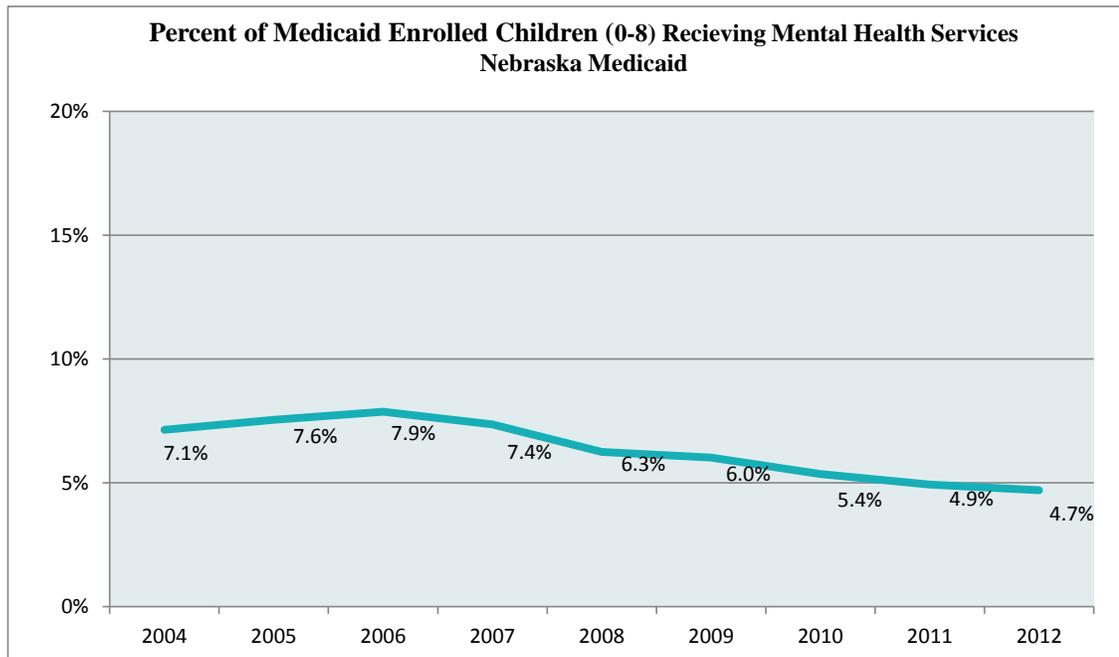


<sup>7</sup> Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS), Nebraska Health and Human Services, <http://www.dhhs.ne.gov/prams/>

### Indicator 6: Percent of Kids Connection eligible children receiving mental health treatment

This indicator focuses on the identification of social-emotional-behavioral issues among Nebraska children and access to treatment. Data for this indicator are limited to those children enrolled in Medicaid or CHIP and do not provide a comprehensive picture of mental health services for all Nebraska children.

On average, 6.4 % of all children birth through age 8 enrolled in Medicaid/CHIP benefit programs received mental health treatment services over the past nine years (2004 through 2011).<sup>8</sup> The range went from a high of 7.9% in 2006 to a low of 4.7% in 2011. This represents a statistically significant decline.



## **Social/Emotional Support for Young Children and Their Families**

### **The Pyramid Model**

Nebraska was selected in 2007 for state technical assistance through the Center for Social Emotional Foundations in Early Learning (CSEFEL) to support implementation of the research-based Pyramid Model, a model framework for promoting children's social-emotional competence and to assist in prevention and/or to address challenging behavior in young children. The Pyramid Model includes a comprehensive approach of

<sup>8</sup> Nebraska Department of Health and Human Services, Medicaid Claim Data 2004-2011. Unpublished

increasing levels of intervention, beginning with a foundation of an effective workforce and moving upward: 1) positive and nurturing relationships with children, families, and colleagues; 2) a supportive and responsive learning environment; 3) social and emotional teaching strategies; and 4) inclusive early childhood positive behavioral intervention and support strategies.

The framework and strategies of the Pyramid Model can be used by any early childhood care and education program serving children birth to five. For maximum benefit, the entire staff, along with parents, should be committed to implementing the program-wide strategies. Expectations for implementation of the model include a local leadership team be established, a self assessment conducted, and an implementation plan created that includes training, coaching, strategies for including parents, and regular review and reflection about success in implementing the plan.

### **Necessary Infrastructure for The Pyramid Model Implementation**

The Nebraska Department of Education's Early Childhood Training Center (ECTC), along with the professional development team associated with the CSEFEL work, developed a self-assessment tool to assist early childhood programs in determine what changes might be useful before implementing The Pyramid Model. The self-assessment is designed to help early childhood programs self-assess their current practices and policies in supporting social and emotional development in young children. This process is intended to optimize the readiness for and focus on change and establish a climate of commitment to program-wide implementation. The self-assessment is downloadable from [http://www.education.ne.gov/OEC/teaching\\_pyramid/pyramid/program\\_implementation/resources/self\\_assesment.pdf](http://www.education.ne.gov/OEC/teaching_pyramid/pyramid/program_implementation/resources/self_assesment.pdf)

### **Planning for State-wide Implementation**

The training materials originally developed by CSEFEL and now part of the TACSEI training and technical assistance system have provided opportunity to observe and determine the elements of state and local infrastructure that will be essential to successful replication of The Pyramid Model practices across the state. The foundation of this infrastructure is being established through a cadre of specialized trainers and coaches who can be deployed through the state's Early Learning Connection, the regional system of early childhood professional development. UNL Extension has also been trained in the Pyramid Model and provides additional trainers across the entire state. Trainers and coaches are essential supports to local program implementation that begins with local leadership team development and definition of planning and implementation monitoring processes. The Department of Education is supporting school district team's implementation of the Pyramid Model to fidelity. A Pyramid Model academy is planned for June 2013.

### **Together for Kids and Families Mental Health Work Group**

In 2010 a cross-discipline group was convened and completed strategic planning on Early Childhood Mental Health. The group agreed upon two strategies:

- Assist communities to develop/enhance an effective system of care to support the social, emotional, and behavioral health needs of Nebraska's young children.
- Build the capacity of individuals who interact with young children to support social, emotional and behavioral health.

The group began implementation of activities related to the strategies by developing the Community Early Childhood System of Care (ECSOC) Self-Assessment:

- Prevention and Intervention Services and Supports are rated using a rubric in order to capture strengths and gaps related to early childhood mental health and healthy social emotional development.
- Community stakeholders complete the self-assessment (electronic or paper survey or in person as a group) and then through a process complete sections on prioritization and action planning.
- The ECSOC was piloted in Valentine, Ogallala, and Omaha. Feedback on the process was utilized to edit the document before broad dissemination.
- THE ECSOC will be utilized in communities implementing Nebraska Maternal, Infant, Early Childhood Home Visiting and an evaluation will be done of the tool.

**Nebraska's Early Childhood Integrated Skills and Competencies for Professionals:** Service Principles for Early Childhood Mental Health, Education and Home Visiting were also developed by the TFKF Mental Health Work Group:

- This document reflects the view that the three disciplines of early childhood mental health, education, and home visiting are highly integrated
- Core Competencies listed with how they may look in practice across disciplines
- Piloted through cross-discipline focus groups and edited based on feedback
- Dissemination and promotion of use is underway; feedback has been positive with requests for a training curriculum to accompany document
  - Plans to develop training curriculum are underway
- Posted on TFKF website: [www.dhhs.ne.gov/TogetherKidsFamilies](http://www.dhhs.ne.gov/TogetherKidsFamilies)

### **Children's Behavioral Health Services through the Division of Behavioral Health**

In 2009 the Nebraska Legislature passed the Children and Family Behavioral Health Support Act, LB 603. The bill passed after the "Safe Haven" experiences in Nebraska brought forth a large number of families struggling with their children's behavioral health needs and having found few resources to assist them. New Services implemented with the passage of LB 603 were the Nebraska Family Helpline, the Family Navigator program and Right Turn, a program to assist families after adoption/guardianship). The goal of all three programs is to provide

empathetic support to families in meeting the needs of their children who may be experiencing behavioral and emotional problems; they generally focus on helping families clarify their concerns, identify their strengths and needs, and develop plans to address the needs.

**The Nebraska Family Helpline** provides assistance 24 hours per day, 7 days a week and 365 days per year. The helpline has specially trained operators answering the phone, clinical oversight is provided by Licensed Mental Health Professionals.

**Family Navigators** are specially trained and have relevant system and life experience with children's behavioral health issues. The program uses a peer mentoring model. Referrals come only through the Family Helpline. Family Navigators make first contact with the family referred within 24-72 hours. Family Navigators provide an average of 8 hours of service within 45-60 days.

**Right Turn** is a program to assist families after adoption or guardianship to ensure that the adoptive parents and other caregivers have adequate support to deal with the special issues they face.

#### **Description and Outcomes: Evaluation Services**

Evaluation Services for the Nebraska Family Helpline, Family Navigator Program and Right Turn (Post Adoption/Post Guardianship Services) are responsible for providing services to evaluate and analyze the fidelity, effectiveness and outcomes of such services. The contractor for the evaluation services is Hornby Zeller Associates, Inc. (HZA)

HZA performed an evaluation of the service implementation and analysis of the required data elements as well as additional elements as identified by the evaluator and the Service Providers. To implement a collaborative evaluation process, HZA utilized an Evaluation Team consisting of representatives from the State, each program, family members and community stakeholders, and participated in a Quality Improvement Team with the Helpline, Family Navigator/Support Services and DHHS. The Dashboard Reporting System which serves as a visual report of selected indicators to measure over time and is utilized and posted on the DHHS website at: <http://nebraskadashboard.hornbyzeller.com/>

HZA has to date remained on budget and provided all required reports, and DHHS expects the timely report for the fiscal year 2011-2012 activities and final project summary in October 2012. Here are a few key elements:

- *Fidelity:* HZA finds the 3 services to be operating satisfactorily per contractual requirements and has partnered with the providers to make process improvements.
- *Effectiveness:* HZA finds the 3 services to be satisfactorily effective to their initial expected service outcome, with some recommendations for quality improvements.
- *Outcomes:* HZA has identified several service outcome trends as well as some system implications, resulting in recommendations of additional strategies to positively impact these 3 services and the children's behavioral health system at large.

Within this fiscal period, HZA has performed a healthy evaluation project that has resulted in several noteworthy items: consumer-driven process improvements for all three service recommendations for further consideration.

**Professional Partners Program (PPP)** is a wraparound program that utilizes intensive therapeutic service coordination, flexible funding and purposeful family-centered practices to increase youth functioning, decrease risk for out-of-home placement and/or multiple system involvement, and to stabilize the family environment. PPP is an evidence-based approach to serving youth with mental health challenges and has existed in Nebraska for over a decade with significant success.

### **New Services in Children's Behavioral Health**

The **Prevention Professional Partners Program (PPPP)** provides intensive case management designed to bring together community resources to help families in need of supports and services for their children. The PPPP demonstrates significant success, positive youth and family outcomes and system savings by connecting families to appropriate community-based services and averting restrictive environments.

The **Rapid Response Professional Partner Program (RR-PPP)** provides short term (90 days) services for severely emotionally disturbed (SED) youth ages 0-19 to achieve goals of stability, improve functioning, and reduce the need for involvement with the juvenile justice system. The program is a voluntary in-home case management service, meeting with the family weekly to coordinate services and implement formal and informal supports into the family structure. The program promotes the use of strength-based strategies intended to build upon the family's natural resources and abilities.

### **Gaps and Barriers in Children's Mental Health**

#### **More resources are needed to address the social and emotional needs of young children**

Nebraska has developed several initiatives to address young children's social and emotional development. However, the demand far exceeds the available resources. State agencies have pooled resources in order to develop social/emotional supports for young children. Planning Region Teams from across the state indicate there is a lack of resources to meet the social-emotional needs of young children. The ECICC continues to hold this work as a priority for problem-solving and ongoing monitoring to achieve equitable access to resources and support throughout the state.

#### **Need for more mental health professionals prepared to work with young children**

There continues to be a need for more mental health professionals who are prepared to work with children birth to age 5 and their families. There continues to be a need for more early childhood care and education professionals trained and implementing the Teaching Pyramid as well as Helping Babies from the Bench, that have been described elsewhere in this report.

The reality of the situation is that without children having social and emotional skills and strong attachments to caregivers, and caregivers to children, learning becomes very difficult. Focusing simply on cognitive development without meeting children's social/emotional needs will not help children become successful learners.



### **c. Early Care and Education**

**Early Care and Education Goal: Early care and education in Nebraska is high quality, developmentally appropriate and accessible to all children.**

#### **Early Care and Education Data Indicators**

##### Indicator 7: Percent of licensed child care providers receiving child care subsidy

The child care subsidy is a supportive resource designed to assist low-income families in purchasing quality child care services in order to work or attend school. The child care subsidy is administered by NDHHS and is primarily funded by the federal Child Care and Development Funds, state matching funds, and federal TANF funds.

In 2012, 48% of 4,106<sup>9</sup> licensed providers accepted and received the child care subsidy. The number of providers receiving the subsidy has declined since 2008; this decline, however, is not statistically significant. Knowing and tracking the proportion of licensed providers who receive payments helps to understand access to child care services for families in need, however, many families that would qualify don't apply. Thus a change in the rate of providers receiving the subsidy does not necessarily reduce amount of unmet need.

##### Indicator 8: Number of licensed child care slots per 1,000 Nebraska children (birth through age 8)

This indicator illustrates the capacity of the regulated childcare system to adequately serve children and families. The goal is for all children to have access to high quality developmentally appropriate care. Unfortunately, there is no standard measure used to determine quality, and licensing regulations are minimal. The indicator measures the availability of licensed child care slots, but does not measure the number of children who are receiving the care or the unmet demand for services. There were 485.7 available slots per 1,000 children age 0-8 years in 2012.<sup>9</sup>

This rate has remained unchanged over the past several years.

### **Other Early Care and Education Data**

#### **Nebraska Department of Education Preschool Classroom Data**

Across the country, states have been focusing time and resources on the education of children three to five years old. Nebraska is no exception. Nebraska's prekindergarten effort is comprised of early childhood education classrooms operated by school districts and/or educational service units (ESUs) and their partners.

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<sup>9</sup> Nebraska Department of Health and Human Services, Child Care Subsidy and Licensing program data January, 2012. Unpublished

<b>2011-2012 School Year Data on Children Ages 3 to 5 in Preschool Classrooms</b>	
# of children served in public school preschool	10,382
# of children English Language Learners	748
# of school districts offering preschool	163
Total funding from federal, state, and local sources for preschool (further described in chart below)	\$21,368,211

Each early childhood program participated in the Results Matter, Child, Family and Program Outcome framework to ensure that children are progressing, families' needs are being met, and the program is of high quality.

The most current report regarding longitudinal data for programs funded by early childhood education grants is available at [http://www.education.ne.gov/OEC/pubs/eceg\\_reports/2010-2011.pdf](http://www.education.ne.gov/OEC/pubs/eceg_reports/2010-2011.pdf).

The following chart reflects the state and federal dollars that are utilized to serve children age three to five through Nebraska's educational service units and public schools.

<b>Federal funds</b>		<b>State funds</b>		<b>Local funds</b>	
IDEA Part B*	4,099,871	NE ECE Grant^	3,186,060	Local District	3,900,577
IDEA Part C**	10,090	TEEOSA^^	6,433,205	Parent Fees	220,573
Head Start	2,832,516	State Flex Funds***	10,225	Community Programs	22,954
Title 1	540,939				
HHS Subsidy+	46,872				
<b>Total</b>	<b>7,530,288</b>	<b>Total</b>	<b>9,629,490</b>	<b>Total</b>	<b>4,208,433</b>

\*Individuals with Disabilities Education Act Part B

\*\*Individuals with Disabilities Education Act Part C

+Federal Health and Human Services Child Care Subsidy

^Nebraska Early Childhood Education Grant

^^ Tax Equity and Education Opportunity Support Act (TEEOSA-State Aid)

\*\*\*State Funded Special Education Flexible Funds

### Accredited Early Care and Education Programs Data

<b>National accreditation organization</b>	<b># of programs accredited in Nebraska in 2010</b>	<b># of programs accredited in Nebraska in 2012</b>	<b>Date of report</b>
National Association for the Education of Young Children- (Child Care Centers)	65	59	12/1/2012
National Association for Family Child Care (Family Child Care Homes)	9	0	12/1/2012

### Child Find to Identify Infants, Toddlers, and Preschoolers with Disabilities

Nebraska conducts a comprehensive Child Find System resulting in the identification, evaluation and assessment of infants, toddlers, and preschoolers (birth through age five) with disabilities. Child Find is a state-led, regionally implemented set of activities to provide early intervention information to the public, parents, medical providers, schools, child protection services, Migrant and Early Head Start, tribal populations, homeless shelters and child care providers. Region implementation of Child Find occurs through 27 geographical Planning Region Teams.

The federal Office of Special Education Programs (OSEP) approximates that out of the general population 1% of infants age birth to one have special needs, and 2% of the general population of infants and toddlers ages birth to three have special needs. Nebraska's percentages have consistently been lower than the national percentages. The variation from year to year does not appear to be significant, but efforts continue to be made to increase the verification rates.

Ages	December 1, 2010	December 1, 2011	2011 Percentage
Birth to One	185	176	.68%
Birth to Three	1627	1496	1.91%

*OSEP Child Count Data: Infants and Toddlers verified for Part C (Birth to 3) from Nebraska Student and Staff Record System (NSSRS) Special Education Template reporting children verified with disabilities according to NDE Rule 51, Regulations and Standards for Special Education Programs.*

The annual OSEP child count of young children with disabilities, ages 3-5, served under part B of the Individuals with Disabilities Education Act is displayed below.

Age	October 1, 2010	October 1, 2011	October 1, 2012
3	1306	1244	1245
4	1871	1870	1880
5	2083	2061	2245
Total	5260	5175	5370

*OSEP Child Count Data: Preschoolers verified for Part B, Ages 3-5 from Nebraska Student and Staff Record System (NSSRS) Special Education Template reporting children verified with disabilities according to NDE Rule 51, Regulations and Standards for Special Education Programs.*

### Results Matter Data

Results Matter in Nebraska is a child, program, and family outcomes measurement system designed and implemented to improve programs and supports for all young children birth to age five (B-5) served by districts and their community partners, which may include Head Start and other community early childhood programs.

Districts and Educational Service Units (ESUs) are expected to serve children within inclusive classrooms that represent a full range of abilities and disabilities and the social, linguistic and economic diversity of families within the community. In addition, many provide home-visiting services.

Results Matter is responsive to Nebraska Department of Education (NDE) Rule 11-Regulations for Early Childhood Programs, Rule 51-Regulations and Standards for Special Education Programs, and the federal

mandate of the Individuals with Disabilities Education Act (IDEA) Part C (birth to age three) and Part B-619 (ages three to five).

Each February, NDE submits an Annual Performance Report (APR) to the Office of Special Education Programs (OSEP). Child outcome data are reported in five progress categories for each of three outcomes. The data represents infants, toddlers and preschoolers (birth to age 5) who met the following OSEP criteria:

- Children who exited from the program between July 1 and June 30 of each year,
- Had entry data; and
- Had been in the program for at least six months.

The Results Matter online system collects data required by OSEP to monitor Indicator 3 in the Part C Annual Performance Report and Indicator 7 in the Part B Annual Performance Report. These indicators require states to provide data on the following three outcomes:

Percent of infants and toddlers (Part C) with Individual Family Service Plans (IFSPs) and preschoolers (Part B) with Individual Education Plans (IEPs) who demonstrate improved:

- A. Positive social-emotional skills (including social relationships);
- B. Acquisition and use of knowledge and skills (including early language/communication and early literacy); and
- C. Use of appropriate behaviors to meet their needs.

OSEP requires states to report progress data in these five categories for each of the three outcomes:

- a. Percent of children who did not improve functioning.
- b. Percent of children who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers.
- c. Percent of children who improved functioning to a level nearer to same-age peers but did not reach it.
- d. Percent of children who improved functioning to reach a level comparable to same-aged peers.
- e. Percent of children who maintained functioning at a level comparable to same-aged peers.

In addition, OSEP requires NDE to report Summary Statements for each of the three outcomes.

- Summary Statement 1 combines data from two progress categories to reflect the percentage of children who made greater than expected progress at exit.
- Summary State 2 combines data from two progress categories to reflect the percentage of children who exited the early childhood program at age level.

Both Summary Statements are calculated according to formulas required by OSEP.

### Part C Infant and Toddler Actual Progress Data for Children Exiting 2011-2012

The charts below contain Nebraska's child progress data for infants and toddler exiting during FFY 2011 (2011-2012)

Infant/Toddler Child Progress Data for FFY 2011-2012	OUTCOME A: Positive social-emotional skills		OUTCOME B: Acquisition and use of knowledge and skills		OUTCOME C: Use of appropriate behaviors to meet their needs	
	# of children	% of children	# of children	% of children	# of children	% of children
a. Percent of infant/toddler children who did not improve functioning.	13	3.0% (13/431)	14	3.3% (14/430)	13	3.0% (13/431)
b. Percent of infant/toddler children who improved functioning but not sufficient to move nearer to functioning comparable to same aged peers.	37	8.6% (37/431)	69	16.0% (69/430)	47	10.9% (47/431)
c. Percent of infant/toddler children who improved functioning to a level nearer to same-age peers but did not reach same-aged peers.	38	8.8% (38/431)	33	7.7% (33/430)	44	10.2% (44/431)
d. Percent of infant/toddler children who improved functioning to reach a level compared to same aged peers	139	32.3% (139/431)	134	31.1% (134/430)	181	42.0% (181/431)
e. Percent of infant/toddler children who maintained functioning at a level comparable to same-aged peers.	204	47.3% (204/431)	180	41.9% (180/430)	146	33.9% (146/431)
<b>Total</b>	431	100%	430	100%	431	100%

Infant/Toddler ACTUAL SUMMARY STATEMENT DATA for FFY 2011	Outcome A Positive Social-emotional	Outcome B Acquisition and use of Knowledge and skills	Outcome C Use of appropriate behaviors to meet their needs
<b>Summary Statement 1:</b> "Trajectory Changers at Exit" Of those infants and toddlers who entered or exited early intervention below age expectations in each Outcome, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program.	78.0%	68.8%	78.9%
<b>Summary Statement 2:</b> "Meeting Age Expectations at Exit" The percent of infants and toddlers who were functioning within age expectations in each Outcome by the time they turned 3 years of age or exited the program.	79.6%	73.0%	75.9%

### Measurable and Rigorous Targets/Actual Target Data for Children Exiting Part C FFY 2011 (2011-2012)

Nebraska met all of its targets for Part C child outcomes.

	Targets FFY 2011 (% of children)	Actual FFY 2011 (% of children)
<b>Summary Statement-Outcome A-Positive social-emotional skills (including social relationships)</b>		
1. Of those children who entered or exited the program below age expectations in Outcome A, the percent who substantially increased their rate of growth by the time they exited the program.	71.4%	78.0%
2. The percent of children who were functioning within age expectations in Outcome A by the time they exited the program.	74.6%	79.6%
<b>Summary Statement-Outcome B –Acquisition and use of knowledge and skills (including early language/communication and early literacy)</b>		
1. Of those children who entered or exited the program below age expectations in Outcome B, the percent who substantially increased their rate of growth by the time they exited the program.	61.7%	66.8%
2. The percent of children who were functioning within age expectations in Outcome B by the time they exited the program.	71.3%	73%
<b>Summary Statement-Outcome C-Use of appropriate behaviors to meet their needs</b>		
1. Of those children who entered or exited the program below age expectations in Outcome C, the percent who substantially increased their rate of growth by the time they exited the program.	74.8%	78.9%
2. The percent of children who were functioning within age expectations in Outcome C by the time they exited the program.	69.9%	75.9%



## Part B Preschool Results

The charts below contain Nebraska's child progress data for FFY 2011 (2011-2012) as well as Summary Statement 1 and Summary Statement 2 for preschool children exiting 2011-2012.

	Outcome A		Outcome B		Outcome C	
	Social emotional skills		Acquiring and using knowledge and skills		Taking appropriate action to meet needs	
Preschool Child Progress Data For FFY 2011	# of children	% of children	# of children	% of children	# of children	% of children
a. Percent of preschool children who did not improve functioning.	12	1.4% (12/882)	13	1.50% (13/882)	12	1.4% (12/879)
b. Percent of preschool children who improved functioning but not sufficient to move nearer to functioning comparable to same age peers.	116	13.2% (116/882)	124	14.1% (124/882)	86	9.8% (86/879)
c. Percent of preschool children who improved functioning to a level nearer to same-age peers but did not reach same -aged peers	113	12.8% (113/882)	132	15.0% (132/882)	115	13.1% (115/882)
d. Percent of preschool children who improved functioning to reach a level compared to same aged peers	283	32.1% (283/882)	296	33.6% (296/882)	295	33.6% (295/879)
e. Percent of preschool children who maintained functioning at a level comparable to same-aged peers.	358	40.6% (358/882)	317	35.9% (317/882)	371	42.2% (371/879)
<b>Total</b>	882	100%	882	100%	879	100%

ACTUAL SUMMARY STATEMENT DATA for Preschool Children FFY 2011	Outcome A Positive Social-emotional	Outcome B Acquisition and use of Knowledge and skills	Outcome C Use of appropriate behaviors to meet their needs
<b>Summary Statement 1:</b> "Trajectory Changers at Exit" Of those preschoolers who entered the preschool program below age expectations in each Outcome, the percent who substantially increased their rate of growth by the time they turned 6 years of age or exited the program.	75.6%	75.8%	80.7%
<b>Summary Statement 2:</b> "Meeting Age Expectations at Exit" The percent of preschool children who were functioning within age expectations in each Outcome by the time they turned 6 years of age or exited the program.	72.7%	69.5%	75.8%

Nebraska met all of its targets for Part B child outcomes with the exception of Outcome A, Summary Statement 2 which was slightly below the target (0.7% below the target). The targets were based on incremental increases of 0.5 each year. Given the impact of missing data, it is not surprising that there would be at least one of the targets that would fall slightly below projection.

<b>PRESCHOOL SUMMARY STATEMENTS RESULTS</b>	<b>Targets FFY 2011 (% of children)</b>	<b>Actual FFY 2011 (% of children)</b>
<b>Outcome A: Positive social-emotional skills (including social relationships)</b>		
1. Of those children who entered or exited the program below age expectations in Outcome A, the percent who substantially increased their rate of growth by the time they exited the program.	63.6%	75.6%
2. The percent of children who were functioning within age expectations in Outcome A by the time they exited the program	73.4%	72.7%
<b>Outcome B: Acquisition and use of knowledge and skills (including early language/communication and early literacy)</b>		
1. Of those children who entered or exited the program below age expectations in Outcome B, the percent who substantially increased their rate of growth by the time they exited the program	61.4%	75.8%
2. The percent of children who were functioning within age expectations in Outcome B by the time they exited the program	61.8%	69.5%
<b>Outcome C: Use of appropriate behaviors to meet their needs</b>		
1. Of those children who entered or exited the program below age expectations in Outcome C, the percent who substantially increased their rate of growth by the time they exited the program	64.2%	80.7%
2. The percent of children who were functioning within age expectations in Outcome C by the time they exited the program	75.0%	75.8%

For more information on children with disabilities ages birth to five, see the Annual Performance Reports (APRs) at <http://www.education.ne.gov/sped/data.html> website.

### **Sixpence Data**

Sixpence, the Early Childhood Education Endowment, is a public-private partnership of \$60 million (\$40 state, \$20 private) with the interest being used to fund school districts in partnership with community providers. The targeted population is infants and toddlers (birth to age three) who are most at risk of starting school behind. Sixpence utilizes the same definition for at risk as the Department of Education's preschool program: 1) participation in the federal free or reduced lunch program; 2) premature birth or low birth weight as verified by a physician; 3) language other than English as primary means of communication; 4) parents younger than 18 or have not completed high school.

In 2011-2012, a total of 334 infants and toddlers and 317 families were served by Sixpence across 11 school districts. Based on each community's need, services were provided either through center-based child care or by engaging the parents in their critical role of parenting and involving parents in their child's development.

Sixpence has just completed its fourth year of implementation, and includes a comprehensive evaluation process designed to monitor program and child outcomes uniformly across programs. The most significant gain this year was in children's social-emotional skills showing a marked increase in the percentage of children scoring higher in the areas of regulating their emotions and a decrease in behavior concerns. Sixpence programs had a major impact in mitigating one risk factor, a parent's lack of a high school diploma. By June 2012, 51% of these parents completed their GED or graduated with their class. To learn more about Sixpence, go to [www.SingaSongofSixpence.org](http://www.SingaSongofSixpence.org)

### **Head Start State Collaboration Offices**

The Head Start State Collaboration Offices (HSSCOs) exist to "facilitate collaboration among Head Start agencies...and entities that carry out activities designed to benefit low income children from birth to

school entry, and their families. They provide a structure and a process for OHS to work with State agencies and local entities to leverage their common interests around young children and their families to formulate, implement, and improve state and local policy and practice.

*Head Start Act Section 642(B)(a)(2)(A) and 642 (B)(a)(3)(B).*

Scope of Work for HSSCOs

**1-School Transitions**-to foster seamless transitions and long-term success of Head Start children by promoting continuity of services between the Head Start Child Development Learning Framework and State early learning standards including pre-k entry assessment and interoperable data systems.

**2-Professional Development**-to collaborate with institutions of higher education to promote professional development through education and credentialing programs for early childhood providers in states.

**3-Child Care and Early Childhood Systems**-to coordinate activities with the State agency responsible for the CCDBG program and resource and referral, to make full-working-day and full calendar year services available to children. Include Head Start Program Performance Standards in State efforts to rate the quality of programs (Quality Rating and Improvement System, or QRIS) and support Head Start programs in participating in QRIS and partnering with child care and early childhood systems at the local level.

**4-Regional Office Priorities**-to support other regional office priorities such as family and community partnerships; health, mental health, and oral health; disabilities; and support to military families. Other special OHS and ACF initiative requests for HSSCO support should be routed through the OHS Regional Offices.

#### **Head Start and Early Head Start and School District Partnership Development**

Head Start/Early Head Start funds in Nebraska serve 60% of the preschool eligible population and only about 2% of the eligible pregnant teens, women, and infants and toddlers. Local school districts also offer early childhood services and partnerships exist between Head Start, Early Head Start and their respective public school and "Sixpence" Endowment program partners.

Various partnership models exist among head Start and school districts in Nebraska. While there are challenges in forming and maintaining partnerships, partnership agreements or Memoranda of Understanding (MOU) help define those parameters that assist programs in better addressing the needs of all children, including those with disabilities. MOU templates were developed pursuant to a qualitative study that explored collaborative agreements. Those templates are embedded in the NDE Early Childhood Birth-Kindergarten Programs Guide found at

[http://www.education.ne.gov/oec/ec\\_grant/A\\_Guide\\_to\\_Serving\\_Young\\_Children\\_Final.pdf](http://www.education.ne.gov/oec/ec_grant/A_Guide_to_Serving_Young_Children_Final.pdf).

**2011-2012 Head Start Program Information Report**

<b>Total Cumulative Enrollment</b>	
Preschool Children (Head Start, American Indian and Alaska Native and Migrant Head Start)	5115
Infants and Toddlers Ages Birth-2 (Early Head Start, American Indian and Alaska Native and Migrant Early Head Start)	1,590
Pregnant Women	73

*2011-2012 Nebraska Head Start Program Information Report (PIR) State Level with American Indian/Alaska Native and Migrant Head Start.*

<b>Head Start and Early Head Start Data</b>		<b># Programs</b>
Program Types	Early Head Start	12
	Head Start	16
	Migrant and Seasonal Head Start	1
Agency Types	Community Action Agency (CAA)	14
	Private/Public Non-Profit (Non-CAA) (e.g. church or non-profit hospital)	7
	School System	7
Agency Descriptions	Delegate Agency	4
	Grantee that delegates all of its programs; it operates no program directly and maintains no central office staff	1
	Grantee that directly operates program(s) and has no delegates	21
	Grantee that directly operates programs and delegates services delivery	2

*2011-2012 Nebraska Head Start PIR State Profile Report including Region VII American Indian Alaskan Native, Region XI, and Migrant Seasonal Head Start, Region XII*

<b>Head Start Performance Indicators</b> (Health and Dental Indicators in Medical Status Section)		Nebraska		
		HS	EHS	MSHS
153	Percentage of preschool classroom teaching assistants that meet the degree/credential requirements	82.8%	N/A	50.00%
151	Percentage of preschool classroom teachers that meet the current degree/credential requirements	85.9%	N/A	91.67%
161	Percentage of infant and toddler classroom teachers that meet the degree/credential requirements	N/A	99.0%	83.3%
121	Percentage of funded enrollment reported as children with an IFSP or IEP (Individual Family Service Plan or Individual education plan)	17.8%	12.6%	9.8%

*2011-2012 Nebraska Head Start PIR State Profile Report including Region VII American Indian Alaskan Native, Region XI, and Migrant Seasonal Head Start, Region XII*

## New Developments in Early Care and Education

### Kindergarten

In 2009, the Education Committee of the Nebraska Legislature conducted an interim study to examine issues related to early childhood education and kindergarten eligibility. This resulted in the introduction and subsequent passage of LB 1006, which changed the eligibility date for children entering kindergarten. Prior to 2012, Children who turned 5 on or before October 15 were eligible to attend kindergarten the year they turned 5. Beginning with the 2012-2013 school year, children must be 5 on or before July 31 to enter school.

The Nebraska Department of Education (NDE) has created materials to assist families and schools to prepare children for kindergarten and to ensure that the kindergarten experience is most beneficial for each child.

- A position statement from NDE outlines current research on kindergarten and includes recommendations for policy makers, educators, families, and communities. It is available at <http://www.education.ne.gov/OEC/pubs.KStatement.pdf>.
- A companion document to guide the implementation of Nebraska's revised standards in the areas of mathematics, and language arts. The Kindergarten Early Learning Guidelines: Language and Literacy can be found at [http://www.education.ne.gov/OEC/pubs/ELG/kgn\)langlit.pdf](http://www.education.ne.gov/OEC/pubs/ELG/kgn)langlit.pdf). The Kindergarten Early Learning Guidelines: Mathematics can be found at [http://www.education.ne.gov/OEC/pubs/ELG/kgn\\_math.pdf](http://www.education.ne.gov/OEC/pubs/ELG/kgn_math.pdf)
- A resource to assist parents about preparing for, and entering, kindergarten is available at [http://www.education.ne.gov/OEC/pdfs/Ready\\_for\\_Success\\_Booklet.pdf](http://www.education.ne.gov/OEC/pdfs/Ready_for_Success_Booklet.pdf).

### System of Support to Improve Quality

The collaborative work of the Nebraska Department of Health and Human Services and the Nebraska Department of Education is to develop a unified early childhood data system that can better inform program quality improvement efforts. Key components of the early childhood data system include early childhood workforce education and professional development data, program quality data, and child health data, and assessment of children's learning and development data to better understand children's outcomes and ways programs can better support children.

The State Advisory Council Grant is providing support for development of recommendations for the unified early childhood data system. Two data summits have been hosted to help inform these recommendations. The first in June 2011 identified the "key questions that could help us answer". Those questions were categorized in three areas: children/families; programs and workforce. The second data summit held in January 2013, allowed stakeholder to better understand some contexts for early childhood data and provided a focused segment to respond to DRAFT recommendations for a unified early childhood data system. Compiled results will be available on the Head Start-State Collaboration office web page at <http://www.education.ne.gov/OEC/hssco.html>.

## **Gaps and Barriers in Early Care and Education**

### **Finding available and qualified interpreters**

Local providers remain challenged in trying to serve families who are English Language Learners or whose first language is anything other than English. In addition there is the need for available and qualified sign language interpreters for families who are deaf or hearing impaired. More available and qualified bilingual staff or interpreters are needed to assist providers in better serving young children and their families in Nebraska.

### **Challenges in working to integrate and align all early childhood data systems among Head Start and state data systems**

Head Start children that are served in highly integrated early childhood programs operated in conjunction with programs administered by school districts, or Head Start services directly administered by school districts are included in the NDE state education data system. This prevents anyone from seeing data that is statewide and aggregated. Without children served by all Head Start Grantees, a complete picture is not available and prevents state partners from using data to inform program improvement and policy in Nebraska.

### **Limited availability of high quality services for children from birth to age 3**

Nebraska has a number of early intervention services to provide for children with developmental delays or disabilities from birth to age three. As a birth mandate state, all infants who need assistance and support due to a verified disability are eligible to receive Special Education Early Intervention services offered through IDEA Part C. There are also Early Head Start programs for children birth to age three from low income families in some areas of the state. However, for most children from birth to age three there are few high quality programs offered across the state.

The Sixpence program was created to begin to address the developmental needs of our state's youngest children. Sixpence is committed to continual funding as long as the programs are meeting the quality standards. The Board of Trustees opened the RFP process in April 2013 for the first time since its inception. Understanding how important the first three years are in young children's development it needs to be emphasized that expanding Nebraska's ability to offer high quality early childhood services for infants and toddlers is critical to the state's economic future and young children's learning and development.

### **Need to access professional development other than through face to face training**

Nebraska has a well-defined and established professional development system that offers training to all types of early care and education providers in the state. Providers indicate it is difficult to have many early childhood professionals gone from the same program at any one point in time to participate in face-to-face training. It would be helpful to providers to have more options for accessing recorded or and videotaped training. Online offerings or interactive training via the web of similar information

offered face to face would increase the number of providers who can access training their colleagues may have participated in face-to-face.



#### **d. Access to Health Care: Medical and Dental Home/Health Care**

**Medical Home Goal: All Nebraska children have access to a medical/dental home and receive high quality health services.**

##### **Medical Home Data Indicators**

Indicator 9: Ratio of licensed physicians and licensed dentists to the number of children (0-8)<sup>10</sup>:

Having access to a medical provider is a key to having a medical home. In 2011 Nebraska had a total of 3,652 physicians and 1,012 dentists. There were 19/93 counties without a physician and 20/93 counties without a dentist. The ratio of all providers (physicians and dentists) per child age 0-8 was 1:51 in 2011. However, when considering only pediatricians, family and general practice physicians, and dentists, the ratio is one provider for every 142.4 children. This remained largely unchanged between 2004 and 2011. In 2011, 47.9% of all medical providers were practicing in Douglas County, Nebraska.

Indicator 10: Percent of Kids Connection-eligible children who received an EPSDT exam during most recent state fiscal year:

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is the child health component of Medicaid. Required in every state, it is designed to improve the health of low-income children by financing appropriate and necessary pediatric services. EPSDT addresses physical, mental, and developmental health needs. Screening services “to detect physical and mental conditions” must be provided at periodic intervals, as well as diagnostic and treatment coverage.<sup>11</sup>

In 2011, 56.6% of eligible children received at least one periodic exam. The average rate from 2004-2011 was 53.5%, ranging from a low of 47.1% in 2004 and a high of 56.6% in 2006. There was no significant linear increase in these rates. When considering only children 1-9, the average rate was 56.6%, significantly lower than the average rate for infants of 96.3%.

Indicator 11: Percent of children 19 through 35 months who have received the 4:3:1:3:3:1 immunization series:

A fully vaccinated child is an indication that the child has received preventive medical care. According to the Centers for Disease Control and Prevention, the immunization rate for Nebraska’s young children averaged 74.9 % between 2004 and 2010, ranging from a high of 83.9% in 2005 to a low of 59.9% in 2009 (no significant trend).<sup>12</sup> The lower rate is at least partially due to a shortage of Hib vaccine (the

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<sup>10</sup> University of Nebraska Medical Center, Health Professions Tracking Center Directory of Nebraska & Western Iowa Healthcare Resources 2009-2012.

<sup>11</sup> US Department of Health and Human Services, Health Resources and Service Administration.

<http://www.hrsa.gov/epsdt/default.htm>

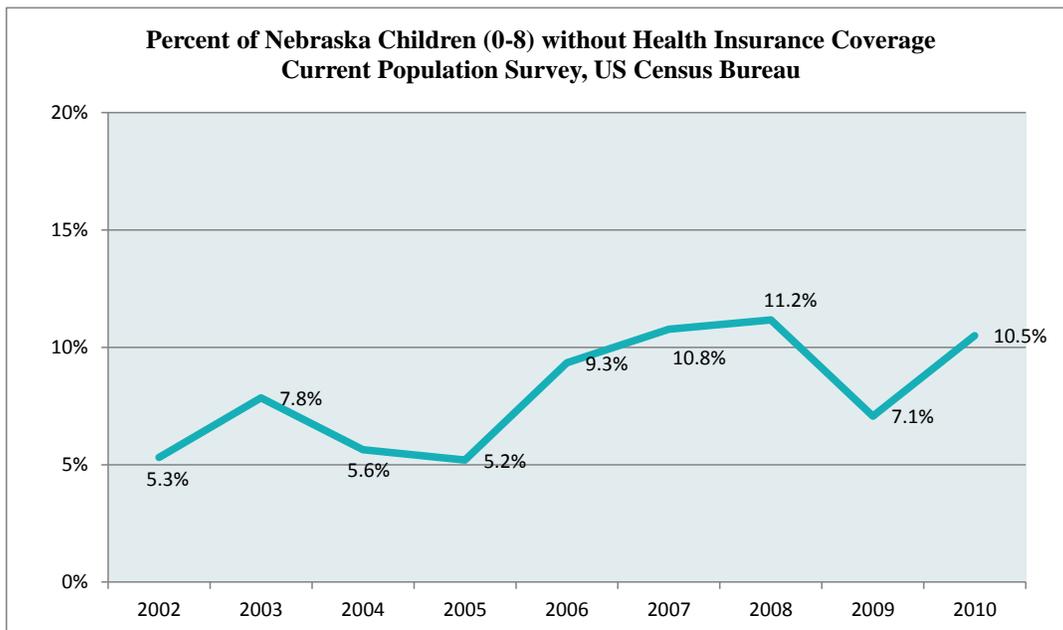
<sup>12</sup> Centers for Disease Control and Prevention, National Immunization Survey, Estimated Vaccination Coverage\* with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Local Area Q1/2009-Q4-2009. [http://www.cdc.gov/vaccines/stats-surv/nis/data/tables\\_2009.htm](http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2009.htm)

second 3 in the series 4:3:1:3:3:1) that began in 2007 and ended in April of 2010 (returned to 79.8% in 2010). The drop in the vaccination rate therefore does not necessarily indicate a lack of preventive care for children.

Indicator 12: Percent of Nebraska children (birth through age 8) who do not have health insurance coverage:

Health insurance at a young age is an important indicator of access and quality of health care. Children with health insurance are more likely to have a Medical Home and receive timely comprehensive care. Access to well-child health care early in life is a crucial component contributing to prevention of chronic health issues over the lifespan.

According to the US Census Bureau, on average, 8.1% of Nebraska's children (0-8 years) did not have health insurance between 2002 and 2010. The range went from a high of 11.2% in 2008 to a low of 5.2% in 2005. There was no trend detected.



## Other Early Childhood Health Data

### Insured/Underinsured People in Nebraska:

Many people in both rural and urban areas of Nebraska have experienced difficulty in gaining access to timely health and medical services. According to the US Census Bureau there were 225,277 people (12.3%) in Nebraska without health insurance coverage in 2011. It is unknown how many are underinsured because their insurance policy includes a high deductible and coinsurance payments. In many cases, underinsured families fail to receive appropriate preventive care and may delay seeing a primary care practitioner until a medical problem becomes more serious. Racial and ethnic minorities are disproportionately represented among the uninsured. For many individuals, the lack of health

insurance coverage is magnified by language and other cultural barriers. *Source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2012*

### Live Births in Nebraska

2010 Live Birth in Nebraska	25,916
2011 Live Births in Nebraska	25,722
Crude birth rate in 2011	14.0 live births per 1,000 population

*Nebraska Vital Statistics Birth Highlights*

### Low Birth Weight Rate

Long-term trends show that Nebraska's annual low birth weight rate has increased steadily since falling to an all-time low of 52.8 in 1990. Low weight birth rates in Nebraska declined throughout the 1970s and 1980s, before reversing direction in the 1990s and during the present decade.

For many years, Nebraska's annual very low birth weight rate showed no consistent trend in any direction, but between 1986 and 1996, it rose by about 50%, and has changed little since.

*Nebraska Vital Statistics Highlights*

#### *Low and very low birth weight numbers and rates*

2011-number of low birth weight babies (less than 2500 grams or 5 ½ pounds)	1,707
2011-low birth weight rate	66.4 per 1,000 live births
2010-low birth weight rate	71.1 per 1,000 live births
2011-very low birth weight (less than 1500 grams or 3.3 pounds at birth)	284
2011-very low birth weight rate	11.0 per 1,000 live births

### Prenatal Care

Nebraska used the Kotelchuck Index for the first time in 2005 as an indicator of the adequacy of prenatal care. This statistic combines information from the birth certificate concerning when prenatal care began and the number of prenatal visits from when prenatal care began to delivery. Using this measure, 14.0% of Nebraska's live births occurred among women who did not receive adequate prenatal care, compared with 14.1% in 2010. *Nebraska Vital Statistics Birth Highlights*

#### *Prenatal Care Rates*

2011- Prenatal care during first trimester of pregnancy	74.1% of all Nebraska live births
2011-percentage when missing data excluded	75.1% of all Nebraska live births
2011-Kotelchuk Index	14.0% of Nebraska live births occurred among those who did not receive adequate prenatal care

### Birth Defects

The birth defect rate for 2011 is 44.1 cases per 1,000 resident live births and stillborns, and is an increase from the 2010 rate of 35.2. Nebraska's 2011 data also show that birth defects were reported five times more often among low birth weight (less than 2500 grams) babies than among babies of normal weight, and that they were more likely to be diagnosed among males and children born to women 40 years of age and older. *Nebraska Vital Statistics Birth Highlights*

2011-number of children born with birth defects	1,140
2011-Total number of birth defects diagnosed among children	2,117
Child birth defects rate	44.1 per 1,000 resident live births and stillborns
2011- most common type of birth defects	655 defects of the circulatory system (30.9%)
Other most frequently reported birth defects	Musculoskeletal conditions (355 diagnoses) Genitourinary system defects (308 diagnoses)

### Infant Mortality

Neonates (infants less than 28 days old) accounted for the majority of Nebraska's 2011 infant deaths, with a count of 95, while post-neonates (infants between 28 days and one year of age) accounted for the remaining. *Nebraska Vital Statistics Death Highlights*

2011 Infant Deaths	143
2011 Infant Mortality rate	5.6 per 1,000 live births
2011 leading cause of death	Birth defects (50 deaths)
Low birth weight babies	95 infant deaths (67 were very low birth weight)

### Mortality Information from the Child Death Review Team

2009 number of Nebraska children who died	237
Percentage decrease in death compared to 1993	34% lower
1993 child death rate	82.6/100,000 children ages (0-17)
2009 child death rate	52.5/100,000 children
Leading causes of deaths	Pregnancy-related causes (65 deaths) Birth defects (56 deaths) Motor vehicle-related incidents (32 deaths) Sleep-associated deaths (23 deaths)

The Nebraska Child Death Review Team (CDRT) was established by the Nebraska Legislature in 1993 and charged with undertaking an ongoing, comprehensive review of existing information regarding child deaths in Nebraska. All cause of death categories showed drops from the 2006-2007 reporting period. Leading causes of death are similar across racial and ethnic groups, but African-American children continue to have significantly higher death rates than White children. An excess of pregnancy-related deaths is a major contributor to this disparity. Native American and Hispanic death rates are also higher than Whites, but these differences were not statistically significant.

Pregnancy-related factors such as prematurity, maternal complications, and events of labor and delivery were the underlying causes of one-quarter (27.5%) of all infant and child deaths in 2007 and 2008, the largest single cause of death category. The second highest category was birth defect-related deaths from the neural tube defects, which are largely preventable through regular, pre-pregnancy intake of folic acid. Motor vehicle crash deaths, largely to teenagers, increased slightly from 2008. Among those involved in a crash, children who were not properly restrained were 11 times more likely to die. *Source: Nebraska Child Death Review Report 2009 (draft).*

### **Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)**

The Nebraska Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides nutrition and health information, healthy foods, breastfeeding support and referrals to other community services for pregnant, postpartum and breastfeeding women and infants and children under five years of age. The WIC program is available at approximately 100 clinic sites located throughout Nebraska. The program currently serves about 42,000 participants each month. Participants shop for WIC approved foods at 400 authorized stores across Nebraska. In addition, there are three tribal WIC programs that serve others beyond those indicated in this report.

In 2011, seventy-three percent (73%) of mothers participating in the WIC program breastfed their infants. Fifty-five percent (55%) were still breastfeeding five weeks after the baby was born.

### **Early Hearing Detection and Intervention**

Significant hearing loss is one of the most common birth defects with an estimated incidence rate of one to three per thousand live births. Left undetected, hearing loss in infants can negatively impact speech and language acquisition, academic achievement, and social and emotional development. Before newborn hearing screening, many hearing losses were not diagnosed until 2 ½ to 3 years of age. If detected early, however, the negative impacts can be diminished, and even eliminated, through early intervention. Recent studies have consistently shown that children who were identified with a hearing loss later in childhood have delays in the development of speech, language, social and academic skills compared with those identified during the first six months of age.

In 2000, the Infant Hearing Act established newborn hearing screening in Nebraska. The statute requires birthing facilities to educate parents about newborn hearing screening, to voluntarily begin screening newborns for hearing loss, and, by December, 2003, to include hearing screening as part of the standard of care and to establish a mechanism for compliance review.

The number of birthing facilities conducting newborn hearing screening has increased rapidly from 2000 when only 11 hospitals were conducting either targeted or universal newborn hearing screening (see Table 1). Since 2003, 100 percent of the birthing facilities in Nebraska have been conducting hearing screenings. In 2012, 55 of the 56 birthing facilities conducted the hearing screenings during the birth admission and one conducted the screenings on an outpatient basis following discharge. The table was abbreviated due to similar percentages from 2003-2012.

For 2011 births, audiologists reported identifying 58 infants with a permanent hearing loss, an incidence rate of 2.2 per thousand births. The average age at the confirmation of diagnosis was 177 days and 29% of the confirmatory evaluations occurred within three (3) months of birth. Of the babies born in 2011 and identified with permanent hearing loss, 79% were verified for early intervention services through the Early Development Network (EDN). Of those verified, 60% were verified prior to six (6) months of age.

#### *Newborn Hearing Screening in Nebraska*

<b>Year</b>	<b>Number of Birthing Facilities in Nebraska</b>	<b>Number Conducting Newborn Hearing Screening</b>	<b>Percentage Conducting Newborn Hearing Screening</b>	<b>Number of Newborns Screened for Hearing Loss</b>	<b>Percent of Newborns Screened for Hearing Lost</b>
2000	69	11	16%	8,978	36%
2001	69	24	35%	15,272	61%
2002	69	57	83%	22,615	89%
2003	67	67	100%	25,275	97%
2008	61	61	100%	26,772	99%
2012	56	56	100%	26,272	99%

#### **Newborn Blood-Spot Screening**

The goal of newborn screening for inherited disorders is to identify newborns at risk for certain conditions that would otherwise not be detected until damage has occurred, and for which interventions and/or treatment can prevent damage and improve the outcome for the newborn. The types of conditions screened are endocrine, metabolic, hematologic and other genetic conditions such as cystic fibrosis. Morbidity is variable, depending on the condition. Effects include mental retardation, blindness, deafness, organ damage, seizures, risk of metabolic crisis, chronic illness and stroke. Some conditions if left undetected and not treated, can even result in infant or childhood mortality.

Newborn screening starts with the collection of 5 drops of blood from a simple heel stick onto special filter paper. This specimen is sent overnight 6 days a week to the newborn screening laboratory and tested for several conditions. The laboratory phones abnormal results immediately to the newborn's physician, hospital or submitter, and the State follow-up program. The State follow-up program staff fax and in urgent cases phone the physician with additional information about how to confirm the results, recommended tests to assist with diagnosis, and referral information on available specialists specific to the condition.

Once diagnosed and connected with specialty services when needed, in Nebraska, the newborn screening program helps with the cost to manage some diseases. Patients with conditions requiring metabolic formula and foods (which often are inadequately covered by insurance) can get assistance through the newborn screening program. For conditions requiring pharmaceutical treatment, insurance, Medicaid and State Children's Health Insurance Program (SCHIP) generally cover those necessary medical expenses.

Screening is mandated for 28 conditions, which until early in 2010 was consistent with the list of core conditions recommended and endorsed by the Secretary of the Department of Health and Human Services. On average about 50 babies each year are saved from serious morbidity and premature mortality. The number of babies spared since adopting the 28-condition panel was: 43 in 2006, 42 in 2007, 47 in 2008, 54 in 2009, 32 in 2010, 35 in 2011, and (as of 1/3/2013 50 in 2012).

The U. S. Secretary of HHS has recommended including Severe Combined Immune Deficiency (SCID) in the core panel of conditions every State should screen. The Nebraska Newborn Screening Program Advisory Committee evaluated capacity to add this to the State required panel, and developed follow-up diagnostic and treatment protocols. Following Advisory Committee recommendations to add SCID, the Department met with Medicaid and major health insurance medical directors in Nebraska to ensure understanding and agreement for support of these protocols. Regulation revisions proposing to add SCID are under consideration.

The Nebraska NBS Advisory Committee also commissioned a sub-specialist committee to address the clinical and public health implications of the Secretary of the US HHS' endorsement to add screening for critical congenital cyanotic heart disease (CCHD) to the Recommended Universal Screening Panel (RUSP). CCHD screening is point of care testing requiring different modes of follow-up and rapid referral and evaluation, but which could save lives and prevent severe disability of babies with otherwise undetected heart disease.

### Nebraska Head Start and Early Head Start Health and Dental Data

Head Start and Early Head Start programs offer a comprehensive array of services including health, dental, family support, nutrition, and educational services. The following performance indicators are related to the status of health and dental care for children enrolled in Head Start, Early Head Start, and Migrant and Seasonal Head Start programs.

Health and Dental Performance Indicators		Nebraska		
		HS	EHS	MSHS
122	Percentage of children up to date on a schedule of preventive and primary healthcare per the state's EPSDT schedule	93.2%	92.6%	86.3%
123	Percentage of children diagnosed as needing medical treatment	11.2%	7.9%	11.4%
111	Percentage of children with health insurance at end of enrollment year	94.6%	96.5%	76.5%
113	Percentage of children with up-to-date immunizations or all possible immunizations to date	91%	95.5%	98.0%
114	Percentage of children with a dental home (at the end of enrollment)	82.9%	N/A	88.2%
132	Percentage of preschool children completing professional dental exams	91.2%	N/A	78.8%
133	Percentage of preschool children needing professional dental treatment	18.9%	N/A	19.2%
134	Percentage of preschool children receiving dental treatment	89.8%	N/A	80.0%

*2011-2012 Nebraska Head Start Program Information Report Performance Indicator Report with American Indian and Alaska Native, and Migrant and Seasonal Head Start Data*

## **New Developments in Health and Medical/Home Services**

### **Major Accomplishments for the WIC Program**

- Nebraska DHHS, Division of Public Health, the Nebraska Breastfeeding Coalition and the Nebraska Women's Health Advisory Council have partnered to launch a new program to recognize breastfeeding-friendly businesses that provide a supportive environment for breastfeeding employees. In June, over 4000 Nebraska Businesses received information on the provisions of the 2010 Fair Labor Standards Act (FLSA) in support of nursing mothers. The information included resources and guidelines on how businesses can accommodate employers who breastfeed. The State WIC Breastfeeding Coordinator and two WIC Local Agency staff serve on the Leadership Team of the Nebraska Breastfeeding Coalition (NEBFC). The NEBFC continues to expand its presence as a key resource for breastfeeding support and promotion in Nebraska.
- Six local WIC agencies have implemented a breast pump program as a component of their breastfeeding support services. The breast pump program provides electric breast pumps to WIC mothers who have a need for this type of support.
- The Breastfeeding Peer Counseling program has been implemented in 11 WIC local agencies. The use of breastfeeding peer counselors adds the critical dimension of mother-to-mother support to WIC's efforts to help women initiate and continue breastfeeding. Peer counselors are mothers who have personal experience with breastfeeding and are trained to provide basic breastfeeding information and support to other WIC mothers in a socially and culturally appropriate context, and promote breastfeeding as an important element in the health development of the mother and baby.
- Nebraska WIC program implemented use of the World Health Organization Standards and Growth Charts for use with children age birth to 23 months. The WHO standards establish growth of the breastfed infant as the norm for growth; provide a better description of physiological growth in infancy; are based on high-quality study designed explicitly for creating growth charts; and are an international standard for normal growth and development. With implementation of the WHO Growth Charts, WIC nutrition risk criteria related to length and weight have been adjusted according to the new standards. The 2000 CDC growth charts continue to be used for children ages 2-4 years.
- In 2010, the Participant Centered Services (PCS) project was initiated to evaluate all areas of the WIC program, such as program policies, clinic environment, service delivery and nutrition promotion, and to implement changes to improve services. The project continued into 2011-2012.

- Planning continues for the implementation of a new computer system for the WIC Program. The system will allow the WIC program to operate electronically and without paper forms at the WIC clinics.
- Planning has been initiated to implement the use of electronic benefit transfer (EBT) cards in the WIC program. EBT cards would replace paper checks.

### **Nebraska Children's Hearing Aid Loaner Bank**

Nebraska has a statewide hearing aid loaner bank, a partnership of the audiology program at the University of Nebraska-Lincoln (UNL), and the Nebraska Early Hearing and Detection and Intervention (NE-EHDI) Program. Formerly called the Nebraska Children's Hearing Aid Loaner Bank, the name was changed to HearU Nebraska in 2012. HearU partnered with the University of Nebraska Foundation for fund raising and financial donation purposes. As of December 2012, HearU was serving 37 children; 16 were fitted with 26 new hearing aids and 21 children were fitted with 39 hearing aids from the loaner bank inventory. Since 2004 225 hearing aids have been dispensed to 131 children from the age of 3 months to 18 years.

NE-EHDI Program funds are used to purchase hearing aids, hearing aid repairs, and some administrative costs. In 2011, the NE-EHDI Program provided one-time funds to purchase 43 hearing aids, 21 care kits; one bone anchored hearing device, verification equipment, and hearing screening equipment.

### **Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program**

The federal Maternal, Infant, and Early Childhood Home Visiting Program provides support for evidence-based home visiting. Through these evidence-based programs nurses, social workers, or other professionals meet with at-risk families in their homes, evaluate the families' circumstances, and connect families to the kinds of help that can make a real difference in a child's health, development, and ability to learn - such as health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance.

There is strong research evidence that these programs can improve outcomes for children and families and also yield Medicaid savings by reducing preterm births and the need for emergency room visits. Based on these findings, the Affordable Care Act provides a total of \$1.5 billion for these initiatives over the next five years, beginning in federal fiscal year 2010.

Nebraska was among forty-nine states, the District of Columbia, and five territories that applied for and were awarded funding under this program, demonstrating the broad support that exists for these efforts. States and jurisdiction conducted statewide assessments to identify existing home visiting programs and areas of high need. These assessments informed how they use these funds to assure effective coordination and implementation of evidence-based high-quality home visiting programs that are designed to improve maternal and child health, foster healthy child development, and prevent child maltreatment.

Nebraska's home visitation needs assessment may be found at:

<http://dhhs.ne.gov/publichealth/Documents/EHBSubmission09-20-2010.pdf>

The Nebraska Department of Health and Human Services, Division of Public Health, Lifespan Health Services Unit is responsible for administering this federally funded program, which in Nebraska is called N-MIECHV. In 2011-2012, N-MIECHV launched evidence-based home visiting in three of the high need counties identified in the needs assessment: Scotts Bluff, Morrill, and Box Butte. Through a contract with a local provider, home visiting services using the Health Families America model are being provided in these counties.

In 2012, N-MIECHV supported a community assessment to determine need and readiness for evidence-based home visiting in Lincoln County, another identified high need county. Based on this community assessment, N-MIECHV will be launching evidence-based home visiting in Lincoln County in 2013 through a contract with another local provider, again using the Healthy Families America model as chosen by community stakeholders.

Another development in 2012 was the transfer of administrative responsibility from the Division of Children and Family Services to Public Health for the home visiting programs supported with State General funds. This transfer has facilitated closer alignment of these programs with the federally supported evidence-based home visiting programs.

The last major development in N-MIECHV in 2012 was the successful application for additional competitive federal funds. Awarded in late September 2012, these additional funds will further support implementation of evidence-based home visiting in Lincoln County, assist a locally and state supported home visiting program in Lancaster County achieve full fidelity to its evidence-based model and meet federal MIECHV standards, and determine need and readiness for MIECHV supported evidence-based home visiting in Douglas County. These funds are also supporting efforts to better communicate the value of evidence-based home visiting to families and referral sources, better connect visited families to behavioral health services when needed, and enhance data collection and continuous quality improvement activities.

### **Oral Health for Young Children**

The Oral Health Access for Young Children Program (OHAYC) began in January 2011 and concluded in August 2012 upon the end of the HRSA grant that funded the program. The OHAYC program provided dental screenings, fluoride varnish and dental referrals to high-risk children and families across Nebraska through working partnership with state government, local health departments, federally qualified health centers, WIC clinics, Head Start facilities, child care centers and dental hygienists.

In January 2011, OHAYC was implemented by 15 grantees representing Nebraska local health departments and FQHCs. By August 2011, these 15 grantees implemented the program in 31 local communities at 43 individual sites; by August 2012 the intervention grew to 37 local communities at 53 individual sites. Between August 2011 and August 2012, the average number of patients seen per month rose by 23% from 1,137 to 1,477. In total, this program provided dental screening and referrals, oral

health education and 24,167 fluoride varnish applications service 19,086 children through 6,813 clinical hours and the work of 62 individuals. Of the clinical patient encounters, 7,991 were repeat visits.

The children served in this program ranged in age from 3 days to 14 years old. Of the children served 91% were 5 years old and younger. Based on returned dental screening forms, 49% of the participants were Hispanic; 38% were White/Caucasian; 9% were Black/African American; 2% were American Indian/Alaska Native; 1% were Asian, and 1% were "Other". In addition:

- 8.2% of children had unhealthy gums.
- 15.8% of children had early childhood caries.
- 14% of children required further dental care.
- 47.8% of children did not have a dental home.
- 78.1% of families were on Medicaid.
- 85.8% of families did not have dental insurance.

Independent evaluation by the Creighton University Center for Health Services Research and Patient Safety (CHRP) concluded that OHAYC successfully expanded the YCPO pilot program model to communities across the state and demonstrated the ability to successfully reach high-risk families with children with preventive services in both urban and rural areas. In addition, they report that parents were very satisfied with the services provided (96% reported being satisfied or highly satisfied), and that 90% of parents were likely to refer others to the program. CHRP also reports that this program increased the capacity of local communities to improve the oral health of children through the initiation and development of new partnerships, and was strengthened by a focus on influencing parental behavior through education. The OHAYC program provides a promising model for provision of dental services to communities and populations with limited access to care that are traditionally hard to reach. For a few local health departments, this program was the first to prioritize oral health since the health department was established. Additional funding is being sought to continue the program.

## **Gaps and Barriers in Medical/Health Services**

### **Shortage of Health and Dental Professionals in Many Nebraska Counties**

Nebraska has several designated Health Professional Shortage areas where barriers exist to obtaining adequate health care. In 2012, 62 of Nebraska's counties have been designated, either in full or in part, as primary medical care Health Professional Shortage Areas (HPSAs). In addition, 70 of Nebraska's 93 counties have been designated, in full or in part, as containing Medically Underserved Areas (MUAs) or Medical Underserved Populations (MUPs). Within state-designated HPSAs, a high degree of shortage exists in each of the defined health specializations:

- 66% (61/93) of Nebraska's counties currently have a shortage of family practice physicians
- 94% (87/93) have a shortage of pediatricians
- 91% (85/93) have a shortage of obstetricians/gynecologists
- 76% (71/93) have a shortage of general surgeons

- 95% (88/93) have a shortage of internal medicine physicians
- 97% (90/93) have a shortage of psychiatrists
- 55% (51/93) of Nebraska counties have a shortage of dental health professionals
- 67% (62/93) have a shortage of pharmacy professionals
- 48% (45/93) have a shortage of occupational therapists
- 29% (27/93) have a shortage of physical therapists.

*Source: DHHS, Office of Rural Health, December 2012.*



## VI. Infrastructure

The Infrastructure section of the report describes the key components of the state governmental system that support the early care and education work in Nebraska. Key components that will be discussed include governance; financing; standards, monitoring and accountability (including child care licensing reporting requirements and data systems development); provider/practitioner supports and professional development; communication; and family leadership development.

### a. Governance

Early childhood care and education services are governed primarily through the Department of Health and Human Services, a code agency (reporting directly to the governor), and the Department of Education, a constitutional agency, governed by the State Board of Education. Collaborative working relationships between these two agencies have been ongoing and long-term including the establishment of the two agencies as Co-Leads for administering infant/toddler services through Part C of the Individuals with Disabilities Education Act. A Memorandum of Understanding developed between the two agencies helps support critical infrastructure in early childhood care and education using a portion of the Child Care Development Fund dollars dedicated for infant/toddler support and ensuring quality environments.

### b. Financing

Early care and education services are funded with a variety of federal and state funds. The majority of funding for early care and education services is federal funding. Recent increases in state funding have included the early childhood education grants program through the Nebraska Department of Education and the Early Childhood Endowment (Sixpence) program which included both private and public funds to support early care and education programs for infants and toddlers.

The Department of Health and Human Services estimates that the following amount will be available for child care services and related activities during the 1 year period from October 1, 2011 through September 30, 2012.

FY 2012 Federal Child Care Development Fund (CCDF) Allocation (Discretionary, Mandatory, and Matching) \$33,725,518

Federal Temporary Assistance to Needing Families Transfer to CCDF \$17,000,000

State CCDF Maintenance of Effort Funds \$6,498,998

State Matching Funds \$7, 294,999

The Department of Health and Human Services provides \$1,514,330 of CCDF funds to the Nebraska Department of Education (NDE) through a Memorandum of Understanding (MOU). This MOU provides funds to support early childhood quality initiatives administered by NDE.

The largest source of federal funds support for early care and education in Nebraska are:

- Child Care Development Fund
- Individuals with Disabilities Education Act (Part C infant/toddlers, Part B 619 (children 3-5))
- Head Start and Early Head Start
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The largest sources of state funds support:

- State portion of child care subsidy
- Early childhood programs operated in public schools
- State funds for medically handicapped children's program

### **Part C ARRA Funding**

In June 2009 the state of Nebraska received Individuals with Disabilities Education Act (IDEA) Part C American Recovery and Reinvestment Act (ARRA) funds from the federal government. All funds were expended by September, 2011, per federal requirements.

A number of initiatives begun using the Part C ARRA funding continue to provide enhancement to benefit infants and toddlers with disabilities and their families and those professionals who serve them, including:

- Upgrading and improving technology capabilities of school districts, ESUs, and EDN Services Coordination agencies to facilitate communication across Nebraska.
- A series of professional development workshops in various locations in the state to provide support to service providers working with families living in poverty.
- Statewide organization of regional forums to promote inter-agency collaboration and discussion about Social Emotional assessment, services and supports for children birth-age 5.
- Helping Babies from the Bench, a series of multi-disciplinary trainings and follow-up action planning conducted at various sites across Nebraska, is focused on infants and toddlers in the child welfare system. The training assists those who work with child court cases and other stakeholders to ensure best possible outcomes for children, ages birth to 5. Topics included Part C early intervention/EDN services, the impact of stress, neglect and trauma on child development, focusing the Pre-Hearing Conference and Protective Custody hearing on the infant or toddler, and infant/parent relationships therapy. Led by Judge Douglas Johnson of the Separate Juvenile Court of Douglas County. The group of trainers includes a child psychologist, an early development specialist, an education specialist, and an infant-parent relationship therapist. Co-sponsored by the UNL Center for Children, Families and the Law-Through the Eyes of a Child Initiative and the Early Development Network, these training are continuing through 2013.
- Development of an on-line training series on home visitation for services coordinators, Part C service providers, and other professionals who make home visits. The training modules were adapted from the home visitation training that was previously offered face to face through the

Department of Education's Early Childhood Training Center. The online trainings are now accessible to anyone who wants to learn more about home visitation and can be taken at any time.

- Child Find and public awareness efforts designed to improve outreach for difficult-to-reach populations including American Indian, Migrant, and Homeless families.
- Coordination of networking opportunities to facilitate collaboration between the Early Development Network providers and Migrant Outreach case workers in an effort to increase child find referrals to Part C services.
- Routines-Based Interview (RBI) National Institute Training: Financial support for six EDN/ECSE providers to attend the National RBI Institute in Chattanooga, TN, each year.
- Support for Family Representative Training and Parent Leadership Training through the Parent Training and Information Center (PTI-NE).

### **State Advisory Council Grant**

The Early Childhood Interagency Coordinating Council submitted a proposal for State Advisory Council American Recovery and Reinvestment Act funds in July 2010. These "stimulus" funds were made available out of the federal Office of Head Start to meet the intent of and to financially appropriate the Head Start Act (§642B), which states: "The Governor of the State shall (i) designate or establish a council to serve as the State Advisory Council on Early Childhood Education and Care for children from birth to school entry...and designate an individual to coordinate activities of the ...Council."

Furthermore, the responsibilities of the Council include, "conduct a periodic statewide needs assessment concerning the quality and availability of early childhood education and development programs and services for children birth to school entry including an assessment of the availability of high-quality prekindergarten services for low-income children in the State;" ...identify opportunities for, and barriers to, collaboration and coordination" among all types of early childhood programs and services.

The Nebraska ECICC was designated by Governor Heineman to meet this federal requirement and the ARRA funds through August 31, 2013 will assist the Council in meeting these requirements with a focus on two key priorities over the next few years: 1) "School Readiness" will be explored by discussing with families, schools, and communities what school readiness really means, what types of supports may be available or needed to support young children as they enter school and what is needed to support schools as they prepare young children. A public media initiative will also be part of this focus. And 2) "Unified Early Childhood Data Systems", will focus on gathering input from key stakeholders, better understanding and defining what data we have, and opportunities and recommendations for developing a unified data system.

### c. Standards, Monitoring and Accountability

Type of programs	Rules/Regulations	Last Updated	Monitoring Mechanism
Public School Early Childhood Education (Ages 3-5)	Title 92 NAC-Rule 11	August 2007	Results Matter data system for child/program outcomes, onsite visits. Nebraska Student and Staff Record System (NSSRS)
Public School Early Childhood Endowment (Ages birth-3)	Title 92 NAC-Rule 11	August 2007	Results Matter data system for child/program outcomes, onsite visits. Nebraska Student and Staff Record System (NSSRS)
Special Education including early childhood education	Title 92 NAC -Rule 51	May 2010	Results Matter data system for child/program outcomes, onsite visits, ILCD monitoring process (Improving Learning for Children with Disabilities).
Child care subsidy	Title 392 NAC	March 2009	Annual visits by resource developers. Overpayment reporting process.
Child care center licensing	Title 391 NAC	February 2013	Regular inspections and investigations
Family child care home licensing	Title 391 NAC	February 2013	Regular inspections and investigations
Licensed preschool (not operated by public school)	Title 391 NAC	February 2013	Regular inspections and investigations
School-Age care licensing	Title 391 NAC	February 2013	Regular inspections and investigations

Federal Head Start and Early Head Start programs are monitored every three years by an external group of reviewers. The state of Nebraska has no monitoring or regulatory authority over the Head Start grantees. The federal Office of Head Start has established more stringent regulations and criteria for Head Start grantees. More regular monitoring and findings of non-compliances or deficiencies may result in programmatic changes and if corrections are not made may compromise the program's capacity for continued operation.

#### 1. Required Child Care Licensing Report

The Early Childhood Interagency Coordinating Council Act requires a report on child care licensing be included in the biennial report. The information required includes:

- a) the number of license applications received under the Quality Child Care Act and the Child Care Licensing Act;

- b) the number of licenses issued;
- c) the number of license applications denied;
- d) the number of complaints investigated regarding such licenses;
- e) the number of such licenses revoked;
- f) the number and dollar amount of civil penalties levied pursuant to section 71-1920; and
- g) any information which may assist the Legislature in determining the extent of cooperation provided to the Department of Health and Human Services by other state and local agencies pursuant to section 71-1914.

Nebraska requires any individual or agency providing child care to four or more children, at the same time, from different families, for compensation to be licensed. Licensing regulations focus on minimum standards of health and safety. Fire safety inspections are conducted on all licensed programs. Sanitation inspections are conducted on Child Care Centers

#### **NUMBER AND CAPACITY OF LICENSED CHILD CARE/PRESCHOOL PROGRAMS**

License Type	# of programs		License Capacity	
	June 2011	June 2012	June 2011	June 2012
<b>Family Child Care Home I</b> (licensed for 4 – 10 children)	2,275	2,108	22,388	21,468
<b>Family Child Care Home II</b> (licensed for 11 – 12 children)	682	707	8,083	8,383
<b>Child Care Center</b> (license capacity based on facility size and staff)	972	983	79,759	82,444
<b>Preschool</b> (license capacity based on facility size and staff)	225	223	5,247	5,244
<b>TOTAL</b>	<b>4,154</b>	<b>4,021</b>	<b>115,477</b>	<b>117,539</b>

This compares to 4,096 programs with a license capacity of 111,562 in June 2010 and continues the trend of a decrease in the number of small programs and an increase in the license capacity of larger programs.

#### **INSPECTIONS COMPLETED BY CHILD CARE LICENSING STAFF**

##### **Routine Inspections**

All licensed programs receive a minimum of one unannounced inspection each year. Programs licensed for 30 or more children receive two unannounced inspections each year. Routine inspections include: inspections to Family Child Care Home I programs carried out within 60 days of the issuance of a provisional or operating license and annual and semi-annual inspections. Other inspections that are conducted include: follow-up inspections to determine compliance after violations have been observed;

and, monitoring inspections to determine compliance while programs are on corrective action status or some level of discipline; and consultations.

<b>Routine Inspections</b>	<b>Number of Inspections FY 2011 (7/1/10 – 6/30/11)</b>	<b>Number of Inspections FY 2012 (7/1/11 – 6/30/12)</b>
Family Child Care Home I	<b>4,278</b>	<b>3,266</b>
Family Child Care Home II	<b>1,092</b>	<b>1,038</b>
Child Care Center	<b>2,448</b>	<b>1,879</b>
Preschool	<b>352</b>	<b>279</b>
<b>TOTAL</b>	<b>8,170*</b>	<b>6,462*</b>

*\*From June 2011 through September through September 2012, inspection data for all inspection types was lost due to technical problems with software.*

### **Complaint Inspections**

All complaints alleging violations of licensing regulations and complaints alleging illegally operating child care are investigated with an on-site inspection. This compares with 959 complaints investigated in FY 2009 and FY 2010.

<b>Complaint Investigations</b>	<b>Number of Complaints FY 2011 (7/1/10 – 6/30/11)</b>	<b>Number of Complaints FY 2012 (7/1/11 – 6/30/12)</b>
Family Child Care Home I	<b>261</b>	<b>232</b>
Family Child Care Home II	<b>125</b>	<b>112</b>
Child Care Center	<b>562</b>	<b>592</b>
Preschool	<b>4</b>	<b>2</b>
Unlicensed Care Investigations	<b>146</b>	<b>83</b>
<b>TOTAL</b>	<b>1,098</b>	<b>1,021</b>

### **71-1917 Report**

The Child Care Licensing Act (at 71-1917) requires the following information be included in the biennial report:

<b>Required Data</b>	<b>FY 2011 (7/1/10 – 6/30/11)</b>	<b>FY 2012 (7/1/11 – 6/30/12)</b>
Number of license applications received	<b>Data not available*</b>	<b>Data not available*</b>
Number of licenses issued	<b>894</b>	<b>813</b>
Number of license applications denied	<b>4</b>	<b>5</b>
Number of complaints investigated	<b>1,098</b>	<b>1,021</b>
Number of licenses revoked	<b>32</b>	<b>30</b>
Number of civil penalties levied	<b>13</b>	<b>28</b>
Dollar amount of civil penalties levied	<b>\$7,469</b>	<b>\$15,031</b>

\*Data was lost due to a server crashing so it is not available for this report.

## Data Coalition and Data Systems Development

In the early years of the Together for Kids & Families initiative a cross-systems Data Work Group began to address the need for a clearer picture of what data systems exist, what types of indicators the project wanted to probe over time and what gaps in data there may be. The Data Work Group combined efforts with other early childhood stakeholders both public and private, to form an Early Childhood Data Coalition. According to the charter the purpose of the group is to:

- establish a coalition of key stakeholders regarding early childhood specific data across Nebraska;
- enhance collaboration regarding data through clearly defined policies and procedures;
- develop a plan for a comprehensive early childhood data system.

Data Coalition stakeholders agreed to four outcomes:

- Outcome 1. Articulate and agree to follow a set of data business rules and ethical guiding principles that meet and follow local, state, federal regulations as appropriate.
- Outcome 2. Map data systems on a biennial basis.
- Outcome 3. Identify and select indicators and outcomes for joint and individual purposes.
- Outcome 4. Collect, analyze, and report data on identified indicators and outcomes (or otherwise determined by the Coalition).

The Data Coalition has a leadership role to help implement priority 2, a Unified Data System, of the State Advisory Council American Recovery and Reinvestment Act (ARRA) grant initiative.

### d. Provider/Practitioner Supports/ Professional Development

#### CHILD CARE GRANTS

The Department of Health and Human Services (“DHHS”) established a grant fund from Child Care Development Funds to award grants to child care programs in order to increase and support the number of licensed child care slots available to families receiving Child Care Subsidy. The child care grant categories are:

1. Start-Up/Expansion Grants
2. Child Care Mini-Grants
3. Quality Improvement Grants
4. Legally Exempt Provider Grants

**Start-Up/Expansion Grants** are available for programs that are:

- New (not yet licensed);
- Expanding (increasing the license capacity)
- Expanding from a Family Child Care Home I to a Family Child Care Home II, or a Family Child Care Home II to a Child Care Center.

The maximum start-up/expansion grant awards are \$5000 for home-based child care programs, and \$10,000 for center-based child care programs.

**Mini-Grants** are available to assist licensed home-based and center-based child care programs with items that are required to maintain licensure. To be eligible for grant funds, a child care facility must be licensed, and have a Child Care Subsidy agreement or be willing to obtain an agreement. Maximum grant awards are \$1000 for a child care program with a provisional license, and \$2000 for a child care program with an operating license.

**Quality Improvement Grants** are available to both home-based and center-based licensed child care programs currently serving low-income families. These grants fund items that will increase the quality of care provided. Maximum grant awards are \$500.

Once selected for grant funding, grant recipients agree to submit reports on the use of the funds, continue providing licensed child care for three consecutive years, continue to participate in training opportunities, and obtain and/or maintain a Child Care Subsidy agreement with the Department of Health and Human Services.

**Legally Exempt Provider Grants** are available to “legally exempt” child care providers (serving 3 or fewer children and not required to be licensed) who have a current Child Care Subsidy agreement to serve low-income families. A reimbursement of up to \$100 is available for specific items to assist with provision of child care services.

In FFY 2010 and 2011, DHHS awarded 45 Start-Up/Expansion Grants and 94 Mini-Grants, totaling \$357,153.30, and created or supported the enrollment of 2443 children across the state. Nineteen Legally Exempt Grants were awarded statewide, totaling \$1642.38. DHHS awarded 182 Quality Improvement Grants since their inception in May of 2005, totaling \$86,609.20.

### **Department of Health and Human Services Early Head Start Infant/Toddler Quality Initiative**

The overall purpose of the Early Head Start Infant/Toddler Quality Initiative (EHS I/TQI) is on the improvement of the quality of infant and toddler child care in Nebraska. This initiative is funded with a portion of the Child Care and Development Block Grant funds earmarked specifically for infant and toddler care. Funds are distributed equally among the initiative participants.

Five EHS programs currently participate in this initiative, each of whom were selected through a granting process involving a plan for selection and recruitment of home and center-based child cares, descriptions of professional development opportunities for the child care partners, developmentally appropriate practices to be used, and consultation and technical assistance provided for moving toward

licensing and accreditation. EHS staff are contractually required to maintain reliable rater status on the ITERS (Infant Toddler Environment Rating Scale) and FCCERS (Family Child Care Environment Rating Scale) evaluation methods used, and submit the evaluation data on the providers as well as accountings of funds expended.

The EHS programs categorize their participating child care partners by the level of interaction and service provided. This categorization allows the EHS staff to set priorities regarding the available resources, and match the types and intensity of services provided. These levels are categorized as follows:

- **Option 1 Providers:** The most intensive involvement with the initiative, pre- and post-tests on the environmental rating scales are conducted, goals are set, program visits are conducted, support group activities are provided, and access to program opportunities, trainings, mailings, and other resources are offered;
- **Option 2 Providers:** Involved in all levels of involvement as the Option 1 providers, however, only one set of environmental rating scales (FCCERS or ITERS) data is collected; and
- **Option 3 Providers:** A less frequent/intensive level of involvement, have access to trainings, technical assistance, and resources.

The primary element of the EHS/ITQI lies in the partnerships established with EHS programs and their community child care partners. Through these partnerships, EHS grantees:

- Provide professional development opportunities and other support to home-based and center-based providers;
- Assist in training and mentoring of the child care partners regarding infant and toddler development issues;
- Observe and report best outcomes, greatest challenges, and measures of quality within the child care settings.

As a result of their involvement with this initiative, the participating child care partners have consistently demonstrated a statistically significant improvement in their overall ITERS or FCCERS scores. The child care partners either “agreed” or “strongly agreed” in the feedback of the initiative, that EHS staff helped them to increase the quality of care and education provided to the infants and toddlers in their care, and that participation in this initiative helped them to further their knowledge about infants and toddlers.

## **Professional Development System/Early Childhood Resource and Referral System**

### **The Current State of the Early Childhood Professional Development System**

**The Nebraska Early Learning Connection (ELC)** is the statewide system of professional development for early childhood care and education professionals. The hub of this system is the Early Childhood Training Center, part of the Nebraska Department of Education (NDE) Office of Early Childhood.

NDE also supports a network of regional Early Learning Connection partnerships through continuation grants. The Early Learning Connection Partnerships are housed in seven Educational Service Units spread across the state. The Early Learning Connection Partnerships are staffed by full-time coordinators who helps plan and promote professional development opportunities across define regions of the state. Each

Early Learning Connection Partnership works with local colleges and universities, UNL Extension educators from the Learning Child team, school districts, Head Start programs, child care centers, and family child care homes to identify priorities for the region for the year. The *Nebraska Early Learning Connection* offers a wide array of professional and career development opportunities to those who touch the lives of young children and their families.

Key components of Nebraska's *Early Learning Connection Professional Development Services*:

- A wide-array of focused workshops and professional development activities through both the state agencies and the regional Early Learning Connection Partnerships.
- A searchable early childhood statewide [training calendar](#).
- [Nebraska's Core Competencies for Early Childhood Professionals](#) and associated planning tools
- [Early Learning Guidelines](#) that describe what children should know and be able to do at various ages from birth through Kindergarten.
- Training on [Program Quality measures](#) by trained observers: Environment Rating Scales (ERS); CLASS
- Supports for [early childhood program accreditation](#)
- Resources about Child Abuse Prevention, Safe Sleep, and Shaken Baby training; [Safe with You](#)
- [Child Development Associate \(CDA\) Scholarships](#)
- Free-loan access to large [Media Center Catalog](#)
- [Telephone consultations](#) for parents seeking child care
- [Telephone consultation](#) regarding a wide range of early childhood topics

### **Child Care Prepared Fact Sheets**

The Together for Kids and Families (TFKF) Child Care Health Consultation Work Group identified the need for information dissemination to child care providers via other methods besides face to face health consultation. The following fact sheets have been developed and disseminated to child care providers. Topics were selected based on feedback from the Inclusive Child Care Survey in which providers noted concerns about caring for children with special health care needs.

Child Care Prepared for Asthma

Child Care Prepared for Food Allergy

Child Care Prepared for Seizures

Child Care Prepared for Diabetes

Child Care Prepared for Methicillin Resistant Staphylococcus Aureus (MRSA)

Child Care Prepared for Emergency and Disaster Preparedness

Child Care Prepared to Prevent Transmission of Bugs

Car Seat Recommendations

[http://dhhs.ne.gov/publichealth/Pages/lifespanhealth\\_childcarehealthconsultations.aspx](http://dhhs.ne.gov/publichealth/Pages/lifespanhealth_childcarehealthconsultations.aspx)

### **Early Childhood Professional Development Data System**

The Nebraska Department of Health and Human Services and Nebraska Department of Education are working collaboratively on the development of the Early Childhood Professional Development Data System. The data system would be a voluntary system that early childhood care and education professionals could house their professional development records. In addition, the data system provides

Nebraska with better data and information on the early childhood workforce, early childhood program capacities and enrollment of children, and the fees charged for care of infants, preschoolers, and school-age children.

Early childhood professionals and early childhood programs would benefit by being able to have a centralized location for their professional development records. The state benefits by being able to use aggregated data to better understand the spectrum of education of providers in the early childhood field, the annual training clock hours that early childhood providers receive, the degree to which training addresses the core competencies of early childhood professionals, and the extent to which programs are tracking and monitoring program quality. The Early Childhood Professional Development Data System can also help support analysis of data to determine the degree to which education or training of early childhood professionals influence the quality of early childhood programs.

### Higher Education Teacher Preparation Programs in Nebraska

Nebraska's two year and four year higher education institutions offer an array of certificate programs, diploma programs, and degree and endorsement programs that address child development and early childhood education. The early childhood education unified endorsement prepares early childhood education professionals for working with all children from birth through grade three. The program includes a combination of general education courses, child development courses, teacher education courses, and special education courses. Nebraska now has six public colleges and universities offering the early childhood unified degree. The chart below indicates the current status of articulation of courses between the associate degree programs in early childhood education at Nebraska's community colleges and the four year degree programs at the four year colleges/universities for the early childhood education unified endorsement.

### Articulation of Courses between 2-year and 4-year colleges and universities for unified early childhood education degrees

<b>2-yr colleges</b> <b>4-year colleges/ universities</b>	Metro Community College	Southeast Community College	Central Community College	Northeast Community College	Mid-Plains Community College- McCook Campus	Western Nebraska Community College
University of Nebraska at Kearney	62	64	65	61	67	61
University of Nebraska Lincoln	41	53	50	50	53	41
Chadron State College	69	67	65	59	47	67
Wayne State College	47	66	66	65	36	35
Peru State College	63	69	61	61	64	64

### Number of Early Childhood Education Degree Programs by Colleges/Universities

4-year Colleges/ Universities	Teacher Education Endorsements approved by State Department of Education					Child Development (non-teacher education degree)
	El Ed/Early Childhood Ed Endorsement	Early Childhood Unified	Early Care and Education- Special (Birth-5)	Preschool Disabilities	Early Childhood Special Ed	
Number of higher education institutions offering ECE/Child Development degree	11*	6*	1*	1*	1*	3◇

\*August 2012 Office of Educator Preparation Program Approval Report

◇ 2012 College websites

2-year colleges	Associate of Applied Science Early Childhood Education	Associate of Arts (Focus in early childhood education)	Associate of Science (Focus in early childhood education)
Number of higher education institutions offering degree	5◇	8◇	1◇

### Program Completers in Endorsement Areas for Early Childhood Education

Turnover in the early childhood care and education field can be as high as forty-five percent. There is an increasing demand for persons with four year degrees in early childhood education across the profession. The chart below provides information on the number of people graduating with an endorsement in early childhood education from Nebraska's colleges and universities.

Endorsement	Year	2008-2009	2009-2010	2010-2011	Total
Early Childhood Education with Elementary Education		134	102	114	350
Early Childhood Unified		60	81	76	217
Preschool Disabilities		2	1	1	4
<b>Total Early Childhood Education Endorsements</b>		<b>196</b>	<b>184</b>	<b>191</b>	<b>571</b>

Source: 2008-2009, 2009-2010, 2010-2011 Title II Reports to the Nebraska Department of Education

### T.E.A.C.H. Early Childhood® NEBRASKA Scholarships

Studies of quality early childhood care and education programs indicate the best quality of programs are those where staff are well educated and turnover is low. T.E.A.C.H. Early Childhood® is designed to provide scholarship funds for those working with young children. Each scholarship addresses three key issues facing those in the early care and education field:

- The education level of staff,
- High turnover rates

- Low salaries

Nebraska began providing scholarship in 2002. T.E.A.C.H. Early Childhood® NEBRASKA served 174 students in Nebraska July 1, 2011-June 30, 2012. One Hundred and Twenty Five Associate Degree Students and 49 Bachelor/Bachelor Gap Students received scholarships during that period.

<b>T.E.A.C.H. Early Childhood®NEBRASKA Outcomes</b>	<b>2011-2012 Nebraska Data</b>
Compensation Increase	The average salary increase for teachers was 5%
Education Increase	1422 semester credits earned
Reducing Turnover	4% turnover rate
Student Grade Point Average	AA Degree 3.6, BA Students 3.3

*Source: Nebraska Association for the Education of Young Children, July 1, 2011-June 30, 2012 Annual Report*

### **e. Communication-websites, public information, information to field, logistical supports**

State agencies offer a myriad of web-pages that provide information on early childhood care and education services available, effective practices, required state and federal reports, and research and statistics on state services. Links to many of these websites can be found in the appendix section of this report.

#### **On-Line Roster of Licensed Child Care/Preschool Programs**

A roster of licensed child care and preschool programs has been available on-line for the past nine (9) years. The list of licensed Family Child Care Home I, Family Child Care Home II, Child Care Centers, and Preschools is in zip code order and is updated each week. The link for the roster can be found on the Child Care Licensing Web Page. The roster is long, but contains all programs in zip code order, starting with the lowest zip code in the state. In 2009, the roster was changed to identify programs that are accredited and continued to identify programs that accept Child Care Subsidy.

## **II. Summary**

The Early Childhood Interagency Coordinating Council is made up of broad representation across the early childhood field. All of its members are appointed by the Governor of Nebraska. Some membership requirements are defined by state and federal statutes. The passage of the Improving Head Start for School Readiness Act resulted in an increased set of responsibilities for the Council, as well as, responsibility for establishing priorities related to the State Advisory Council grant.

Recommendations developed and reported in the Executive Summary of this report were reviewed and approved by the Early Childhood Interagency Coordinating Council at their February 2013 meeting.



**Early Childhood Interagency Coordinating Council Members  
December 2012**

Pam Dobrovlny Chairperson Grand Island, NE	Jane Happe Educare of Omaha Omaha, NE	Christy Pelton Parent Representative Bertrand, NE
Mike Adams Parent Representative Omaha, NE	Melody Hobson Department of Education Office of Early Childhood Omaha, NE	Senator Pete Pirsch District 4 Omaha, NE
Sue Adams Department of Health and Human Services-Behavioral Health Lincoln, NE	J. P. Holys Public Schools Falls City, NE	Shirley Pickens-White Department of Health and Human Services-Children and Family Services Lincoln, NE
Carol Benson Family Child Care Home Provider Coleridge, NE	Dr. Sian Jones-Jobst Physician Lincoln, NE	Roger Reikofski Department of Education Homeless Education Lincoln, NE
Rebecca Bimler Child Development Center Seward, NE	Eleanor Kirkland Head Start State Collaboration Office Lincoln, NE	Julie Rother Public Health Wayne, NE
Annie Bruns Parent Representative Lincoln, NE	Heather Krieger Department of Health and Human Services-Medicaid & Long Term Care Lincoln, NE	Susan Strahm Professional Development Wakefield, NE
Lois Butler Head Start Kearney, NE	Amy LaPointe Winnebago Head Start Winnebago, NE	Carolyn Thiele Mental Health Agency Omaha, NE
Teri Chasten Health and Human Services- Children and Family Services Lincoln, NE	Carol McClain Department of Education Special Education Lincoln, NE	Salene Ulrich Parent Representative Garland, NE
Eric Dunning Department of Insurance Lincoln, NE	Julie Mizner Parent Representative Ainsworth, NE	Cristen Witte ESU 17 Valentine, NE
Barb Esch Services Coordinator McCook, NE	Dawn Mollenkopf University of Nebraska Kearney Kearney, NE	
Melinda Graham Parent Representative Neligh, NE		

**Websites with Additional Information and Content Related to This Report**

**Early Childhood Interagency Coordinating Council (ECICC) website** <http://www.education.ne.gov/ecicc/index.html>

**Department of Education (NDE)**

Head Start State Collaboration Office <http://www.education.ne.gov/OEC/hssco.html>

Head Start State Collaboration Office Needs Assessment

[http://www.education.ne.gov/OEC/hssco/June\\_2009\\_needs\\_assessment\\_report.pdf](http://www.education.ne.gov/OEC/hssco/June_2009_needs_assessment_report.pdf)

NDE Office of Early Childhood <http://www.education.ne.gov/OEC/index.html>

Evaluation Reports on NDE early childhood education programs

[http://www.education.ne.gov/OEC/ec\\_grant\\_reports.html](http://www.education.ne.gov/OEC/ec_grant_reports.html)

NDE Special Education <http://www.education.ne.gov/sped/index.html>

State Performance Plans and Annual Performance Reports for Part C and Part B, 619

<http://www.education.ne.gov/sped/data.html>

NDE/DHHS Early Development Network <http://edn.ne.gov/>

**Department of Health and Human Services (DHHS)**

DHHS Children's Behavioral Health [http://dhhs.ne.gov/behavioral\\_health/Pages/beh\\_mh\\_childmh.aspx](http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_childmh.aspx)

DHHS Child Care Licensing [http://dhhs.ne.gov/publichealth/Pages/crl\\_childcare\\_childcareindex.aspx](http://dhhs.ne.gov/publichealth/Pages/crl_childcare_childcareindex.aspx)

DHHS Child Care Subsidy [http://dhhs.ne.gov/publichealth/Pages/chs\\_chc\\_ccsubsyapa.aspx](http://dhhs.ne.gov/publichealth/Pages/chs_chc_ccsubsyapa.aspx)

DHHS Child and Family Services [http://dhhs.ne.gov/children\\_family\\_services/Pages/children\\_family\\_services.aspx](http://dhhs.ne.gov/children_family_services/Pages/children_family_services.aspx)

DHHS Child Welfare [http://dhhs.ne.gov/children\\_family\\_services/Pages/jus\\_jusindex.aspx](http://dhhs.ne.gov/children_family_services/Pages/jus_jusindex.aspx)

DHHS Child Welfare Data Reports [http://dhhs.ne.gov/children\\_family\\_services/Pages/jus\\_reports.aspx](http://dhhs.ne.gov/children_family_services/Pages/jus_reports.aspx)

DHHS N-MIECHV Home Visitation [http://dhhs.ne.gov/publichealth/Pages/lifespanhealth\\_home\\_visitation\\_home-visiting-needs-assessment.aspx](http://dhhs.ne.gov/publichealth/Pages/lifespanhealth_home_visitation_home-visiting-needs-assessment.aspx)

DHHS Public Health [http://dhhs.ne.gov/publichealth/Pages/public\\_health\\_index.aspx](http://dhhs.ne.gov/publichealth/Pages/public_health_index.aspx)

DHHS Lifespan Health <http://dhhs.ne.gov/publichealth/Pages/lifespanhealth.aspx>

DHHS Reports and Statistics <http://dhhs.ne.gov/Pages/stats.aspx>

DHHS Together for Kids and Families [www.dhhs.ne.gov/TogetherKidsFamilies](http://www.dhhs.ne.gov/TogetherKidsFamilies)

DHHS Vital Statistics [http://dhhs.ne.gov/publichealth/Pages/ced\\_vs.aspx](http://dhhs.ne.gov/publichealth/Pages/ced_vs.aspx)

**Other Websites:**

Nebraska Resource and Referral <https://nrns.ne.gov>

Answers4Families [www.answers4families.org](http://www.answers4families.org)

PTI Nebraska <http://pti-nebraska.org/>

Sixpence Programs [www.SingaSongofSixpence.org](http://www.SingaSongofSixpence.org)

**Appendix C****What has happened to the recommendations from the 2010 Strategic Report to the Governor?****Parent Education and Family Support****1. Fund and support community capacity building to provide respite, home visitation, and mentoring models for parent education and family support.**

Update: The Department of Health and Human Services has developed home visitation programs in counties with increased risk factors as determined through a rigorous needs assessment. This needs assessment was completed in 2010 in accordance with the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program. Seventeen counties were identified as having greater levels of risk that would benefit from evidence-based home visiting. The Healthy Families America evidence-based program was selected by stakeholders and implemented in three of the seventeen counties: Scottsbluff, Morrill, and Box Butte. An additional county, Lincoln County, has also selected Healthy Families America as its evidence-based home visitation model and is in the early stages of program planning and implementation. Program implementation in these initial counties has been supported with MIECHV formula grant funds awarded to the Nebraska Department of Health and Human Services (NE DHHS). In 2012, NE DHHS competitively applied for and received additional federal MIECHV funds, which are being used to further support implementation in Lincoln County, enhance existing evidence-based home visiting in Lancaster county, and to conduct community-level planning for evidence-based home visiting in Douglas County. NE DHHS is also coordinating the administration of both State General Funds appropriated to home visiting and MCH Block Grant funds with that of the federal MIECHV funds as a means of further building capacity. A Home Visitation Partnership is being established in Nebraska to improve evidence-based practices, and help promote effective home visitation practices in other home visitation programs.

The ECICC wrote a letter of support for the competitive MIECHV federal grant.

The Home Visitation Training that was previously offered face to face through the Early Childhood Training Center is now available online for training through the Answers4Families website. This training is now free of charge and available to any home visitor across the state. Agencies can add modules specific to their home visiting staff to the general training foundation.

**2. Continue to provide information, resources and supports to all families with young children acknowledging that parents are a child's first teacher.**

Update: The state agencies continue to provide information, resources and supports to families of all young children. The Answers4Families website has been updated to include more specific information on child care resources in Nebraska. Answers4Families also added The Right Place information on their website to help educate parents about selecting child care. The Resource and Referral Phone Line at the Early Childhood Training Center continues to offer information to parents on questions to pose to child care providers when looking for a quality program for their child. Additionally, parents are provided with a listing of child care programs in their area that might meet their needs.

PTI Nebraska continues to provide parent specific training across the state to assist parents in understanding how to advocate effectively for their children, especially for those children with special needs.

The Early Learning Guidelines (Ages 3-5) in Nebraska are under revision as part of the State Advisory Council grant to the Department of Education. New materials are planned to help parents better understand how they can help support young children's learning and development related to what children need to know and do (based upon their age).

The "Ready For Success: What Families Want to Know about Starting School in Nebraska" brochure was developed. This brochure was supported with funds from the State Advisory Council Grant. The brochures have been widely distributed throughout the state and can be printed directly from the web at:

[http://www.education.ne.gov/OEC/pdfs/Ready\\_for\\_Success\\_final\\_QR.pdf](http://www.education.ne.gov/OEC/pdfs/Ready_for_Success_final_QR.pdf)

The Nebraska Child Find website and staff provides information to assist parents in finding resources if their children may have developmental delays. Nebraska Child Find attends conferences and events throughout the state to help get information to parents on the Early Development Network and the help available through regional Planning Region Teams.

**3. Stabilize the child care subsidy system to support families in the workforce by moving the income eligibility rate to 185% of poverty.**

The child care subsidy system does support parents who are transitioning off of TANF (Temporary Assistance for Needy Families) for 24 months if their incomes are at or below 185% of the federal poverty level. For all other families child care subsidy is limited to those families whose income is at or below 120% of the federal poverty level. This is one of the lowest eligibility rates in the country.

The state budget challenges of the last few years have prevented Nebraska from taking action on this eligibility criteria level.

### **Social-Emotional Development/Mental Health**

#### **4. Fund statewide implementation of a comprehensive framework that promotes the social and emotional competence of young children and their families in all early childhood settings.**

The Together for Kids and Families work team has developed a System of Care Self-Assessment that can assist any community in considering their current capacity for providing social and emotional supports for young children and their families.

<http://dhhs.ne.gov/publichealth/Documents/System%20of%20Care-Final.pdf>

The Teaching Pyramid Leadership Team made up of key stakeholders from NDE, DHHS, higher education, UNL Extension, and others have been providing training across the state to address young children's social and emotional development. Some ESUs and school districts have developed action plans to improve Teaching Pyramid practices in their school buildings and districts to better support young children's social and emotional development.

UNL Extension's Learning Child Team members have all been training in the CSEFEL (Center for Social and Emotional Foundations in Early Learning) modules for supporting young children's social and emotional development. Training is now provided across the state through the Early Learning Connection Regional Partnerships.

The Early Development Network has offered a variety of professional development events that emphasize the importance of supporting young children's social and emotional development. The trainings have included "Helping Babies from the Bench" addressing the juvenile court system and other professionals who can help improve outcomes for young children. Jodi Pfarr, a nationally recognized speaker from AHA! Processes, has provided many professional development offerings addressing "Bridges Out of Poverty: Strategies for Professionals working with Young Children and their Families Living in Poverty". The Early Development Network has facilitated establishment of Social-Emotional Task Forces in a number of communities.

#### **5. Support DHHS' efforts to improve outcomes of children in both in-home and out-of-home care.**

The Department of Health and Human Services' Division of Children and Family Services continues to try to improve the outcomes for children who are in both in-home and out-of-home care. The number of children who are wards of the state is decreasing. Some of the efforts to contract with outside organizations to manage the care of young children were not successful. There remains one contract with the Nebraska Families and Children Collaborative in the metro Omaha area.

The Legislature is closely monitoring developments within the Department to ensure that children are being served well and that planned outcomes are being successfully addressed in the Child Welfare System.

**6. Support Mental Health Consultation for children ages birth through age 8 through targeted prevention funds and expanded partnerships with regional behavioral health systems.**

There continues to be limited support for mental health consultation across the state. The Kids Squad program in Omaha managed through Child Saving Institute continues to offer mental health consultation to child care programs in the metro Omaha area.

There has not been work done with the regional behavioral health system to determine if some of their local funds could support mental health consultation to date.

**7. Utilize technology, including telehealth and help lines, to support early childhood mental health service delivery and consultation.**

Nebraska's hospitals and medical professionals utilize the telehealth system to provide consultation to children and families across the state.

**8. Expand the availability of appropriately trained, credentialed, and licensed professionals; and additionally, the availability of para-professionals in order for Nebraska to provide sufficient behavioral support services for young children.**

Integrated Core Competencies have been developed for all professionals addressing young children's social and emotional development, mental health, and/or providing home visitation services. The Together for Kids and Families Mental Health Work Group is now exploring the option of providing a training curriculum for the competencies.

<http://dhhs.ne.gov/publichealth/Documents/EC%20Integrated%20Skills%20Competencies-Final.pdf>

**9. Ensure that all children from birth to age 8 are screened for social-emotional development delays and referred for support services when needed.**

All referrals to the Early Development Network (EDN) are evaluated in six domains including social-emotional. School districts determine the means by which they will screen children for social-emotional development delays. The Early Development Network has provided several trainings over the last few years on the DC (Diagnostic Classification) Zero to Three assessment instrument. Mental health providers from across the state have participated in the training.

### **Early Care and Education**

**10. Improve school readiness and ready schools by sustaining and expanding the availability of quality early childhood care and education settings through Nebraska's Early Childhood Education Grant Program and Early Childhood Education Endowment**

**Fund Program (Sixpence Programs) in collaboration and coordination with community programs including Head Start and Early Head Start.**

Nebraska continues to see the number of local school districts offering early childhood services expand. There currently are 174 districts/ESU's offering early childhood services in the state. The total number of children in the age 3 and 4 preschool programs is approximately 10,842.

The Sixpence programs continue to operate with eleven programs across the state. The number of children served through the Sixpence programs is approximately 334 children.

Head Start and Early Head Start Program partnerships with local districts are struggling to continue in some parts of the state while in a few places they continue to thrive.

**11. Promote physical activity and healthy nutrition practices in all early care and education settings.**

Nebraska sent a state leadership team to a regional meeting to develop a plan for increasing physical activity and improving nutrition practices across the state. The TFKF Child Care Health Consultation Work Group is currently developing additional strategies around this topic. The Work Group is in the process of adding other partners to the work group as well as gathering information about what is currently occurring. They have done a cross-walk of three state plans to determine priorities and stakeholders. The three plans the work group is looking at include: oral health, physical activity and nutrition and the EC State Strategic Plan.

Nebraska has developed a cadre of trainers (over 40) across the state that is trained to offer the I Am Moving I am Learning (IMIL) training modules across the state. The cadre of trainers includes the Learning Child team through UNL Extension. Trainings are now being offered through the Early Learning Connection Regional Partnerships across the state.

The Head Start Body Start website also provides a wealth of materials to assist programs in knowing how to support young children's physical activities and nutrition.

<http://www.aahperd.org/headstartbodystart/>. Also, Michelle Obama's initiative to get kids moving and eating healthier has resources available at the Let's Move website:

<http://www.letsmove.gov/>

The Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) program has provided training to family child care homes on improving nutrition and physical activities for several years. This year new federal funding has allowed the NAP SACC program to work with a few child care centers to improve their nutrition and physical activities within their program. NAP SACC includes a Nutrition and Physical Activity Self-Assessment that programs conduct and then they utilize that information to plan for improving nutrition and physical activity practices in the early childhood program.

**12. Continue to investigate quality improvement models that can be applied in partnership with all early care and education settings.**

Nebraska continues to examine ways to improve the quality of early care and education services across the state. Nebraska's MIECHV Home Visitation services funded through the Affordable Care Act are required to adopt an evidence-based model for home visitation. Other home visitation services are determining how they might incorporate elements of the evidence-based practices into their home visitation services.

Nebraska wrote the Race to the Top Early Learning Challenge grant in the fall of 2011. The grant would have provide \$50 million dollars to improve early childhood services across the state and to create a data system that would provide better information on the quality and impact of early care and education services. Included in the application was a proposal for a possible Quality Rating and Improvement System for Nebraska, and a child assessment process. Unfortunately, Nebraska's application was not funded.

In the summer of 2012 several members of the Legislature convened a group of key state agency representatives and other key stakeholders to discuss what elements from the Race to the Top application could still be pursued without such a hefty cost.

State agency representatives have been meeting over the last few months to discuss how the Criteria for the Quality Rating and Improve System could be refined and more workable for the state of Nebraska.

**13. Continue to promote inclusive practices for children with special needs in all early childhood care and education programs, school districts, and before and after school programs.**

Public schools are required to see all children regardless of special needs. Schools must comply with Rule 11 and Rule 51. Some early care and education programs that are housed in public school buildings are actually run by School Foundations. When school foundations operate the early care and education programs and/or the before and after school program, they do not need to comply with Rule 11 and Rule 51.

Continued efforts need to be made to encourage early care and education programs and before and after school programs whether operated by public schools or not to provide care and services to children with special needs.

**14. The proposed draft of the Department of Health and Human Services Child Care Regulations should move to public hearing, be revised and approved.**

Two public hearings were held during 2012 by the Department of Health and Human Services regarding the proposed Child Care Regulations. The proposed regulations have been revised based upon public testimony at the public hearings. The draft regulations were reviewed and approved by the State Board of Health. The Attorney General reviewed and approved the regulations and forwarded them on to the Governor for final approval. The Governor approved the child care regulations in February 2013.

**Medical and Dental Home and Health Services**

**15. Increase the number of dentists serving young children and families in a dental health care home that provides regular routine dental care and education and recommendations for any special dental health care the child might need.**

The Department of Health and Human Services has recently started an Oral Health Coalition to try to address access for young children and families to dental health care. The Head Start Dental Home Initiative did provide training for dentists on how to work with young children.

**16. Support, promote and expand a medical home approach to ensure continuity of health services for all young children and their families.**

The Department of Health and Human Services Managed Care contracts have added language in them to promote families and children having a medical home. The Together for Kids and Families Dental/Medical Home Work Group has been working with a tool: "Collaboration and Action to Improve Child Health Systems Toolkit for State Leaders" to develop ideas/strategies around medical home and Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Medicaid's child health component.

The Early Development Network funds "Family Enhancement Partners" who are parents employed in pediatric practices. The Family Enhancement Partners support families in areas that will contribute to good health outcomes for their children and families. The programs supported are in Lincoln, Omaha, Winnebago, and Hastings. The Family Enhancement Partners are trained and coordinated by PTI Nebraska.

**17. Focus outreach to eligible families and health providers to improve EPSDT (Early Periodic Screening and Diagnostic Testing) utilization rates.**

The Together for Kids and Families Medical/Dental Home Work Group is addressing this issue currently. The work group plans to talk with the managed care programs regarding this topic and then to explore strategies for development.

**18. Improve access to comprehensive health services for women of childbearing age to improve birth outcomes.**

Nebraska had passed legislation that prohibited women who were not in this country legally from receiving prenatal care services. In 2012 the Nebraska Legislature debated LB 599 which would define a child as an individual under the age of 19 years, including any period of time from conception to birth, up to the age of 19. The State Children's Health Insurance Program would be able to provide prenatal care and health care to the child, regardless of the mother's eligibility and immigration status. The rationale for providing the care is that prenatal care for children will significantly reduce infant mortality and morbidity rates and spare many infants from the burden of congenital disabilities and ensure that a great number of serious and life-threatening disabilities are prevented or treated in utero. This bill passed and became law in July 2012.