Nebraska's Preschool Development Grant: Needs Assessment Report

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Introduction

With its strong community leadership and high levels of employment, Nebraska needs a birth-5 mixed delivery system that provides quality full-day, year-round care and education options that are accessible to all families. Families need a wide range of programs and services to ensure their children's learning and development, and Nebraska is striving to build an early childhood system that supports optimal learning and development for all children, regardless of their background or geographic location.

> *"So I just think, why do we think parents can do it all on their own up until age 5? Because really the first five years are some of the hardest years. When you think about how much happens in the first five years, it's crazy, but we expect parents to do it on their own for the most part. But yeah, when their kids turn 5 we're willing to help them eight hours of the day. So I just wish we could do different kinds of funding to help. I don't know, have some more kind of ... just different options for people." – Family Focus Group Participant, North Platte*

Nebraska's Preschool Development Grant Birth through 5 (PDG B-5) is guided by the vision of a system where community leaders work together to provide opportunities for quality early childhood care and education (ECCE), starting at birth, and in coordination with the full suite of health, mental health, and social supports that families may need. The goal of this work is to align state systems to equip local communities to deliver services, resulting in parents and families choosing options that support their children's healthy development. The work is led by Nebraska's Department of Health and Human Services, with support from the Nebraska Children and Families Foundation and in close partnership with the Nebraska Department of Education. The Buffett Early Childhood Institute at the University of Nebraska is collaborating with these organizations to complete the PDG B-5 Needs Assessment, create the state's Strategic Plan, and conduct a thorough program performance evaluation.

Purpose and Objectives of the Needs Assessment

By deploying this needs assessment, Nebraska's PDG leadership hopes to accomplish two related goals:

- Gather statewide, community-level data about the needs of families and providers as well as the availability and quality of ECCE services.
- Gather information that can be combined with other data sources to directly inform the creation of the state's PDG strategic plan.

In February and March, 2019, the needs assessment team spoke with stakeholders across the state to learn about their specific questions and concerns. This input was synthesized with federal requirements to develop a set of nine objectives for Nebraska's PDG B-5 Needs Assessment.

Objectives

- Objective 1. Understand the B-5 population of children and families in Nebraska.
- Objective 2. Describe availability and accessibility of high-quality ECCE services for vulnerable families.
- Objective 3. Examine current systems for assessing and improving quality of care in Nebraska's ECCE system.
- Objective 4. Understand how families make choices about ECCE and how they are involved in their children's care and education.
- Objective 5. Analyze current mechanisms through which Nebraska families gain access to the full range of services needed to support their children's healthy development.
- Objective 6. Examine practices that facilitate transitions from early care and education to elementary school.
- Objective 7. Examine collaboration and coordination among early childhood education programs in a mixed delivery system.
- Objective 8. Assess capacity of Nebraska's administrative infrastructure to support coordination and alignment of early childhood programs and services.
- Objective 9. Identify opportunities for greater efficiency in Nebraska's early childhood programs and services.

Methods

This comprehensive, statewide needs assessment employed multiple methods to meet the objectives above, as illustrated in Table 1 and summarized below.

Table 1. Needs Assessment Data Collection Methods

Method	Participants	No. of responses	Objectives addressed
Survey, paper	Families	3,541	1, 2, 4, 5, 6
Survey, paper	Providers	1,337	2, 3, 4, 5, 6, 7
Focus group, in person	Families	87	1, 2, 4, 5, 6
Interview, web conference or in-person	Key informants	9	2, 3, 7, 8, 9
Survey, online	Key informants	61	3, 7, 8, 9
Stakeholder meetings	Stakeholders	72	3, 5, 6, 7, 8, 9
Family child care study	In-home providers	101	3, 7

Statewide surveys with families and early childhood care and education providers.

Nebraska's PDG B-5 Needs Assessment placed a strong emphasis on understanding the needs and concerns of families and ECCE providers in communities across the state. Two large-scale statewide surveys, conducted in partnership with the Bureau of Sociological Research (BOSR) at the University of Nebraska–Lincoln, serve as the foundation for the needs assessment. The Focus on Nebraska Families survey was mailed to over 90,000 households across the state,

yielding responses from 3,541 families with children birth through age 5. The Early Childhood Program and Leadership survey was mailed to a total of 4,002 leaders from all licensed child care center and family child care homes, Head Start and Early Head Start programs, license-exempt providers, and public PreK programs in Nebraska, yielding responses from 1,337 ECCE providers. Copies of these surveys, along with a detailed description of the methodology for the sampling and analysis, are available in Appendix A.

Focus groups with families.

A series of focus groups with families provided deeper, more nuanced information about families' perspectives. BOSR conducted 10 focus groups (50 participants total) with families of young children in communities across the state. Approximately half of the participants in these focus groups meet the state's definition for low income (200% of Federal Poverty Level). The Buffett Early Childhood Institute conducted five focus groups (37 participants total) with targeted populations, including African American, Latino, and Native American families. Qualitative coding of transcripts from family focus groups generated a set of themes that complement the quantitative findings from the family survey. A detailed description of methods for these focus groups is available in Appendix B.

Interviews and surveys with key informants.

The needs assessment team conducted 90-minute individual interviews with nine key informants, who provided high-level perspectives on strengths and gaps in Nebraska's B-5 mixed delivery system. Thematic coding of these interviews informed the development of an online key informant survey, which gathered similar information from a broader audience of stakeholders, including leaders and service providers from state agencies, early childhood nonprofits, Educational Service Units, public schools, and higher education.

Stakeholder meetings.

Early in the process, the needs assessment team created a draft of the needs assessment priorities by integrating themes and issues from the PDG application (which included themes from stakeholders) with the federal guidance on the needs assessment. The major themes were Access to Care, Engagement and Support, Quality of Services, Efficiency in State Systems, Community Collaborations, and Integrated Child Support Systems Under each theme, we listed issues that stakeholders had identified as needing to be addressed in the PDG project.

In order to ensure that the list of themes was complete and the issues under each theme represented the full scope of stakeholder interests, the draft PDG themes and issues document was distributed to a group of stakeholders representing all regions of the state and all areas of the ECCE system in Nebraska. A meeting was held on March 7 to review the themes and issues and seek input from this group. In order to give all stakeholders the opportunity to fully respond to the request, including those who could not participate on the Zoom call, the stakeholders were also invited to submit written revisions to the draft and provide explanations about the impact of each of their suggestions. Stakeholder comments were integrated into the

final draft of themes and issues that served as the basis for the framework of this PDG B-5 Needs Assessment and the eventual PDG Strategic Plan.

In early August 2019, the needs assessment team conducted a second set of stakeholder engagement sessions to solicit feedback on preliminary findings from the two large-scale surveys conducted as part of the needs assessment. Three 2.5-hour meetings were held in three locations across Nebraska (Bridgeport, Kearney, and Lincoln). A total of 72 stakeholders participated in these meetings, both in person and via teleconference. Participants represented a wide range of roles and organizations, including public schools, state agencies, Head Start grantees, home visitation programs, and university faculty. After reviewing key findings from the family and provider surveys, related to vulnerability, access, quality, family engagement, and collaboration, stakeholders participated in small group discussions and summarized their conversations. Highlights from these discussions were captured by notetakers onsite, and transcripts from each meeting were later reviewed and analyzed for key themes. This stakeholder input guided further analysis of the survey data and informed the development of the Key Informant Survey.

Family child care study

A team of researchers at the University of Nebraska Medical Center conducted a targeted study of family child care homes to investigate the strengths, challenges, and needs for quality improvement among these providers. The study included three points of contact for data collection: two surveys and a focus group or interview. Before participating in a focus group, providers were asked to fill out a survey with basic information on their program, participation in Step Up to Quality and other training, and location of residence. If the provider indicated willingness to participate in an interview or focus group, they were contacted by a member of the research team and were scheduled to complete a focus group or interview either in person or online (video conference). The focus group questions were focused on providers' experiences, challenges, and strengths and on Step Up to Quality and training. After completing the focus group, a more detailed survey was administered with questions on education, income, and perceptions of quality and access to child care. A total of 101 providers filled out one or both surveys, and 50 providers participated in the focus groups. A detailed description of these methods is available in Appendix C.

Building on Previous Needs Assessments

Recognizing the extensive scope of the needs assessment and with the intent to ensure the most efficient use of time and resources, the needs assessment team identified and analyzed recent existing reports, needs assessments, and other materials that had the potential to address some of the objectives of the PDG statewide needs assessment. Building from existing knowledge provides valuable context for the needs assessment and allowed us to appropriately focus the work on missing or incomplete information. A complete list of reports reviewed is available in Appendix D.

Strengths of the current system.

Previous ECCE needs assessments conducted at the local level provide valuable information on services and programs. The assessments highlighted a variety of references to the strengths of the current system, with the following themes:

- Many communities are currently enacting programs and initiatives to address access and availability of ECCE.
- There is a general sense of community pride in and support for Head Start, Early Head Start, and Sixpence programs.
- Head Start operating grantees indicate that they connect participating families to a wide range of essential services to support children's healthy development.
- Two components of the ECCE system were identified as being essential to the effectiveness of services:
    - access to developmental screening and early intervention services
    - initiatives to promote social and emotional learning

Challenges in the current system.

Previous needs assessments also reflected common concerns, which we explore further in the PDG needs assessment:

- Access to quality, affordable care is insufficient and limited in many communities.
- Affordability of care and compatibility with work schedule are frequently cited as challenges for parents.
- Lack of care can affect a parent's ability to find or keep a job or continue with education.
- Some parents lack awareness of child care options, developmental screening services, and other supports.
- Lack of access to mental health services for adults and children is a concern.

The chapters that follow aim to build on this previous work, describing the current state of Nebraska's population of young children (Chapter 1) and its ECCE system (Chapter 2), then identifying strengths and opportunities for improvement in three areas: Access (Chapter 3), Quality (Chapter 4), and Collaboration and Alignment (Chapter 5).

Chapter 1: Nebraska's Children and Families

The U.S. Census Bureau estimates that there are 154,771 children aged 5 or younger in Nebraska. This represents 26.6% of the population of children in Nebraska.

Nebraska's Rural Population

To define rurality, we combined the United States Department of Agriculture (USDA) Rural-Urban Continuum codes into three categories, which reflect the major regional distinctions within Nebraska:

- **Children in rural areas.** Children living in a county in a remote rural area, which is a region with a population less than 2,500.
- **Children in micropolitan areas.** Children living in a county that includes a small town or micropolitan community with a population between 2,500 and 250,000.
- **Children in metropolitan areas.** Children living in a county that includes a metropolitan community with a population of 250,000 or more.

In all, 56.2% of young children live in the "Big 3" counties: Douglas, Sarpy, and Lancaster. Approximately 26,000 children aged 0 to 5 live in rural counties, and many children live in micropolitan areas. Throughout this report, we will report data for families and ECCE providers that are disaggregated according these three rural-urban categories.

Who are "Vulnerable" Children in Nebraska?

Our definition of vulnerability encompasses many factors that may adversely impact the learning and development of young children, and it includes input from a wide range of stakeholders. We define vulnerable children as those experiencing conditions that could have a negative impact on their development and learning. Poorer developmental outcomes are expected when children experience multiple conditions. According to previously reported data, these conditions may include, but are not limited to, those listed in Table 2 below.

Table 2. Conditions for Vulnerability in Children and Prevalence in Nebraska

Condition	Prevalence in Nebraska
Parental mental illness (including maternal depression)[a]	• 11.8% of mothers self-reported depression in 3 months before pregnancy. • 10.8% of mothers self-reported depression during pregnancy. • 10.2% of mothers self-reported postpartum depressive symptoms.
Trauma, including adverse childhood experiences (ACEs)[a,b]	• 66.0% of children birth to 5 have had no adverse childhood experiences. • 23.1% of children birth to 5 have had one adverse childhood experience. • 11.0% of children birth to 5 have had two or more adverse childhood experiences.

Condition	Prevalence in Nebraska
	• 1,660 substantiated victims of abuse or neglect aged 0 to 5 in 2017.
Poverty and low socioeconomic status[c]	• 18.4% of Nebraska families were at or below 100% of the federal poverty level, as defined on a yearly basis by the U.S. Census Bureau. • 41.7% of Nebraska families were at or below 200% of the federal poverty level, as defined on a yearly basis by the U.S. Census Bureau. • 30,277 children birth to 5 lived in poverty.
Homelessness or housing insecurity[d]	• 236 Nebraska households experienced homelessness.
Food insecurity[e]	• 13.5% of Nebraska households were food insecure on average from 2015 to 2017.
Inadequate prenatal care[f]	• 15.3% of mothers received inadequate prenatal care.
Low birth weight[f]	• 7.5% of newborns were classified as being low birth weight.
Teen parents[f]	• 1.9% of births are to females aged 15 to 19.
Parents without high school education[g]	• 8.4% of women in Nebraska had a birth in the past 12 months had less than a high school diploma.
Primary home language is not English[h]	• 14.0% of Nebraska children speak a language other than English at home.
Special health needs or disability[i]	• 13.7% of Nebraska children (aged 0 to 17) have a special need. • 1,619 infants and toddlers had an Individualized Family Service Plan.
In state care/foster care[j]	• 1,468 children age 0 to 5 were Nebraska Department of Health and Human Services state wards as of June 30, 2018.
Immigration or refugee status[k]	• 1,218 Nebraska children under 5 were foreign born.

[a]Prevalence of Selected Maternal and Child Health Indicators for Nebraska, Pregnancy Risk Assessment Monitoring System (PRAMS), 2016-2017. [b]Nebraska Department of Health and Human Services, Child Abuse and Neglect Annual Report, 2017. [c]U.S. Census Bureau, 2013-2017 ACS 5-Year Estimates. Table B17024. Kids Count 2018. [d]U.S. Department of Housing and Urban Development, 2018. [e]U.S. Department of Agriculture, Household Food Security in the United States, 2017. [f]Vital Statistics (2016), Department of Health and Human Services. [g]U.S. Census Bureau, 2013-2017 ACS 5-Year Estimates. Table B13014. [h]U.S. Census Bureau, 2013-2017 ACS 5-Year Estimates. Table S16007. (Note: This is for children 5 to 17 years of age in Nebraska. No data exist for households with children 0 to 5.) [i]Nebraska Title V 2015 Needs Assessment. (Note: These data do not exist publicly for the 0 to 5 population.) [j]Nebraska Foster Care Review Office, 2018 Annual Report. [k]U.S. Census Bureau, 2013-2017 ACS 5-Year Estimates. Table B06001.

Characteristics of Families Who Responded to the Needs Assessment Survey

In sampling for the Focus on Nebraska Families survey, we aimed to reach a large number of families with young children who accurately represent the overall population of Nebraska. As displayed in Table 3, our sample slightly underrepresents racial and ethnic minority groups, despite efforts to oversample these populations (see Appendix A). The median household income for our sample was $80,000, which is higher than the average income of $59,970 for the state as a whole.

Table 3. Focus on Nebraska Families Survey Respondents by Race and Ethnicity

Race or ethnicity[a]	No. in this sample	% in this sample	% for all of Nebraska
White	3,197	92.8	88.3
Hispanic, Latino/a, or Spanish origin	278	8.2	11.2
Black or African American	75	2.2	5.1
American Indian or Alaskan Native	55	1.6	1.5
Asian	38	1.1	2.7
Native Hawaiian or Pacific Islander	5	0.1	0.1

[a]Race and ethnicity were reported in two separate questions.

Table 4. Vulnerability Indicators Reported by Nebraska Families

Vulnerability indicator	% reporting
Reported income 200% or less of federal poverty level	26.70
Child diagnosed with a disability or condition	25.70
Housing insecurity	21.20
Less than high school education for spouse/partner	18.60
Food insecurity	18.30
Frequent mental distress (15 or more days/month) for primary caregiver	11.40
Less than high school education for primary caregiver	10.60
Hispanic, Latino/a, or Spanish origin ethnicity	8.20
Reported income 100% or less of federal poverty level	8.10
Spouse/partner mental health fair or poor	6.10
Race other than White	4.80
Speak a language other than English	4.25
Inadequate prenatal care	2.20
Sought assistance using supports for families experiencing domestic violence	1.90
Child in foster care	0.40

Despite these differences from the general population, we succeeded in gathering responses from a large number of families who fit our definition of vulnerability. Overall, about 61.7% of families reported at least one condition that might negatively impact their children's learning and development. This includes 26.7% of families experiencing poverty and 25.7% reporting a child with a disability (Table 4).

While race and ethnicity do not directly cause vulnerability, racial and ethnic minority families may be more likely to experience other conditions that contribute to vulnerability. These include the factors described above as well as other conditions related to systemic racism and discrimination. With this in mind, the PDG team sought to understand the intersection of race, ethnicity, and vulnerability among surveyed families. As displayed in Figures 1 and 2 below, racial and ethnic minority families are substantially more likely to experience conditions of vulnerability. Every family who identified their child as Black/African American, Asian, American Indian/Alaska Native, or Hispanic also reported at least one indicator of vulnerability.

As noted in our definition, vulnerability is intersectional, and the risk of negative outcomes is compounded when children experience multiple vulnerability factors. In Nebraska, there is no current means of estimating how conditions of vulnerability overlap. However, the family survey data demonstrate that 36.3% of families experience two or more factors that may make their children vulnerable. Racial and ethnic minority families are more likely than White, non-Hispanic families to report multiple indicators of vulnerability. For example, 65.4% of Hispanic/Latinx families reported 4 or more vulnerability indicators, compared to 11.6% of non-Hispanic families. Likewise, 49.3% of Black/African American families reported 4 or more vulnerability indicators on average, compared to 13.3% of White families. Appendix E contains information about the rate of each vulnerability indicator for each of these subgroups.

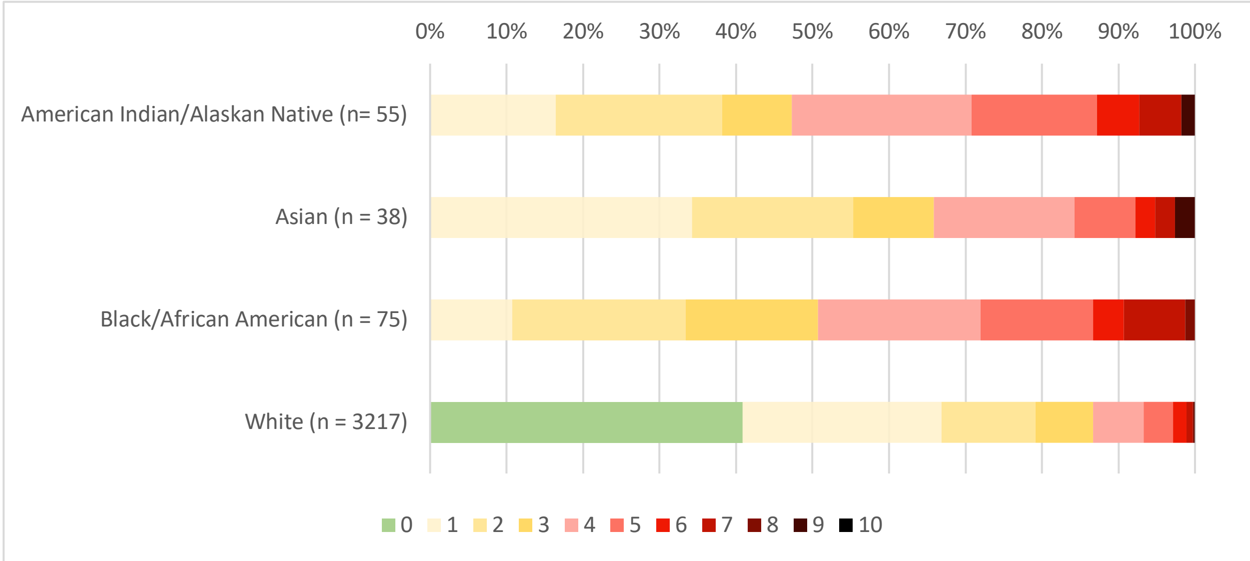


Figure 1. Number of Vulnerability Indicators by Race

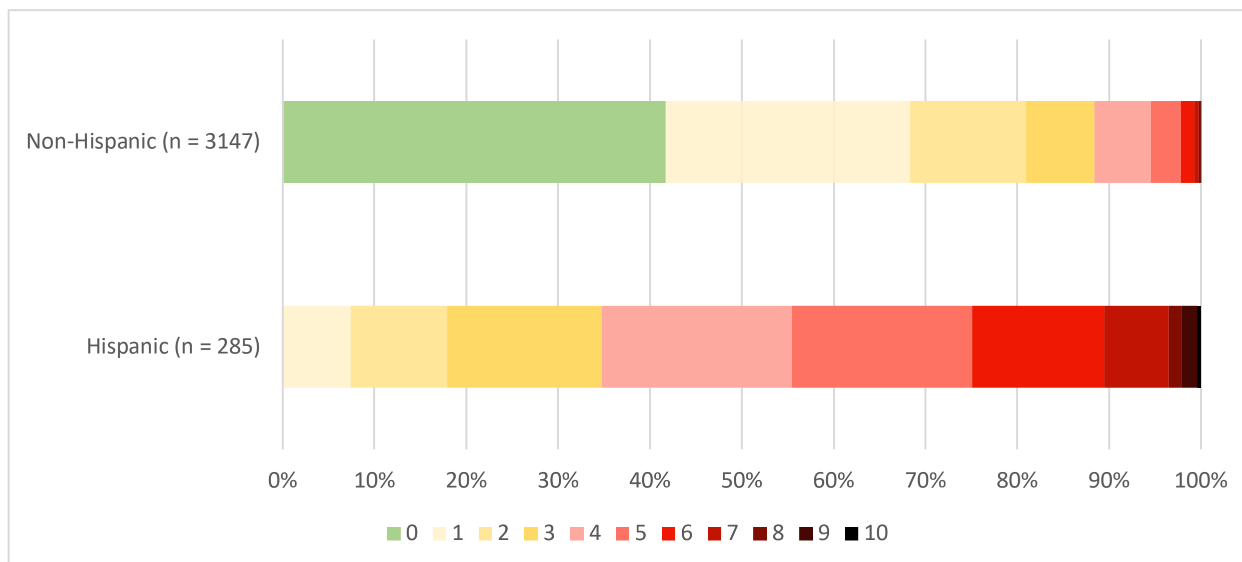


Figure 2. Number of Vulnerability Indicators by Ethnicity

Gaps and Opportunities to Improve Understanding of Nebraska's Birth Through 5 Population

Depending on the specific data source for the vulnerability indicator of interest, data may or may not be available for the how far children and families live from an urban area. Vulnerability factors based on the U.S. Census Bureau's American Community Survey (ACS), for instance, can often be specified down to the census track block group. However, a given census block may include only a very small number of families with children birth through age 5, and issues with estimate reliability often arise when estimates are broken down into small geographic areas. Vulnerability indicators based on Nebraska Department of Health and Human Services (NDHHS) vital statistics are available at the county level, and vulnerability indicators originating from state agency databases are broken down by ZIP code. Substantial effort will be necessary to merge data from all these sources to fully understand how vulnerability is geographically distributed across the state.

The strengths of available data on vulnerability are that the data are from various quality sources and can be disaggregated by various demographic and socioeconomic categories. The primary weakness of these data is that they are not integrated at the individual level, and thus it is difficult to estimate children or families that are experiencing multiple vulnerability factors. A number of efforts are underway in Nebraska to improve these data. The Nebraska Early Childhood Integrated Data System (ECIDS) is building a new approach to updating unique counts of children receiving various services. The federated approach to data matching will utilize data linked across source data housed within the Nebraska Department of Health and Human Services (NDHHS), the Nebraska Department of Education (NDE), and other partners. A secure and unique linking identifier created through the matching process will be used to protect data privacy and support the delivery of distinct counts for reporting and analysis purposes.

Through the PDG, Nebraska will conduct the first phase of an implementation study that will position the state to issue an RFP for system build-out. The state has engaged consultants to study the data currently held by agencies and map what it would take to link data across agencies to be able to answer the critical questions raised by Nebraska's forthcoming PDG strategic plan. The consultant(s) will also examine Nebraska's data governance structures and make recommendations for potential improvements to that structure. The study will examine what data fields Nebraska already collects; what linkages among systems are needed to generate the information desired; technical and regulatory barriers to building those linkages, with recommendations for addressing those barriers; and the state's situational readiness to manage data going forward, from both an organizational and a technological standpoint.

Nebraska's Early Childhood Data Coalition (ECDC) developed 15 key indicators significant for predicting child well-being and success. An indicator report highlighting the trends among these indicators was published in 2011. The ECDC is in the process of reviewing the 15 key indicators for a new report while supporting broader efforts related to the creation of a Nebraska ECIDs. The ECDC's current indicators informed the design of the PDG needs assessment, and ECDC members gave input throughout the needs assessment process. These issues are explored in more detail in Chapter 5 of this report.

Chapter 2. Nebraska's Early Childhood Mixed Delivery System

Prior to the PDG needs assessment, there had not been a shared definition of the early childhood mixed delivery system in Nebraska. Consistent with one of the primary aims of the PDG—to create an integrated and coherent early childhood system that supports families—the needs assessment team worked with stakeholders to draft the following definition. This definition intentionally integrates the components of the early childhood care and education (ECCE) system with the essential services for early childhood development in an effort to guide and shift thinking among all stakeholders in the state toward the importance of alignment and integration across ECCE and essential service providers.

Nebraska's early childhood mixed delivery system for children from birth to age 5 includes an array of services and providers that support children's social, emotional, cognitive, and physical development to build a solid foundation for lifelong learning and well-being. In order to holistically support a child's needs, the mixed delivery system is composed of an integrated network of services across two broad domains: early childhood care and education (ECCE) and essential services for early childhood development.

ECCE services are offered through a variety of programs in three main setting types:

Home-based settings
- *Family child care homes*
- *In-home child care*
- *Home visitation, including early intervention*

Center-based settings
- *Private child care centers (profit and non-profit)*
- *Preschools*

School-based settings
- *Public schools*

Essential services for early childhood development are offered by state agencies and regional and local community-based organizations to children and their families matched to needs such as:

- *Health care*
- *Mental health care*
- *Dental care*
- *Family crisis*
- *Developmental screening*
- *Parenting supports*
- *Transportation support*
- *Nutrition support*
- *Housing assistance*

By defining the mixed delivery system with both ECCE and essential services, Nebraska's PDG needs assessment has created the opportunity to direct the conversation about systems change toward integration of these programs and services. The challenge is that it is a new way of defining the system for most partners in the state, and even nationally. But given that the two large components each has its own scope of services defined, we do not anticipate that this will impede progress.

ECCE services and essential services are often regulated and housed by different agencies and departments within the state system (e.g., Nebraska Department of Education, Office of Early Childhood; Nebraska Department of Health and Human Services, Division of Child and Family Services, Division of Public Health, Division of Medicaid and Long-Term Health). These agencies and departments currently have memorandums of understanding and partnerships that can be strengthened with this definition of integrated services for children aged 0 to 5 and their families. The public school systems in Nebraska are invested in ECCE services (especially within PreKindergarten programs), and this definition creates opportunities for them to better connect their families with an array of services not typically associated with public schools.

Early Childhood Care and Education in Nebraska

Nebraska's ECCE system is composed of 3,181 licensed child care providers, representing the three settings described above. This includes 661 child care centers and 145 private preschools, which we classify as center-based settings. Home-based providers include 1,281 settings classified as Family Child Care Home 1 (maximum of 8 children) and 548 settings classified as Family Child Care Home 2 (maximum of 12 children). The ECCE system also includes a variety of providers who are not subject to licensure, including 22 Head Start and Early Head Start grantees and 269 preschool programs in public schools.

When looking at the breakdown of providers across counties and rural-urban categories, it is not surprising that the majority of Nebraska's ECCE providers are in metropolitan areas with populations above 250,000 people. In the state, the majority of the population (63.0%) lives in a small number of metropolitan counties. As illustrated in Table 5 below, only seven counties are classified as metropolitan counties with populations above 250,000, but 54.13% (n = 1,722) of the providers on our list of licensed center-based and home-based providers, Head Start programs, and PreKindergarten programs exist within those metropolitan counties. When looking at rural counties, it is equally interesting to note that 40 counties are classified as completely rural or as having a town center population of less than 2,500 people, but those 40 counties include fewer than 10 percent of the state's ECCE providers. Closer examination of Table 5 reveals instances in which the proportion of licensed providers in a given county is lower than the percent of the population that resides in that county. These counties may be more likely to experience a shortage of ECCE options for families. However, one should note that the number of providers is not a direct estimate of capacity, as the number of children that each provider can accommodate varies widely.

Table 5. Early Childhood Care and Education Providers in Nebraska by Rural/Urban Classification and County

County	No. of licensed providers	% of total licensed providers	% of total population
Metropolitan—Counties in metro areas of 250,000 or more			
Cass	29	0.91	1.36
Douglas	833	26.19	29.38
Lancaster	509	16.00	16.45
Sarpy	249	7.83	9.56
Saunders	39	1.23	1.10
Seward	29	0.91	0.90
Washington	33	1.04	1.07
Total Metropolitan	1,722	54.13	63.01
Micropolitan—Counties in metro areas of fewer than 250,000 population or urban populations of over 2,500			
Adams	44	1.38	1.63
Box Butte	16	0.50	0.56
Buffalo	125	3.93	2.57
Butler	18	0.57	0.42
Cherry	12	0.38	0.30
Cheyenne	11	0.35	0.48
Colfax	17	0.53	0.56
Cuming	16	0.50	0.46
Custer	23	0.72	0.56
Dakota	31	0.97	1.04
Dawes	24	0.75	0.45
Dawson	48	1.51	1.23
Dixon	7	0.22	0.30
Dodge	57	1.79	1.91
Gage	47	1.48	1.11
Hall	87	2.73	3.19
Hamilton	10	0.31	0.48
Holt	32	1.01	0.53
Howard	9	0.28	0.34
Jefferson	14	0.44	0.37

County	No. of licensed providers	% of total licensed providers	% of total population
Kearney	15	0.47	0.34
Keith	16	0.50	0.42
Lincoln	51	1.60	1.82
Madison	84	2.64	1.83
Merrick	11	0.35	0.40
Nemaha	15	0.47	0.36
Otoe	34	1.07	0.83
Phelps	23	0.72	0.47
Platte	76	2.39	1.73
Red Willow	27	0.85	0.56
Richardson	14	0.44	0.41
Saline	24	0.75	0.74
Scotts Bluff	63	1.98	1.87
Wayne	19	0.60	0.29
York	30	0.94	0.41
Total Micropolitan	1,150	36.15	31.0
Remote rural—Completely rural or less than 2,500 urban population			
Antelope	18	0.57	0.33
Boone	15	0.47	0.27
Brown	12	0.38	0.15
Burt	12	0.38	0.34
Cedar	12	0.38	0.44
Chase	7	0.22	0.21
Clay	10	0.31	0.32
Deuel	3	0.09	0.09
Dundy	1	0.03	0.09
Fillmore	12	0.38	0.29
Franklin	3	0.09	1.63
Frontier	4	0.13	0.14
Furnas	8	0.25	0.24
Garden	3	0.09	0.10
Garfield	5	0.16	0.10
Gosper	5	0.16	0.10
Grant	1	0.03	0.03
Greeley	6	0.19	0.12

County	No. of licensed providers	% of total licensed providers	% of total population
Harlan	3	0.09	0.18
Hitchcock	1	0.03	0.15
Hooker	4	0.13	0.04
Johnson	5	0.16	0.27
Kimball	3	0.09	0.19
Knox	29	0.91	0.44
Morrill	3	0.09	0.24
Nance	13	0.41	0.18
Nuckolls	7	0.22	0.22
Pawnee	2	0.06	0.14
Perkins	6	0.19	0.15
Pierce	19	0.60	0.37
Polk	9	0.28	0.27
Rock	4	0.13	0.07
Sheridan	9	0.28	0.27
Sherman	4	0.13	0.16
Stanton	8	0.25	0.31
Thayer	16	0.50	0.26
Thomas	2	0.06	0.04
Thurston	9	0.28	0.38
Valley	11	0.35	0.22
Webster	5	0.16	0.18
Total Remote Rural	309	9.71	9.70

Survey Respondents: Providers

Respondents to the Early Childhood Program and Leadership survey are roughly representative of the overall population of ECCE providers in Nebraska. Respondents represented 61.7% (*n* = 797) home-based, 24.9% (*n* = 321) center-based, 10.8% (*n* = 140) school-based settings, 0.5% (*n* = 6) not subject to license, 1.3% (*n* = 17) not licensed, and .8% (*n* = 10) other. The ECCE system overall is composed of 64% home-based providers, 29% center-based providers, and 7% school-based providers. This includes 4% of providers who identified as Head Start/Early Head Start grantees.

Of the respondents, 42.1% (*n* = 525) indicated that they were located in counties in metropolitan areas of 250,000 or more, 44.1% (*n* = 550) were from counties in micropolitan areas of fewer than 250,000 or urban populations of over 2,500, and 13.9% (*n* = 173) were from rural counties with urban populations of less than 2,500. These numbers indicate a slight

overrepresentation of providers in micropolitan areas and a slight underrepresentation of providers in metropolitan areas.

Providers reported that, overall, 84% of the children enrolled in their programs were White, 8% of children were multicultural or mixed race, 7% were Hispanic/Latino, 6% were Black or African American, and 2% were Native American. These data suggest that the survey respondents serve a population of children that slightly underrepresents racial and ethnic minority groups. School-based providers reported a far higher proportion of children with Individualized Education Plans (IEPS) or Individualized Family Service Plans (IFSPs) than home- or center-based providers, which is not surprising given that schools are a primary source of early childhood special education services. It is interesting to note that, in this sample, center-based providers serve a far greater percentage of children through child care subsidy than school- or home-based providers. See Table 6 for details.

Table 6. Characteristics of Children Served by Respondents to Provider Survey, by Provider Type

	M %			
Characteristic	Overall	Home-based	Center-based	School-based
Hispanic/Latino	7	6	9	13
White	84	87	78	82
Black/African American	6	5	7	4
Native American	2	1	3	3
Multicultural/Mixed Race	8	8	8	3
Speak a language other than English at home	4	3	6	8
Full or partial child care subsidy	15	12	25	13
Children who have an IEP/IFSP	6	3	5	19
Children who have a physical condition that affects how you care for them	1	2	1	2
Children who have an emotional, developmental, or behavioral condition that affects the way you care for them	5	4	5	8
Children who reside in an unsafe neighborhood	1	1	3	3
Children who experience family violence	2	1	2	5
Children whose parent is a teen	1	1	2	1
Children whose parent has a mental health problem	2	1	2	3
Children whose parent has a substance abuse problem	2	1	2	5

Note. IEP = Individualized Education Plan; IFSP = Individualized Family Service Plan.

Where Do Children Receive Care and Education?

Families who responded to the Focus on Nebraska Families survey reported high rates of use for ECCE. Overall, 81.5% of respondents reported that their child was cared for by someone

other than a primary caregiver in the preceding week. This is very consistent with employment estimates, which suggest that all adults are working outside the home in about 80% of Nebraska households. On average, families are reporting that their children spend 27.86 hours per week in the care of others.

Table 7 illustrates that larger numbers of families reported using care provided by either family members (both in their own home [*n* = 690] and in their family members' homes [*n* = 1,381]) or by child care or day care centers (*n* = 1,585). However, respondents indicated that, on average, their children spent longer amounts of time per week in the care of nannies/au pairs (*M* = 20.53 hours, *SD* = 14.69 hours), at school in a Kindergarten classroom (*M* = 20.28 hours, *SD* = 13.80 hours), or in a child care or day care center (*M* = 33.15 hours, *SD* = 12.46 hours). This pattern suggests that while care provided by family members is available, parents may not be utilizing it for the full amount of care that is needed. Additionally, it should be noted that many families are using more than one form of ECCE: 43.1% (*n* = 1,435) reported using one arrangement, 28.8% (*n* = 959) used two arrangements, 8.7% (*n* = 290) used three arrangements, 1.1% (*n* = 37) used four arrangements, and 0.2% (*n* = 7) used five or more arrangements.

Table 7. Usage of Early Childhood Care and Education by Type of Service

Service	No. of families utilizing	Mean hours per week utilized
Other family member who lives in your home	690	17.51
Family member who does not live in your home	1,381	12.40
Friend or neighbor	298	7.60
Nanny or au pair	156	20.53
Child care center/day care provider	1,585	33.15
Preschool/PreKindergarten	255	19.28
Special education PreKindergarten classroom	21	11.33
Kindergarten	25	20.28

When asked about the ECCE setting in which their child spends the most time each week, the majority of families reported using a home-based ECCE provider (Figure 3a). These trends are similar across subgroups but are more pronounced in some cases. For example, vulnerable families are much more likely than non-vulnerable families to use a home-based ECCE provider (Figure 3b). Vulnerable families and those living in remote rural areas are more likely to use unlicensed ECCE providers: 37.5% of vulnerable families indicated that their provider was unlicensed, while 27.0% of non-vulnerable families indicated that their provider was unlicensed. In remote rural areas, 36.0% (*n* = 135) of families reported their provider being unlicensed, compared with 29.8% (*n* = 281) of the families from counties in metropolitan areas and 24.8% (*n* = 458) of those in micropolitan areas (Figure 3c).

As would be expected given the age range targeted for this survey, more families are enrolled in home-based and center-based care than in school-based care. Many more families use

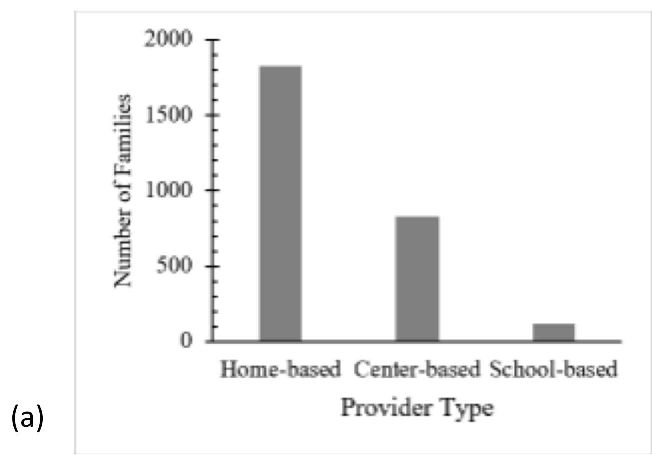
home-based care than center-based care. These patterns hold across race and ethnicity categories.

Do Providers Have Availability?

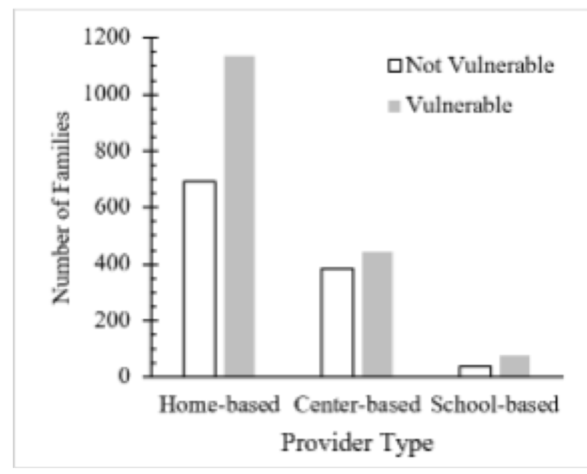
For Nebraska's PDG B-5 grant, we define availability as *the supply of quality child care arrangements being sufficient in a community for all families with children 0–5 years old to find a placement.* Responses to the Early Childhood Program and Leadership survey suggest that Nebraska's ECCE system is very near capacity. Overall in the past year, 73.0% of providers reported having to turn away families who wanted to enroll children because they did not have an available slot. For home-based providers, this percentage was 79.6% (*n* = 620), while center-based providers reported 72.2% (*n* = 229), and school-based providers reported 47.4% (*n* = 63). Providers in remote rural areas were less likely than providers in more populous areas to report turning families away because they did not have a vacancy (67.1% versus 74.5% for metropolitan areas and 73.9% for micropolitan regions). The average provider reported that, at the time of the survey, they had no vacancies for infants and toddlers (birth to age 3) and approximately two openings for children aged 3 to 5. This varied somewhat by provider type, as home-based providers reported the fewest vacancies across all age ranges (median = 0) and center-based providers reported comparatively more openings across all age ranges (median = 2).

Overall, 51.5% (*n* = 668) of providers had a waitlist for their program, and this rate was consistent across metropolitan, micropolitan, and remote rural areas. Center-based providers were more likely to say that they maintain a waitlist (62.9%) compared with home-based (48.8%) and school-based (46.6%) providers, but school-based providers reported longer waitlists, on average. Overall, providers indicated that they have about 11 children on their waitlists, but this varied widely (from 0 to 750). Home-based providers indicated that their waitlists had a mean of 4.35 children, center-based providers reported an average of 16.26 children on their waitlists, and school-based providers reported an average of 35.14 children on their waitlists. Providers in metropolitan areas reported longer waitlists (average of 15.01 children) than those in micropolitan (7.94) or remote rural (7.44) areas.

(a)



(b)



(c)

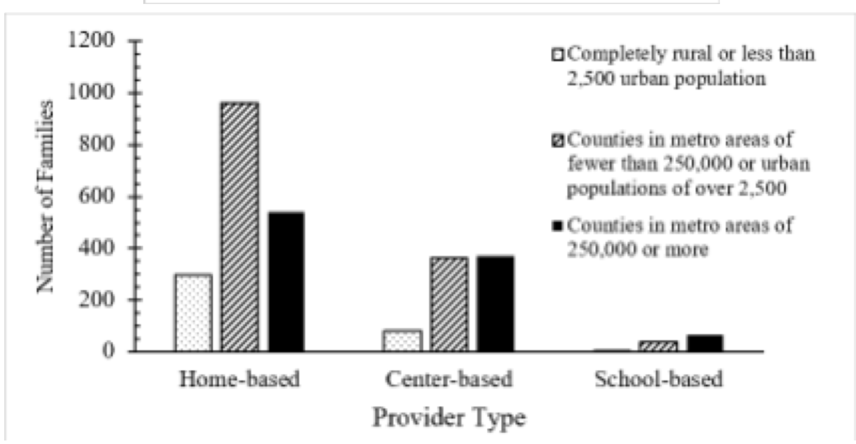


Figure 3. Types of Early Childhood Care and Education Settings Used by Families Overall (a), by Vulnerable and Not Vulnerable Families (b), and by Families in Rural and Metropolitan Areas (c)

Efforts to Increase Availability of Early Childhood Care and Education in Nebraska

Nebraska's **state preschool program** is operated by school districts and regional Education Service Units (ESUs)—and is noteworthy for its balance between 3- and 4-year-olds, in keeping with the state's recognition that serving children earlier offers the best strategy for success. The program seeks to serve children of diverse social and economic characteristics. At least 70% of the children served with grant funds must have at least one of the following risk factors: disability or developmental delay, living in a home in which English is not the primary language, eligibility for free- or reduced-price lunch (185% Federal Poverty Level), having teen parents or parents who have not completed high school, or having been born prematurely or with a low birth weight. In the latest national preschool rankings, Nebraska placed seventh for the percentage of 3-year-olds served (15%); it placed 16th for the percentage of 4-year-olds served (32%). In Nebraska, 4-year-olds are included in the school funding formula (NIEER, 2018).

In addition to the almost 14,000 3- and 4-year-olds served by school districts and ESUs, Nebraska also serves more than 4,000 3- and 4-year-olds through the federally funded **Head Start program**. Almost half of these children (1,983) were served in inclusive, collaborative programs with school districts—which is encouraged by state law. Nebraska's innovative infant-toddler program, Sixpence (described below), also collaborates with Early Head Start and local school districts. This collaborative system demonstrates Nebraska's commitment to efficient use of resources.

In addition to these programs, Nebraska's signature infant-toddler program is the **Sixpence Early Learning Fund**, a public-private partnership that promotes high-quality early care and education for infants and toddlers. Sixpence supports statewide and community-level collaboration, with an emphasis on school district leadership at the local level. It provides grants to support family engagement, home visiting, center-based early care and education, and partnerships between schools and licensed child care programs. Under the Sixpence model, services are supported through a combination of state funds, federal Child Care Development Fund (CCDF) money, and/or the proceeds of a $60-million endowment created by $40 million in state money and $20 million from private donations. Grant recipients are required to provide a 100% match to ensure local investment in the programs. In the 2017-18 program year, the Sixpence Early Learning Fund supported 31 school district grantees across the state (Sixpence Annual Report, 2017 – 2018).

Another way in which Nebraska is a national leader is in **Educare** schools. Educare schools serve children aged birth to 5 and are national leaders in high-quality infant and toddler education. They offer education and comprehensive services to low-income children on a full-day, full-year schedule, utilizing private support to leverage public funding. Nebraska has four Educare schools, including the nation's only Educare school on tribal lands.

Nebraska also recognizes the importance of services that begin before birth. **Early Head Start** provides services to new and soon-to-be mothers, which is another focal area for Nebraska. The **federally funded Maternal, Infant, and Early Childhood Home Visiting (MIECHV)** program serves 244 children (228 of them aged birth to 3) at three sites, and Nebraska uses state funds

to support four additional sites serving an additional 259 children (251 of them aged birth to 3). Nebraska's early childhood systems have strong support from the public higher education system. Three of the four campuses of the University of Nebraska system have identified early childhood as a priority and have significant research and teaching investments in early childhood. The fourth campus has numerous programs focusing on young children, especially childhood obesity. The Nebraska system has also invested in a significant endowment with the **Buffett Early Childhood Institute**, the largest endowment of a public university in early childhood in the nation. The Institute works across the four campuses and the state to close the achievement gap and strengthen the early childhood workforce.

Nebraska's statewide early childhood funding is administered by two separate agencies: the Nebraska Department of Health and Human Services (NDHHS) and the Nebraska Department of Education (NDE). NDHHS is responsible for child care licensing and subsidy, and the federal and state MIECHV programs. NDE is responsible for the state's preschool program, houses its Head Start State Collaboration office, administers IDEA Part B 619 Preschool Special Education services, and has primary responsibility for the state's early childhood professional development system. The two agencies have joint responsibility for Step Up to Quality (the state's quality rating and improvement system), Nebraska's professional recognition and improvement system, and Part C-Early Intervention (EI). Together, they also support the Early Childhood Interagency Coordinating Council (ECICC), which serves as the State Advisory Council under the Head Start Act and the state interagency coordinating council for Part C. Additionally, both agencies are responsible for the administration of the public dollars going into the public/private Sixpence Early Learning Fund; both agency heads sit on the Sixpence Board of Trustees.

Nebraska's community-level leadership has led to numerous local initiatives focused on early learning. For example, **Prosper Lincoln** is the state capital's comprehensive community agenda. After an extensive stakeholder engagement process, Lincoln chose early childhood as one of three key priority areas. Lincoln is far from alone in prioritizing this work—since 1997, the **Nebraska Children and Families Foundation** (NCFF) has been working in communities across Nebraska to support collaboration around a shared vision of strengthening families and communities to promote child well-being. This requires multiple entities—including government, private organizations, business leaders, funders, family, and other stakeholders—working collectively toward a shared vision for community well-being and desired outcomes for all in a community. These community collaboratives review community-level data revealing strengths and challenges, then develop a local plan to support improved outcomes. Each community has identified early childhood services as an integral part of its work, with one or more committees focused on children birth to age 5. Another NCFF initiative is **Rooted in Relationships**, which partners with communities to implement evidence-based practices that enhance social-emotional development for children birth to age 8; in 2017, a mix of public and private funds supported services impacting over 1,200 children.

Statewide initiatives like **Bring Up Nebraska** and the **Communities for Kids** project have demonstrated the state's commitment to building community-level capacity. Bring Up

Nebraska has been strongly supported by First Lady Susanne Shore and helps communities develop long-term strategies to reduce the number of families in crisis. The Communities for Kids project is another effort to help communities build better systems to meet the needs of families and increase the supply of quality early learning environments for children. The program helps facilitate the conversation among a community's public and private organizations and provides expertise, tools, and resources to the community to support the creation and implementation of solutions to child care shortages (NCFF, 2019). Another important statewide support for communities is the University of Nebraska's Extension office, which includes an initiative called The Learning Child that supports families and providers across the state. Extension educators live in or near the communities they serve, with a significant focus on parent engagement and support, as well as coaching for providers. Stakeholders from all these initiatives participated in this grant preparation process, ensuring that the overall goals and outcomes will be relevant to Nebraska communities and families.

Data Available About Families and Service Utilization

Currently, only those data related to early childhood programs and services under the purview of the NDE can describe the unduplicated count of children being served. In 2016-17, Nebraska's mixed delivery system served an unduplicated count of 22,543 children in public schools, ESUs, and Head Start/Early Head Start, including children with disabilities. This system is supported by local school district funds, State TEEOSA (Nebraska's compensatory state aid formula), Federal IDEA B and C funds, Every Student Succeeds Act (ESSA) funds, Federal Head Start funds, and some parent pay. The NDE data system contains the number of children who are served by school districts and ESUs, including children from birth on receiving services in Early Intervention and Early Childhood Special Education. Additionally, the NDE system tracks children served by Head Start in classes in which schools and the Head Start grantees collaborate. Head Start data from state-level data has been examined, and duplicate Head Start child records were subtracted to reach the unduplicated count. The biggest data gaps exist in producing an unduplicated count of children receiving services in programs that cross state agencies, including licensed child care, IDEA Part B and Part C, Home Visiting, Temporary Assistance for Needy Families (TANF), Medicaid, Child Welfare, and others. Challenges in this area include identifying and securing resources to build the data management system and establishing a shared governance structure and/or overarching memorandum of understanding between agencies.

Currently, Nebraska collects information on the capacity numbers of licensed child care providers, which provides an estimation of the number of spots available. These data are combined with information from the state's quality rating and improvement system (QRIS) so that the number of quality spots available can also be estimated. It should be noted, however, that Nebraska does not currently collect data on the actual enrollment of licensed providers, so the capacity number is a rough, and likely inaccurate, estimate of the availability. Need for child care is most commonly estimated from community-level census population estimates for the number of children aged 0 to 5 in the specific area. There are efforts at the local level to estimate the need for and capacity of ECCE, supported by various entities. For instance, NCFF

works closely with communities to conduct needs assessments around child care through its Communities for Kids initiative, described above.

The data systems that house the majority of data about the young children of Nebraska and the extent of their service utilization are managed by state agencies. These data systems contain the eligibility information collected on children and their families who apply for services and the services received. Currently, information about children and families is available as a result of analysis performed by each agency of its own data through reports that are required for federal reporting, required by state statute, or for specific requests from state leadership or state partners. Service utilization reports for families and children are prepared independently within each agency and in some cases within programs within each agency.

There is currently no mechanism that allows state agencies to exchange data for combined or comparative analysis. There is also not a mechanism, such as a unique identifier, that allows Nebraska to track service utilization by individual children or families across programs. Much of the data describing the vulnerable children and families in Nebraska are gathered and reported by state programs and reflect primarily the use of essential services for early childhood development (for example health, mental health, dental, and developmental screening care services). These data do not provide a picture of Nebraska families' utilization of ECCE services. Available data include the following:

- NDE gathers information about children who are enrolled in school-based PreK programs.
- Information about children in Head Start/Early Head start programs is available from the U.S. Office of Administration for Children and Families, because in Nebraska, some of the Head Start/Early Head Start programs operate outside of the scope of the state government.
- There are numerous statewide and regional nongovernmental organizations that provide additional support services to families and their children in the ECCE system. Each of these organizations collects and reports their program utilization data independently.

The PDG Focus on Nebraska Families survey has presented the first opportunity to gather data directly from families about the ECCE services they choose for their children and why they made those choices. Before these data were available, a general and reliable understanding of where Nebraska's children are cared for was largely available only through anecdotal reporting. While each of the stakeholder groups that represent different types of providers may have had an understanding of the number of children in their care settings, there wasn't a single source of data that simultaneously captured utilization rates across the whole state and across all settings at one time.

The data about service utilization within the ECCE system that has been reported prior to the PDG B–5 Needs Assessment were based on the systems operated by state agencies that regulate certain care settings. Because these were the only data available, policies and

programs are built around them. A significant challenge with this situation is that 60% of children in Nebraska are cared for every day in a home-based setting, for which reliable data are not available. Therefore, data about the needs and characteristics of vulnerable children served in these settings are simply not captured and may be underrepresented in decisions about policy and funding.

Chapter 3: Access and Choice for Nebraska's Families

For Nebraska's PDG, **access** to quality ECCE means that families can enroll their children in arrangements that support the children's development and meets the parents' needs with minimal barriers. Ideally, every family in Nebraska, regardless of location or other conditions, would be able to choose the early care and education that best accommodates their work schedule, meets their child's developmental needs, and is compatible with their values and priorities, and families could ensure that their child receives the full range of essential services (as defined in Chapter 2) that she or he needs for healthy development.

Unfortunately, findings from the needs assessment suggest that many families are not able to enroll their children in ECCE programs that meet their needs, and many struggle to find adequate medical, dental, behavioral health, or other essential services. As noted in Chapter 2, we are still striving to quantify the gap between families' needs and the available programs and services. What we know, however, is that families experience many barriers to accessing programs and services, even when they are available, and these barriers disproportionately affect vulnerable families. This chapter summarizes findings on how families make choices about their children's care and education, and why they are often unable to gain full access.

Where Do Families Get Information About B-5 Programs and Services?

Data from the Focus on Nebraska Families survey provide some insight into how families get information about programs and services for children birth to age 5. Findings suggest that families most commonly turn to friends and neighbors for information (80.1%), and more than half rely on web searches (62.7%) or their local school district (56.8%). Overall, most families do not utilize government websites (77.7%) or social services agencies (87.8%), but vulnerable families are more likely than others to rely on these more formal sources of information (see Table 8). Nearly all the families surveyed reported that, in making decisions about ECCE, it would be helpful to have a list of providers in their area, estimated costs, user ratings, and quality scores.

Table 8. Sources Families Use to Get Information about Services for Young Children

Source	% selecting the source		
	Overall	Not vulnerable	Vulnerable
Do you get information about services for children under 6 years old (such as child care, preschool, medical care, subsidies) from any of these sources?			
Web searches	62.7	63.1	62.4
Newspaper	17.3	15.8	18.3
Government website	22.3	18.2	25.0
Social service agency	12.2	4.7	17.0
School district	56.8	55.1	57.9
Friends and neighbors	80.1	85.4	76.8

In focus groups, families echoed these themes. Many families said that they found their ECCE provider via word of mouth and stated that, without these personal referrals, they would have little information on which to base their decisions. For example, one parent said:

> *"…We ended up going with (the provider) where a co-worker had his kids at, so that helped a lot just knowing someone else who recommended the place. But without that I don't even know how we would have picked other than cost and location to our workplaces. But yeah ... we didn't even know where to begin."*

A few families were aware of more formal resources for locating ECCE providers and found these to be a useful starting point. One parent stated:

> *"I got the printout from DHHS and I literally just seen which centers match the hours that I needed. They were all pretty much the same and I just started calling to see who had openings and just going down the list crossing people off."*

What Factors Are Most Important to Families in Choosing Early Childhood Care and Education?

Respondents to the family survey report that they value ECCE settings where staff are warm, kind, and well educated; communicate with them frequently about their child's development; and support whole child development (social-emotional, physical, nutrition) in a clean, sanitary environment (Table 9). Other factors, such as curriculum, licensure, location, and even recommendations from friends and family, are comparatively less important. Although cost is certainly a consideration and a significant barrier to access (see below), particularly for vulnerable families, it was rated as less important than factors that are indicative of quality.

These general trends are consistent for vulnerable families and those who use all types of ECCE, with a few notable exceptions: vulnerable families are more likely than non-vulnerable families to say it is important that their ECCE provider is affordable and accepts child care subsidies. They also place comparatively more value on providers' ability to accommodate special needs,

connect them with resources in the community, and provide bilingual education; families who use home-based ECCE were less likely to place importance on finding a provider that is licensed or uses a curriculum.

Table 9. Factors that are Important to Families in Choosing Early Childhood Care and Education

	% important or very important					
		Family type		Setting		
Factor	Overall	Not vulnerable	Vulnerable	Home-based	Center-based	School-based
When you think about choosing a child care or education provider, how important is it that the child care provider:						
Has staff who are warm and kind	98.8	99.1	98.6	98.3	99.6	99.1
Is clean and sanitary	98.4	99.0	98.0	97.9	99.4	99.1
Provides plenty of exercise or physical activity	95.8	95.8	95.7	94.5	98.4	93.0
Provides healthy and nutritious food	95.6	95.3	95.9	94.5	98.4	91.2
Does a good job meeting my child's behavior and social-emotional needs	94.6	93.4	95.4	93.8	96.4	92.2
Has well-educated staff	94.2	93.5	94.7	92.2	97.4	98.2
Communicates with me regularly about my child's development	92.5	91.3	93.2	91.7	93.8	92.2
Is affordable	89.8	**86.6**	**92.0**	89.8	90.2	85.8
Has staff who speak the same language as my family	82.0	81.0	82.7	82.1	82.6	79.1
Is located near my home or workplace	77.4	76.2	78.2	76.5	78.8	76.3
Offers flexible hours	74.8	72.3	76.4	72.9	78.7	71.3
Can take all my children	74.0	75.7	72.9	72.3	78.9	66.7
Is licensed by the State of Nebraska	72.6	74.8	71.1	**62.9**	**91.0**	**84.3**
Uses a curriculum	70.1	68.1	71.4	**62.3**	**83.0**	**86.0**
Is recommended by a friend or family member	67.5	69.5	66.1	69.7	65.1	54.8
Can accommodate my child's special needs	59.2	**48.0**	**66.8**	58.1	59.9	57.1

Factor	% important or very important					
	Family type			Setting		
	Overall	Not vulnerable	Vulnerable	Home-based	Center-based	School-based
Connects families to other resources in the community	46.1	**39.1**	**50.9**	44.3	49.0	43.5
Provides a religious or faith-based education	34.9	35.0	34.9	36.7	30.2	43.5
Accepts child care subsidies	20.8	**7.5**	**30.0**	19.8	20.8	23.2
Provides bilingual education	19.9	**13.1**	**24.5**	18.2	20.2	32.5

Barriers to Access for Early Childhood Care and Education

After families have gathered information about available options, their ability to enroll their child in an ECCE program that meets their needs is contingent upon a number of factors. Findings from the needs assessment reveal that three major barriers constrain families' ability to access the care and education that they need for their children: availability, cost, and flexibility. Chapter 4 addresses concerns about the quality of care and education that children receive.

Lack of available options.

As noted in the previous chapter, lack of vacancies in ECCE programs is a fundamental barrier to access. For many families, there are simply not any available ECCE placements that meet their needs. In response to a survey question about challenges to finding ECCE, 35.7% of families said they were challenged by having too few ECCE options. Not surprisingly, families in remote rural areas (75.7%) compared to those in metropolitan (47.6%) or micropolitan areas (60.9%).

Low availability also emerged as a theme in family focus groups throughout the state, particularly as it related to infant care. Participants described the stress they experienced when they needed to return to work and were unable to find care for their infant:

> *"Stressful, it was right after I was getting off maternity leave and I couldn't find anybody. I ended up having to rely on my mom to do it, but she kind of lived far away so it was kind of spotty whether I'd get to work on time, whether she'd be able to even come down, so it was hard."*

Some noted that wait lists for quality facilities are often extremely long, even for older children:

> *"I found out I was pregnant like late summer, early fall and I started calling in the fall and I was getting on waiting lists for the next August."*
>
> *"We had the wait list problem for a 2½-year-old, like it's really hard because we live in [community] and we couldn't find anything here."*

According to survey responses, families spend about 20 minutes on average transporting their youngest child to and from their ECCE provider each day. However, this number varies depending on the type of care a family is using. Families in home-based care spend an average of 15 minutes transporting their child to and from care, compared with 26 minutes for those using child care centers and 29 minutes for those in a school-based setting. However, these numbers do not reflect the extent to which ECCE options for families in remote rural areas are constrained by distance.

Cost.

Cost was the most commonly experienced barrier among families who responded to the survey. Of all the families responding, 47.7% endorsed "ECCE programs are too expensive" as a challenge that they experienced in finding care and education for their child (Table 10). Among families who pay for early care and education, 9.1% (*n* = 380) indicated that it was difficult or very difficult to pay for their care arrangement. Data suggest that cost may be experienced as a challenge for families in metropolitan (52.5%) and micropolitan (47.7%) areas more so than those in remote rural areas (35.9%).

Table 10. Barriers to Accessing Early Childhood Care and Education (All Families)

Barrier	% some or a lot
To what extent did you experience each of these challenges in finding an early care and education provider for this (your youngest) child?	
Early childhood care and education programs are too expensive	47.7
Too few early childhood care and education programs available	35.7
The hours of operation for early childhood care and education settings are not flexible enough	29.2
Early childhood care and education programs are of low or poor quality	24.9
Transportation problems getting to and from early childhood care and education settings	16.4
Lack of information (e.g., I don't know enough about available programs and how to access them)	11.2
Early childhood care and education programs don't understand my culture and/or speak my language	2.2

The issue of cost came up in every focus group with families. Many participants explained that the cost of ECCE nearly outweighs what they can earn in their employment, but they cannot afford to stop working.

> *"If I kept the job and put my son in day care I would be paying for day care and it's like why not just stay home and eliminate the worry and the cost. But I need to work because we won't make it just on my husband's income."*

"[I am] working from home now with a 6, 4, 2, and 8-month-old. It's a little much, and I can't get a lot done until my husband comes home from work, but the price of child care, especially for four kids, is just outrageous. There's no, I wouldn't even be working, it'd be pointless, so I did look but it's just so expensive that I just deal with it."

Lack of flexibility.

Many families are challenged to find ECCE arrangements that accommodate their scheduling needs: 29.2% of families stated that they had experienced lack of flexible hours as a challenge to finding ECCE. In focus groups, families described scenarios in which, due to the cost of ECCE, they must arrange their employment schedules so that they do not need full-time care, staggering schedules with a partner or working nontraditional shifts. This creates a need for part-time or irregular care arrangements that are not offered by many providers.

"They [public school] have one full-day class…you do half-day, some parents can't accept that, not because they don't want their child to have the education but because they don't have the transportation or it just doesn't work with work schedule and stuff. So it's like then you have no choice but to use the center or an in-home and hope that they're getting what they need because it doesn't meet your needs. Like why don't all the rooms go full-day?"

"Where I'm at for work I don't have enough work to send my kids to day care full time and just pay if they don't go. But I'm bombarded with work sometimes, I wish I could send my kids somewhere occasionally and there's nothing like that here."

Indeed, many ECCE providers who responded to our survey reported that they do not offer flexible scheduling options (see Table 11). School-based ECCE programs are often part-time with inflexible hours. Home-based providers are more likely to offer flexible options, such as early morning or late evening hours.

Table 11. Flexibility of Services Offered by Early Childhood Care and Education Providers

	% yes			
Type of service	Overall	Home-based	Center-based	School-based
Are the following services available in your program?				
Part-time care	74.3	74.9	79.2	59.8
Full-time care	86.4	97.9	78.3	37.9
Care before 6 a.m.	21.6	26.7	16.7	1.6
Care after 6 p.m.	17.8	22.1	11.9	1.6
Drop-in care	50.2	62.3	38.1	8.6
Sick child care	6.5	8.6	1.0	1.6
Emergency care	31.1	39.3	19.0	8.6

In the absence of flexible, affordable options, some parents feel they have no choice but to leave the workforce. One focus group participant explained:

> *"As of right now I still stay at home with the girls…part of that reason though is because there isn't a lot of availability and it is expensive too. So I mean, I know in the next year, I do want to go back to work, like as of right now I'm just going to try doing work at home ... it's too hard to find places…"*

Perhaps due in part to a lack of flexible ECCE options, many families reported that they have experienced challenges in their employment because of issues with ECCE: 50.4% of parents indicated that they had either had to miss a full day of work, had been late for work, left work earlier than normal, or had been distracted while at work because of child care issues; 32.0% of parents indicated that they had either turned down a job offer/promotion, turned down a job reassignment, reduced their regular work hours, or quit a job because of problems with child care.

Equitable Access

Findings from the family survey and focus groups suggest that access to ECCE is particularly challenging for vulnerable families, because they disproportionately experience the barriers described above (see Table 12). At the most basic level, lack of information about available ECCE options is more challenging for vulnerable families (14.9%) than non-vulnerable families (5.9%). Vulnerable families are also more likely to experience instability in their care and education arrangements: 20.4% of vulnerable families reported that they had changed arrangements two or more times in the past 12 months, compared with 11.1% of non-vulnerable families. This means that that vulnerable families are more often faced with the arduous task of finding acceptable ECCE arrangements in the context of limited availability.

Not surprisingly, the cost of ECCE is a substantial barrier for vulnerable families: 54% of vulnerable families indicated that expense was a barrier to their finding child care, compared with 38.3% of non-vulnerable families. Likewise, in a separate survey question, vulnerable families were nearly four times more likely to indicate that it was difficult or very difficult to pay for their care arrangement (28.8%), compared with non-vulnerable families (7.6%).

For families that were considered vulnerable, 37.7% of parents indicated that they had either turned down a job offer/promotion, turned down a job reassignment, reduced their regular work hours, or quit a job because of problems with child care. For families that were not considered vulnerable, 22.8% of parents indicated that they had either turned down a job offer/promotion, turned down a job reassignment, reduced their regular work hours, or quit a job because of problems with childcare.

Table 12. Barriers to Accessing Early Childhood Care and Education (by Family Type)

Barrier	% some or a lot	
	Vulnerable	Not vulnerable
To what extent did you experience each of these challenges in finding a child care provider for this child?		
Too few early childhood care and education programs available	37.8	32.7
Early childhood care and education programs are of low or poor quality	28.3	20.4
Early childhood care and education programs are too expensive	54.4	38.6
The hours of operation for early childhood care and education settings are not flexible enough	33.9	22.8
Transportation problems getting to and from early childhood care and education settings	18.6	13.3
Early childhood care and education programs don't understand my culture and/or speak my language	3.2	0.9
Lack of information (e.g., I don't know enough about available programs and how to access them)	14.9	6.1

In focus groups, families representing cultural and racial minority groups also described some unique challenges that were not articulated by other families. These families described a lack of trust in ECCE providers, and even fear of mistreatment, as illustrated in these excerpts:

> *"And the truth is I do not trust my kids to anyone, and he doesn't either. For now, I have not been able to work for that same reason. Because it's not … we can't trust. And it's worse with babies."*

> *"I don't go to work … well, my husband won't let me either ... He says 'they won't treat them well. Who knows if they will feed them on time or not.' And they get sick sometimes. I knew a girl who had to hospitalize her baby girl, about 5 months old, because the babysitter wouldn't change her diaper, so she got a bad infection."*

> *"I didn't trust them enough because of all that can happen at day care, the abuse, and the hitting, so my mom … she raised, you can almost say, my two kids for the first years. It wasn't that hard because I knew who I was leaving them with, the trust I had in my mom."*

Perhaps related to issues of trust, racial and ethnic minority groups also placed a high value on finding a provider that matches their racial and cultural background. However, some expressed frustration with the state of the facilities they encountered in minority-owned child care.

> *"You see some of the non-black-owned day care centers and they are extremely well kept and I look around and think 'why can't we have this?' Like why is that the difference? The people that work there [black-owned day cares] seem they actually like*

working there. The non-black ones it's just a job, so you have to choose between cleanliness and care in my opinion."

"I'm still trying to explore is a black-owned day care but there are massive unfortunate differences between white-run facilities and non-white facilities."

Child Care Subsidy

In Nebraska, childcare subsidy is designed to allow low-income families to receive free or reduced-cost child care so that adults in the family can work or attend school. This option has the potential to mitigate some of the challenges that vulnerable families face in accessing quality ECCE. However, only about half of providers in this sample accept childcare subsidy, which is consistent with the approximately 50% of licensed providers who accept subsidy statewide. In our sample, this includes 45.8% of home-based providers, 70.1% of center-based providers, and 17.5% of school-based providers. Note that these numbers reflect the fact that childcare subsidy is not available to pay for a "formal preschool education setting."

When asked to report why they do not accept child care subsidy, nearly half of providers (45.4%) responded that they do not accept subsidy because none of their families are eligible for reimbursement, and over a third (36.4%) believe that it requires too much paperwork. The most common response was "other." Analysis of open-ended responses revealed two themes: (1) subsidy rates are not on par with the cost of care; and (2) subsidy only covers days that a child actually attends, and providers fear losing revenue if families are not reliable in their attendance.

Child care subsidy was not commonly mentioned in focus groups with families, but it did emerge in a few groups with families representing targeted, vulnerable populations. They described difficulty in qualifying for subsidy and the extent to which using subsidy limits their choice in selecting an ECCE provider.

"Sometimes you have to go with a certain place because you don't have the opportunity to go somewhere else and use subsidy, and I've heard that from a lot of people. That's a disconnect that they feel you have to make that sacrifice to send your child to a day care when you would prefer the other one but they don't take subsidy, so you have to send them somewhere else."

Access for Vulnerable Families to Essential Services for Child Development

All families need access to a wide range of services beyond early care and education to ensure healthy physical, cognitive, social, and emotional development for their child. Nearly all families in our sample reported that, in the past 12 months, they have accessed basic medical and dental care for their child. However, while families are fairly consistent in their need for these services, vulnerable families are much more likely to report difficulty in accessing many essential services, including health insurance, prenatal care, dental care, family planning services, and maternal depression screening (see Table 13). Moreover, there are many services for which vulnerable families have greater need, due in part to the very circumstances that

make then vulnerable. These include support for children's social and emotional development, nutrition assistance, Medicaid, job training, and support for families experiencing domestic violence (see Table 14). Among respondents who indicated having children with disabilities, 28.4% indicated that it was somewhat difficult, 9.6% indicated that it was very difficult, and 1.5% indicated that it was not possible to obtain care.

Table 13. Family Use of and Access to Health-Related Essential Services

	% yes			% difficult, very difficult, or not available		
Type of service	Overall	Not vulnerable	Vulnerable	Overall	Not vulnerable	Vulnerable
	Have you used any of the following services for yourself and your family in the past 12 months?			*How easy or difficult was it for you to access this service?*		
Health insurance for child	95.1	96.8	94.0	6.9	2.6	9.7
Health insurance for adults	89.2	95.5	85.2	9.5	3.1	13.9
Prenatal health care	32.4	33.3	31.9	10.3	4.6	13.9
Well-child visits	83.4	87.5	80.8	2.9	1.1	4.1
Medical care when my child is sick	88.6	90.6	87.3	3.5	2.3	4.3
Dental care for my child	78.8	80.0	78.1	5.9	2.1	8.3
Immunizations for my child	89.1	91.7	87.4	2.2	1.3	2.8
Family planning services	13.8	12.4	14.7	21.5	10.7	26.5
Depression screening and treatment for me or my partner	16.8	11.6	20.1	26.3	13.7	30.7

Table 14. Family Use of Other Essential Services

Type of Service	% yes		
	Overall	Not vulnerable	Vulnerable
Have you used any of the following services for yourself and your family in the past 12 months?			
Services to address my child's social, emotional, and/or behavioral issues	11.7	4.2	16.4
The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	13.1	1.1	20.7
Group parenting classes for parent of children with challenging behaviors	2.2	0.5	3.4
Assistance to find affordable housing	3.3	0.1	5.3
Assistance to apply for Medicaid	9.8	0.8	15.5
Assistance to apply for a child care subsidy	4.4	0.2	7.0
Support for families experiencing domestic violence	1.9	0.0	3.1
Support for a family member with a disability	3.4	0.3	5.4
Job training programs	2.4	0.2	3.8

In focus groups with families in rural areas, participants explained that certain types of services simply are not available in their community.

> *"For ours so we did do behavioral therapy down in [town], but it just didn't seem like he was learning anything. And as of right now there is no kind of if you haven't liked, if you have like a child who is autistic, ADHD, ADD, there is no kind of help down here … So we just kind of have to wing it and figure it out on our own."*

ECCE providers have the potential to serve as a critical link for helping vulnerable families gain access to essential services. However, fewer than 10% of providers provide essential services to families, and only about 20% of providers report that they refer families to essential services (see Table 15 for detail).

Most school-based providers utilize developmental assessments (77.5%) and health screening (72.9%) to identify children who might need referrals for additional services, but these screenings are used by only a small percentage of home- and center-based providers. Overall, only 28.1% of providers report that they offer developmental screenings, and 15.9% report that they conduct routine health screenings.

Table 15. Essential Services Offered by Early Childhood Care and Education Providers

Service	% provide	% refer
Please indicate if you offer any of the following services to families directly, by referral, or not at all.		
Pediatrician services	0.6	13.8
Adult health care	0.4	7.4
Dental care	1.9	12.7
Prenatal care	0.4	9.6
Family planning services	0.3	8.5
Services for family members with disabilities	2.5	14.9
Emergency assistance for families in crisis	3.7	16.7
Education or job training	1.5	10.3
Mental health screenings/assessments and/or treatments for adults	0.9	9.1
Parenting classes	4.7	13.6
Help to apply for child care subsidy	6.1	19.8
Help to apply for other forms of public assistance (WIC, Medicaid, public housing)	3.6	20.0

Our key informant survey also asked leaders from a variety of organizations whether they provide or connect families to any essential services, and their responses were similar. Results were higher than those for ECCE providers, suggesting that there are some ongoing efforts to improve access to these services (Table 16).

Table 16. Essential Services Offered by Other Organizations

Service	% provide	% refer
Key Informants: Please indicate whether your organization offers any of the following services to families directly, by referral, or not at all.		
Pediatrician services	0.0	42.0
Adult health care	0.0	30.0
Dental care	6.0	28.0
Prenatal care	2.0	30.0
Family planning services	2.0	26.0
Services for family members with disabilities	18.0	34.0
Emergency assistance to families in crisis	16.0	38.0
Education or job training	26.0	24.0
Mental health screening, assessment, and/or treatment for adults	8.0	30.0
Parenting classes	28.0	24.0
Help to apply for child care subsidy	22.0	28.0
Help to apply for other forms of public assistance (WIC, Medicaid, public housing)	18.0	36.0

In interviews, key informants described a variety of programs that are designed to connect vulnerable families with essential services. Then, in a follow-up survey with a broader group of key informants throughout the state, we asked about familiarity with each of these initiatives in hopes that this might offer some insight into the spread of these programs. These findings, which are summarized in Table 17, may be useful in planning for program expansion and integration.

Table 17. Early Childhood Leaders' Familiarity with Existing Programs to Connect Families with Essential Services

Program	% not at all familiar	% somewhat familiar	% very familiar
Key Informants: Please indicate your familiarity with each of the following approaches to connecting vulnerable families with essential services			
Educational Service Units	2.0	10.0	66.0
Head Start/Early Head Start	0.0	14.0	62.0
Early Development Network	16.0	14.0	52.0
Planning Region Teams	30.0	14.0	38.0
Educare Family Engagement Specialists	34.0	28.0	32.0
Child Care Resource and Referral	46.0	26.0	26.0
Kid Squad	68.0	12.0	20.0
Nebraska Resource and Referral System	46.0	30.0	20.0
Community Response	56.0	20.0	18.0
N-MIECHV (Nebraska Maternal Infant Early Childhood Home Visiting)	54.0	26.0	18.0
Community Outreach Specialists	54.0	32.0	14.0
Educational Navigators through Learning Community of Douglas and Sarpy Counties	72.0	16.0	10.0
Nebraska Homeless Assistance Program	60.0	28.0	10.0
Family Care Enhancement Project (parent resource coordinators)	76.0	14.0	8.0
Nebraska Resource Project for Vulnerable Young Children	68.0	24.0	8.0
Bring Up Nebraska	72.0	20.0	6.0

Discussion: Gaps and Opportunities to Improve Access and Choice

Findings confirm that vulnerable families experience more challenges to accessing programs and services for their young children. By definition, children in vulnerable families are at risk for negative developmental outcomes. If they do not experience quality ECCE and do not receive the necessary services to support their development, then this risk is compounded. However, if

Nebraska can create a system that ensures access to quality care and services for all families, particularly those facing conditions that make them vulnerable, then this effect can be mitigated.

A study in Florida in 2010 comparing 4-year-olds with access to a quality preschool program with their own sibling who did not have access yielded strong causal evidence about the positive impact of prioritizing access (Meloy, Gardner, & Darling-Hammond, 2019). Ensuring equitable access to affordable early care and education will require state and community leaders to critically examine existing systems and take the lead and responsibility for problem solving and action. Achieving equity is a top-down and bottom-up process that requires explicit attention and support (Singleton, 2018).

One major concern that emerged from these data is the lack of a widely known, reliable source of information for families about available ECCE options. This leaves families to rely on informal sources, such as internet searches and personal referrals. Existing resource and referral systems could be expanded to be more informative and comprehensive, but they are only useful if families are aware that they exist. Findings suggest that many families rely on their local public school for information about programs and services for young children, which elevates an opportunity for schools to perhaps be a more effective conduit for disseminating information about ECCE providers in their communities.

Vulnerable families may also need additional information and resources to navigate the various forms of free or low-cost care that are available to low-income families (i.e., Head Start/Early Head Start, child care subsidy, public school programs, Educare). Key informants pointed out that these programs have different eligibility criteria, application processes, and regulations that are likely a barrier for vulnerable families. One key informant described this issue succinctly:

> *"As we create our own policies for each individual program or each individual agency, sometimes those don't align or they're contradictory or again we unintentionally create a barrier for families to get access. Especially when you think of vulnerable or at-risk families. There's so much that goes as you can imagine that, you know, we could talk about that creates barriers for those families."*

An enhanced ECCE resource and referral system could also address these concerns, providing a central source for vulnerable families to learn about what is available, whether they are eligible, and how to apply.

In interview and survey responses, key informants in Nebraska's ECCE system identified several systemic barriers that, if overcome, could enhance equitable access. First, they echoed providers' and families' concerns about the challenges of child care subsidy, and they emphasized the need to maximize the number of providers who accept subsidy and the ability of eligible families to successfully enroll and stay enrolled. They also mentioned that ECCE services for vulnerable families are not consistent across the birth to 5 continuum. Families may

qualify for programs that provide care and education from birth to age 3, but then there is nothing available for their child until they can enroll in public PreK at age 4. One parent described this quandary in a focus group:

> *"He's [her son] enrolled in Early Head Start here so that was what really saved me. I'm stressing now that he…it's a few years off but when he's 3, he ages out of here and there's absolutely no preschool or really child care for him to go to that's affordable."*

A further challenge is ensuring that all families have access to the full range of essential services required to support their child's healthy development. Findings suggest that many families, particularly vulnerable families, have difficulty accessing these services. ECCE providers have the potential to be a critical link to connect vulnerable families to essential services, but findings suggest that very few providers currently fulfill that function. Moreover, we know that vulnerable families are more likely to receive care and education from unlicensed or home-based providers, which are less likely to be linked into a broader network of resources and information that might facilitate referrals for essential services. One promising approach may be to focus on expanding use of developmental screening by providers across all settings, which is currently low. At minimum, screening tools could provide a more structured way for providers to communicate with families about their child's development and alert them to the need for additional services.

More information is needed about the reach and impact of existing initiatives that connect families to essential services, with particular emphasis on ways in which these many programs could be aligned for optimal impact. Findings suggest that public schools, Education Services Units, and the Early Development Network will be important players in this work, but it is not clear whether these organizations are equipped to make links to a full range of essential services (e.g., medical and dental care, crisis intervention). In Chapter 5, we will revisit this theme as we examine collaboration within the mixed delivery system.

Chapter 4: Quality in Early Childhood Care and Education

Definitions of quality in early care and education, in Nebraska and in the wider national ECCE system, focus primarily on the environment, creating a common perception that quality is context/setting specific. In fact, quality early care and education is best defined by a child's experiences, reflected in the child's engagements and interactions with adults and children in the environment. In the context of two annual statewide, community-focused conferences, (called *Thriving Children, Families, and Communities)*, a definition of quality emerged, which articulates a shared understanding of how quality is experienced by children across multiple settings.

Stakeholders reviewed this definition of quality and provided feedback in regional meetings and in an online survey of key definitions. The feedback was used to refine the definition of quality:

QUALITY in early childhood care and education is defined by each child's experiences and consists of those experiences supported by an ecologically nested set of provisions.

QUALITY early childhood care and education is the degree to which a child—from birth—experiences (1) physical and emotional safety and (2) frequent, 1:1, language-rich, warm interactions with a caring adult (serve and return). From birth, children observe caregiving adults with all their senses, noticing when adults are responsive and sensitive to their needs and when adults are under stress. Young children experience adults' stress as a lack of safety, and their sensitive caregiving as safety.

A child's experiences of quality occur in the context of interactions with individuals (e.g. parents, childcare professionals), ECCE program characteristics, and broader community and societal factors. Quality provisions are processed and inputs that increase the likelihood that children experience physical and emotional safety in the context of frequent serve and return interactions. Quality provisions include:

1. Family caregivers possess capacities and resources to provide for their children's development and learning. In the context of ECCE, families' home culture and language are valued, and they are supported in their efforts to provide for their children, are provided essential information and referrals, and are partners in the care and education process (National Association for the Education of Young Children).
2. Caregivers (across settings) initiate and sustain consistent, sensitive, and responsive interactions with each child. Instruction that addresses the whole child (physical, emotional, social, cognitive) is scaffolded to individual needs, and in group settings, flows from a curriculum (Burchinal, 2018). Recent research suggests that instructional quality is most frequently experienced by children in settings that prioritize learning in the context of play (Zosh et al., 2017).
3. Programs and/or services engage in systemic continuous improvement related to facilities/settings that consider (1) health and safety; (2) materials for learning; and (3) adult caregiver's knowledge, competencies, and well-being.
4. Teachers (including providers) have the knowledge, training, and supports (including compensation, benefits, and workplace wellness) they need to provide appropriate care and education to all the children and families they serve.
5. Communities provide infrastructural systems of support for families and for ECCE services and programs. These systems can include funding, local resources, and coordinated efforts to build public will and knowledge related to providing, identifying, and making available quality ECCE.
6. State and federal policies and practices provide processes via which communities can access and organize supports. Quality in early care and education is supported by local, state, and federal policies that enable ECCE providers to create this nested set of provisions. Such policies include economic, social, regulatory, and funding policies, as

well as guidelines and resources that support measuring quality by observations of the child's experiences in addition to observations of the environmental provisions.

Currently in Nebraska, quality of ECCE is assessed at the program level, with an emphasis on health and physical safety provisions. The state QRIS system adopts a more focused approach on environmental materials and staff qualifications, but it includes limited observation of processes that enhance children's experience of quality, such as adult-child interactions and instructional quality. While quality is typically observed and measured by provisions in the environment, the definition of quality as a child's experiences suggests that the development and adoption of new approaches toward observing and measuring quality are needed. No current assessments of quality examine the degree to which the child is experiencing physical and emotional safety and warm, complex interactions with adults. Chapter 5 of this report examines state- and community-level provisions related to quality.

Provisions That Support Quality

While identifying strategies for observing and assessing quality at the level of the child is needed, ongoing attention to assessing and enhancing the provisions for quality is essential. The following provides guidance for provisions that increase the likelihood that children in ECCE programs experience quality across settings.

Families.

Providing for quality involves racially, culturally, and linguistically responsive family engagement practices that provide positive, affirming messages for children and their families about their own race, culture, and identity. Quality early care and education programs approach being inclusive of families' culture and language with thoughtfulness and intentionality. In parallel with enhancing inclusive practices of diverse families, quality programs also include multiple and varied opportunities for children to develop understanding and respect for others from diverse backgrounds (Fleming et al., 2016; James & Iruka, 2018). In addition, when parents are more engaged and empowered in support of children's learning, they are better able to support their children's development, build their children's resiliency, and advocate for their children's long-term educational success (National Black Child Development Institute, 2016).

Programs.

Whether the ECCE program is a family child care home, center-based, part-day, or full-day, provisions for quality are focused on providing for the child's experiences. Higher-quality ECCE programs demonstrate positive effects on children's developmental and academic outcomes. Defining and elevating quality components in preschool programs is of utmost importance in efforts to maximize support for children's learning and development. Aspects of quality include structural elements (such as length of the day and teacher-child ratios), the classroom environment, teacher-child interactions, and performance indicators (such as quality rating and improvement systems). These aspects of early care and education determine the level of quality in children's direct experiences and how these experiences foster a child's learning and development (Pianta, Downer, & Hamre, 2016).

Whole child development includes support for social and emotional learning integrated with opportunities for cognitive, language, and physical development. Quality ECCE programs provide explicit and intentional support as children develop emotional regulation, social skills, and executive functioning while also attending to children's academic needs. "To do this, school systems must integrate social-emotional learning (SEL), including trauma-informed practices, into all aspects of teaching and learning in ways that are accessible, sustainable, evidence-based, culturally responsive, and equity literate. This creates the conditions where all youth can thrive and ensures that SEL approaches are not used to oppress marginalized social groups." (Simmons, Brackett, & Adler, 2018)

Teachers/Providers.

Increasing quality in children's experiences requires attention to the adults who care for them. Highly qualified early childhood professionals are the cornerstone of high-quality early care and education. Providing developmentally appropriate care and education for young children requires specialized knowledge and skills including, for example, an understanding of early childhood development (across cognitive, social-emotional, and physical domains), the ability to facilitate children's learning through nurturing relationships and intentional interactions, and the ability to work effectively with children and families from diverse backgrounds and with diverse learning needs. Teachers who are connected with their peers, comfortable in their work environment, and feel included and respected are better able to provide quality through sensitive and responsive interactions with each child, as well as providing comprehensive and integrated approaches to promote the development of the whole child (Thapa, Cohen, Guffey, & Higgins-D'Alessandro, 2013). The most important provision for quality is ensuring that the members of the early childhood workforce have the qualifications and support they need to build positive relationships with the diverse children and families they serve.

Quality preschool classroom environments include sensitive and responsive interactions with each individual child, with particular attention to children who have experienced trauma or are in groups experiencing gaps in opportunity and achievement based upon their race, culture, language, or socioeconomic status (Allensworth et al., 2018). Sensitive and responsive interactions and emotional connections with teachers are factors in children's attitudes about school, confidence in their abilities, and long-term school performance. On the flip side, negative, conflict-ridden interactions with teachers correlate with children avoiding school, disliking school, and being less self-directed and cooperative, all resulting in lower quality classroom experiences (Hamre & Pianta, 2001; Thapa, Cohen, Guffey, & Higgins-D'Alessandro, 2013).

Communities and Governments.

The Center for the Study of Social Policy and the National League of Cities have identified building blocks to support communities' ability to provide for high-quality early learning communities. These include garnering public will and commitment to engage community leadership, providing quality services for all young children and families, creating neighborhoods in which families can thrive, and enacting policies to be supportive and

responsive to families (Whitehouse, O'Connor & Meisenheimer, 2019). The National Center for Children and Poverty outlined policy recommendations for ensuring that young children experience quality. These include a focus on the whole child, combining early childhood investments with investments in family economic security, and increasing access to critical services and supports (Stebbins & Knitzer, 2007).

Measuring and Improving Quality of Early Childhood Care and Education: Step Up to Quality

In June 2013, the Nebraska Legislature passed the Step Up to Quality Child Care Act, which established the Step Up to Quality program. The purpose of the Step Up to Quality Child Care Act is to: provide a path to higher-quality child care and early childhood education, improve child development and school readiness outcomes, provide parents with a tool to evaluate the quality of child care and early childhood education providers, and provide accountability for public funds invested in child care and early childhood education providers. Licensed family child care homes, private child care centers, Head Start and Early Head Start providers, public school-operated early childhood providers, and licensed preschools are eligible to participate in Step Up to Quality. Currently, 95 providers are required to participate in the program because they receive high rates of child care subsidy dollars, and an additional 447 providers participate voluntarily. Of these participants, 7.2% are family child care homes, 37% are child care centers, and 55.8% are school-based providers.

Step Up to Quality includes five steps to help providers reach their highest potential and attain rewards and recognition for high quality. To achieve the higher ratings (Steps 3–5), providers are assessed in five areas: (1) program curriculum, learning environments, and interactions; (2) child outcomes; (3) professional development and ongoing training; (4) family engagement and partnerships; and (5) program administration. After completing the requirements for Step 2, participating providers are offered coaching and financial incentives to support their movement up the steps of quality. Step Up to Quality also implements a tiered subsidy reimbursement scale, based on the providers' quality ratings, with reimbursements paid directly to providers to reduce the gap between the rates paid by childcare subsidy and the actual cost of providing quality care.

Of the providers who responded to our survey, 20.4% reported that they participate in Step Up to Quality. However, participation rates varied considerably across settings: 38% of center-based providers said that they participate, compared with 15.2% of home-based providers and only 9.8% of school-based providers. When asked why they do not participate in the program, the most commonly expressed concerns pertained to time: 49% said they did not have time to participate in training sessions, and 43.2% said they did not have time to complete other requirements (Table 20). These challenges seem to pertain more to home- and center-based providers than to school-based providers, which may reflect the fact that public schools are waived from certain requirements in the early "steps" of the program. Also of note is the fact that 32.4% of providers who do not participate in Step Up to Quality said that they don't know about the program. Home-based providers were more likely than others to say that being

evaluated by an outside person prevents them from participating in the program. A relatively small percentage of providers stated that they did not participate because might not meet the program's standards across the five areas, but this varied by provider type.

Table 20. Issues Preventing Providers from Participating in Step Up to Quality

	% identifying the issue as a barrier to participation			
Issue	Overall	Home-based	Center-based	School-based
Have any of these issues prevented you from participating in Step Up to Quality?				
Don't have time to complete training sessions	49.0	50.4	51.4	51.4
Don't have time to complete other requirements	43.2	43.5	50.0	27.0
Don't know about the program	32.4	33.4	24.9	37.8
I prefer not to have my program evaluated by an outside person	27.2	34.8	16.6	9.6
Participation would not be beneficial for my program	26.3	28.0	20.7	28.6
My staff do not want to participate	15.7	10.9	22.3	23.9
My program may not meet quality standards for curriculum, learning environments, and interactions	13.1	15.6	9.8	5.3
My program may not meet standards for staffing, business practices, facilities	11.7	12.9	9.5	7.4
My program may not meet standards for family engagement and partnerships	11.6	13.1	10.9	4.3
I have heard negative things about the program	10.5	11.1	10.4	8.5
My program may not meet standards for professional development and trainings	9.6	11.8	6.4	3.2
My program may not meet standards for child outcomes	8.4	10.4	5.4	2.1

Surveys and focus groups with family child care providers provide more insight into low rates of participation in Step Up to Quality among home-based providers. These providers expressed frustration with the lack of alignment between requirements for licensing, Step Up to Quality, and other programs in the state, and they believe that the evaluation criteria in the program are not well suited to family child care settings. Overall, they believed that the disincentives to participation outweighed the incentives, and they felt that parents and community members do not understand or value the program. On the contrary, a rating of 1 or 2 out of 5, which requires substantial effort to achieve, may actually be viewed negatively by families, whereas nonparticipation in Step Up to Quality is a nonissue for most families.

PDG Needs Assessment: Findings Related to Quality Early Childhood Care and Education

Families' perceptions of quality early childhood care and education.

As described in Chapter 3, families' responses to the Focus on Nebraska Families survey suggest that they want an ECCE setting where staff are warm, kind, and well educated; communicate with them frequently about their child's development; and support whole child development (social-emotional, physical, nutrition) in a clean, sanitary environment. Focus groups provided a more nuanced picture of how parents think about what constitutes quality care. Overwhelmingly, families described a strong desire to place their child with a caregiver who genuinely cares for their child and will provide them with the kind of loving, one-on-one attention that they give themselves.

> *"I loved the fact that my provider treats her as her own, and I had so much love and admiration for her because of that because I realized how fortunate she is to get that because that's, that's, especially with your first child that's hard to leave somebody you've been with them forever and then drop them off and expect that they're going to do things the way that you do."*
>
> *"It probably goes without saying but like with caregivers who love them as much as I love them, that would be ideal and that I trust and who they have a good relationship with. I mean obviously that's in a perfect world."*

Families appreciate the value of having a structured environment with a regular schedule, but they also want their children to have time for unstructured play, creative expression, and opportunities to just "be a kid." The desire for outdoor play and exploring nature was particularly common. Families also value ECCE settings as opportunities for their child to socialize with peers.

> *"I want them to explore but I want them to have, like, a guided involvement with their caregiver to bring them on, to help them learn more about whatever they're interested."*
>
> *"I want him to be able to you know, get messy and put his hands in different textured things and to be able to like not just learn about you know different bugs and things because he saw them on like a little program but because he went for a walk in the park ... I want him to learn through experience because he was getting out and doing things or you know, building things so he knows like what's a square."*

Families also described various barriers to their child's experience of quality, nearly all of which relate to staffing. Many expressed a frustration with high rates of turnover and settings that were short-staffed, as these conditions preclude the type of caring, one-on-one interactions that they want for their child.

“...at the center we were at beforehand there was kind of a bond with that teacher, but then when you have all those circulating teachers in a center you lose that.”

“They had a lot of turnover and her class her first year of preschool, she didn’t learn anything.”

Some families in focus groups were also concerned with the level of experience or qualifications of their child’s teacher.

“A lot of times…they just hire girls fresh out of college who are doing Early Education and they don't really have, they have the educational experience but not the hands-on experience like a lot of moms do…so it does make a difference.”

Providers’ perceptions of quality early childhood care and education provisions.

To assess providers’ understanding of quality, the Early Childhood Program and Leadership survey asked a series of questions about providers’ goals and the provisions that they believe are most important for children’s learning and development. The first question asked about program goals. Of the options presented, providers gave the highest importance ratings to “enhancing overall child development” (98.1% rated important or very important) and “promoting child health and physical development” (97.8%). They also placed a high level of importance on identifying development delays for early intervention (93.1%).

Home-based providers were slightly more likely than others to prioritize goals related to supporting parents, such as “improving parent self-sufficiency" and “providing family mental health services.” On the other hand, home-based providers were less likely to say that expanding services to meet community needs was an important goal of their program, likely because their licensing parameters only allow them to serve a limited number of families. School-based providers were more likely than others to report that supporting families with special needs was a goal of their program, which is perhaps not surprising given that public schools are a primary provider of special education services for preschool children. See Table 18 for details.

Table 18. Provider Ratings of Importance for Early Childhood Care and Education Program Goals

Goal	% important or very important			
	Overall	Home - based	Center -based	School -based
Programs have many goals they are working toward. How important are each of the following goals for children and families to your program?				
Enhancing overall child development	98.1	98.0	99.6	98.4
Promoting child health and physical development	97.8	98.3	98.7	96.9
Identifying development delays to provide early intervention	93.1	93.4	95.4	91.5
Improving parenting skills	79.5	80.3	79.7	76.2
Improving parent self-sufficiency	75.4	77.6	74.1	70.0
Promoting positive, nurturing parent-child relationships	88.3	89.7	89.0	81.6
Enhancing parents' knowledge of child development	85.3	85.7	86.5	82.2
Providing family mental health services	64.5	66.1	61.7	67.5
Providing support to families with special needs	78.3	77.2	78.2	89.2
Expanding services to meet community needs	70.4	65.9	77.6	83.1

The survey also asked providers to rate the importance of various characteristics to the overall quality of early childhood programs. The highest-rated characteristic was "teacher-child interactions" (95.8% important or very important), followed closely by "physical environment and materials" (93.8%). Curriculum, assessment, and program administration were the lowest rated, but ratings varied widely across provider types. Center- and school-based providers gave much higher ratings to these characteristics than home-based providers (Table 19).

Table 19. Provider Ratings of Importance for Characteristics of Early Childhood Settings

Characteristic	% important or very important			
	Overall	Home-based	Center-based	School-based
How important do you think the following items are to the overall quality of early childhood settings?				
Teacher-child interactions	95.8	93.6	99.7	100.0
Physical environment and materials	93.8	91.4	97.4	97.7
Teacher-to-child ratio, group sizes	91.1	87.6	97.8	94.6
Staff qualifications	88.1	83.2	96.2	96.1
Family engagement and partnerships	86.0	82.7	88.8	93.0
Program administration	76.9	67.4	93.0	86.8
Assessment of children	75.9	70.2	84.0	85.2
Curriculum	74.1	62.7	93.0	89.1

Current Quality of Early Childhood Care and Education in Nebraska

In this section, we synthesize data from a variety of sources in an effort to characterize the current quality of care and education available to Nebraska's families with young children, birth through age 5. The most formal data available are Step Up to Quality ratings, which indicate 183 Step 1 Programs, 125 Step 2 Programs, 54 Step 3 Programs, 41 Step 4 Programs, and 19 Step 5 Programs. However, as noted above, these ratings capture only a narrow segment of the state's ECCE providers, and they do not reflect children's experience of quality in these settings. Taken together, other data from the needs assessment provide a broader perspective on the quality of ECCE in Nebraska, but significant gaps remain.

Family satisfaction.

Overall, 88.3% (*n* = 2,385) of families who responded to the Focus on Nebraska Families survey indicated that they were satisfied or very satisfied with the current quality of care and education that their youngest child received. This includes 86.4% of families using home-based providers, 91.0% of parents using center-based providers, and 95.6% of families using school-based providers. The link between satisfaction and quality is complex, but for families who responded to our survey, we can assume that the criteria they used to rate their satisfaction are aligned with the factors that they rated as most important in selecting care. These include warm, caring staff; clean sanitary environment; nutrition and physical activity; and social-emotional support.

Family engagement.

Quality early care and education programs set a clear expectation for reciprocal and active partnerships between educators and families. Family engagement is a critical component of quality early care and education because when parents are more engaged and empowered in support of children's learning, they are better able to support their children's development, build their children's resiliency, and advocate for their children's long-term educational success (National Black Child Development Institute, 2016). It is important to define family engagement as reciprocal partnerships rather than one-sided, isolated events of parent participation because children's development and learning is enhanced when parents are engaged in supporting their children's learning as opposed to attending events. "Parent engagement is no longer defined as one-way participation in select school activities, with teachers being the sole experts on child learning and development. Instead, parents are being recognized as equal partners and leaders in their children's education" (Park & McHugh, 2014, p. 12).

Family-school partnerships in quality programs are developed and sustained through effective teacher-parent communication. Recommendations to ensure that communication is effective include: prioritize building trust, utilize multiple forms of written and oral communication (with priority on families' preference), communicate in families' preferred language, balance school- and family-initiated interactions, ensure frequent and continuous contact, provide explicit attention to families' cultural backgrounds, and focus on children's learning and development

(Allensworth et al., 2018; Halgunseth, Peterson, Stark, & Moodie, 2009; Malkus, 2006; Scully et al., 2015; Woods & Lindeman, 2008). “Consistent, two-way communication is facilitated through multiple forms and is responsive to the linguistic preference of the family. Communication should be both school- and family-initiated and should be timely and continuous, inviting conversations about both the child’s educational experience as well as the larger program” (Halgunseth et al., 2009, p. 3).

Looking at the preceding year, 43% of parents reported that they had not talked to their ECCE providers about their child's development at all or only once or twice. When it came to talking to the provider about their child's behavior, 38.2% of parents reported that they did not talk at all or only talked once or twice over the past year; 77.3% of parents reported that over the past year they had either never talked to providers about parenting issues or did so only once or twice. Over the preceding year, 70.6% of parents reported either not talking at all or only talking once or twice about how to improve educational opportunities for their children.

In focus groups, families reported that their child’s teacher or caregiver most commonly communicated with them through apps, written notes, or verbally at pickup or drop-off. Families described communicating with their child’s teacher or caregiver about behavior issues and information about the child’s daily schedule. When asked about their involvement in their child’s care and education, parents described events such as classroom parties, family nights, conferences, and volunteer opportunities (help in classroom and field trips).

For their part, providers reported that very few families participate in any engagement activities, as seen in Table 21. The majority of providers reported that none (0%) of the families in their program support the program (as parent council members, volunteers, etc.), and just about half report that none of their families attend parent-teacher conferences. More inquiry is needed to understand whether these engagement opportunities are simply not available in many ECCE settings (particularly home-based settings) or if families choose not to participate.

In interviews, key informants described several ongoing efforts to strengthen parent engagement. Many noted that Head Start/Early Head Start and Educare are successful at engaging families, especially those who experience conditions that may make their children vulnerable. Others mentioned Ready Rosie, a technology-enabled platform that facilitates communication between families and ECCE providers, which is being piloted throughout the state. Circle of Security was also mentioned as an effective approach to building parents’ capacity to foster healthy child development at home.

Table 21. Providers' Reports of Parent Participation

Activity	0%	1–25%	26–75%	76–100%	Don't know
What percentage of the children in your program have parents who participate in your program in any of the following ways?					
As members of a parent council or other governing bodies	62.3	15.9	1.5	0.6	19.6
As classroom volunteers	57.8	21.6	5.7	2.3	12.6
By doing maintenance, chores, or shopping for the program	74.6	10.8	2.0	1.0	11.6
By helping at special events or activities	49.9	23.8	10.4	4.8	11.1
By attending special events and activities, such as performances, holiday parties, etc.	41.6	12.1	14.8	21.3	10.2
By attending parent education or group activities	58.4	13.5	9.4	5.5	13.2
By attending parent-teacher conferences	50.1	7.5	9.9	21.2	11.3

Early childhood workforce.

Previous efforts document the competencies and supports experienced by the early childhood workforce. In a survey of the Nebraska early childhood workforce (Roberts, Iruka, & Sarver, 2017), the authors reported that early childhood teachers (birth to Grade 3) engaged in a variety of professional development activities, are fairly homogenous (white and female), feel less prepared to work with families than children, vary in their educational qualifications, receive generally poor wages, and experience mid-level stress and depression. In a report on turnover among early childhood teachers, the average turnover rate in the state was higher in child care (26%) than in public school PreK settings (16%) (Roberts, Gallagher, Sarver, & Daro, 2018). Turnover for assistant teachers was very high (36%). Child care teachers left for higher salaries (58%), and administrators reported difficulty hiring qualified teachers. Turnover is a serious problem in ECCE nationally, and in Nebraska may be higher in some settings (e.g., Head Start).

Nebraska has an online system for tracking the training and credentials of the early childhood workforce, called the Nebraska Early Childhood Professional Record System (NECPRS). Currently, statewide participation rates are relatively low, with 700 ECCE programs participating and 7,236 active users entered into the record system. However, efforts are underway to increase participation, the most significant of which is requiring providers to enter all of their staff into the record system as a condition of enrollment in Step Up to Quality. In our sample, 47.1% of respondents reported that they had entered a profile in NECPRS. Center-based providers were more likely to report using NECPRS (68.1%) compared to home- (40.9%) or school-based (36.1%) providers.

Overall, providers in our sample reported that 27.7% of all caregivers in their programs had obtained a bachelor's degree. The number of caregivers with bachelor's degrees is much higher in school-based settings (48.2%, including teachers and paraprofessionals), where in many cases regulations require that lead teachers have a bachelor's degree. Interestingly, our data suggest that programs in remote rural areas have a higher percentage of professionals with bachelor's degrees (35.1%) than those in micropolitan (25.6%) or metropolitan (26.7%) areas. The same trends were observed for percentage of staff with teaching endorsement in early childhood and elementary education.

The Child Development Associate (CDA) certificate is a competency-based credential that allows professionals without a bachelor's degree to demonstrate their qualifications in working with young children. Providers reported that 11.3% of their staff have a CDA certificate, and this rate was fairly consistent across provider types and regions.

Overall, nearly half of providers (49.1%) said that it is difficult for them to hire staff with appropriate qualifications. However, the data suggest that this issue disproportionately affects center-based providers (66.9%) compared to home- (23.6%) and school-based (47.4%) providers. Not surprisingly, center-based providers report that they experience various challenges related to hiring at higher rates than home- or school-based providers (Table 22). Interestingly, providers in metropolitan areas (53.9%) were more likely to report difficulty in hiring than those in micropolitan (45.8%) or remote rural (45.5%) areas. This is somewhat contrary to perspectives expressed by some stakeholders and key informants, who report that there is a shortage of early childhood professionals in rural areas and small towns.

Table 22. Providers' Reports of Factors that Make it Difficult to Hire Caregivers

	% somewhat or a lot			
Factor	Overall	Home-based	Center-based	School-based
What extent do the following factors make it difficult for you to hire caregivers?				
Lack of qualified candidates	66.6	45.2	81.3	62.0
Inability to pay enough	70.4	55.3	81.8	65.0
Inability to provide benefits	59.2	52.0	69.0	47.4
Program hours are undesirable for candidates	22.5	26.2	21.7	18.7
Program location is remote or difficult to access	8.1	10.2	5.4	11.8
Complicated hiring process	13.8	17.4	13.7	7.5
Candidates cannot pass background checks	9.1	11.8	7.6	4.2

Teacher turnover also appears to be an issue that most affects center-based providers, who reported having to replace at least one teacher and nearly three assistants in the past 12 months. By comparison, home-based providers reported almost no turnover, as many of

these providers do not employ any staff. School-based providers reported that they had replaced approximately one assistant and fewer than one lead teacher.

Professional development.

Ongoing opportunities for professional development are a crucial provision for quality care. Predicated on longitudinal evidence that young children need high-quality experiences in the early years to support optimal learning and development (Campbell et al., 2002; Shonkoff & Phillips, 2000), numerous efforts have sought to improve early childhood teaching practices (e.g., Early et al., 2017). These efforts have honed in on the specific knowledge and skills early childhood teachers need to effectively support young children's learning and development (Winton, Snyder, & Goffin, 2016), including specific interactional and instructional practices such as intentional teaching and scaffolding (Burchinal, 2018). Furthermore, recognition that widespread inconsistencies exist in early childhood teacher knowledge and skills (Barnett & Riley-Ayers, 2016) further fuels teacher improvement initiatives.

National efforts to bolster the quality of early childhood settings are manifest in a comprehensive volume published by the Institute of Medicine and the National Research Council (IOM/NRC, 2015) entitled *Transforming the Early Childhood Workforce for Children Birth Through Age 8: A Unifying Foundation.* Chief among the contributions of this work is a logic model articulating factors that contribute to quality professional practices and child outcomes. Drawing on developmental science, the model suggests that efforts to enhance the "behaviors/actions of the practitioner" are influenced by (1) professional learning supports, (2) policy, (3) professional knowledge and competencies of practitioners and leaders, (4) practice environment/working conditions, and (5) the well-being of the practitioner.

Overall, the most common type of activity that providers make available to staff is training after hours or on weekends (73.5%). However, most providers report that staff do not receive compensation for time spent in this training. When we examine the data by provider type, it is clear that home-based ECCE professionals have far less access to professional development activities than center- or school-based providers. School-based providers are four times more likely than home-based providers to report that their staff participate in conferences to talk about their work and progress, and school-based providers are 10 times more likely than home-based providers to report that their staff have the opportunity to participate in a mentoring program. See Table 23 for details.

Respondents to the provider survey were asked how many hours of professional development they required for caregivers in their programs each year. The median response for home-based, center-based, and school-based providers was 12 hours, which is the minimum requirement to maintain licensure. However, there was variability in the average number of hours for each setting. Home-based providers reported an average of 7.63 hours, while center-based providers reported an average of 13.75 hours and school-based providers reported an average of 11.56 hours.

Coaching is one of the most effective forms of support for professional development. However, most providers in our sample did not receive any coaching or consultation in the past 12 months: 25.4% of home-based providers indicated that they have received support from a coach or consultant in the past 12 months, while 33.8% of center-based providers and 47.3% of school-based providers indicated they had received this support. Here again, home-based providers appear to have the lowest levels of access.

Table 23. Providers' Reports of Professional Development Activities that They Make Available to Staff

Activity	% yes			
	Overall	Home-based	Center-based	School-based
Which of the following professional development activities do you or your program provide for caregivers?				
Formal conferences with teachers to talk with them about their work and progress	55.4	21.1	65.4	83.3
Training during the school day (provided by you or others)	52.2	19.2	58.4	82.0
Training after hours or on the weekend	73.5	57.0	87.2	67.2
Attendance at regional, state, or national early childhood conferences	48.4	30.8	50.3	70.8
Paid preparation/planning time	55.5	17.4	67.8	83.2
Formal recognition for excellence (awards night, etc.)	16.4	3.8	22.5	19.5
Participation in a mentor program	21.1	4.4	20.6	44.5
Other, specify	19.0	6.3	22.2	35.5

Nebraska stakeholders had a specific interest in learning more about providers' access to supports for children's social and emotional development. When asked if they have access to a family support resource, mental health consultant, or guidance counselor to help support children with challenging behavior, most school-based providers (85%) responded yes. This is in contrast to 51.4% of center-based providers and only 29.8% of home-based providers. Interestingly, in this case, providers in metropolitan areas were less likely (35.7%) than either those in micropolitan (45.4%) or remote rural (48.5%) areas to report that they have access to this type of support.

Barriers to professional development.

Providers across settings were fairly consistent in their reports of barriers to professional development. The greatest barrier is that sessions are offered at inconvenient times. Relatedly, providers reported that they do not have enough staff to care for children when someone is absent for professional development, and home- and center-based providers are challenged by a lack of funds to compensate staff who attend. See Table 24 for details.

Table 24. Challenges to Participating in Professional Development

Challenge	% somewhat or a lot		
	Home-based	Center-based	School-based
To what extent have the following challenges prevented your staff from participating in professional development?			
Sessions are offered at inconvenient times.	57.9	60.9	61.9
Not enough caregivers to care for children when someone is absent for professional development.	47.5	57.1	52.9
Professional development is too expensive.	42.4	50.0	32.0
There are not enough professional development sessions offered in our region.	41.3	42.4	42.5
Staff feel that sessions are not engaging or worthwhile.	35.0	46.5	31.6
Lack of compensation for staff to attend.	30.9	32.4	17.5
We do not get enough notice about upcoming professional development opportunities.	25.2	16.9	21.7

Curriculum and assessment.

Overall, almost half of providers reported that they use a curriculum or prepared set of learning activities with children (43.6%), and 26.1% of providers reported that they use a formal child assessment system. These numbers, however, vary widely by provider type, as shown in Table 25. The types of curricula and assessments used are summarized in Tables 26 and 27, respectively.

Table 25. Providers' Use of Curriculum and Formal Child Assessment Systems

Survey Question	% yes			
	Overall	Home-based	Center-based	School-based
Does your program use curriculum or prepared set of learning and play activities in the classroom?	43.6	25.4	72.5	80.0
Does your program use a formal child assessment system?	26.1	7.5	48.7	80.9

Table 26. Types of Curricula Used by Early Childhood Care and Education Providers

Curriculum	% yes
Creative Curriculum	32.3
A curriculum developed by our center/program	26.7
Other, specify	26.1
HighScope	5.3
A curriculum developed by school district or school	3.8
Montessori	2.2
Learn Everyday	1.8
Opening the World of Learning	0.9
Assessment, Evaluation, and Programming System for Infants and Children (AEPS)	0.4
Curiosity Corner	0.2
Reggio Amelia	0.2

Table 27. Types of Formal Child Assessment Systems Used by Early Childhood Care and Education Providers

Formal Child Assessment System	% yes
Creative Curriculum/Teacher Strategies	43.7
An assessment developed by our center/program	26.1
Ages and Stages	15.5
Other, specify	9.5
HighScope/CORE Assessment	3.5
Evaluation, and Programming System	1.4
Work Sampling System	0.4

Continuity and Transitions

Children's learning and developmental outcomes are enhanced when transitions are smooth, predictable, and comfortable. During transitions, children and their families experience new expectations, relationships, and competencies (Pianta, Kraft-Sayre, Rimm-Kaufman, Gercke, & Higgins, 2001). Navigating these changes can be difficult, especially for families from certain racial, cultural, linguistic, and socioeconomic backgrounds. Unfortunately, systems of early care and education are too often disconnected, and this leads to families feeling confused and uncomfortable during the transitions to Kindergarten.

Positive transitions create stability and promote children's positive developmental and learning outcomes. Elevating quality in children's school experiences requires prioritizing enhancements to transition practices by listening to families to gain an understanding of their transition experiences, enhancing collaboration between key school staff and community providers, and thinking critically about families' current experiences during transitions in order to make adaptations. Building understanding and connection between traditionally siloed programs is a start, but taking action with the information gained in order to make necessary changes and improvements is critical. Important considerations for transitions include focusing on building relationships of trust with families, regular patterns of communication among all stakeholders, building peer relationships (for both children and families), developing comfort with new people and environments before starting, and providing support and insight for parents to act as advocates for their children (Daniels, 2014; Geiser et al., 2013; Pacchiano et al., 2016; R. C. Pianta et al., 2001).

We define *transition supports* as processes within a program or a stand-alone service designed to support families and children in preparation for the transition from one ECCE setting/service to another, including:

- All transitions as children age out (infant, toddler, etc.)
- Children transitioning from Early Head Start to PreK or from a PreK environment to Kindergarten
- Transitions between settings for any other reason

To optimize a child's experience of quality in ECCE, it might be ideal for the child to remain in the same setting, with the same caregiver, as long as possible. However, this is often not possible. Overall, 43.1% of families who responded to the survey reported that they had used one care arrangement in the preceding week, 28.8% had used two care arrangements, 8.7% had used three care arrangements, and 1.3% had used four or more care arrangements. Families facing at least one vulnerability factor were more likely to use three or more care arrangements (11.1%) than families who did not report any vulnerability factors (7.9%). Families using school-based ECCE are much more likely to be using two or more forms of care than families whose primary form of ECCE is home- or center-based, perhaps because many school-based ECCE programs are half-day.

A majority of families (66.4%) had not changed their ECCE arrangements in the past 12 months, and a few had changed one time (16.9%). However, families classified as vulnerable were almost twice as likely as other families to have changed their child's care and education arrangements two or more times in the past 12 months (20.4% vs. 11.2%).

Transition to Kindergarten.

The transition from home, preschool, or child care into Kindergarten is a key milestone in children's early learning and development. In focus groups, many families expressed concerns that their children would not experience quality in the transition to Kindergarten, and some cited examples of challenges they had encountered with their older children. They worried about the length of the school day and whether their child could stay focused and engaged for

such a prolonged period of time. Relatedly, some families worried that activities in Kindergarten are too structured and that their child would not be allowed to play, explore, and be creative. A few described a perception that there is an overemphasis on testing and assessment in Kindergarten.

> *"And is she going to be able to sit there and focus? I mean that's a lot of sitting for such little minds, and they have cut recess back even more. My son ... he doesn't have hardly any recess."*

Many families expressed a fear that their child would be bullied or mistreated by peers in Kindergarten and that their child's teacher may not appropriately prevent and respond to these issues. For some this was related to a more general concern about communication with their child's Kindergarten teacher and worry that she or he may not be responsive to their needs and concerns.

> *"I guess one thing that I would worry about is just kind of the other kids, I guess. Otherwise I worry about, I don't want him to be a bully but just if he got bullied or because there's some rougher things going in the environment that younger kids are exposed to that I worry about."*

Key informants, who are leaders in organizations across the ECCE system, responded to a survey question about their perceptions of the importance of various factors in preparing children for Kindergarten. Their responses are summarized in Table 28. In general, their responses seem to prioritize activities that ensure that children have the knowledge and skills to meet expectations in Kindergarten classrooms, with moderate emphasis on ensuring that Kindergarten teachers have the knowledge that they need to be responsive to children's needs.

Table 28. Factors in Preparing Children for Kindergarten that Early Childhood Leaders Identify as Important

Factor	% important or very important
How important are each of the following for children's success in Kindergarten?	
Parents read to their children.	100.0
Children with special developmental needs have been identified and received appropriate services prior to start of school.	96.0
Schools hold an open house for parents of entering kindergartners.	90.7
Schools hold an open house for entering kindergartners.	83.7
Parents meet individually with their child's Kindergarten teacher prior to the start of school.	82.6
Children attend preschool (e.g., private preschool, public PreK, Head Start).	80.0

Factor	% important or very important
Records of children's previous care and education are shared with Kindergarten teacher.	73.3
Kindergarten teachers communicate Kindergarten expectations with professionals who work with children birth through 5.	72.7
Children spend time in a Kindergarten classroom prior to the start of school.	68.1
Child’s previous teachers/caregivers meet in person with Kindergarten teacher.	63.6
Kindergarten teachers visit the homes of each student at the start of school.	62.2
Schools have a multiday summer program for entering kindergartners.	36.4
Children receive formal reading instruction prior to entering Kindergarten.	25.5
Schools provide an alternate schedule for kindergartners at the beginning of the school year (e.g., shorter day, staggered start time).	21.4

Respondents to the Early Childhood Program and Leadership survey gave information about whether they engage in various activities to facilitate children’s transition to Kindergarten. As shown in Table 29, the most common types of activities are those that provide opportunities for children and families to get familiar with the Kindergarten classroom. Only a small percentage of providers reported activities that involve communication and collaboration between ECCE providers and Kindergarten teachers.

Table 29. Activities Providers Engage in to Facilitate Children’s Transition to Kindergarten

Activity	% yes
The following activities relate to transitioning children into Kindergarten. Do each of the following activities occur in your program?	
Children will visit a Kindergarten classroom	46.9
There will be a spring orientation about Kindergarten for children	36.7
There will be a spring orientation about Kindergarten for parents of children	33.5
There will be a school/program-wide activity in which children are involved (assemblies, spring programs, etc.)	27.1
We will hold individual meetings with parent(s) of children about Kindergarten issues	26.9
We will share written records of children’s experience and status with elementary school personnel	26.7
We will have contact with Kindergarten teacher(s) about curriculum or specific children	26.2
Teachers will visit a Kindergarten classroom	22.6
A Kindergarten teacher will visit our classroom	15.5

Physical environments.

As part of the stakeholder engagement process, we crafted a definition of “facilities issues,”

which defines the types of physical environments that foster children's healthy development and learning. Factors of an ECCE setting that contribute to the safety, developmental appropriateness, and quality of the physical environment include the following:

- Physical health and safety (including food handling and mealtime, appropriate storage of cleaning products and medicines, sanitizing surfaces, toy and equipment safety, etc.)
- Toilets, sinks, and other fixtures and furniture that are easily accessible to children, including children with disabilities
- Appropriate amount of physical space for the number and age of children being served in each classroom or home for play, education, and nap time
- Playground and outdoor spaces that allow children to connect with nature and promote physical activity
- Bathrooms adjacent to classrooms and to playgrounds when possible
- Appropriate acoustics
- Windows in classrooms and common areas
- Soothing colors, open spaces, and different types of lighting that are comfortable, homelike, and inviting
- Entry ways, common areas, and hallways that foster engagement with other children and teachers

Because the physical spaces of ECCE settings vary significantly, not all of these factors apply to all settings. Overall, 11.7% of providers reported that facilities issues were a barrier to their participation in Step Up to Quality. This number is higher for center-based providers (19.3%) than for home-based (10.6%) or school-based (10.0%) providers, suggesting that facilities issues may be a particular concern for child care centers. Interestingly, providers in remote rural areas are about half as likely to report that facilities issues were a barrier to their participation in Step Up to Quality (6.9%) compared to those in metropolitan (13.2%) or micropolitan (14.4%) areas. This finding is somewhat contrary to national trends, which suggest that the average age of buildings in rural areas is significantly older than in more densely populated areas, which may contribute to facilities issues for rural providers.

Recall that clean, sanitary environment is among the most important factors that respondents to the family survey reported in their consideration of ECCE settings. In focus groups, some families expressed some concern about the poor condition of ECCE facilities in their area. As described in Chapter 3, some families, particularly Black and Latino families, felt torn between choosing a clean, modern facility and one that felt safe and comfortable for them and their child.

Quality and Equity

Equity demands ensuring that children from vulnerable families experience conditions that do not simply match those of their less vulnerable peers but are responsive to their specific developmental needs and buffer against the potential negative effects of adversity (National Association for the Education of Young Children, 2019). "Studies also reveal that participating in

quality early learning can boost children's educational attainment and earnings later in life. Children who attend high-quality ECCE programs are less likely to utilize special education services or be retained in their grade, and are more likely to graduate from high school, go on to college, and succeed in their careers than those who have not attended high-quality preschool programs" (U.S. Department of Education, 2015). Participating in high-quality ECCE has substantial positive impacts on all children's learning (Yoshikawa et al., 2013). Knowing this, it is critical to target and overcome barriers that cause inequitable access for children from vulnerable families in order to eliminate disparities and avoid increasing gaps in opportunity and achievement.

As described above, our findings suggest that vulnerable families are less likely to experience various provisions that support quality experiences for their children, such as continuity of care and frequent engagement with their child's caregiver. These conditions can compromise quality of children's learning and development, as children are required to undergo multiple transitions in a given day or week, and they may not have the opportunity to form trusting relationships with caregivers.

Although licensure is not necessarily a direct indicator of quality, it is worth noting that vulnerable families are more likely than others to report using unlicensed care. A total of 37.5% of vulnerable families indicated that their ECCE provider was unlicensed, while 27.0% of nonvulnerable families indicated that their ECCE provider was unlicensed. As noted in Chapter 2, vulnerable families are also more likely to use home-based providers. This means that vulnerable families receive care and education from providers who have the least access to professional development opportunities that might improve quality (i.e., home-based providers and unlicensed providers).

Discussion: Gaps and Opportunities

Definition.

There is a clear need to align disparate definitions of quality and disseminate them widely. In the needs assessment, families' perceptions of quality, such as having providers who are warm and kind, is in alignment with the definition of quality that emerges from the experiences of the child. The relationship of trust, caring, respect, and understanding a child has with his or her ECCE provider involves and impacts all areas of development (Center on the Developing Child, 2016; Darling-Hammond & Cook-Harvey, 2018; Hamre & Pianta, 2001). Elevating understanding of quality as what the child experiences, along with understanding the provisions that support quality ECCE, will help programs align around how to improve ECCE in communities.

Provisions for quality.

Families. Results show that ***parents' definition of provisions of quality involves meeting their child's behavioral and social-emotional needs***. In connection to this, evidence supports that quality early care and education demands taking a comprehensive view of each child's academic and developmental needs. This concept is commonly referred to as a focus on the whole child by recognizing the interrelationships between all areas of development, including

social, emotional, cognitive, language, and physical. A whole child approach also focuses attention on children's access to nutritious food, health care, and social supports. Learning is maximized and children's development is best supported through attention to the notion that all aspects of the whole child are connected and supported.

Parents are instrumental partners in children's learning, so providing parents with opportunities to develop understanding of child development and strategies to support their children's learning yields positive impacts. Needs assessment results show that parents value opportunities to talk with educators about their children's development. However, families reported having few conversations with providers about their children's development and learning. Evidence demonstrates that quality early care and education programs that approach child development from a two-generation approach (reaching both children and their parents) see more positive learning and developmental outcomes for children (Teti et al., 2017). Building providers' capacity to partner with families in supporting children can be addressed in many activities, most importantly in the initial and ongoing training of providers.

Providers. From the provider survey and input from key informants and other stakeholders, it is clear that Nebraska needs to elevate the early childhood workforce and recognize the professionalism of all. A goal from the Nebraska Early Childhood Workforce Commission states that Nebraska's early childhood workforce will be highly qualified and will reflect the diversity of the children and families they serve. To address this goal, it is recommended that a framework be developed that (1) defines shared terminology for professional roles, (2) establishes a common set of core professional competencies for all professionals working with children from birth through Grade 3, and (3) identifies entry-level requirements for early childhood professionals across all settings. Nebraska's future depends upon the state defining and supporting high-quality early childhood experiences and professionals, no matter the setting.

The Nebraska Early Childhood Workforce Commission recommends that the state develop professional pathways that are affordable and accessible in order to recruit and retain a diverse early childhood workforce. This would include explicitly defining the competencies needed for professionals upon entry into the field—and, over time, defining competencies for specialized roles within the field—allowing clear delineation of career pathways for all professionals in the field.

Overall, providers reported not accessing professional development at rates that increase the likelihood that children experience quality in ECCE settings and that available opportunities are not accessible to providers across all settings. In particular, there is a need to expand access to professional development opportunities for home-based providers, as these providers reported the greatest gaps in accessing professional learning. To close this gap, professional learning opportunities must be designed to be relevant to the home-based providers, offered at times that are feasible (often evenings and weekends), and advertised in ways that will effectively reach the intended audience. Our current family child care study (referenced in the

Introduction to this report) provides some insight into effective strategies for supporting home-based providers, but more focused effort is needed.

Efforts are underway in the state to increase and cross-train early childhood coaches in several communities. However, most providers still do not have access to coaching support. Nebraska would benefit from investing in the regional early childhood infrastructure to spread and deepen coaching capacity and improve quality and equity.

Related to this, providers do not feel equipped to provide quality care to children who need intensive emotional and behavioral support. Expanding and enhancing access to professional supports that increase providers' capacity to support children's social and emotional development, with a focus on home-based and urban providers (who reported lowest levels of access to these types of services) could improve providers' skills and address families' desire for care and education that serves the whole child.

Communities. Families reported significant challenges related to continuity across their children's ECCE settings, with greater challenges for vulnerable families. More vulnerable families reported having more ECCE setting arrangements and more frequent changes in settings. Communities can address these issues by examining ways to provide ECCE with the flexibility to meet families' work needs. To support these efforts, state and local systems can ensure that this flexible care is affordable for all families.

System-wide, families and ECCE providers are seeking assistance with understanding what is needed to prepare their child for Kindergarten. Schools and community-based programs do not typically share that information with families, nor do they engage in many practices to support children in the transition to Kindergarten. It is clear that Nebraska needs a better understanding of what supports children and families need to ensure success in Kindergarten, as well as how schools and community programs can provide that support.

Finally, the needs assessment findings present several opportunities to improve Step Up to Quality. First, the definition of quality that underlies this system should be aligned to the definition of quality described above, with an emphasis on ensuring that each child experiences quality care and education, regardless of the setting. Findings also identified challenges with providers' awareness of the Step Up to Quality program and motivation to participate. A large proportion of the providers who responded to the survey reported that they were not aware of the program, and many felt that the costs of participation far outweighed the benefits. These concerns can be addressed by minimizing administrative burdens associated with program participation and maximizing benefits. The large upfront investment of time and energy that is currently required to access program benefits may be too large a hurdle for some providers.

As mentioned above, Step Up to Quality has the potential to be a powerful mechanism for aligning and expanding coaching to improve quality. Currently, quality improvement resources available through the program may not be reaching providers in most need of support because these resources are not accessible until providers reach Step 3. Greater focus on improving the

quality of children's experiences, with complementary supports to advance through the administrative processes required for each step, could enhance the impact of this system.

Chapter 5: Alignment and Coordination in Nebraska's Mixed Delivery System

Many of the needs and gaps identified in previous chapters call for enhanced alignment and coordination: productive collaboration among the multiple organizations that support young children and their families; tighter alignment of the many programs and initiatives that work to improve access and quality within the mixed delivery system; data systems that allow for efficient sharing of information for program evaluation and improvement; and policies that adequately support the system and remove unnecessary barriers.

Current Efforts to Promote Collaboration

Key informants discussed a variety of current efforts that promote collaboration within Nebraska's mixed delivery system. Statewide initiatives like Bring Up Nebraska and Communities for Kids have fostered collaboration at the community level. Bring Up Nebraska helps communities develop long-term strategies to reduce the number of families in crisis by bringing the critical players in the community to the table. One key informant shared

> *"Bring Up Nebraska is about helping communities come together and do a service array and decide what their gaps are across the lifespan of zero to 24 for well-being. So that's one area where that's all about collaborating in a community and identifying the goals together and getting them all around the table."*

The Communities for Kids project is another effort to help communities build better systems to meet the needs of families and increase the supply of quality early learning environments for children. The program helps facilitate the conversation among a community's public and private organizations and provides expertise, tools, and resources to the community to support the creation and implementation of solutions to child care shortages (NCFF, 2019). Another initiative that promotes collaboration is Rooted in Relationships, which partners with communities to implement evidence-based practices that enhance social-emotional development for children birth to age 8.

In addition to these programs, Nebraska's signature infant-toddler program is the Sixpence Early Learning Fund, a public-private partnership that promotes high-quality early care and education. Sixpence supports statewide and community-level collaboration, with an emphasis on school district leadership at the local level. It provides grants to support family engagement, home visiting, center-based early care and education, and partnerships between schools and licensed child care programs. Under the Sixpence model, services are supported through a combination of state funds, federal Child Care Development Fund (CCDF) money, and/or the proceeds of a $60-million endowment created by $40 million in state money and $20 million from private donations. Grant recipients are required to provide a 100% match to ensure local investment in the programs (Sixpence Annual Report, 2017 – 2018).

Key informants also discussed how the implementation of the Nebraska Early Childhood Pyramid Model for Supporting Social/Emotional Competence supports collaboration.

"One of the things that comes to mind is the implementation of the Pyramid as a social-emotional support. That's a strong collaboration between Nebraska Children and Families Foundation, Step Up to Quality, which is our QRIS system at NDE, and through the office through CCDF and our special ed office for preschool, and Head Start. So, across those programs we're trying to implement the Pyramid, we're leveraging our funding. We have a collaborative internal team that's made up of the administrators from all the organizations I just mentioned."

Key informants were also asked to list the agencies and organizations in Nebraska that support collaboration. They mentioned the following:

- Early Childhood Interagency Coordinating Council (ECICC), which advises and assists collaborating agencies in carrying out the provisions of state and federal statutes pertaining to early childhood care and education initiatives under state supervision. https://www.education.ne.gov/ecicc/
- Nebraska Early Childhood Collaborative operates as the central hub of a shared services network composed of early childhood organizational partners and other industry leaders. Its shared service structure facilitates knowledge sharing, time saving, and cost reduction. https://nebraskaearly.org/our-organization/about-us/
- Nebraska Early Childhood Data Coalition also promotes collaboration by including key stakeholders to explore aspects of early childhood data collections, processes, and reporting in an attempt to connect and develop a comprehensive early childhood data system.
- Nebraska's 29 Early Childhood Planning Region teams serve as interagency coordinating councils made up of local schools, health and human service agencies, Head Start, families, and others that are responsible for implementation of an interagency system of services (Early Development Network, 2017). https://edn.ne.gov/cms/sites/default/files/EDN-PRT-Resource-Guide-Final-October2017.pdf

Key informants also described ways in which Nebraska Children and Families Foundation (NCFF) has been working in communities across Nebraska to support collaboration around a shared vision of strengthening families and communities to promote child well-being. This requires multiple entities—including government, private organizations, business leaders, funders, family, and other stakeholders—working collectively toward a shared vision for community well-being and desired outcomes for all in a community. These Community Collaboratives review community-level data revealing strengths and challenges, then develop a local plan to support improved outcomes. Each community has identified early childhood services as an integral part of its work, with one or more committees focused on birth to 5.

Key informants discussed people and roles in the state of Nebraska that support coordination. The Early Learning Connection coordinators are fundamental in providing access to

comprehensive professional and development opportunities for ECCE providers in their region. One key informant shared

> "*They are the people that sort of broker trainings for child care providers in their communities. They make sure that the trainings they need for licensing are available and make sure those happen, and they're just a good contact. They know who all the providers are, they've been really helpful. And I would say they do a great job too of pulling people together*."

Some programs place parent resource coordinators in medical clinics to provide information and support to families that have children with disabilities and special health care needs and to assist families in accessing needed community resources. There coordinators were also named as a conduit for collaboration in the mixed delivery system.

In the state of Nebraska, coaching has increasingly become important to support teachers and adults working with young children and families (Jayaraman, Knoche, Marvin, & Bainter, 2014). Coaches are utilized across a variety of early childhood contexts (e.g., Sixpence Early Learning Fund, Nebraska Department of Education Pyramid Project, Step Up to Quality, Go NAP SACC). These coaching projects include both private, local, and state initiatives, as well as federally funded projects such as the coaching associated with Head Start Programs. Since 2009-10, key stakeholders have worked collaboratively to support coach training and development, including a semi-annual coach training to provide foundational coaching skills and competencies (Schachter, 2019).

Table 30. Key Informants' Familiarity with Approaches for Promoting Collaboration

Approach	% not at all familiar	% somewhat familiar	% very familiar	I am involved in administering this project/initiative
Please indicate your familiarity with each of the following approaches for promoting collaboration between providers.				
All Our Kin	75.5	17.0	7.5	0.0
Communities for Kids	52.8	20.8	17.0	9.4
Bring Up Nebraska	68.6	21.6	7.8	0.02
Early Childhood Training Center	18.9	17.0	52.8	11.3
Rooted in Relationships	32.1	24.5	34.8	7.5
Sixpence school-child care partnerships	3.8	32.7	44.2	19.2
Nebraska Early Childhood Collaborative	7.7	40.4	32.3	9.6
Planning Region Teams	24.5	18.9	39.6	17.0
Early Learning Connection Coordinators	18.9	20.8	39.6	20.8

The key informant survey asked providers to indicate their familiarity with various approaches for promoting collaboration between providers. Several approaches were fairly widely known, including those that have been in place across the state for several years, such as the Early Childhood Training center (53% very familiar), Sixpence school-child care partnerships (39% very familiar) and Planning Region Teams (40% very familiar). Newer approaches such as All Our Kin (8% very familiar), Bring Up Nebraska (8% very familiar), and the Superintendents' Early Childhood Plan (14% very familiar) were the least familiar among key informants. See Table 30 for details.

Collaboration Among Early Childhood Care and Education Providers

Responses to the PDG provider survey suggest that there is minimal partnership among schools and ECCE providers, and very little true collaboration. A little over half (52.8%) of the early childhood care providers reported that they work with schools to provide before- and after-school care; 48.6% of providers responded that the school provides special education services for some of their children. Fewer providers reported that they collaborate with schools on offering one or more of their classrooms together (13.4%) and on teachers representing families at parent-teacher conference/meetings (16.8%). See Table 31 for details.

Table 31. Providers' Collaborative Activities with Schools

	% yes			
Activity	Overall	Home-based	Center-based	School-based
Which of the following characterize your relationship with the local school district?				
We plan transitions for children moving to preschool or Kindergarten.	34.6	20.7	48.0	84.0
The school(s) provide special education services for some of our children.	48.6	29.4	74.6	92.6
We engage in professional development activities together.	26.5	12.9	36.0	82.2
We communicate about children who attend both our programs.	36.8	17.8	58.8	88.1
We coordinate transportation.	27.8	15.0	40.8	66.4
We provide care and/or enrichment activities for children during school breaks.	38.4	32.1	55.8	30.8
We provide before-and-after care.	52.8	53.2	62.7	27.6
Teachers represent families at conferences/meetings.	16.8	7.4	20.8	58.3
Teachers participate in IFSP/IEP meetings.	28.3	9.4	45.3	88.1
We collaborate to offer one or more of our classrooms together.	13.4	4.5	17.8	51.3

Findings on Collaboration Within the Mixed Delivery System

Overall, providers reported that professionals in their programs are most likely to receive training online (72.3%), from the Early Childhood Training Center (69.5%), and from their Educational Service Unit (66.2%). Home-based providers are most likely to receive training from the Early Childhood Training Center (56.1%) or from an online source (48.3%). Similarly, caregivers in center-based providers are most likely to receive training from an online source (82.6%) or from the Early Childhood Training Center (81.0%). However, school-based providers are most likely to receive training from their Educational Service Unit (84.9%), an online source (84.6%), or from their local school or district (81.3%). See Table 32 for details.

Table 32. Providers' Reports of Sources for Professional Development Training

	% yes			
Source	Overall	Home-based	Center-based	School-based
In the past year, have caregivers in your program received training from any of the following groups or organizations?				
Online training from any source	72.3	48.3	82.6	84.6
Early Childhood Training Center	69.5	56.1	81.0	62.9
Educational Service Unit	66.2	44.3	73.0	84.9
Providers' network in your community or area	45.0	41.2	49.0	40.5
Nebraska Cooperative Extension	40.2	33.9	47.9	31.4
Coaching or mentoring from a trained coach	35.0	17.9	39.3	46.0
Local school or district	33.1	12.9	23.5	81.3
Early Learning Connection Partners	22.0	15.9	26.7	15.3
Nebraska AEYC	19.9	11.8	29.7	9.2

As seen in Table 33, child care programs are most likely to receive child care information, support, or services from the Early Childhood Training Center (66.0%), their Educational Service Unit (59.6% *n*=722), or from the University of Nebraska Cooperative Extension (52.8%). Fewer programs receive information, support, or services from Planning Region Teams (15.4%) and other organized child care support or training efforts (16.9%). More specifically, home-based (64.6%) and center-based (74.8%) programs are most likely to receive child care information or support from the Early Childhood Training Center. However, school-based programs are most likely to receive child care information or support from their Educational Service Unit (86.6%). Stakeholder feedback suggests that Early Learning Connection Coordinators play a more central role than these data suggest, and perhaps providers are unaware of which organizations actually sponsor and coordinate the professional development sessions that they attend.

Table 33. Providers' Reports of Sources for Child Care Information, Support, or Services

Source	% yes			
	Overall	Home-based	Center-based	School-based
Do you or your child care program receive child care information, support, or services from any of the following?				
Resource and Referral Agency	21.7	19.5	20.1	36.4
Educational Service Unit	59.6	50.8	70.9	86.6
University of Nebraska Cooperative Extension	52.8	49.5	60.9	56.8
Early Childhood Training Center	66.0	64.6	74.8	62.3
Early Learning Connection	43.1	39.1	50.8	47.0
Planning Region team	15.4	7.8	17.4	51.7
Teacher or provider network in your community or area	26.1	18.8	29.6	59.5
Other organized child care support or training effort	16.9	15.0	19.3	17.2

Helps and Hindrances to Collaborations

Key informants described several factors that support collaboration with other organizations, including a shared vision and mission, effective communication, aligned and collaborative funding, existing relationships, and allotted time. They also described factors that hinder collaboration with other organizations including competition between organizations, lack of time to meet, lack of staff and/or capacity, restrictive or limited funding, location or distance between organizations, and lack of awareness or understanding of other organizations' roles and what they offer.

Integrated Data Systems

In 2016-17, the Early Childhood Data Coalition (ECDC) subcommittee of the PDG leadership team examined available data in administrative data systems about the status of Nebraska's young children. The ECDC examined potential gaps in data that, if addressed, could help policymakers and community leaders craft evidence-based policy to support young children in Nebraska. The ECDC identified 27 indicators across five key areas that impact children's development, as summarized in Table 34. The aim of this effort was to identify indicators that could set the stage to develop a coordinated Early Childhood Integrated Data System (ECIDS) in the state to answer critical policy questions about public early childhood care and education.

Table 34. Early Childhood Integrated Data System Indicator List (2017)

Category	Indicator
Health and Safety	
Prenatal care	% babies receiving adequate or greater prenatal care
	% infants born at low or very low birth weight
Breastfeeding	% mothers reporting ever breastfeeding their infants
Intended and teen pregnancies	Teen birth rate/1,000 female teens 14 – 19 years (expand to 10 – 19 years)
Early medical care	% children <36 months who have received the 4:3:1:3:3:1:4 immunization series
Medical insurance	% children under 6 without health insurance
Contaminants	# children with elevated blood lead levels
Learning and Development	
Social-emotional development	% meeting expectations in GOLD social-emotional area
Language development	% meeting expectations in GOLD language development area
Reading	% with 3rd grade NSCAS English language arts proficiency
	% of 3rd grade children who had PreK (anyone in state-funded early childhood program) reading proficiency
Math	% with 3rd grade NSCAS math proficiency
	% of 3rd grade children who had PreK math proficiency
Families	
Child abuse	# substantiated victims of child maltreatment 0 – 8 years
Access to out-of-home care	Children 0 – 8 in out-of-home care rate/1,000 (3a cases)
Upward mobility	% children <6 living at or above 185% FPL
	% children under 6 below 50% FPL
	% children under 6 living between 50 – 99% FPL
	% children under 6 living between 100 – 149% FPL
	% children under 6 living between 150 – 184% FPL
Education	
Public school involvement	# children enrolled in public school PreK
	# districts offering public PreK
	# FRL children enrolled in public school PreK
Quality Rate and Improvement System involvement	# of sites enrolled in QRIS
Workforce	
Early childhood workforce	% of teachers reporting race as white
	% of early childhood teaching staff with B.A./B.S. degrees
	Median hourly wage

Note: FPL = Federal Poverty Level; NSCAS = Nebraska Student-Centered Assessment System; QRIS = Quality Rating and Improvement System

Many of the indicators on this list are helpful in understanding individual and family vulnerability factors experienced by the birth to 5 population in Nebraska. Some of the indicators capture useful information regarding how young children are prepared for and are performing in school by the third grade, painting a picture of the outcomes of their early experiences. Other indicators describe in part how the ECCE system is equipped to provide high-quality ECCE services.

The strengths of these indicators include that they are consistently available data; they are evidence-based indicators of current and future well-being; and they reflect areas of potential impact with the goal of change and improvement.

While these indicators could be used to describe or identify the vulnerable, underserved, and rural populations in Nebraska, they unfortunately do not capture many of the conditions experienced by those populations that impact the children's long-term outcomes. This list of indicators does not describe the many elements and interconnections of the ECCE system that would be instrumental in improving the availability, access, and quality of ECCE services. Additionally, the indicators are based on data from multiple, uncoordinated sources at NDHHS and NDE. These indicators do not reflect the breadth and depth of outcomes that are being targeted by the PDG needs assessment and, eventually, the strategic plan. Therefore, to track the impact of efforts under the PDG, the state needs an expanded list of indicators.

Community Assessment Tool.

In 2019, Nebraska completed a feasibility analysis about implementation of a Community Assessment Tool (CAT), which will provide useful, accurate, and timely data related to early childhood programs and services at the community level. Previously isolated data sources will be available in a single interface that provides a full description of the community's needs and program availability. The data are organized around four types of information: Eligibility, Access, Services, and Impact (EASI). The EASI framework allows community leaders and providers to examine issues across the four topics and from that identify action steps to meet the needs of families and children.

Initially, the targeted users of the CAT will be agency service providers and key program staff involved in providing program decisions and priorities. Users will include key staff from NDHHS and NDE, researchers, and representatives of ECCE nonprofit organizations, program providers, and institutions of higher education.

After the CAT has been established and functions as expected, secondary users of the tool will include community leaders, parents, policymakers, state administrators, childcare providers, teachers, program directors and staff, grant writers, and funders. Funding for the implementation of the CAT was released by NDE in 2019 under the PDG. A minimal viable product is currently in development.

Key indicators and the design of Nebraska's Early Childhood Integrated Data System.

As part of the PDG needs assessment and strategic planning processes, Nebraska has developed a strategy to define the priority indicators that will track the identified PDG outcomes and take significant steps forward in developing its ECIDS.

The Key Indicator/ECIDS strategy will focus on the PDG outcomes that are at the center of the PDG strategic planning process. In addition to identifying indicators that will describe changes in the system and in the population of young children over time, the Key Indicator strategy will identify the performance indicators that will track progress along a strategic path for integrating and strengthening the state's early learning B-5 mixed delivery system. Therefore, the performance indicators identified for the PDG Strategic Plan will be fully aligned with the Key Indicators used to track the outcomes in the ECCE system and for children.
The process of developing both the Key Indicator list and the ECIDS design is centered on a stakeholder engagement process with members of the Early Childhood Data Coalition.

The ECIDS team asked ECDC members to 1) identify what they as stakeholders, data experts, and data users want to be able to measure to track progress in improving the early childhood mixed delivery system and 2) name indicators that could meaningfully measure progress toward desired outcomes. After integrating responses to the first request, progress was made toward defining outcomes and potential indicators in five categories: parents, the early childhood mixed delivery system, community, state-level systems, and children. This led to the development of draft definitions and metrics related to the outcomes. Select ECDC members were interviewed by phone to review the draft definition and metrics. Their responses were captured and integrated.

In October 2019, an ECDC meeting was held in Lincoln for an in-depth discussion of the core definitions, the draft indicators, and the operational questions addressed by the indicators that were identified for the five categories of outcomes. This discussion represented a significant step forward in Nebraska's ongoing efforts to track meaningful outcomes for children and the ECCE system. The output of the meeting will:

- be expanded and aligned to the goals and objectives of the PDG Strategic Plan;
- provide clarity to the focus of the ongoing needs assessment and strategic plan implementation activities;
- allow for the alignment of how data is gathered and reported for decision makers in the newly emerging Community Assessment Tool; and
- establish the basis for defining and visualizing what the Nebraska ECIDS will provide.

The ECDC Indicator Subcommittee will continue its work through January 2020 to refine the list of Key Indicators.

As the first phase of work is completed, the Key Indicator/ECIDS project will shift into an analysis of the more technical requirements for developing an ECIDS. This phase of work will involve a variety of data managers, users, and experts. These experts will be engaged in a deep-

dive analysis of these indicators, available measures and data for those indicators, and policies and technical issues through a series of data use case and data governance workgroups. The results of those workshops will be a long-term road map for the creation of the ECIDS that Nebraska envisions for the future.

Nebraska has defined the planned ECIDS as follows:

ECIDS collects, connects, integrates, and reports information from early childhood programs across multiple agencies and organizations across the state that serve children and families from birth through age 8. ECIDS enables (1) better collaboration and coordination across service providers to families and children, (2) informed decision making to achieve common goals and outcomes in the communities, (3) continuous improvement of service excellence, and (4) magnified collective impact.

- Nebraska is planning to use a hybrid, federated architecture for its ECIDS, taking advantage of existing centralized resources at NDHHS and NDE, while connecting and linking data from those and many other systems.
- Specific views of the data will be provided to support parents and the public with pertinent aggregate and summary data; to support operations and cross-agency case management with unified individual data; to support decision makers with timely, actionable data; and to support research and data analysis needs with anonymized longitudinal data.
- The design of ECIDS will ensure the highest level of security across the various systems, while being maximally restrictive as to who may access the most sensitive information, protecting the privacy of parents and their children.

The road map for development of ECIDS will be integrated into the PDG Strategic Plan.

Funding and Policy Barriers That Limit Access to Quality Early Childhood Care and Education for Vulnerable Families

The needs assessment team, in partnership with First Five Nebraska, examined the funding and policy barriers to providing quality ECCE, as well as barriers to integration and interagency coordination in three ways:

- PDG key informant interviews and survey
- A policy landscape analysis in collaboration with the Pritzker Children's Initiative
- Analysis of findings of the Nebraska Early Childhood Workforce Commission's recent *Elevating Nebraska's Early Childhood Workforce* report (public release January 2020)

About the Policy Landscape Analysis

In collaboration with the Pritzker Children's Initiative, a planning grant focused on significantly improving the healthy development and school readiness of Nebraska children from the

prenatal period to age 3, the PDG team analyzed more than 130 policies related to providing high-quality ECCE services and essential services to Nebraska's vulnerable children.

The Pritzker Children's Initiative landscape was expanded, consistent with PDG federal guidance to address policies related to children's and families' access to essential services for early childhood development and to include children up to age 5.

Policies relevant to the scope of PDG included in this analysis were state statutes, administrative codes, and specific program policies that implement both statutes and codes. The analysis included the following steps:

1. All of the policies were categorized by the nine objectives of the PDG framework, which were derived from the PDG domains in federal guidance and refined by stakeholders as part of the needs assessment process.
2. Each policy was coded to reflect whether it was a funding, policy, or practice barrier to:
    a. The provision of high-quality ECCE services
    b. System integration or interagency coordination

The team identified three broad types of barriers:

- Funding policy barriers are the restriction of the amount or use of funds that limit access to or provision of services or system integration. Budget action is required for change.
- Policy barriers occur when state statute or administrative code intentionally or inadvertently limits access to or provision of services or system integration. Legislative or administrative action is required for change.
- Practice barriers occur when implementation of a program (public or private) through rule or organizational policy impedes the provision of services or system integration. No legislative action is required to make a change for these barriers.

Given that the starting place for this policy landscape analysis included statues, codes, and program policies, when the coding was completed, not all of the PDG objectives had relevant policies. Objectives 6 (transitions) and 7 (collaboration) do not appear in this analysis.

Policies related to providing high-quality early childhood care and education services.

OBJ 2. Describe availability and accessibility to high-quality ECCE services for vulnerable populations.

Key Informants, through interviews and surveys, identified systemic barriers to access of high-quality ECCE services. The two most common systemic barriers identified were:

- The need to strategically set eligibility in ways that support families' access to quality child care (i.e., not be priced out)
- The child care subsidy not covering the cost of providing high-quality care that meets the developmental needs of young children

Other systemic barriers identified included:

- Gap in funding for 3-year-olds due to current policy on PreK funding
- Insufficient availability in the system (not enough slots; more funding would provide more slots)
- Differences in eligibility requirements for essential services
- Restrictions on how money can be spent
- School district funding (funding is tied to age of children 4–21)
- Policies are not aligned across different agencies

Table 35. Key Informants' Ranking of Barriers that Limit Access to Quality Early Childhood Care and Education for Vulnerable Families

Barrier	Median rank	SD
In your opinion, what are the most significant systemic barriers that limit access to quality ECCE for vulnerable families?		
The general public does not understand the importance of early care and education.	3	3.44
Policymakers and community leaders do not understand the importance of early care and education.	4	3.07
Lack of public investment in quality infant and toddler care.	4	2.91
Difficulty recruiting highly qualified ECCE professionals to settings that serve the most vulnerable children.	4	3.02
Child care subsidy rates are inadequate to provide quality care and education.	5	2.09
Child care subsidy restrictions make it difficult for providers to offer the flexible care that vulnerable families need.	6	2.4
There is no system for families to find affordable, quality care.	6	3.05
Eligibility and application requirements for various forms of subsidized care and education (Title XX, Head Start, PreK) are inconsistent and difficult to navigate.	7	2.5
Financial disincentives for family child care homes.	9	2.56
Licensing requirements create disincentives for providers to serve vulnerable families.	10	2.56
Subsidy requirements create disincentives for providers to serve vulnerable families.	11	2.42

Key informants responded to survey items about the most significant barriers that limit 1) access to quality services for vulnerable families and 2) improving quality in the ECCE system. For both of these questions, the highest-ranked barriers pertain mostly to lack of understanding and public investment in early care and education (see Tables 35 and 36). The lack of funding is

an issue for most states for providing access to and improving quality ECCE. But the high ranking of lack of knowledge for the importance of high-quality ECCE (in parents, community leaders, and policymakers) is an easier barrier to address. Improved information channels and dedicated communication campaigns can address both the importance of ECCE and a better understanding of what constitutes high-quality ECCE.

Table 36. Key Informants' Ranking of Barriers to Improving Quality in the Early Childhood Care and Education System

Barrier	Median rank	SD
In your opinion, what are the most significant barriers to improving quality in the ECCE system?		
Limited funding to support quality improvement.	3	2.6
Families do not understand what constitutes quality ECCE.	4	2.9
Policymakers and community leaders do not understand what constitutes quality ECCE.	4	2.63
The public does not view ECCE providers as professionals.	4.5	2.85
ECCE providers do not understand what constitutes quality ECCE.	6	2.94
Child care subsidy rates are inadequate to provide quality care and education.	6	2.4
Lack of professional development opportunities for family child care homes.	7	3.81
Licensing requirements do not capture essential provisions for quality.	7	2.8
The physical environment and facilities in many ECCE settings are not conducive to quality care and education.	8.5	2.87
Few providers have access to coaching.	9.5	2.43
Step Up to Quality does not measure things that matter most for quality.	11	2.6
Step Up to Quality does not offer adequate incentives for providers to participate.	11	2.96

Another notable feature of these data is the large range of responses for each potential barrier. This suggests that there may not be strong consensus among ECCE leaders about the best approach to removing barriers to improve access and quality. Data from key informant interviews yielded similar results, as responses to questions about systemic barriers yielded a wide range of answers with very few common themes across respondents.

The team examined a range of policies related to increasing access to ECCE services and making system changes intended to improve the quality of services:

- Policy changes to the child care subsidy and reimbursement rates would address the funding barriers to ECCE services.

- Policies that restrict certain provider types (home-based) from receiving the child care subsidy and tax credits are primarily funding and practice barriers that reflect limited coordination across three agencies.
- Funding, policy, and practice barriers prevent the integration efforts of expanding Sixpence child care partnerships across the state (focus on school/child care collaboration).
- Multiple policy changes related to improving quality of ECCE and the ability to adequately track and report on quality across the system were identified.
    - Policy changes necessary to implement revisions to Step Up to Quality, the state QRIS system.
    - To achieve greater alignment among coaching programs across the state, policies may be pursued that will both improve quality of care and require interagency coordination.

Policies related to parent engagement and support.

OBJ 4. Understand how families make choices about ECCE and how they are involved in their child's care and education.

Policies also have the ability to impact and encourage nurturing and responsive parent-child relationships. The policy review and analysis in this grouping focused on supporting parent knowledge of child development and environmental factors that may take a parent's focus away from their child's development:

- Child development trainings for parents (i.e., Circle of Security) and/or participation in the Nebraska Early Development Network (EDN) fulfill all or part of Aid to Dependent Children/Temporary Assistance for Needy Families (ADC/TANF) work requirements for parents with children under 5.
- Increase Early Development Network (EDN) involvement among children 0 to 5 in the child welfare system.

These changes largely face policy and practice barriers and will require interagency coordination to be implemented.

Policies related to state system efficiencies and capacity to support integration and efficiency.

OBJ 8. Assess capacity of Nebraska's administrative infrastructure to support coordination and alignment of ECCE.
OBJ 9. Identify opportunities for greater efficiency in Nebraska's ECCE programs and services.

The Nebraska Early Childhood Workforce Commission has studied a wide range of issues related to improving the ECCE system by building a qualified workforce with the aim of building revenue stability among service providers and supporting investment in high-quality programs delivered by highly qualified professionals.

- The strategy identified and recommended by the commission is a quality-oriented, cost-based approach to financing early care and education and sets funding targets to levels that meet the total cost of high-quality early care and education, including a highly qualified and adequately compensated early childhood workforce.
- The approach places the emphasis on developing funding levels to cover the cost of quality for all children instead of letting quality and access be determined by the funding available.
- A quality-oriented, cost-based approach to full funding builds into the funding system the accountability and measurement of high-quality ECCE services (Step Up to Quality).

The Workforce Commission conducted a comprehensive assessment of the early childhood care and education funding streams (state and federal) in Nebraska.

- The federal and state combined contribution to early care and education in Nebraska was $211.4 million in fiscal year 2017.
- Federally, Nebraska received a total of $134.7 million in funding that was allocated through six different financing mechanisms originating in three agencies of the federal government—the U.S. Department of Health and Human Services, the U.S. Department of Agriculture, and the U.S. Department of Education.
- The State of Nebraska provided a total of $76.7 million allocated through nine different financing mechanisms originating in two agencies of state government—the Nebraska Department of Health and Human Services and the Nebraska Department of Education.

By mapping the financing mechanisms that distribute money to providers, families, and the early childhood workforce, distinctions between financing mechanisms can be identified and places where standards are not coordinated, or are even in conflict, across mechanisms can be highlighted. These misalignments create complexities and costs of compliance with the requirements that demand provider attention, thus drawing their time and energy away from the children in their care. Nebraska will explore options for greater alignment around the same high-quality standards.

Policies related to state system efficiencies and capacity for data integration.

OBJ 8. Assess capacity of Nebraska's administrative infrastructure to support coordination and alignment of ECCE.

OBJ 9. Identify opportunities for greater efficiency in Nebraska's ECCE programs and services.

Assessment of and revisions to data sharing and integration statutes and policies will be necessary as Nebraska moves toward the development of an Early Childhood Integrated Data System (ECIDS). There will be multiple policy and practice barriers to overcome, given that the majority of statutes and administrative policies around the current data systems were created independently and at different times. These will be addressed as the governance structure for ECIDS is created throughout the implementation of the PDG Strategic Plan.

The alignment of funding mechanisms described above will also contribute to integration and efficiency.

Policies related to access to essential services for early childhood development.

OBJ 1. Understand the B-5 population of children and families in Nebraska
OBJ 5. Analyze current mechanisms through which families gain access to full range of essential services.

Statutes and current policies under the first and fifth needs assessment objectives relate to defining who is eligible for services (using the new definition of vulnerability) and providing families the essential services for early childhood development. These policies and statutes address:

- Defining the characteristics of vulnerable (at-risk) children
- Screening and prevention services for maternal and child health
- Children's mental health
- Children with disabilities
- Food insecurity
- Poverty
- Child welfare involvement (trauma and foster care)
- Child tax credits
- Collecting population data

Both policy and funding barriers were identified that, if addressed, would expand the number of children defined to be eligible for services, including:

- TANF and Supplemental Nutrition Assistance Program (SNAP) requirements
- Wage and unemployment policies
- Child tax credits
- Medicaid eligibility definitions and services

Some of these policy changes also would require overcoming policy and practice barriers to interagency coordination or system integration:

- Services for children's and maternal mental health
- Increasing access to Medicaid and WIC services

Working with stakeholders through the time frame that aligns with the initial stages of the PDG strategic planning work (November – December), the policies outlined above will be evaluated for potential impact and prioritized for implementation. Efforts on the prenatal – 3 planning grant will conclude with a report in January 2020. Based on stakeholder feedback and further analysis, the ECICC Task Force assigned to oversee and approve the PDG Strategic Plan will determine which policies are included in the final Nebraska Strategic Plan.

Next Steps: Integrating the PDG Into State Policymaking Processes

The PDG team and other stakeholders have begun to identify some of the steps necessary to integrate the PDG Strategic Plan into policymaking processes, thereby changing the funding, policy, and practice barriers identified here. A key partner in the PDG grant is First Five Nebraska, an organization that focuses on government relations and strategic communications to advocate for children aged 0 to 8. First Five is the recipient of the Pritzker Children's Initiative grant and will provide guidance across the state for policy change. The Nebraska Early Childhood Workforce Commission will form a statewide, multiagency, diverse stakeholder coalition to address its recommendations. This coalition, while focusing primarily on a highly qualified early childhood workforce, will partner with PDG leadership to pursue shared goals.

Nebraska's PDG leadership team will also coordinate with the Nebraska Maternal and Child Health Needs Assessment process. A preliminary list of priorities to include in their state plan will be developed by April 22, 2020. The final assessment will be submitted to the federal government on July 15, 2020.

PDG leadership will take the newly approved strategic plan to the March 2020 Nebraska State Board of Education meeting, discuss needs assessment findings, and begin discussions of how the needs assessment and strategic plan can be utilized by the Nebraska State Board of Education. The Nebraska State Board of Education is an elected body and has numerous strong early childhood advocates. One of the state board members participates in the Nebraska Early Childhood Workforce Commission and has been supportive of its final report. The team will also explore opportunities with the Nebraska Department of Education to utilize PDG findings and future work to inform early childhood components of Nebraska's education accountability system, known as AQuESTT. Building strong accountability into the policy process will allow a stronger focus on high-quality ECCE.

The NDHHS will use the PDG B–5 Needs Assessment and PDG Strategic Plan to inform the development of the Child Care Development Fund State Plan, which will be in effect October 1, 2021 – September 30, 2024. This plan has the potential to address many of the gaps and opportunities identified herein, expanding access to quality ECCE for all families in Nebraska.

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