Maternal Infant Early Childhood Home Visiting Program

Supplemental Information Request for the Submission of the Statewide Needs Assessment Update

Nebraska Department of Health & Human Services

Nebraska Maternal Infant Early Childhood Home Visiting Program

HRSA Grant Award #: X10MC32204

September 2020

Table of Contents

Maternal Infant Early Childhood Home Visiting Program

Supplemental Information Request for the Submission of the Statewide Needs Assessment Update

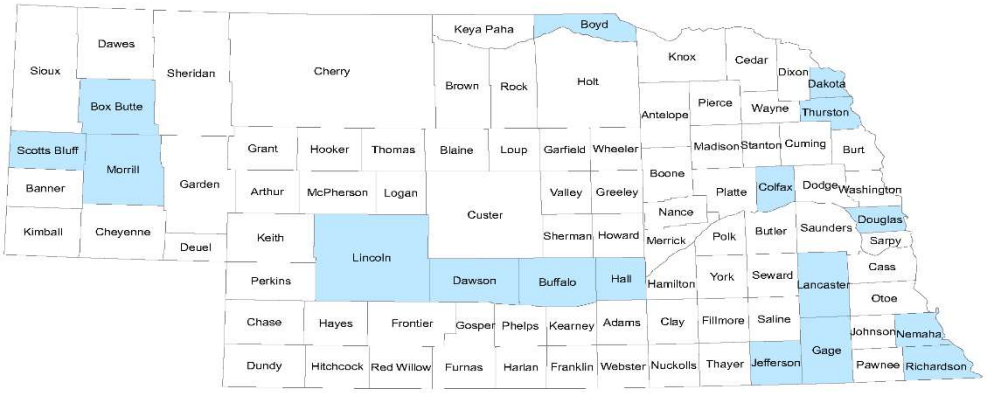
Nebraska Department of Health and Human Services

September 2020

A. *Introduction*

The Nebraska Department of Health and Human Services (NDHHS) conducted a statewide needs assessment for the Maternal Infant Early Child Hood Home Visiting Program (MIECHV) in September 2010. The findings of this needs assessment identified 19 of Nebraska's 93 counties as at risk and that would benefit from evidence-based home visiting services (Figure 1). Since then, Nebraska has used the needs assessment findings to implement seven MIECHV programs serving twenty-six counties.

Figure 1: Nebraska Counties At-Risk, 2010



In January 2019, the MIECHV Supplemental Information Request (SIR) for the Submission of the Statewide Needs Assessment Update was released by the Health Resources Services Administration (HRSA) to each of the states and territories that receive MIECHV funding. The SIR required an updated needs assessment, due on October 1, 2020. The updated needs assessment is linked to Title V Block Grant Funding. The following narrative describes the methodological process and findings of the 2020 updated needs assessment.

B. *Identifying Communities with Concentrations of Risk*

Overview

The first key component of the needs assessment was the prioritization of the communities (counties) at highest risk that would most benefit from home visiting services. To identify at-risk communities, Nebraska implemented the simplified method developed by HRSA that uses nationally-available data standardized for all states. This methodology is based on indices of risk in five domains: low socioeconomic status, adverse perinatal outcomes, child maltreatment, crime, and substance abuse disorder. Indicators in each domain align with the required characteristics described in statute to identify communities at risk. County was chosen as the unit for describing "community" and for the analysis of risk because it is the smallest geographic unit for which reliable data are generally available across Nebraska.

Methodology

The following steps were conducted to determine if a county was at-risk:

1. HRSA provided the Needs Assessment Data Summary to Nebraska in January 2019. The workbook provided data for 2012-2017 by county.

2. The Needs Assessment Data Summary was reviewed by the Nebraska MIECHV team (N-MIECHV) to assess the degree to which the indicators reflected the needs of the population being served by the N-MIECHV program. Staff determined that the list would not identify several of the state's most at-risk counties.

3. Staff researched additional data indicators and sources, based on stakeholder input, MIECHV's priority populations, indicators utilized in the 2010 MIECHV Needs Assessment, and identified four additional indicators. The additional indicators were compared to the Needs Assessment Data Summary. It was determined that three additional indicators would adequately reinforce the existing list:

   a. Percentage of women who obtained prenatal care in the 1st trimester,
   b. Substantiated child maltreatment rates and,
   c. Percentage of veterans aged 18-54.

   One proposed indicator, rate of infant mortality, was not included due to small numbers.

4. While the Needs Assessment Data Summary contained data on reported child maltreatment, there was a significant amount of missing data. To improve the measurement, additional information on child maltreatment was obtained from the Nebraska Division of Children and Family Services (DCFS) for 2016-2017 and converted into rates, using population estimates from 2016-2017 U.S. Census Bureau as denominators for children aged 0-17.

5. The table below shows the final list of 16 indicators by domain, including the additional indicators (in bold).

Table 1. Final List of Indicators	
Domain	**Indicator**
Socioeconomic Status (SES)	Poverty
	Unemployment
	HS Dropout
	Income Inequality
	Veteran Status
Adverse Perinatal Outcomes	Preterm Birth
	Low Birth Weight
	Prenatal Care
Substance Use Disorder	Alcohol
	Marijuana
	Illicit Drugs
	Pain Relievers
Crime	Crime Reports
	Juvenile Arrests
Child Maltreatment	Child Maltreatment
	Substantiated Child Maltreatment

6. The additional indicator data were standardized to a mean of 0 and a standard deviation of 1 using the z-score formula provided in the Needs Assessment Summary Data file, and incorporated into to the domains.

7. While the Needs Assessment Data Summary workbook suggested counties with a Z-score of 1.0 or higher would be identified as at-risk in a domain, Nebraska desired to identify additional counties so modified the selection to the following three criteria:

    a. A z-score at or above 1.0, for at least one-half of the indicators, in two or more of the domains. 17 counties met this criterion.

    b. A z-score at or above 1.0, for at least one-half of the indicators, in one domain, and a z-score between 0.5 and 1.0, for at least one-half of the indicators, in one of more of the remaining four domains. 12 counties met this criterion.

    c. A county did not meet the above criteria, but had been identified in the 2010 needs assessment and is currently serving clients through N-MIECHV funding. 2 counties met this criterion.

Findings

Thirty-one at-risk counties were identified through the indicator analysis. Table 2 lists the counties identified by type and number of domains. The table is broken down into four color-

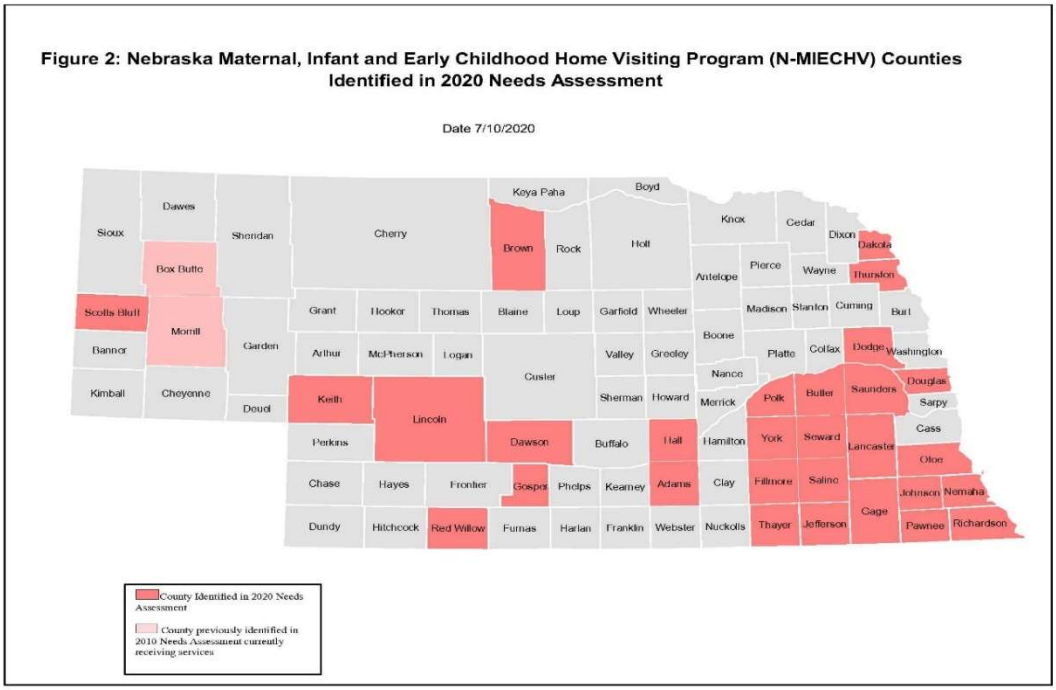
coded categories based on results of the at-risk analysis. Counties were in green were identified in three domains, those in pink in two domains, and those in orange were identified in one domain. Counties in blue were not identified in this current analysis, but had been identified in the 2010 needs assessment and are currently being served by a MIECHV program.

Table 2: At-Risk Counties By Domain

County	Socioeconomic Status	Adverse Perinatal Outcomes	Substance Use Disorder	Crime	Child Maltreatment	Number of Domains
Gosper		√	√		√	3
Keith		√	√	√		3
Lancaster			√	√	√	3
Lincoln			√	√	√	3
Pawnee	√		√		√	3
Dawson			√	√		2
Dodge				√	√	2
Gage			√	√		2
Jefferson			√	√		2
Nemaha			√		√	2
Otoe			√	√		2
Polk			√		√	2
Red Willow			√	√		2
Richardson			√		√	2
Scotts Bluff				√	√	2
Thayer			√		√	2
Thurston	√				√	2
Adams				√		1
Brown					√	1
Butler			√			1
Dakota				√		1
Douglas				√		1
Fillmore			√			1
Hall				√		1
Johnson			√			1
Saline			√			1
Saunders			√			1
Seward			√			1
York			√			1
Box Butte						0
Morrill						0

Figure 2 is a map of Nebraska that highlights the 31 counties identified at-risk. It is evident that there are geographic clusters, particularly in the southeast corner of the state. To further analyze the clusters, maps were created to visualize the identified counties by domain, these maps (Attachment 3) suggest that the 16 counties in the southeast corner of the state were identified by the Substance Use Disorder domain.

Figure 2: Nebraska Maternal, Infant and Early Childhood Home Visiting Program (N-MIECHV) Counties Identified in 2020 Needs Assessment



There are differences between the 2010 and the 2020 counties identified, because of the broader inclusion criteria there are 16 new counties in 2020. In addtion, based purley on the data analyis, there are four counties that are no longer at-risk (Box Butte, Buffalo, Colfax, and Morrill). However, as noted earlier two of the four counites are currenly being served by N-MIECHV (Box Butte and Morrill), so they remain at-risk and are identified on Figure 2 in a lighter shade.

C. *Identifying Quality and Capacity of Existing Programs*

Overview

The second key component of the needs assessment was to determine the capacity within the state, and specifically within the at-risk communities, to provide home visiting services. N-MIECHV engaged the University of Nebraska Public Policy Center (PPC) to conduct a statewide capacity assessment of early childhood home visiting programs. The PPC worked collaboratively with key stakeholders to design a provider survey (Attachment 2, and maintained the stakeholder group to inform data collection, analysis, and interpretation of the survey, as well as collaborate in presenting findings.

Methodology

To assess the state's capacity to provide evidence-based and high quality home visitation services and meet the reporting requirements of the 2020 Needs Assessment, N-MIECHV chose

to conduct a survey of current home visiting services. The following narrative describes the methods utilized in the survey development and deployment.

Development of the Capacity Survey

A survey development team of representatives from organizations that fund and/or provide home visiting services in Nebraska was assembled in December 2019. The following organizations participated on the survey team:

- Nebraska's Head Start/Early Head Start (HS/EHS) Collaboration Office representing Early Head Start programs providers of evidence-based home visiting that promotes high quality early care and education for infants and toddlers.
- Sixpence Early Learning Fund is a public private partner promote school readiness of children ages birth to five from low-income families by supporting the development of the whole child offer home-based services that assign dedicated staff who conduct weekly visits to children in their own home and work with the parent
- Public Health Solutions Health Department receives funding for MIECHV, has had a program since 2014, and continues to successfully implement evidence based home visiting.
- Nebraska Early Development Network (EDN) provides early childhood intervention and/or special education services for children, and incorporates home visits into its delivery model.
- NDHHS/Division of Children and Families representing Child Abuse Prevention Treatment Act (CAPTA). CAPTA supports of prevention efforts, assessment, and treatment activities in Nebraska.
- NDHHS/DPH is the parent agency for the Lifespan Health Services Unit which oversees the MIECHV program, the Office of Maternal Child Health Epidemiology, and multiple programs oriented to families and children, including WIC, Immunizations, and the Title V Block Grant program.

The N-MIECHV Healthy Families America program, HS/EHS, and Sixpence provide the bulk of home visiting services across the state. These programs formed the core team. To begin development of the capacity survey the full team had a kick-off meeting in January 2020 and met approximately every two weeks until the final development of the survey in March. Questions for the survey were developed and refined during these meetings. Using the SIR as a guide, topic areas that were selected for the survey included funding sources, evidence-based models being implemented, curriculum used, number of families and children served, eligibility criteria, counties served, enrollment capacity, and staff attrition. A full list of indicators and a copy of the survey can be found in Attachment 2.

The survey was designed to cover the entire state, however to conduct the needs assessment analysis data was essential for the 31 counties identified at-risk. The team assembled a list of local home visiting programs across the state that totaled 57. To assure proper coverage team members contacted their local programs and implementing agencies to identify all possible home visiting programs in their service areas. This outreach resulted in the identification of fourteen

additional programs for a total of 71 programs asked to respond to the capacity assessment survey.

Survey Deployment

The survey was created and distributed using online survey software (Qualtrics). Following the Dillman Total Design Method, advance notification of the survey was sent to all identified targets on March 11, and an email invitation with a link to the online survey on March 18th and a reminder on March 25. The survey was originally set to close on March 31; however, the launch date of the survey occurred as many public health organizations were facing sudden demands as a result of the COVID-19 pandemic while also transitioning to working from home. Therefore, the survey deadline was extended, with four additional reminder emails sent, and officially closed on May 4. The three funding organizations sent survey participation invitations, and periodic reminder emails, to their programs, the additional programs, and the state's 23 local public health departments

Survey Results

There were a total of 51 non-duplicated responses, however three respondents did not provide home visiting services and so were excluded, leaving 48 responses (a response rate of 67.6%). The following narrative highlights results of the survey:

Extent to Which Programs Meet Needs and Gaps

Regarding the need for services, the vast majority of respondents (85%), believed that there were families who could benefit from home visiting in their area who were not receiving services. Three agencies (7.3%) reported recent reductions in funding that impacted the number of families they could serve. The survey asked about the counties their programs served. Six home visiting programs reported operating in Sarpy County, which is in the east-central region of the state and part of the Omaha metro area, the highest number in any county. While several counties did not have any identified home visiting programs, only five of these were among the 31 identified high-risk counties.

Slightly over half of respondents (54.1%), reported a need for additional home visiting programs in their area. This unexpectedly low perception of need was explored further. Further analysis of at-risk counties showed that those who responded no to this question were counties that had a high enrollment capacity versus those who responded yes which had a low enrollment capacity.

Meeting the Needs of Diverse Clients

Respondents were asked about the ways they meet the needs of diverse clients. Most programs reported the use of brochures and educational materials printed in other languages (72.3%), and the availability of in-person interpreters (74.5%). Most respondents (85.4%) reported having home visiting staff who reflected the population being served and/or having community members or clients involved in an advisory role for the program (87.2%). The most commonly reported other responses were having bilingual staff directly providing services in the clients' language (33.3%), and collaborative efforts with other community programs (27.8%).

Quality of home visiting programs

Quality of home visiting programs is an important topic to assess. Nebraska chose to measure quality by looking at training opportunities, staff turnover, and ease of refilling vacancies, among other things. Home visiting staff reported doing trainings in a variety of topic areas related to home visiting. These topic areas include child abuse/neglect prevention (76.6%), cultural competency (40.4%), communication (27.7%), and infant/toddler development (57.4%). Programs reported their average staff attrition rate at 15% in one year. The average number of days to fill a position is 38. Half of respondents reported the minimum educational required for positions was a bachelor's degree.

Capacity Analysis

The capacity survey yielded important information for the analysis and further prioritization of Nebraska's 31 at-risk communities. There are children and families in each of Nebraska's 93 counties that would benefit from evidence-based home visitation, and any of the communities or programs could likely expand their ability to cover all eligible children (capacity). However, some communities have higher levels of risk and needs (previously described), and among those counties there is considerable variation in the ability to provide new or expanded evidence–based home visitation services. This analysis proposes 12 of the 31 at-risk communities as priorities for the readiness assessment phase, and possible expansion of the N-MIECHV program.

Methods

1. Capacity. To determine the capacity of the community to cover all eligible children, the percent of coverage was calculated as the number of children reported served by the county's program(s) in the past year, divided by the number of children age 0–6 reported in families at 199% of the Federal Poverty Level (FPL).[1] The chosen denominator is the closest available estimate to the income eligibility algorithm used by the state's largest home visiting programs. While there are a number of factors that can make a child or family eligible for services, it was determined that income is the best proxy variable for eligible children, for this analysis. Community-level coverage was calculated for 26 counties; five of the 31 at-risk counties reported no known home visiting services at the time of the survey. The following range was used to determine counties' "coverage capacity":

a. High Capacity = 75–100% of children are covered
b. Medium Capacity = 30–74% of children are covered
c. Low Capacity = 1–29% of children are covered

2. Feasibility of expansion. The survey also helped describe programs' and communities' potential to expand their services. This was assessed through a number of factors, including recent or in-progress expansion of services, program waiting lists, programs who had lost funding, or programs not meeting enrollment targets.

The five counties currently without home visiting programs also have low numbers of young children in families at or below 199% of the FPL. Due to the low population a new program is not likely to be feasible, unless there is a larger economy of scale, for instance an existing program in an adjacent community that could expand to provide services.

Results

[1] American Community Survey, 2014-2018.

The following table displays the findings and recommendations based on the capacity survey and analysis, with 12 counties proposed for the next phase of the MIECHV process, a community readiness assessment. Because these results are informed by a point-in-time survey, the results and recommendations are subject to change over time.

Table 3: Capacity Assessment of At-Risk Communities			
County	**Coverage Capacity**	**Recent/In-progress Expansion OR Not Likely to Expand**	**Proposed for Readiness Assessment**
Fillmore	High	X	
Gage	High	X	
Jefferson	High	X	
Saline	High	X	
Thayer	High	X	
York	High	X	
Adams	Medium		X
Dakota	Medium		X
Dawson	Medium		X
Morrill	Medium		X
Richardson	Medium	X	
Saunders	Medium		X
Box Butte	Low	X	
Dodge	Low	X	
Douglas	Low		X
Hall	Low		X
Johnson	Low	X	
Lancaster	Low		X
Lincoln	Low		X
Nemaha	Low	X	
Otoe	Low	X	
Pawnee	Low	X	
Red Willow	Low		X
Scotts Bluff	Low	X	
Seward	Low		X
Thurston	Low		X
Brown	None	X	
Butler	None	X	
Gosper	None	X	
Keith	None	X	
Polk	None	X	

D. *Capacity for Providing Substance Use Disorder Treatment and Counseling Services*

The federal Substance Abuse and Mental Health Services Agency (SAMHSA) has estimated that 117,000 Nebraskans (7.52%) aged 12 or older suffered from a substance use disorder in the past year, statistically similar to the regional and national averages of 7.4% and 7.5%, respectively. SAMHSA further estimated a single-day count of nearly 6,500 people enrolled in substance use treatment (2015-2017 data). The following section is an assessment of Nebraska's capacity to provide services to N-MIECHV priority populations.

The NDHHS Division of Behavioral Health (DBH) administers and funds public mental health, gambling, and substance abuse services for Nebraska. The majority of these services are directly managed by six Regional Behavioral Health Authorities (RBHA) (see Figure 3 below) that contract with local providers for public inpatient, outpatient, emergency, and community services. DBH provides funding, oversight, and technical assistance to the RBHAs. The behavioral health regions have been in operation since 1974, providing services to all of the state's 93 counties. Their responsibilities include developing provider networks, service coordination, program planning, and the evaluation and quality review of substance-use related services. Each region has an advisory committee that includes consumers, concerned citizens, and representatives from stakeholder agencies. DBH also licenses mental health and/or substance abuse treatment centers that provide shelter, food, counseling, supervision, diagnosis and treatment, and other services for individuals living at the facility for more than 24 hours. The DBH Licensure Unit routinely inspects the centers for compliance and quality. Figure 3 below shows the location of the behavioral health regions in Nebraska.

Figure 3: Behavioral Health Regions

Table 4 shows the number of Nebraska counties in each RBHA and the number of at-risk counties identified in this assessment. All of the counties in Region 5 are considered at risk; however, each region has at least two at-risk counties.

Table 4. At-risk Counties by Behavioral Health Region		
Region	Number of Counties	At-Risk Counties
1	11	3
2	17	5
3	22	2
4	22	3
5	16	16
6	5	2

Types and Numbers of Behavioral Health Providers in Nebraska

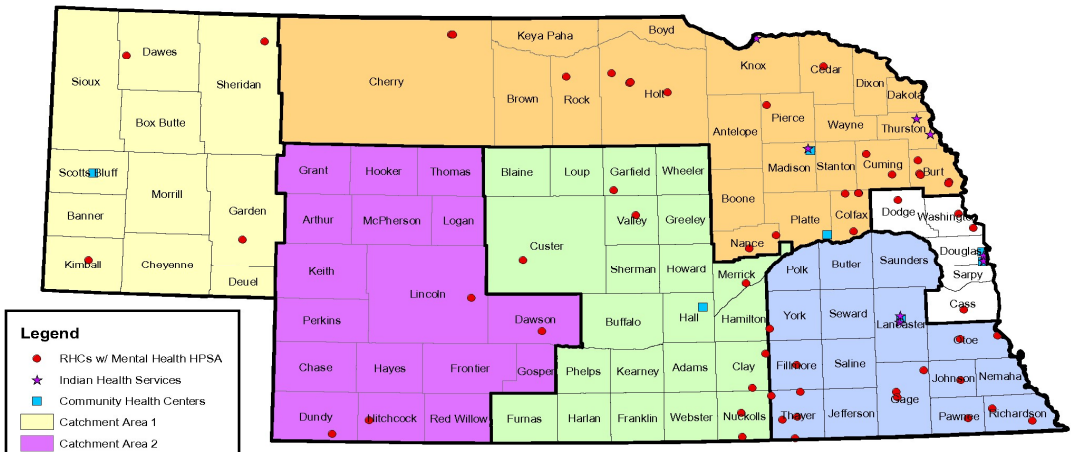
Nebraska has a range of disciplines that provide behavioral health services. Each year the Behavioral Health Education Center of Nebraska, located within the University of Nebraska Medical Center, creates a workforce report outlining the current status of the behavioral health workforce in Nebraska, summarized in Table 5.

Table 5 2018 Nebraska Behavioral Health Workforce Report Results			
Profession	**Practice Full Time**	**Provide Services for Children**	**Counties with Active Practitioners**
Psychiatrist	153	32	12
Advance Practice Registered Nurse	124	31	21
Physician Assistant	15	2	3
Psychologists	369	173	19
Licensed Mental Health Practitioner	705	267	37
Licensed Independent Mental Health Practitioner	582	577	52
Licensed Alcohol / Drug Counselors	447	114	36

Professional Shortages

The majority (95%) of Nebraska's 93 counties are designated shortage areas for Mental Health Providers. It is evident in the maps below that the majority of Nebraska's counties have both federally and state defined shortages of behavioral health providers in all sectors, including psychiatrists, psychologists, and mental health practitioners. The majority of counties with providers are in urban regions, particularly the Omaha metro area.

Figure 4:Federal Health Professional Shortage Areas (HPSAs) Mental Health 2019



Source: Health Professions Tracking Service
https://datawarehouse.hrsa.gov/
K: Rural Health (\\FS1) > Rural Health Intern >
HPSA Federal Deignations > HPSA_2019
Date: January 2019

Cartography: Ryan Ossell | Community & Regional Planning Intern | DHHS
For: Thomas Rauner | Primary Care Office Director
thomas.rauner@nebraska.gov | 402-471-0148

Figure 5: Nebraska Child & Adolescent Psychiatry Shortage Map

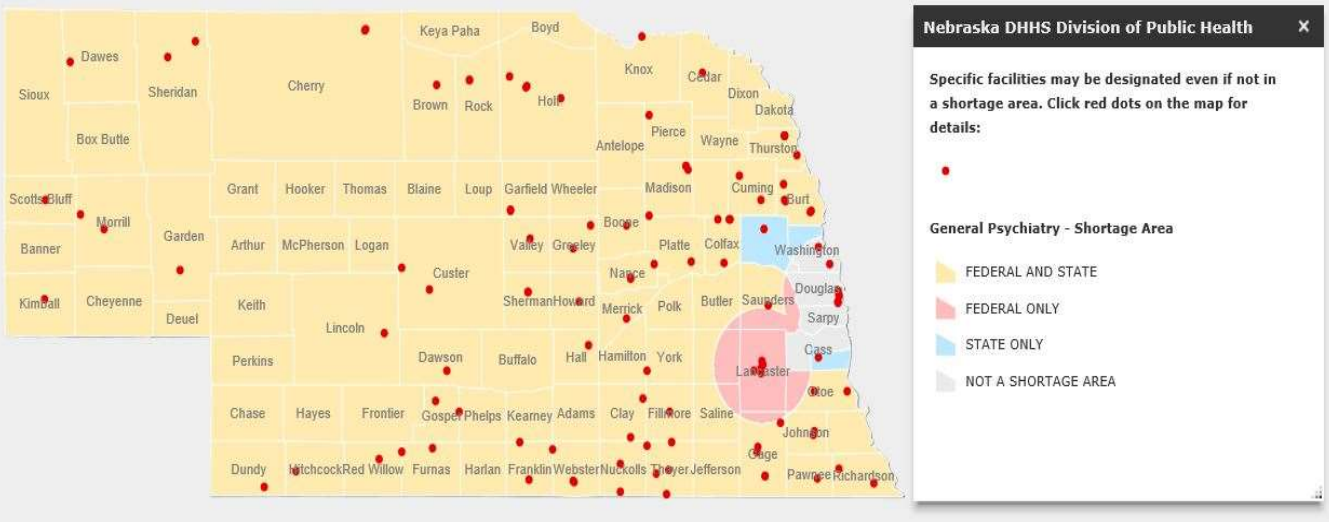


Figure 6: Nebraska General Psychiatry Shortage Map

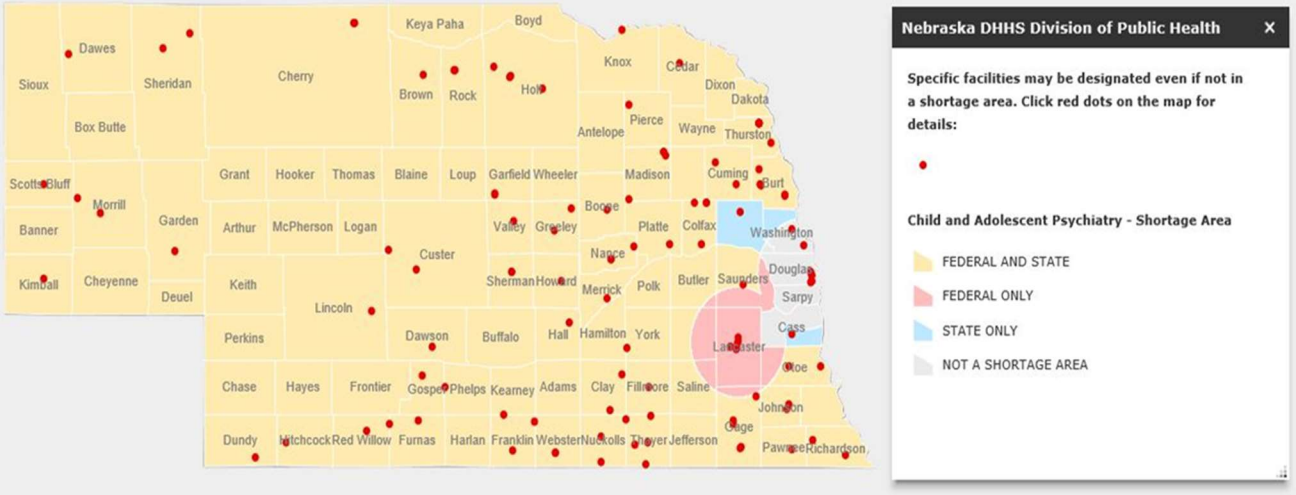
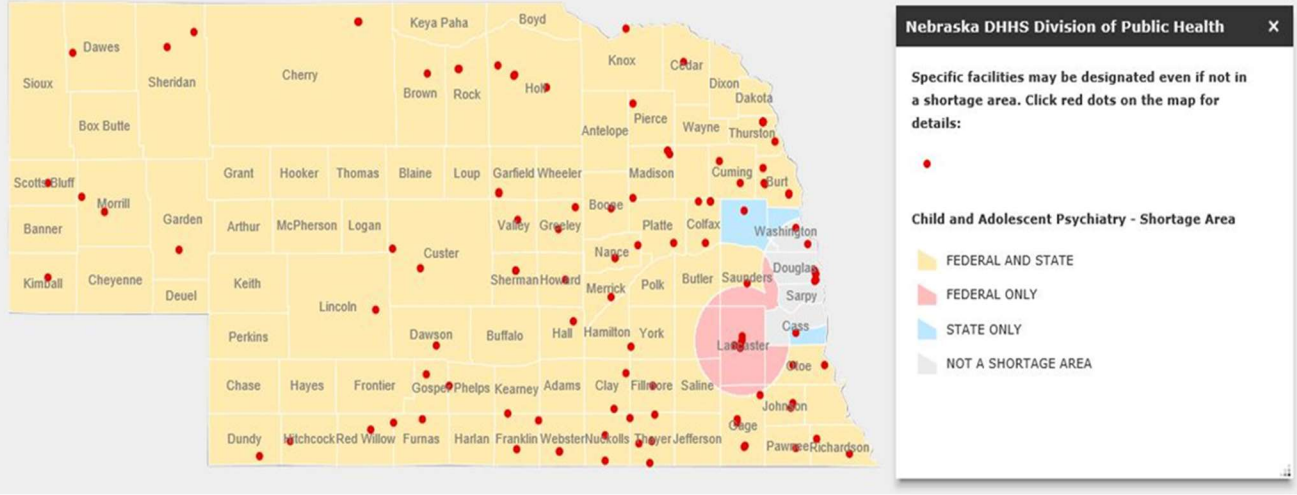


Figure 7: Nebraska Clinical Psychology Shortage Map



Substance Abuse Treatment Services Provided in Nebraska

The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual SAMHSA survey designed to collect data on the location, characteristics, and use of alcohol and drug abuse treatment facilities and services throughout the country. Starting in 2018, N-SSATS no longer reports individual numbers of clients in treatment. As that information is relevant to this needs assessment, the N-MIECHV team decided to include 2017 information on the number of clients.

Table 6. Substance Abuse Treatment Facilities, Nebraska, 2017-2018

		2017		2018	
		Number	**%**	**Number**	**%**
Facility Operation	Private non-profit	79	63.2	76	61.3
	Private for-profit	24	19.2	26	21.0
	Local, county, or community government	5	4.0	7	5.6
	State government	2	1.6	2	1.6
	Federal government	7	5.6	5	4.0
	Tribal government	8	6.4	8	6.5
	Total	**125**	**100.0**	**124**	**124**
Type of Care	Outpatient	101	80.8	98	79.0
	Regular	101	80.8	97	78.2
	Intensive	50	32.0	42	33.9
	Day treatment / partial hospitalization	5	3.2	4	3.2
	Detoxification	5	3.2	3	2.4
	Methadone/buprenorphine maintenance or naltrexone treatment	10	8.0	11	8.9
	Residential (non-hospital)	37	29.6	40	32.3
	Short term (≤ 30 days)	18	14.4	18	14.5
	Long term (> 30 days)	27	21.6	28	22.6
	Detoxification	8	6.4	8	6.5
	Hospital inpatient	3	2.4	3	2.4
	Treatment	3	2.4	3	2.4
	Detoxification	3	2.4	3	2.4
	Total	**125**	**100.0**	**124**	**100.0**

*Facilities may provide more than one type of care.

Table 7 Substance Abuse Treatment Facilities, Nebraska, 2017-2018 Clients in treatment on March 31, 2017						
		All clients		**Clients under age 18**		**% under 18**
		Number	%	Number	%	
Facility Operation	Private non-profit	3,424	53.0	191	35.6	5.3
	Private for-profit	1,151	17.8	175	32.6	13.2
	Local, county, or community government	1,398	21.6	136	25.3	8.9
	State government	25	0.4	25	4.7	50.0
	Federal government	311	4.8	-	-	-
	Tribal government	152	2.4	10	1.9	6.2
	Total	**6,461**	**100.0**	**537**	**100.0**	-
Type of Care	Outpatient	5,604	86.7	486	90.5	0.8
	Regular	4,385	67.9			
	Intensive	606	9.4			
	Day treatment / partial hospitalization	13	0.2			
	Detoxification	66	1.0			
	Methadone/ buprenorphine maintenance or naltrexone treatment	535	8.3			
	Residential (non-hospital)	828	12.8	50	9.3	5.7
	Short term (≤ 30 days)	321	5.0			
	Long term (> 30 days)	488	7.6			
	Detoxification	19	0.3			
	Hospital inpatient	29	0.4	1	0.2	3.4
	Treatment	12	0.2			
	Detoxification	17	0.3			
	Total	**6,461**	**100.0**	**537**	**100.0**	-
*Facilities may provide more than one type of care.						

2018 Data

In Nebraska, 124 substance abuse treatment facilities were included in the 2018 N-SSATS. The survey response rate for Nebraska was 96.2%. As of September 14, 2020, SAMHSA was reporting 119 substance treatment facilities in the state, implying a slow decline in the number of operating facilities.

Prevention

In 2018, DHHS was awarded the Pediatric Mental Healthcare Access Grant, managed by Title V MCH staff. The grant gives the opportunity to build provider capacity and expand appropriate, adequate, and equitable access to early childhood mental and behavioral health services,

specifically in rural areas across the state. The Nebraska project, known as the Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP), has several moving parts: a clinical demonstration project, a cross-sector advisory group, technical workgroups, and smaller subcontracted projects to enhance access, resources, and utilization by families.

The clinical demonstration project is developed and implemented by the University of Nebraska Medical Center (UNMC), Monroe Meyer Institute. A team of licensed mental health professionals serves as consultants to family doctors and general practitioners across the state using telehealth. In many rural areas, family doctors are the only available professionals to serve many complex mental health needs, and often they are not adequately prepared to do so. Through NEP-MAP, primary care providers can contact the expert team to consult about services, resources, medications, and best practice recommendations. Working as a team, primary care providers are able to help families with local recommendations. In return, the primary care providers collect and report aggregate data on both their local population and the mental health needs of the area.

NEP-MAP includes a diverse, inter-disciplinary, and cross-sector team which acts as an advisory body. Partners make recommendations on validated and age-appropriate screening instruments, systems integration work, implementation and assessment of culturally and linguistically appropriate services (CLAS) related to mental, behavioral, and telehealth services in early childhood, as well as assuring parent/family/consumer involvement at all levels, and assessment of the clinical project. Smaller technical workgroups work on each of these issues individually, bringing the results to the Advisory group for suggestions and approval. Provider partners are recognized as leaders in the field, and promote NEP-MAP as a sustainable project in Nebraska.

NEP-MAP is intentionally aligned with other systems in Nebraska, including the Behavioral Health System of Care, Title V MCH Block Grant priorities, Rooted in Relationships (Early Childhood Mental Health), Medicaid and Long Term Care, the private Managed Care Organizations, and the Department of Education.

Scope Overview:

- Assure parent/family consumer inclusion at all levels of project.
- Assess and promote CLAS and Literacy adaptations to serve diverse populations, related to tele-behavioral health, family engagement, mental and behavioral health issues of children, accessing health insurance.
- Assure systems integration with other initiatives and behavioral health system of care.
- Lead spread of screening practices statewide, including and beyond the clinical demonstration project.
- Look for and recommend spread, scale, and replication ideas.
- Identify priorities for Title V and stakeholders to enhance project effectiveness.

The N-MIECHV program is a NEP-MAP Partner, and provides feedback on the use of products and tools such as the *NEP-MAP Screening and Assessment Guide* that promotes universal screening for early childhood mental health, the implementation of CLAS standards within community organizations and partners, and work to normalize the use of mental health services in local communities. Home Visitors are able to use the resources available through the

Partnership to access appropriate mental and behavioral healthcare and resources, as well as support them more effectively if mental health issues are present.

~~N~~ebraska is a large and geographically rural state, with gaps in its capacity (supply) to provide behavioral and mental health services, and an increasing need (demand) for both direct care and preventive programs. Evidence-based home visitation is a meaningful tool in both mitigation as well as primary and secondary prevention of substance use disorders, mental health/wellness, and trauma, however community services must be present for home visitation to be effective. Home visitors must be able to refer families to services if the family is going to be successful. These identified gaps and strengths will be utilized in upcoming community readiness assessments as further investments into home visiting expansion are considered.

E. *Coordination with Title V MCH Block Grant, Head Start, and CAPTA Needs Assessments*

The early childhood community in Nebraska has considerable overlap between stakeholders and agency staff involved in MIECHV, Title V MCH Block Grant, Head Start/Early Head Start, and CAPTA. These partners, as well as Nebraska Sixpence, were active in the N-MIECHV 2020 Needs Assessment Update. The following section describes additional assessments, findings, and coordinated efforts by the partners.

The Title V MCH Block Grant and N-MIECHV program are both located in the Lifespan Health Services Unit, Division of Public Health and staff regularly collaborate on projects and program design. In this case the Office of MCH Epidemiology (Lifespan Health Services) conducted both the N-MIECHV Needs Assessment Update and the Title V MCH Needs Assessment. The MCH Needs Assessment varies from the MIECHV Assessment in that is state-level and population (domain) driven. The outcome of the MCH Needs Assessment is the prioritization of 10 needs for the proceeding five-year period. The 2020 Title V MCH Needs Assessment process concluded in April 2020 with the following results by domain:

Nebraska's Title V - MCH Block Grant – Priorities (2020-2025)

Infants
- Premature Birth
- Infant Safe Sleep

Children
- Child Abuse and Neglect
- Access to Preventative Oral Health

Youth
- Motor Vehicle Crashes
- Sexually Transmitted Diseases
- Suicide

Children/Youth with Special Healthcare Needs
- Behavioral Health in School

Women
- Cardio Vascular Disease

Cross-cutting/Systems
- Access to and Utilization of Mental and Behavioral Health Care

The underlined priorities are those most directly correlated with the work of N-MIECHV.

Nebraska is the recipient of the Preschool Development Grant (PDG) from the US Department of Health and Human Services, Administration of Children and Families. In Nebraska PDG is a collaboration between NDHHS and the Nebraska Department of Education (including Head Start Collaboration Office), the Nebraska Children and Families Foundation (including Sixpence), and the Buffett Early Childhood Institute/University of Nebraska. Nebraska's PDG conducted a Needs Assessment of the Early Childhood Care and Education (EECE) system for birth through five years of age in 2019. The assessment was utilized to inform a strategic plan, implementation of the plan was funded in 2020. The assessment identified the following challenges for the current EECE system:

- Access to quality affordable care insufficient in many communities
- Lack of care can affect a parent's ability to find or keep a job or continue 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

Nebraska's Head Start Collaboration Office conducts on-going annual assessments and share the following goal/finding with Nebraska's early childhood and MCH community: Addressing mental health services for Head Start children and families.

In Nebraska, CAPTA has not conducted an assessment in recent years, however enactment of the Comprehensive Addiction and Recovery Act of 2016 (CARA) resulted in some changes in the Child Abuse Prevention and Treatment Act (CAPTA). CARA aims to address various aspects of substance use disorder, particularly opioid use disorder. CARA adds various requirements to CAPTA, perhaps most significantly to require that the state apply the policies and procedures addressing the needs of infants born with and identified as being affected by all substance abuse (not just illegal substance abuse as was the requirement prior to this change). In addition, the changes require the state to ensure the safety and well-being of infants following the release from the care of health care providers, and develop the plans of safe care for infants affected by all substance abuse (not just illegal substance abuse as was the requirement prior to this change).

Nebraska is a large sparsely populated state, with s relatively small workforce compared to other states. MIECHV, Title V MCH Block Grant, Head Start/Early Head Start, CAPTA, as well as Nebraska Sixpence will continue to partner in dissemination of the findings, the community readiness processes planned in the coming year(s), and expansion of evidence-based home visitation services in Nebraska.

F. *Conclusion*

Nebraska's methodology for conducting the home visiting needs assessment consists of identification of at-risk communities and assessment of capacity.

The at-risk identification used sixteen indicators representing five domains to identify communities at greatest risk for poor child and family outcomes. The capacity assessment surveyed existing home visiting programs to learn about program capacity and community needs. Through these two processes, 31 eligible counties were identified as at-risk and 11 were

recommended for a community readiness assessment and possible expansion of home visiting programs.

When the full Needs Assessment results are complete, a distribution plan will be developed through a collaboration of the core members from the capacity assessment team. This includes sharing county-level data in a single-page infographic document, with the state map of known home visiting programs on the other side. The state-level partners in home visiting[2] have agreed to accept the N-MIECHV assessment of priority counties in Nebraska as evidence of need for high-quality home visiting services. Several of these partners were active participants in the Capacity Assessment, acting on the foundational belief that there are families in Nebraska who could benefit from any one of the programs. Each has agreed that the results of the 2020 Needs assessment will be shared on each of their program location maps to show where shortages of services are in the state. Once published, the underlying information will be available for all partners and programs, and the one-page document will be posted and available for reproduction on partner websites.

Next Steps

Results of this updated needs assessment will provide invaluable guidance in determining areas of the state to consider when starting new or expanding existing evidence-based home visiting programs. The next stage for the project team is conducting community readiness assessments with the recommended communities/regions. This will require an in-depth examination of other early childhood resources in each area, and an assessment of community support for home visiting programs. These assessments are dependent on the availability of funding, which was not a factor analyzed in this 2020 Needs Assessment. The three major funders of these types of programs have already begun discussing this process. These include identifying potential providers with the ability and interest to work in counties without an existing home visiting program, and discussions regarding available funding.

[2] The Head Start State Collaboration Office (Nebraska Dept. of Education), Sixpence Early Learning Fund (Nebraska Children and Families Foundation), and NDHHS Division of Children and Family Services.

Attachment 1: Maternal Infant Early Childhood Home Visiting Programs in Nebraska: Survey of Providers

MATERNAL INFANT EARLY CHILDHOOD HOME VISITING PROGRAMS IN NEBRASKA: Survey of Providers

August 2020

Report prepared by:
Stacey J. Hoffman, PhD
Megan Allen, MA

The University of Nebraska Public Policy Center
215 Centennial Mall South, Suite 401
Lincoln, NE 68588 – 0228
Phone: 402-472-5678
FAX: 402-472-5679
Email: ppc@nebraska.edu

University of Nebraska
PUBLIC POLICY CENTER

The University of Nebraska Public Policy Center provides assistance to policymakers in all three branches of government and researchers on a wide range of public policy issues. The mission of the PPC is to actively inform public policy by facilitating, developing, and making available objective research and analyses of issues for elected and appointed officials; state and local agency staff; the public at large; and others who represent policy interests.

215 Centennial Mall South, Suite 401, Lincoln, NE 68588-0228
Ph: 402-472-5678 | Fax: 402-472-5679
www.ppc.nebraska.edu

CONTENTS

EXECUTIVE SUMMARY

A survey of infant and early childhood home visiting providers was conducted to inform a statewide capacity assessment required by the federal Health Resources and Services Administration (HRSA). A total of 48 respondents provided information for the capacity assessment.

Programs reported receiving a mix of federal, state, private, and foundation funding. Two-thirds of programs received funding from multiple sources. Almost all programs use an evidence-based curriculum or model; two programs did not report using such model.

Several questions on the survey attempted to identify gaps in services. There are some counties which do not currently have home visiting services. There is also a perception that a number of people who could benefit from services are not receiving them. Of programs that responded, 85% felt there were families in their area not being served who could benefit from services. Program capacity was the most often cited reason that people who could benefit were not receiving services.

Surprisingly, given the perception that more people could benefit from services, almost half (46%) of respondents stated there was not a need for additional home visiting programs in their area. Those who stated there was not a need had a significantly higher capacity and higher enrollment, and served more children, than those who responded there was a need for additional programs. Most high need counties are covered by a program; only 4 of 31 identified high-need counties did not report an existing home visiting program.

The level of program staffing is good. Programs appear to have a low staff turnover rate (15% of staff in a year), and a reasonable amount of time to fill a vacant position (38 days). Programs also have good levels of educational requirements for staff. For programs that have a lower level of education required (high school diploma or equivalent), extensive training in early childhood and other topics is required before staff provide home visiting services.

Staffing and program materials are designed to reflect the population served and enable access by diverse populations, including bilingual staff, access to interpreters, and materials in multiple languages.

Programs are well connected with other programs serving the same population. They reported extensive referral networks. All respondents also reported participating in their local community collaborative which included most organizations in their referral networks.

Combined with information from the needs assessment, plans are already being made to use this capacity assessment to identify areas for potential expansion of early childhood home visiting programs. This will include a readiness assessment for each identified area, to ensure service expansion is appropriate for the local area.

INTRODUCTION

The University of Nebraska Public Policy Center (PPC) was engaged by the Nebraska Department of Health and Human Services (NDHHS) to design a survey (Attachment 3), collect data, and analyze information for a statewide capacity assessment of early childhood home visiting. This capacity assessment is part of a larger needs and capacity assessment for home visiting across the state, funded by the Health Resources and Services Administration (HRSA).

A survey development team of representatives from organizations that fund and/or provide home visiting was assembled. Five organizations provided representatives who met bi-weekly for several months, providing input into survey design and guiding data analysis questions.

METHOD

IDENTIFICATION OF PARTICIPANTS

Three organizations – Nebraska Maternal Infant Early Childhood Home Visiting (N-MIECHV), Nebraska Head Start, and Sixpence – contacted their respective funded programs requesting information about any additional home visiting programs in the area they serve. A list of these additional programs with contact information was generated. The three funding organizations sent survey invitations to their funded programs, the additional programs, and public health departments. The three funding organizations also sent periodic survey reminder emails to these programs.

SURVEY INVITATION AND RESPONSE RATE

The survey was distributed using online survey software. Following the Dillman Total Design Method, advance notification of the survey was sent to all identified targets on March 11, 2020. On March 18, an email invitation with a link to the online survey was sent. A reminder email was sent on March 25. The survey was originally set to close on March 31; however, the launch date of the survey occurred around the same date that many organizations were transitioning to working from home as a result of the COVID-19 pandemic. In addition, these organizations operate in the public health sector and had sudden additional demands on their services. Therefore, the survey deadline was extended by two weeks to April 15, 2020. The survey was further extended another two weeks to further enable survey participation, and officially closed on May 4, 2020. Reminder emails beyond the first two weeks were sent to organizations on April 1, April 8, April 15, and April 29, 2020.

There were a total of 48 respondents out of the 71 programs asked to participate. Initially, we received 61 responses; however, responses were trimmed due to duplicate responses per program and non-response. The response rate for this survey was calculated based on 51 non-duplicate responses to the survey; three responses were included in calculation of the response rate despite not providing responses to almost all survey questions because they indicated they did not have home visiting programs, or it is believed they likely do not have programs (such as public health departments who were contacted to find out whether they had home visiting programs). The response rate was 71.8%.

RESULTS

Descriptive data from all questions included in the survey are presented in Attachment 2. This report responds to the specific questions asked by HRSA for the capacity assessment. Here, we focus on statewide information to assist program planning. Additional information regarding specific counties will be provided to N-MIECHV under separate cover.

The Early Development Network out of the Educational Service Unit 16 Early Childhood Special Education program provided answers that were extreme outliers. Therefore, this program was not included in calculations of descriptive data or analyses. Responses for this program are listed separately in tables under the EDN column.

NUMBER AND TYPES OF PROGRAMS

NUMBER OF PROGRAMS AND FUNDING SOURCES

Table 1~~Table 1~~ presents the number of programs broken down by funding source. Programs were funded by three main funders: N-MIECHV, Nebraska Head Start, and Sixpence. Some programs were partially or solely funded by additional funders. Thirty programs (63.8%) reported having multiple funding sources.

Table 1. Number of Programs by Type of Funder

	N-MIECHV	Head Start	Sixpence	Other
Number of programs	7	12	23	11

Respondents were asked to report which funding sources funded their home visiting programs (Table 2~~Table 2~~). More than half of programs reported State (55.3%, *n* = 26) funding sources. A large proportion also reported receiving Federal (44.7%, *n* = 21), Private (36.2%, *n* = 17), and Foundation (29.8%, *n* = 14) funding.

Table 2. Funding Sources (*n* = 47)

	All Programs		EDN
Funding Source*	*n*	%	
Federal	21	44.7	X
State	26	55.3	X
Local	7	14.9	X
Private	17	36.2	
Hospital	5	10.6	
Foundation	14	29.8	
Other (please specify):			
Along with in-kind from local school district and private agencies	1	2.1	

*Note: Respondents could select more than one response option

The average number of years agencies reported providing services was 14 (M = 13.9). Some programs reported having just started up in the past year, while others have been providing services for several decades (Table 3~~Table 3~~).

Table 3. Years Providing Home Visiting

	Mean	SD	Min	Max	EDN
How many years has your agency been providing home visiting services? (n = 45)	13.9	10.1	1	40	42

SERVICE DELIVERY MODELS

Respondents were asked to report which (if any) evidence-based or evidence-informed curriculum or model was used by their program (Table 4~~Table 4~~Table 2~~Table 2~~). The most common curriculum/model programs reported using was Parents as Teachers (44.7%, n = 21). A number of programs also reported using Early Head Start – Home-Based Option (21.3%, n = 10) and Health Family America (19.1%, n = 9). Two programs did not report using an evidence-based curriculum or model.

Table 4. Evidence-Based or Evidence-Informed Curriculum or Model Being Used (n = 47)

Curriculum or Model*	n	%	EDN
Attachment and Bio-behavioral Catch-Up (ABC) Intervention	0	0	
Child FIRST	0	0	
Durham Connects/Family Connects	0	0	
Early Head Start - Home-Based Option	10	21.3	
Early Intervention Program for Adolescent Mothers	0	0	
Early Start (New Zealand)	0	0	
Family Check-Up for Children	1	2.1	
Family Spirit	0	0	
Health Access Nurturing Development Services (HANDS) Program	0	0	
Healthy Beginnings	3	6.4	
Healthy Family America	9	19.1	
Home Instruction for Parents of Preschool Youngsters	0	0	
Maternal Early Childhood Sustained Home Visiting Program	1	2.1	
Minding the Baby	0	0	
Nurse-Family Partnership	0	0	
Parents as Teachers	21	44.7	
Play and Learning Strategies - Infant	0	0	
SafeCare Augmented	0	0	
Other (please specify):			
Getting Ready	3	6.3	X
PIWI [Parents Interacting with Infants]	1	2.0	
Growing Great Kids	7	14.8	
Hawaii Early Learning Profile HS	1	2.1	
None - Home-type visit	1	2.1	

Curriculum or Model*	*n*	%	EDN
Partners for a Healthy Baby	4	8.4	
Incredible Years and Developmental Parenting	1	2.1	

*Note: Respondents could select more than one response option

Families Served

Number of Families/Children Served

Information about the number of individuals and families served is presented in Table 5~~Table 5~~. Average enrollment capacity was 77 families ($M = 77.1$). The average number of families served in the recent fiscal year was 72 families ($M = 71.9$), with the average total number of children served being 89 ($M = 88.9$). The average percent of families who complete the programs was 75 percent ($M = 74.9$).

Table 5. Individuals and Families Served

	Mean	SD	Min	Max	EDN
What is your program's enrollment capacity (number of families)? (*n* = 36)	77.1	98.9	5	400	10,000
How many families (defined by primary caregiver) received services from your program in the most recently ended fiscal year? (*n* = 34)	71.9	94.6	3	400	80
How many total children received services in the most recently ended fiscal year? (*n* = 34)	88.9	116.9	4	450	85
What percent of families complete your home visitation program? (*n* = 34)	74.9	24.8	4	100	100

Eligibility Criteria

Programs reported a variety of criteria they used to determine who they served (Table 6~~Table 6~~). The majority of programs determined services based on the age of the child (72.3%, $n = 34$), with prenatal through 3 years of age being the target ages. There were four programs which served children through age 4 or 5. Other criteria for services used by a majority of programs were that a person was a pregnant or parenting teen (63.8%, $n = 30$), and/or a child being born prematurely or with low birth weight (51.1%, $n = 24$). Several other criteria were used by programs.

Table 6. Eligibility Criteria for Programs ($n = 47$)

Eligibility Criteria*	*n*	%	EDN
Age of child	34	72.3	X
Pregnant/parenting teens	30	63.8	

Eligibility Criteria*	*n*	%	EDN
Low birth weight or premature birth of child	24	51.1	
Pregnant women	22	46.8	
Income limitation	21	44.7	
English as a second language parent/caregiver	19	40.4	
Free/reduced lunch eligible children	19	40.4	
Foster child	15	31.9	
Caregiver drug/alcohol use	14	29.8	
Caregiver mental health diagnosis	14	29.8	
Child with special healthcare needs	14	29.8	
Single parent	14	29.8	
English as a second language child	13	27.7	
First time parent(s)	11	23.4	
Child mental health diagnosis	7	14.9	
Court ordered	4	8.5	
Refugee status of parent/caregiver	4	8.5	
Other	13	27.7	X

*Note: Respondents could select more than one response option

Gaps in Early Childhood Home Visiting

Counties Served

Respondents were asked to list the counties that their program serves. Sarpy County had the most programs (*n* = 6). There were several counties not covered by a home visiting program (Attachment 2, Table 4); however, only 4 of the 31 identified high-need counties did not have a program that claimed to serve them (Attachment 1).

Need for Additional Programs

Most respondents reported a need for additional home visiting programs in their area (54.1%, *n* = 20), although a good portion of respondents did not report a need (45.9%, *n* = 17; Table 7~~Table 7~~). Since there were so many who did not perceive a need, this was explored further through various analyses to determine why a good proportion of respondents did not perceive a need for more programs.

Table 7. Need for Additional Programs (*n* = 37)

Is there a need in the area for additional home visiting programs?	*n*	%	EDN
Yes	20	54.1	X
No	17	45.9	

ANOVA analysis found that those who said "No" to a need for additional programs had an average enrollment capacity of 118.3, which was significantly larger than those who said yes, (M = 38.6), $F(1, 32) = 7.03$, $p = .016$ (Table 8~~Table 8~~).

Table 8. Average Enrollment Capacity by Perceived Need for Additional Home Visiting Programs

		Mean	SD	*n*	*F*	*p*
Need for additional programs	**Yes**	38.6	29.2	19	7.03	.012
	No	118.3	127.5	15		

Those who did not perceive a need served a significantly greater number of families (M = 114.6) than those who did perceive a need (M = 39.6), $F(1, 32) = 5.88$, $p = .021$ (Table 9~~Table 9~~).

Table 9. Average Number of Families who Received Services by Perceived Need for Additional Home Visiting Programs

		Mean	SD	*n*	*F*	*p*
Need for additional programs	**Yes**	39.6	32.8	19	5.88	.021
	No	114.6	130.1	15		

A chi-square analysis was conducted to examine the relationship between the number of families served and program capacity. A variable was created to represent whether or not a program's enrollment exceeded their capacity. There was no significant association between perceived need for additional programs and whether or not program enrollment exceeded capacity, $\chi^2(1) = 0.847$, $p = .358$ (Table 10~~Table 10~~).

Table 10. Capacity by Perceived Need for Additional Home Visiting Programs

		Additional need for programs		
		Yes	**No**	**Total**
Capacity	**Enrollment does not exceed capacity**	10	10	20
	Enrollment exceeds capacity	8	4	12
	Total	18	14	32

The average number of children who received services in the most recent fiscal year was 55.1 children for those who perceived a need for additional programs and 134.1 for those who did not perceive a need. This difference was significant, $F(1, 32) = 4.29$, $p = .046$ (Table 11~~Table 11~~).

Table 11. Average Number of Children who Received Services by Perceived Need for Additional Home Visiting Programs

		Mean	SD	*n*	*F*	*p*
	Yes	55.1	75.3	20	4.29	.046

Need for additional programs	**No**	134.1	147.2	15		

Over half of programs (56.1%, *n* = 23) reported maintaining a waiting list. The average number of people currently on a waiting list for programs for those who perceived a need for additional programs (*M* = 7.5) was not significantly different from those who did not perceive a need (*M* = 36.7), *F*(1, 19) = 2.60, *p* = .123 (Table 12~~Table 12~~).

Table 12. Current Waiting List by Perceived Need for Additional Home Visiting Programs

		Mean	**SD**	***n***	***F***	***p***
Need for additional programs	**Yes**	7.5	9.1	11	2.60	.123
	No	36.7	59.3	10		

The average number of people on programs' waiting list for those who perceived a need for additional programs (*M* = 56) was not significantly different from those who did not perceive a need for additional programs (*M* = 73.1), *F*(1, 14) = .349, *p* = .564 (Table 13~~Table 13~~).

Table 13. Average Number of People on Waiting List by Perceived Need for Additional Home Visiting Programs

		Mean	**SD**	***n***	***F***	***p***
Need for additional programs	**Yes**	56.0	43.3	8	0.349	0.564
	No	73.1	69.6	8		

The staff attrition rate for those who perceived a need for additional programs (*M* = 15.6) was not significantly different from those who did not perceive a need (*M* = 17.5), *F*(1, 33) = .040, *p* = .844 (Table 14~~Table 14~~).

Table 14. Staff Attrition Rate by Perceived Need for Additional Home Visiting Programs

		Mean	**SD**	***n***	***F***	***p***
Need for additional programs	**Yes**	14.8	26.9	19	.086	.771
	No	17.5	27.8	17		

STAFFING

Programs reported their average staff attrition rate at 15% of staff lost in one year (*M* = 15.4), with the average number of days to fill a position being about 38 days (*M* = 37.6; Table 15~~Table 15~~).

Table 15. Staff Attrition

	Mean	**SD**	**Min**	**Max**	**EDN**

What is your staff attrition rate (percent of staff lost in one year)? (*n* = 37)	15.4	26.4	0	100	7
What is the average number of days it takes to fill a new position? (*n* = 37)	37.6	27.3	0	120	30

Half of respondents reported the minimum educational attainment required for home visiting staff positions as a bachelor's degree (50%, *n* = 20) and the majority preferred a bachelor's degree (70%, *n* = 28). Staff requirements are shown in Table 16~~Table 16~~ and Table 17~~Table 17~~. The most common specialization required was Early Childhood Education (23.4%, *n* = 11).

Table 16. Staff Requirements

	n	%	EDN
What is the minimum educational attainment required for home visiting staff positions? (*n* =40)			
High school or equivalent	11	27.5	
Associate's	9	22.5	
Bachelor's	20	50.0	X
What is the preferred educational attainment for home visiting staff positions? (*n* =40)			
Associate's	5	12.5	
Bachelor's	28	70.0	
Master's	1	2.5	X
Same as minimum required education	6	15.0	

Table 17. Specialization(s) or Major(s) Required for Staff (*n* = 47)

Specialization(s) or major(s)	*n*	%	EDN
Early Childhood Education	11	23.4	
Nursing	9	19.1	
Social Work	8	17.0	
Psychology	7	14.9	
Human Relations/Sciences Field	6	12.7	
Sociology	4	8.5	
Education	3	6.4	
Child Development	2	4.1	
Public Health	2	4.2	
Other:			
DEVELOPMENT, EFFECTS OF TRAUMA, COMPASSION	1	2.1	
Service Coordinators are asked to have at least an associates degree. Coaches need a teaching certificate with SPED endorsement or specialized degree as an OT, PT, or SLP.	1	2.1	
ECSE endorsement, speech/language pathology endorsement, OT or PT licensure, deaf educator endorsement	0	0	X

Although some programs required no more than a high school diploma or equivalent, they also required extensive training before staff provided home visiting services (Table 18~~Table 18~~). The most common training topics required for staff of home visiting programs were child

abuse/neglect (76.6%, *n* = 36), safety in home visiting (66%, *n* = 31), infant/toddler development (57.4%, *n* = 27), and cultural competency (40.4%, *n* = 19).

Table 18. Training Topics for Staff (*n* = 47)

Training Topic*	*n*	%	EDN
Child Abuse/Neglect	36	76.6	
Safety in Home Visiting	31	66.0	
Infant/Toddler Development	27	57.4	
Cultural Competency	19	40.4	X
Working with Families Exposed to Violence	17	36.2	
Family Systems	16	34.0	X
Self-Care	14	29.8	
Communication	13	27.7	
Mental Health	13	27.7	
Motivational Interviewing	7	14.9	
Quality Improvement (QI)	6	12.8	
Other	16	34.0	

*Note: Respondents could select more than one response option

COMMUNITY RESOURCES

Respondents were asked about inter-program referrals. Most programs reported having local mental health services to refer clients to (94.9%, *n* = 37) and having local substance use services to refer clients to (79.5%, *n* = 31) (Table 19~~Table 19~~).

Table 19. Referrals to Mental Health or Substance Use Services

	n	%	EDN
Are there local mental health services to which you can refer clients? (*n* =39)			
Yes	37	94.9	X
No	2	5.1	
Are there local substance use services to which you can refer clients? (*n* = 39)			
Yes	31	79.5	X
No	8	20.5	

The programs that respondents most commonly referred clients to were Early Development Network/Developmental Delay (76.6%, *n* = 36), and Food/Nutrition (WIC, food pantry) (76.6%, *n* = 36). There were quite a number of programs that respondents reported referring clients to (Table 20~~Table 20~~).

Table 20. Agencies Clients are Regularly Referred to (*n* = 47)

Service or agency clients are referred to*	*n*	%	EDN
Food/Nutrition (WIC, food pantry)	36	76.6	X
Early Development Network/Developmental Delay	36	76.6	X
Safety (car seat safety check)	34	72.3	X

Service or agency clients are referred to*	*n*	%	EDN
Mental Health	32	68.1	X
Developmental Delay (EDN)	32	68.1	X
Community Health Services (family planning, immunizations, reproductive health screenings)	32	68.1	X
Housing (finding affordable housing)	31	66.0	X
Community Action Programs	30	63.8	X
Child Care Providers	30	63.8	X
Education (going back to school - college, trade school, finishing high school/GED)	28	59.6	
Economic Assistance	28	59.6	X
Dental Care	28	59.6	X
Employment (job training)	27	57.4	
Domestic Violence	27	57.4	X
Primary Healthcare Providers/Federally Qualified Health Centers	26	55.3	X
Breastfeeding Support	26	55.3	
Legal Aid (immigration, child custody, protection against partner)	24	51.1	
Substance Use	23	48.9	
Child Welfare	21	44.7	X
Hospitals	20	42.6	
Schools K-12	19	40.4	
School for Preschool Enrollment	1	2.1	

*Note: Respondents could select more than one response option

The most common referral source reported by respondents were client friends/family (63.8%, *n* = 30) (Table 21~~Table 21~~). The agencies that programs most commonly received referrals from were Early Development Network (EDN)/Developmental Delay (53.2%, *n* = 25), hospitals (46.8%, *n* = 22), and Food/Nutrition (WIC, food pantry) (44.7%, *n* = 21).

Table 21. Services Referrals are Received From (*n* = 47)

Service or agency referrals are received from*	*n*	%	EDN
Family/Friends	30	63.8	X
Early Development Network/Developmental Delay	25	53.2	
Hospitals	22	46.8	
Food/Nutrition (WIC, food pantry)	21	44.7	
Community Action Programs	19	40.4	
Primary Healthcare Providers/Federally Qualified Health Centers	19	40.4	X
Community Health Services (family planning, immunizations, reproductive health screenings)	18	38.3	
Child Care Providers	16	34.0	X
Child Welfare	16	34.0	X
Developmental Delay (EDN)	16	34.0	

Schools K-12	16	34.0	
Breastfeeding Support	9	19.1	
Mental Health	9	19.1	
Domestic Violence	8	17.0	
Economic Assistance	5	10.6	
Dental Care	4	8.5	
Education (going back to school - college, trade school, finishing high school/GED)	4	8.5	
Housing (finding affordable housing)	4	8.5	
Safety (car seat safety check)	4	8.5	
Legal Aid (immigration, child custody, protection against partner)	3	6.4	
Substance Use	3	6.4	
Employment (job training)	2	4.3	
Other (please specify):			
Child Find	1	2.1	
From families that are part of the program	1	2.1	
Self	1	2.1	

*Note: Respondents could select more than one response option

Extent to Which Programs are Meeting Needs of Families

Need for Services and Service Utilization

Regarding need for services, the vast majority of respondents believed there were families who could benefit from home visiting in their area who were not receiving services (85%, *n* = 34; Table 22~~Table 22~~). A small percent reported recent reductions in funding that impacted the number of families they can serve (7.3%, *n* = 3).

Table 22. Need for Services

	n	%	EDN
Do you feel there are families who could benefit from home visiting in your area who are not receiving services? (*n* =40)			
Yes	34	85.0	X
No	6	15.0	
Have there been any recent reductions in funding that impacted the number of families you can serve? (*n* =41)			
Yes	3	7.3	
No	38	92.7	X

If respondents responded "Yes" to whether there were families not receiving services who could benefit from home visiting, they were then asked to expand on the reasons for this (Table 23~~Table 23~~). Program capacity was the most frequently cited reason families are not receiving services (31.9%, *n* = 15).

Table 23. Reasons Families Are Not Receiving Services *(n* = 47)

Reason*	*n*	%	EDN
Program capacity	15	31.9	
Inadequate funding	7	14.9	
Population barriers (please specify):	5	10.6	
Families are not aware of the program	1	2.0	
Families do not want the school "in their business"	1	2.0	
Immigration worries	1	2.0	
They are not low income but still would like assistance with parenting, age of the parent, and/or child depending on which program	1	2.0	
Want center-based services	1	2.0	
Other (please specify):			
Unwillingness/do not want to/choose not to participate/decline offers	7	14.9	
Lack of awareness or knowledge of programs	6	6.3	
Lack of referral	2	4.0	X
Could use additional partners	1	2.0	
Doctors hesitant to refer families with lower needs for fear of offending the parent(s)	1	2.0	
Eligibility limitations	1	2.0	
Families have to meet criteria as having a child with a disability to receive home visiting from our program. There is a large need of families that would benefit from a home visitor in North Platte that do not fall under that category.	1	2.0	
Karen and Burmese special needs population	1	2.0	
Language barriers	1	2.0	
Parents unable to find the time because of work schedules and other on-going family issues	1	2.0	
Staffing	1	2.0	
The assumption that we work with CPS and fear losing their child	1	2.0	
Transportation, time, pandemic	1	2.0	

*Note: Respondents could select more than one response option

The majority of respondents reported maintaining a waiting list (56.1%, *n* = 23), with an average of 21 people (*M* = 21.4) and an average of 66 days (*M* = 65.6) that people were on waiting lists (Table 24~~Table 24~~ and Table 25~~Table 25~~).

Table 24. Do you Maintain a Waiting List for Home Visitation Services? (*n* = 41)

Do you maintain a waiting list?	*n*	%	EDN
Yes	23	56.1	
No	18	43.9	X

Table 25. Waiting List Information

Waiting list information	Mean	SD	Min	Max	EDN
How many people are currently on your waiting list for home visitation services? (*n* = 21)	21.4	42.9	0	200	-
What is the average number of days people are on the waiting list? (*n* = 16)	65.6	56.7	3	180	-

MEETING THE NEEDS OF DIVERSE CLIENTS

Respondents were asked about the ways they meet the needs of diverse clients. This information is presented in Table 26~~Table 26~~ and Table 27~~Table 27~~. Most programs reported that they had brochures and educational materials printed in other languages (72.3%, *n* = 34) and in-person interpreters available and utilized (74.5%, *n* = 35). Most respondents reported having home visiting staff who reflected the population being served (85.4%, *n* = 35) and having community members or consumers involved in an advisory role for the program (87.2%, *n* = 34). When asked what other ways programs meet the needs of diverse clients, the most commonly reported responses were that they have bilingual staff / provide services in the clients' language (33.3%, *n* = 6), and that they utilize collaborative efforts (27.8%, *n* = 5).

Table 26. Meeting the Needs of Diverse Clients (*n* = 47)

Meet needs of clients with diverse language/cultures by:*	*n*	%	EDN
In-person interpreters are available and utilized	35	74.5	X
Brochures and educational materials are printed in a language other than English	34	72.3	X
Forms are printed in multiple languages	28	59.6	X
Pictures on printed materials or decorative materials in office are reflective of different cultures	24	51.1	X
The language line is used for interpretation	11	23.4	X
Other (please specify):			
Bilingual staff	7	14.7	
At this time, we only have English speaking families. We do have materials such as books and posters in English and Spanish. We will utilize the public schools' Spanish teacher if the need would arise.	1	2.0	

*Note: Respondents could select more than one response option

Table 27. Meeting the Needs of Diverse Clients (continued)

	n	%	EDN
Do you have home visiting staff who reflect the population you are serving? (*n*=41)			
Yes	35	85.4	X
No	6	14.6	
Do you have community members or consumers involved in an advisory role for you home visiting program? (*n*=38)			
Yes	34	87.2	X
No	5	10.6	

LOCAL EARLY CHILDHOOD SYSTEMS COORDINATION

All respondents reported participating in community collaboratives centered around services to address early childhood needs (100%, *n* = 39). The majority of respondents reported that community action programs (68.1%, *n* = 32) and EDN/Developmental Delay (61.7%, *n* = 29) were agencies regularly represented at collaborative meetings (Table 28~~Table 28~~). In addition, most or all of the programs in their referral network were also represented.

Table 28. Agencies Represented at Collaborative Meetings (*n* = 47)

Agency that participates in collaborative*	*n*	%	EDN
Community Action Programs	32	68.1	X
Early Development Network/Developmental Delay	29	61.7	
Child Welfare	24	51.1	X
Schools K-12	24	51.1	X
Child Care Providers	23	48.9	
Developmental Delay (EDN)	22	46.8	X
Food/Nutrition (WIC, food pantry)	22	46.8	
Mental Health	22	46.8	X
Economic Assistance	17	36.2	X
Community Health Services (family planning, immunizations, reproductive health screenings)	16	34.0	X
Hospitals	15	31.9	
Education (going back to school - college, trade school, finishing high school/GED)	14	29.8	
Housing (finding affordable housing)	14	29.8	
Primary healthcare providers/Federally Qualified Health Centers	13	27.7	
Domestic Violence	12	25.5	X
Breastfeeding Support	9	19.1	
Employment (job training)	8	17.0	
Substance Use	8	17.0	
Safety (car seat safety check)	7	14.9	
Dental Care	5	10.6	
Legal Aid (immigration, child custody, protection against partner)	4	8.5	X
Other (please specify):			
Probation	2	4.0	
Churches	1	2.0	
Health Department	1	2.0	
Homeless shelter	1	2.0	
Law Enforcement	1	2.0	
Non-Profits	1	2.0	
County Judge	1	2.0	
United Way	1	2.0	
Violence Prevention	1	2.0	

*Note: Respondents could select more than one response option

Recommendations and Next Steps

Combined with information from the needs assessment, the information from this capacity assessment can be used to identify areas of the state for possible expansion of early childhood home visiting programs. The three primary funding organizations for these programs (N-MIECHV, Nebraska Head Start, and Sixpence) can coordinate their resources for planning this expansion, targeting home visiting services to at-risk communities.

The next stage after identification of potential areas for expansion of home visiting is a readiness assessment of the selected areas. This would require an in-depth examination of other early childhood resources in each potential area, and an assessment of community support for home visiting programs. Availability of funding for such expansion would also need to be determined.

The three major funders of these types of programs have already begun discussing this process. Steps in this process have already begun, including identifying potential providers to cover counties without a home visiting program, and discussions regarding available funding.

ATTACHMENT 1 – REQUIRED CAPACITY ASSESSMENT DATA

The table below presents HRSA-required capacity assessment information for high-risk counties. This information is from a survey of providers, and may not reflect all programs in the counties.

High Risk County Information

	Have at least one program		Use evidence-based model		Funded by MIECHV		Families served by program(s) serving county in fiscal year	
	Y/N	#	Y/N	#	Y/N	#	Total	# Programs
Adams	Y	3	Y	3	N	0	415	2
Box Butte	Y	1	Y	1	Y	1	46	1
Brown	Y	1	Y	1	-	-	-	-
Butler	N	0	N/A	N/A	N/A	N/A	N/A	N/A
Dakota	Y	1	Y	1	Y	1	60	1
Dawson	Y	3	Y	3	-	-	260	2
Dodge	Y	4	Y	4	Y	1	122	3
Douglas	Y	4	Y	4	Y	1	305	3
Filmore	Y	1	Y	1	N	0	373	1
Gage	Y	2	Y	2	Y	1	439	2
Gosper	N	0	N/A	N/A	N/A	N/A	N/A	N/A
Hall	Y	2	Y	2	N	0	400	1
Jefferson	Y	2	Y	2	Y	1	439	2
Johnson	Y	1	Y	1	N	0	373	1
Keith	N	0	N/A	N/A	N/A	N/A	N/A	N/A
Lancaster	Y	3	Y	3	Y	1	143	1
Lincoln	Y	1	Y	1	N	0	45	1
Morrill	Y	1	Y	1	Y	1	46	1
Nemaha	Y	3	Y	3	Y	1	45	3
Otoe	Y	1	Y	1	Y	1	22	1
Pawnee	Y	1	Y	1	Y	1	22	1
Polk	N	0	N/A	N/A	N/A	N/A	N/A	N/A
Red Willow	Y	1	N	0	N	0	18	1
Richardson	Y	3	Y	2	Y	1	91	3
Saline	Y	2	Y	2	N	0	424	2
Saunders	Y	1	Y	1	N	0	143	1
Scotts Bluff	Y	3	Y	3	Y	1	71	2
Seward	Y	2	Y	2	N	0	402	2
Thayer	Y	1	Y	1	N	0	373	1
Thurston	Y	1	Y	1	Y	1	60	1
York	Y	3	Y	3	N	0	402	2

"-" Indicates that no programs in the county provided the information, or it cannot be calculated. N/A indicates there are no programs in the county.

ATTACHMENT 2 – COMPLETE DESCRIPTIVE DATA

The Early Development Network out of the Educational Service Unit 16 Early Childhood Special Education program provided answers that were extreme outliers. Therefore, this program was not included in calculations of descriptive data or analyses. Responses for this program are listed separately in tables under the EDN column.

Table 1. Funding Sources (n = 47)

	All Programs		EDN
Funding Source*	***n***	**%**	
Federal	21	44.7	X
State	26	55.3	X
Local	7	14.9	X
Private	17	36.2	
Hospital	5	10.6	
Foundation	14	29.8	
Other (please specify):			
Along with in-kind from local school district and private agencies	1	2.1	

*Note: Participants could select more than one response option

Table 2. Evidence-Based or Evidence-Informed Curriculum or Model Being Used (n = 47)

Curriculum or Model*	***n***	**%**	**EDN**
Attachment and Bio-behavioral Catch-Up (ABC) Intervention	0	0	
Child FIRST	0	0	
Durham Connects/Family Connects	0	0	
Early Head Start - Home-Based Option	10	21.3	
Early Intervention Program for Adolescent Mothers	0	0	
Early Start (New Zealand)	0	0	
Family Check-Up for Children	1	2.1	
Family Spirit	0	0	
Health Access Nurturing Development Services (HANDS) Program	0	0	
Healthy Beginnings	3	6.4	
Healthy Family America	9	19.1	
Home Instruction for Parents of Preschool Youngsters	0	0	
Maternal Early Childhood Sustained Home Visiting Program	1	2.1	
Minding the Baby	0	0	
Nurse-Family Partnership	0	0	
Parents as Teachers	21	44.7	
Play and Learning Strategies - Infant	0	0	
SafeCare Augmented	0	0	
Other (please specify):			
Getting Ready	3	6.3	X
PIWI [Parents Interacting with Infants]	1	2.0	

Curriculum or Model*	*n*	%	EDN
Growing Great Kids	7	14.8	
Hawaii Early Learning Profile HS	1	2.1	
None - Home-type visit	1	2.1	
Partners for a Healthy Baby	4	8.4	
Incredible Years and Developmental Parenting	1	2.1	

*Note: Participants could select more than one response option

Table 3. Number of Years Providing Services

	Mean	SD	Min	Max	EDN
How many years has your agency been providing home visiting services? (*n* = 45)	13.9	10.1	1	40	42

Table 4. Counties Served by Programs (*n* = 47)

County*	*n*	%	EDN	County*	*n*	%	EDN	County*	*n*	%	EDN
Adams	3	6.4		**Fillmore**	1	2.1		**McPherson**	0	0	
Antelope	1	2.1		**Franklin**	1	2.1		**Madison**	2	4.3	
Arthur	0	0		**Frontier**	1	2.1		**Merrick**	1	2.1	
Banner	0	0		**Furnas**	1	2.1		**Morrill**	1	2.1	
Blaine	1	2.1		**Gage**	2	4.2		**Nance**	0	0	
Boone	0	0		**Garden**	1	2.1		**Nemaha**	3	6.4	
Box Butte	1	2.0		**Garfield**	0	0		**Nuckolls**	3	6.4	
Boyd	0	0		**Gosper**	0	0		**Otoe**	1	2.1	
Brown	1	2.1		**Grant**	0	0		**Pawnee**	1	2.1	
Buffalo	3	6.4		**Greeley**	2	4.3		**Pierce**	1	2.1	
Burt	1	2.1		**Hall**	2	4.3		**Platte**	1	2.1	
Butler	0	0		**Hamilton**	2	4.3		**Polk**	0	0	
Cass	1	2.1		**Harlan**	1	2.1		**Red Willow**	1	2.0	
Cedar	1	2.1		**Hayes**	0	0		**Richardson**	3	6.4	
Chase	0	0		**Hitchcock**	0	0		**Rock**	0	0	
Cherry	0	0		**Holt**	1	2.1		**Saline**	2	4.3	
Cheyenne	1	2.1		**Hooker**	0	0		**Sarpy**	6	12.8	
Clay	2	4.3		**Howard**	1	2.1		**Saunders**	1	2.1	
Colfax	1	2.1		**Jefferson**	2	4.3		**Scotts Bluff**	3	6.4	
Cuming	1	2.1		**Johnson**	1	2.1		**Seward**	2	4.3	
Custer	2	4.3		**Kearney**	0	0		**Sheridan**	0	0	
Dakota	1	2.1		**Keith**	0	0		**Sherman**	2	4.3	
Dawes	0	0		**Keya Paha**	0	0		**Sioux**	0	0	
Dawson	3	6.4		**Kimball**	0	0		**Stanton**	1	2.1	
Deuel	1	2.1		**Knox**	1	2.1		**Thayer**	1	2.1	
Dixon	1	2.1		**Lancaster**	3	6.4		**Thomas**	0	0	X
Dodge	4	8.5		**Lincoln**	1	2.1		**Thurston**	1	2.1	
Douglas	4	8.5		**Logan**	0	0		**Valley**	2	4.3	
Dundy	0	0.0		**Loup**	1	2.1		**Washington**	1	2.1	

County*	*n*	%	EDN	County*	*n*	%	EDN
Wayne	1	2.1		**Wheeler**	0	0	
Webster	2	4.3		**York**	3	6.4	

*Note: Participants could select more than one response option

Table 5. Capacity Information

	Mean	SD	Min	Max	EDN
What is your program's enrollment capacity (number of families)? (*n* = 36)	77.1	98.9	5	400	10,000
How many families (defined by primary caregiver) received services from your program in the most recently ended fiscal year? (*n* = 34)	71.9	94.6	3	400	80
How many total children received services in the most recently ended fiscal year? (*n* = 34)	88.9	116.9	4	450	85

Table 6. Eligibility Criteria for Programs (*n* = 47)

Eligibility Criteria*	*n*	%	EDN
Caregiver drug/alcohol use	14	29.8	
Caregiver mental health diagnosis	14	29.8	
Child mental health diagnosis	7	14.9	
Child with special healthcare needs	14	29.8	
Court ordered	4	8.5	
English as a second language child	13	27.7	
English as a second language parent/caregiver	19	40.4	
First time parent(s)	11	23.4	
Free/reduced lunch eligible children	19	40.4	
Foster child	15	31.9	
Low birth weight or premature birth of child	24	51.1	
Pregnant women	22	46.8	
Pregnant/parenting teens	30	63.8	
Refugee status of parent/caregiver	4	8.5	
Single parent	14	29.8	
Age of child	34	72.3	X
Income limitation	21	44.7	
Other (please specify):			
Any child residing in Richardson County or within 10 miles of county border	1	2.1	
Caregiver ACEs, previous CPS involvement, social isolation, poor compliance with prenatal care, history of IPV, caregiver knowledge of milestone is not age-appropriate, low bonding/attachment	1	2.1	

Eligibility Criteria*	*n*	%	EDN
Child must meet criteria as delayed or at risk of developing a delay by guidelines created by NDE	1	2.1	
Disability	0	0	X
Early Development Network	1	2.1	
Homelessness	2	4.3	
HFA positive screen	1	2.1	
Low education	1	2.1	
Parent without a high school diploma	1	2.0	
Pregnant/parenting under 25 years	1	2.0	
Reside in Douglas county, be 22 or older	1	2.0	
Rule 52 eligibility for early intervention	1	2.0	
These are some of the risk factors to qualify	1	2.0	

*Note: Participants could select more than one response option

Table 7. Specific Age Eligibility Requirements if Used (*n* = 47)

Specific Age eligibility requirements*	*n*	%	EDN
Prenatal	31	66.0	
Birth up to age 1	31	66.0	X
1 year of age	30	63.8	X
2 years of age	28	59.6	X
3 years of age	22	46.8	X
4 years of age	4	8.5	X
5 years of age	3	6.4	X
6 years of age	0	0	
Other (please specify):			
Birth to 2 weeks old (can enroll a certain % up to 3 mos after birth)	1	2.0	
TC under 2 weeks old at time of referral	1	2.0	
up to 18 months	1	2.0	

*Note: Participants could select more than one response option

Table 8. Specific Income Limitations if Used (*n = 47)*

Specific Income Limitations	*n*	%	EDN
Dollar Amount	2	4.3	
20000	1	2.1	
Depends, we use FRL based on family size	1	2.1	
Federal Poverty Limit	9	19.1	
100	3	6.4	
100-185%	1	2.1	
100%, 129.9%	1	2.1	
130%	1	2.1	
150%	1	2.1	
200	1	2.1	

Specific Income Limitations	*n*	%	EDN
300	1	2.1	

Table 9. Meeting the Needs of Diverse Clients (*n* = 47)

Meet needs of clients with diverse language/cultures by:*	*n*	%	EDN
Brochures and educational materials are printed in a language other than English	34	72.3	X
Pictures on printed materials or decorative materials in office are reflective of different cultures	24	51.1	X
Forms are printed in multiple languages	28	59.6	X
In-person interpreters are available and utilized	35	74.5	X
The language line is used for interpretation	11	23.4	X
Other (please specify):			
Bilingual staff	7	14.7	
At this time, we only have English speaking families. We do have materials such as books and posters in English and Spanish. We will utilize the public schools Spanish teacher if the need would arise.	1	2.0	

*Note: Participants could select more than one response option

Table 10. Meeting the Needs of Diverse Clients (continued)

	n	%	EDN
Do you have home visiting staff who reflect the population you are serving? (*n*=41)			
Yes	35	85.4	X
No	6	14.6	
Do you have community members or consumers involved in an advisory role for your home visiting program? (*n*=38)			
Yes	34	87.2	X
No	5	10.6	

Table 11. What Other Ways do you Ensure you are Responsive to the Diversity of Your Clientele? (*n* = 18)

Ways programs meet diverse client needs:	*n*	%	EDN
ACTIVELY ENGAGING ALL CLIENTS REGARDLESS OF THEIR DIVERSE BACKGROUND	1	2.5	
All home visitors are Hispanic and bilingual	1	2.5	
Attend trainings	3	16.7	
QA survey to families with that question, education	1	2.5	
Discuss language and cultural preferences for families	1	2.5	
Educate ourselves on the cultural traditions, habits,expectations of the clientele and be respectful of them.	1	2.5	
Collaborative efforts with community agencies	5	27.8	
Migrant program staff serve on our advisory committee. Bilingual home visitor is heavily involved in the Hispanic community.	1	2.5	
Provide services in their home language	1	2.5	
Utilizing interpreters	1	2.5	

Ways programs meet diverse client needs:	*n*	%	EDN
We accept referrals on families from any diverse background. We are non-discriminatory.	1	2.5	
We present materials in their language, we use interpreters, we present community events that embrace different cultures.	1	2.5	
Bilingual story books are utilized. Testing in Spanish is available.	0	0	X

Table 12. Do you Maintain a Waiting List for Home Visitation Services? (*n* = 41)

Do you maintain a waiting list?	*n*	%	EDN
Yes	23	56.1	
No	18	43.9	X

Table 13. Waiting List Information

Waiting list information	Mean	SD	Min	Max	EDN
How many people are currently on your waiting list for home visitation services? (*n* = 21)	21.4	42.9	0	200	-
What is the average number of days people are on the waiting list? (*n* = 16)	65.6	56.7	3	180	-

Table 14. Access to Services

	n	%	EDN
Do you feel there are families who could benefit from home visiting in your area who are not receiving services? (*n* =40)			
Yes	34	85.0	X
No	6	15.0	
Have there been any recent reductions in funding that impacted the number of families you can serve? (*n* =41)			
Yes	3	7.3	
No	38	92.7	X

Table 15. Reasons Families are not Receiving Services *(n* = 47)

Reason*	*n*	%	EDN
Population barriers (please specify):	5	10.6	
Families are not aware of the program	1	2.0	
Families do not want the school "in their business"	1	2.0	
Immigration worries	1	2.0	
They are not low income but still would like assistance with parenting, age of the parent and or child depending on which program	1	2.0	
Want center based services	1	2.0	
Program capacity	15	31.9	
Inadequate funding	7	14.9	
Other (please specify):			
Lack of awareness or knowledge of programs	6	6.3	
Could use additional partners	1	2.0	

Reason*	*n*	%	EDN
Do not seek our services	1	2.0	
Doctors hesitant to refer families with lower needs for fear of offending the parent(s)	1	2.0	
Eligibility limitations	1	2.0	
Families have to meet criteria as having a child with a disability to receive home visiting from our program. There is a large need of families that would benefit from a home visitor in North Platte that do not fall under that category.	1	2.0	
Haven't been referred	1	2.0	
Karen and Burmese special needs population	1	2.0	
Language barriers	1	2.0	
Lack of referral	1	2.0	
Unwillingness/do not want to/choose not to participate/decline offers	6	6.3	
Parents unable to find the time because of work schedules and other on-going family issues	1	2.0	
Staffing	1	2.0	
The assumption that we work with CPS and fear losing their child	1	2.0	
Transportation, time, pandemic	1	2.0	
Haven't been referred			X

*Note: Participants could select more than one response option

Table 16. Percent of Families who Complete Program (n = 34)

	Mean	SD	Min	Max	EDN
What percent of families complete your home visitation program?	74.9	24.8	4	100	100

Table 17. Staff Attrition (n = 37)

	Mean	SD	Min	Max	EDN
What is your staff attrition rate (percent of staff lost in one year)?	15.4	26.4	0	100	7
What is the average number of days it takes to fill a new position?	37.6	27.3	0	120	30

Table 18. Staff Requirements

	n	%	EDN
What is the minimum educational attainment required for home visiting staff positions? (*n* =40)			
High school or equivalent	11	27.5	

Associate's	9	22.5	
Bachelor's	20	50.0	X
What is the preferred educational attainment for home visiting staff positions? (*n* =40)			
Associate's	5	12.5	
Bachelor's	28	70.0	
Master's	1	2.5	X
Same as minimum required education	6	15.0	

Table 19. Specialization(s) or Major(s) Required for Staff (*n* = 47)

Specialization(s) or major(s)	*n*	%	EDN
DEVELOPMENT, EFFECTS OF TRAUMA, COMPASSION	1	2.1	
Early Childhood Education	11	23.4	
Social Work	8	17.0	
Human Relations/Sciences Field	6	12.7	
Nursing	9	19.1	
Sociology	4	8.5	
Child Development	2	4.1	
Psychology	7	14.9	
ECSE endorsement, speech/language pathology endorsement, OT or PT licensure, deaf educator endorsement	0	0	X
Service Coordinators are asked to have at least an associate's degree. Coaches need a teaching certificate with SPED endorsement or specialized degree such as an OT, PT or SLP.	1	2.1	
Public Health	2	4.2	
Education	3	6.4	

Table 20. Training Topics for Staff (*n* = 47)

Training Topic*	*n*	%	EDN
Child Abuse/Neglect	36	76.6	
Communication	13	27.7	
Cultural Competency	19	40.4	X
Family Systems	16	34.0	X
Infant/Toddler Development	27	57.4	
Mental Health	13	27.7	
Motivational Interviewing	7	14.9	
Quality Improvement (QI)	6	12.8	
Safety in Home Visiting	31	66.0	
Self-Care	14	29.8	
Working with Families Exposed to Violence	17	36.2	
Other (please specify):			
All	1	2.1	
Confidentiality, ethics, boundaries, HFA goals/philosophies, curriculum, data collection/documentation, reflective strategies, community resources	1	2.1	

Training Topic*	*n*	%	EDN
Curriculum	3	2.1	
OSHA	1	2.1	
District On-Boarding Training	1	2.1	
EHS Performance Standards	1	2.1	
GOLD	1	2.1	
Home Visiting Core Practices and Principles. First Connections may be required.	1	2.1	
Home Visiting Modules	1	2.1	
Infant Mortality	1	2.1	
Parents and Teachers	1	2.1	
Services Coordination training	1	2.1	
Trauma Informed Services	1	2.1	
Working with Families in Poverty, Trauma Informed Practice,	1	2.1	

*Note: Participants could select more than one response option

Table 21. Agencies Clients are Regularly Referred to (*n* = 47)

Service or agency clients are referred to*	*n*	%	EDN
Breastfeeding Support	26	55.3	
Child Care Providers	30	63.8	X
Child Welfare	21	44.7	X
Community Action Programs	30	63.8	X
Community Health Services (family planning, immunizations, reproductive health screenings)	32	68.1	X
Dental Care	28	59.6	X
Developmental Delay (EDN)	32	68.1	X
Domestic Violence	27	57.4	X
Early Development Network/Developmental Delay	36	76.6	X
Economic Assistance	28	59.6	X
Education (going back to school - college, trade school, finishing high school/GED)	28	59.6	
Employment (job training)	27	57.4	
Food/Nutrition (WIC, food pantry)	36	76.6	X
Hospitals	20	42.6	
Housing (finding affordable housing)	31	66.0	X
Legal Aid (immigration, child custody, protection against partner)	24	51.1	
Mental Health	32	68.1	X
Primary Healthcare Providers/Federally Qualified Health Centers	26	55.3	X
Safety (car seat safety check)	34	72.3	X
Schools K-12	19	40.4	
Substance Use	23	48.9	
School for Preschool Enrollment	1	2.1	

*Note: Participants could select more than one response option

Table 22. Services Referrals are Received From (*n* = 47)

Service or agency referrals are received from*	*n*	%	EDN
Breastfeeding Support	9	19.1	
Child Care Providers	16	34.0	X
Child Welfare	16	34.0	X
Community Action Programs	19	40.4	
Community Health Services (family planning, immunizations, reproductive health screenings)	18	38.3	
Dental Care	4	8.5	
Developmental Delay (EDN)	16	34.0	
Domestic Violence	8	17.0	
Early Development Network/Developmental Delay	25	53.2	
Economic Assistance	5	10.6	
Education (going back to school - college, trade school, finishing high school/GED)	4	8.5	
Employment (job training)	2	4.3	
Food/Nutrition (WIC, food pantry)	21	44.7	
Hospitals	22	46.8	
Housing (finding affordable housing)	4	8.5	
Legal Aid (immigration, child custody, protection against partner)	3	6.4	
Mental Health	9	19.1	
Primary Healthcare Providers/Federally Qualified Health Centers	19	40.4	X
Safety (car seat safety check)	4	8.5	
Schools K-12	16	34.0	
Substance Use	3	6.4	
Family/Friends	30	63.8	X
Other (please specify):			
Child Find	1	2.1	
From families that are part of the program	1	2.1	
Self	1	2.1	

*Note: Participants could select more than one response option

Table 23. Referrals to Mental Health or Substance Use Services

	n	%	EDN
Are there local mental health services to which you can refer clients? (*n* =39)			
Yes	37	94.9	X
No	2	5.1	
Are there local substance use services to which you can refer clients? (*n* = 39)			
Yes	31	79.5	X
No	8	20.5	

Table 24. Community Collaboratives (*n* = 39)

Are there any community collaboratives in your area that you participate in?	*n*	%	EDN
Yes	39	100	X
No	0	0.0	

Table 25. Description of the Community Collaborative Efforts (*n* = 38)

Community collaborative description
Adams County Community for Kids
Advisory meeting, community & family partnership
Birth to Five Advisory Committee, Early Development Network, Foster Grandparents, etc.
Casa, Headstart, Kiwanis, optimist, extension office, treatment team
Communities 4 Kids (Nebraska Children & Families Foundation), 0-3 Coalition, ESU 4 Planning Region Team, Collective Impact, Multidisciplinary Team (LB1184), Head Start Health Advisory, United Against Violence
Community 4 Kids, Early Learning
Community Response Initiatives, Early Childhood Collaboration, MAACH (housing), Black Family Health and Wellness, North Omaha Community Care Council, South Omaha Violence and Prevention, South Omaha Community Care Council, Empowerment Network, Omaha 360, Opportunity Youth
Doane University students, Library programs, School programs, Early Head Start, Blue Valley Community Action programs, Public Health Solutions
ESU 4 PRT Team Meetings
ESU 5 Planning Region Team, 1184 Treatment Team Meetings, County Juvenile Prevention Services, Connected Youth Initiative Meetings
Fremont Family Coalition
Growing Community Connections - South Sioux City, Norfolk Family Coalition and Fremont Family Coalition
Hall County Community Collaborative
Head Start, Community Action,
Head Start Advisory/ public school advisory / local community response team
Health Coalition/Advisory Group
Health partners, Early Childhood coalitions
Healthy Families, public schools, dental offices, doctor offices, WIC, local hospitals, ESU's
Help Me Grow, Prosper Lincoln
HIS, Head Start, South Central Partnership
Interagency Team
LB 1184 local teams, Sixpence Advisory teams, training coalitions, ESU Advisory teams
LB1184
Multiple- NECC, breastfeeding collaboration, One World
Nebraska Early Childhood Collaborative, United Way of the Midlands, Douglas County Community Response
NORFOLK FAMILY COALITION
Planning Region 23

Community collaborative description
Planning Region 27, Communities 4 Kids, Child Abuse Prevention Council, Interagency, High Plains Collaborative, Early Learning Workgroup, Families First Partnership Workgroup, Community Response
Planning Region, MICC, MPS Early Childhood Advisory
Policy Council - NECC and CAN
Policy Council, HSAC, Refugee Taskforce
preschool advisory board, rooted in relationships
Prosper Lincoln, Breastfeeding Coalition, PRAMS, Lancaster County Treatment Team
Regional, multi-county collaboratives, Planning Region Teams,
Safe Kids - Home Safety, Community Safety, School Safety
Sixpence, Fremont family coalition- however, I am not sure we have begun to connect the services with community outcomes, and referrals. It feels like referrals are kept within the group of non profit partners
Sixpence, Southeast SafeKids Coalition, Southeast Nebraska Breastfeeding Coalition, Growing Great Kids
Southeast Nebraska Community Action refer people to the Six Pence program-the Six Pence program refers kids to Head Start
We work together to get services to families!
Community partnership groups in North Platte, Ogallala. Rooted in relationships group in Ogallala*

*EDN response

Table 26. Agencies Represented at Collaborative Meetings (*n* = 47)

Agency that participates in collaborative*	*n*	%	EDN
Breastfeeding Support	9	19.1	
Child Care Providers	23	48.9	
Child Welfare	24	51.1	X
Community Action Programs	32	68.1	X
Community Health Services (family planning, immunizations, reproductive health screenings)	16	34.0	X
Dental Care	5	10.6	
Developmental Delay (EDN)	22	46.8	X
Domestic Violence	12	25.5	X
Early Development Network/Developmental Delay	29	61.7	
Economic Assistance	17	36.2	X
Education (going back to school - college, trade school, finishing high school/GED)	14	29.8	
Employment (job training)	8	17.0	
Food/Nutrition (WIC, food pantry)	22	46.8	
Hospitals	15	31.9	
Housing (finding affordable housing)	14	29.8	
Legal Aid (immigration, child custody, protection against partner)	4	8.5	X
Mental Health	22	46.8	X
Primary Healthcare Providers/Federally Qualified Health Centers	13	27.7	

Agency that participates in collaborative*	*n*	%	EDN
Safety (car seat safety check)	7	14.9	
Schools K-12	24	51.1	X
Substance Use	8	17.0	
Other (please specify):			
Churches	1	2.0	
Health Department	1	2.0	
Homeless Shelter	1	2.0	
Law Enforcement	1	2.0	
Non-Profits	1	2.0	
County Judge	1	2.0	
Probation	2	4.0	
United Way	1	2.0	
Violence Prevention	1	2.0	

*Note: Participants could select more than one response option

Table 27. Need for Additional Programs (*n* = 37)

	n	%	EDN
Is there a need in the area for additional home visiting programs? (*n* = 37)			
Yes	20	54.1	X
No	17	45.9	

Table 28. What Other Information Would You Like to Provide About Home Visiting Programs in Your Area? (*n* = 16)

Other information
Home visiting programs for parents older than 25
More capacity for current programs would be a priority over new programs to prevent confusion and help build on current program services
Not sure if need for more, or more partnership and collaboration within the ones we have
Previously Douglas County has had a collaborative meeting with all home visitation programs in the county. These were extremely helpful in coordinating referrals and services and would be beneficial to start again.
Public Health Solutions also serves Fillmore, Saline, and Thayer counties and we will soon be providing HV services in those counties.
Right now EDN and court ordered Family Support are the only home visiting that is offered in North Platte. We are missing a large group of people and these two groups are not enough to cover the gap.
Sidney could really use a home visitation program.
The home visitor also works with parents on positive discipline strategies with the parents as well as providing activities that promote motor, language, cognitive, and social emotional development. The home visitor also provides parents with Circle of Security classes once a year.
There are minority children that can benefit from programs in this area.

To continue to partner with the programs in the area.
Transportation is an issue and can be a barrier to full participation for required socializations; continuity of providing the quality program is critical to the success of the family; emphasis needs to be put on level of education (4 year degree) and quality of on-going training of the home visitors.
We are in need of more home visitors to serve the families on our waitlist.
We had 3 home visitors for the past 5 years. In Aug 2019, we added 3 more.
We have 24 slots for our program but continue to serve more as the need in our communities is growing.
We have a good relationship in each of our communities with business and providers knowing who we are, what we offer so they can refer families for the services.
We would like to expand the number of teen parents we are able to service by having the funding to hire another home visitor.

Attachment 2: Capacity Survey

HOME VISITING CAPACITY ASSESSMENT 2020

The Nebraska Department of Health and Human Services (NeDHHS) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is conducting a required federal needs and capacity assessment of early childhood home visitation in Nebraska counties. Collaborators in this project include: Sixpence (Nebraska Children and Families Foundation) Head Start and Early Head Start (Nebraska Department of Education) Early Development Network (Nebraska Department of Education) Children and Family Services (Nebraska Department of Health and Human Services) Healthy Families of Gage and Jefferson Counties (Public Health Solutions) Home visitation programs serving the maternal, infant, and early childhood populations are defined as those who provide, as one of their primary interventions, home visitation which gives pregnant women and families necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn .If your program meets this definition, we appreciate your responses to the following questions to assist our needs and capacity assessment, and planning for expansion of services. If you are not one of the people who are most knowledgeable about your organization's home visitation program, please forward the survey link to a person who can provide information about the program.

ABOUT YOUR AGENCY

Agency Name (*Required)

Your Name

Your position at the agency

Agency's home city (*Required)

TYPE OF PROGRAM AND COVERAGE AREA

Home Visiting Program name (*Required)

What type of organization funds your home visiting

program? Please select all that apply:

- ☐ Federal
- ☐ State
- ☐ Local
- ☐ Private
- ☐ Hospital
- ☐ Foundation
- ☐ Other (please specify):

Which of the following evidence-based or evidence-informed curricula or model do you use?

Please select all that apply:

- ☐ Attachment and Bio-behavioral Catch-Up (ABC) Intervention
- ☐ Child FIRST
- ☐ Durham Connects/Family Connects
- ☐ Early Head Start - Home-Based Option
- ☐ Early Intervention Program for Adolescent Mothers
- ☐ Early Start (New Zealand)
- ☐ Family Check-Up for Children
- ☐ Family Spirit
- ☐ Health Access Nurturing Development Services (HANDS) Program
- ☐ Healthy Beginnings
- ☐ Healthy Family America
- ☐ Home Instruction for Parents of Preschool Youngsters
- ☐ Maternal Early Childhood Sustained Home Visiting Program
- ☐ Minding the Baby
- ☐ Nurse-Family Partnership
- ☐ Parents as Teachers
- ☐ Play and Learning Strategies - Infant
- ☐ SafeCare Augmented
- ☐ Other (please specify):

How many years has your agency been providing home visiting services? (Number of years)

Years

In what county(ies) do you provide home visiting? (*Required)

Please select all that apply:

- ☐ Adams
- ☐ Antelope
- ☐ Arthur
- ☐ Banner
- ☐ Blaine
- ☐ Boone
- ☐ Box Butte
- ☐ Boyd
- ☐ Brown
- ☐ Buffalo
- ☐ Burt
- ☐ Butler
- ☐ Cass
- ☐ Cedar
- ☐ Chase
- ☐ Cherry
- ☐ Cheyenne
- ☐ Clay
- ☐ Colfax
- ☐ Cuming
- ☐ Custer
- ☐ Dakota
- ☐ Dawes
- ☐ Dawson
- ☐ Deuel
- ☐ Dixon
- ☐ Dodge
- ☐ Douglas
- ☐ Dundy
- ☐ Fillmore

☐ Franklin
☐ Frontier
☐ Furnas
☐ Gage
☐ Garden
☐ Garfield
☐ Gosper
☐ Grant
☐ Greeley
☐ Hall
☐ Hamilton
☐ Harlan
☐ Hayes
☐ Hitchcock
☐ Holt
☐ Hooker
☐ Howard
☐ Jefferson
☐ Johnson
☐ Kearney
☐ Keith
☐ Keya Paha
☐ Kimball
☐ Knox
☐ Lancaster
☐ Lincoln
☐ Logan
☐ Loup
☐ McPherson
☐ Madison
☐ Merrick
☐ Morrill

☐ Nance
☐ Nemaha
☐ Nuckolls
☐ Otoe
☐ Pawnee
☐ Pierce
☐ Platte
☐ Polk
☐ Red Willow
☐ Richardson
☐ Rock
☐ Saline
☐ Sarpy
☐ Saunders
☐ Scotts Bluff
☐ Seward
☐ Sheridan
☐ Sherman
☐ Sioux
☐ Stanton
☐ Thayer
☐ Thomas
☐ Thurston
☐ Valley
☐ Washington
☐ Wayne
☐ Webster
☐ Wheeler
☐ York

NUMBER SERVED

What is your program's enrollment capacity (number of families)?

[ ] # Families

How many families (defined by primary caregiver) received services from your program in the most recently ended fiscal year?

[ ] # Families

How many total children received services in the most recently ended fiscal year?

[ ] # Children

ELIGIBILITY CRITERIA

What are the eligibility criteria for entry into your home visitation program?

Please select all that apply:

- ☐ Age of child
- ☐ Caregiver drug/alcohol use
- ☐ Caregiver mental health diagnosis
- ☐ Child mental health diagnosis
- ☐ Child with special healthcare needs
- ☐ Court ordered
- ☐ English as a second language child
- ☐ English as a second language parent/caregiver
- ☐ First time parent(s)
- ☐ Free/reduced lunch eligible children
- ☐ Foster child
- ☐ Income limitation
- ☐ Low birth weight or premature birth of child
- ☐ Pregnant women
- ☐ Pregnant/parenting teens
- ☐ Refugee status of parent/caregiver
- ☐ Single parent
- ☐ Other (please specify):

If you selected "Age of child" under Eligibility Criteria, please answer the following question:

What are the specific age eligibility requirements?

Please select all that apply:

- ☐ Prenatal
- ☐ Birth up to age 1
- ☐ 1 year of age
- ☐ 2 years of age
- ☐ 3 years of age
- ☐ 4 years of age
- ☐ 5 years of age
- ☐ 6 years of age
- ☐ Other (please specify age range):

If you selected "Income Limitation" under Eligibility Criteria, please answer the following question:

What income cut-off is used by your program - in other words, a family is eligible for services at:

- ☐ $ Dollar Amount:

  $

- ☐ % Federal Poverty Limit:

  %

In what ways do you strive to meet the needs of clients with diverse languages/cultures?

Please select all that apply:

- ☐ Brochures and educational materials are printed in a language other than English
- ☐ Pictures
- ☐ Pictures on printed materials or decorative materials in office are reflective of different cultures
- ☐ Forms are printed in multiple languages
- ☐ In-person interpreters are available and utilized
- ☐ The language line is used for interpretation
- ☐ Other (please specify)

Do you have home visiting staff who reflect the population you are serving?

- ☐ Yes
- ☐ No

Do you have community members or consumers involved in an advisory role for your home visiting program?

- ☐ Yes
- ☐ No

What other ways do you ensure you are responsive to the diversity of your clientele?

Do you maintain a waiting list for home visitation services?

☐ Yes

☐ No

If you selected "Yes" under Do you maintain a waiting list, Please answer the following TWO questions:

How many families are currently on your waiting list for home visitation services?

[ ] # Families

What is the average number of days people are on the waiting list?

[ ] # Days

Do you feel there are families who could benefit from home visiting in your area who are not receiving services?

☐ Yes

☐ No

If you selected "Yes" under Do you feel there are families who could benefit from home visiting in your area who are not receiving services, please answer the following question:

What are the reasons these families are not receiving services?

Please select all that apply:

☐ Population barriers (please explain):

☐ Program capacity

☐ Inadequate funding

☐ Other (please specify):

What percent of families complete your home visitation program?

%

Have there been any recent reductions in funding that impacted the number of families you can serve?

☐ Yes

☐ No

What is your staff attrition rate (percent of staff lost in one year)?

[ ] %

What is the average number of days it takes to fill a new position?

[ ] # Days

What is the minimum educational attainment required for home visiting staff positions?

- ☐ High School or equivalent
- ☐ Associate's
- ☐ Bachelor's
- ☐ Master's

If you selected "Associate's" or "Bachelor's" or "Master's" to What is the minimum educational attainment required for home visiting staff positions, please answer the following question:

What subject specialization(s) or major(s) are required (if any)?

See what you selected above as your minimum required education level. What is the preferred educational attainment for home visiting staff positions? (May be same as minimum required education.)

- ☐ High School or equivalent
- ☐ Associate's
- ☐ Bachelor's
- ☐ Master's
- ☐ Same as minimum required education

What training topics do home visitation staff need to complete before they can see families?

Please select all that apply:

- ☐ Child Abuse/Neglect
- ☐ Communication
- ☐ Cultural Competency
- ☐ Family Systems
- ☐ Infant/Toddler Development
- ☐ Mental Health
- ☐ Motivational interviewing
- ☐ Quality Improvement (QI)
- ☐ Safety in home visiting
- ☐ Self-care
- ☐ Working with families exposed to violence
- ☐ Other (please specify):

What agencies do you **regularly refer clients to**?

Please select all that apply:

- ☐ Breastfeeding support
- ☐ Child care providers
- ☐ Child welfare
- ☐ Community Action Programs
- ☐ Community health services (family planning, immunizations, reproductive health screenings)
- ☐ Dental care
- ☐ Developmental Delay (EDN)
- ☐ Domestic violence
- ☐ Early Development Network/Developmental Delay
- ☐ Economic assistance
- ☐ Education (going back to school - college, trade school, finishing high school/GED)
- ☐ Employment (job training)
- ☐ Food/Nutrition (WIC, food pantry)
- ☐ Hospitals
- ☐ Housing (finding affordable housing)
- ☐ Legal Aid (immigration, child custody, protection against partner)
- ☐ Mental Health
- ☐ Primary healthcare providers/Federally Qualified Health Centers
- ☐ Safety (car seat safety check)
- ☐ Schools K-12
- ☐ Substance use
- ☐ Other (please specify):

From which services do you **regularly receive referrals**?

Please select all that apply:

- ☐ Breastfeeding support
- ☐ Child care providers
- ☐ Child welfare
- ☐ Community Action Programs
- ☐ Community health services (family planning, immunizations, reproductive health screenings)
- ☐ Dental care
- ☐ Developmental Delay (EDN)
- ☐ Domestic violence
- ☐ Early Development Network/Developmental Delay
- ☐ Economic assistance
- ☐ Education (going back to school - college, trade school, finishing high school/GED)
- ☐ Employment (job training)
- ☐ Food/Nutrition (WIC, food pantry)
- ☐ Hospitals
- ☐ Housing (finding affordable housing)
- ☐ Legal Aid (immigration, child custody, protection against partner)
- ☐ Mental Health
- ☐ Primary healthcare providers/Federally Qualified Health Centers
- ☐ Safety (car seat safety check)
- ☐ Schools K-12
- ☐ Substance use
- ☐ Family/friends
- ☐ Other (please specify):

Are there local mental health services to which you can refer clients?

☐ Yes

☐ No

Are there local substance use services to which you can refer clients?

☐ Yes

☐ No

Are there any community collaboratives in your area that you participate in (e.g.: coalition, collaborative partnership, advisory committee, work groups, universal referral system, etc.)?

☐ Yes

☐ No

If you responded "Yes" to Are there any community collaboratives in your area that you participate in, please respond to the following TWO questions:

Please describe this/these community collaborative(s):

What agencies are regularly represented among the people who regularly attend meetings of this/these collaborative(s)?

Please select all that apply:

- ☐ Breastfeeding support
- ☐ Child care providers
- ☐ Child Welfare
- ☐ Community Action Programs
- ☐ Community health services (family planning, immunizations, reproductive health screenings)
- ☐ Dental care
- ☐ Developmental Delay (EDN)
- ☐ Domestic violence
- ☐ Early Development Network/Developmental Delay
- ☐ Economic assistance
- ☐ Education (going back to school - college, trade school, finishing high school/GED)
- ☐ Employment (job training)
- ☐ Food/Nutrition (WIC, food pantry)
- ☐ Hospitals
- ☐ Housing (finding affordable housing)
- ☐ Legal Aid (immigration, child custody, protection against partner)
- ☐ Mental Health
- ☐ Primary healthcare providers/Federally Qualified Health Centers
- ☐ Safety (car seat safety check)
- ☐ Schools K-12
- ☐ Substance use
- ☐ Other (please specify):

Is there a need in the area for additional home visiting programs?

☐ Yes

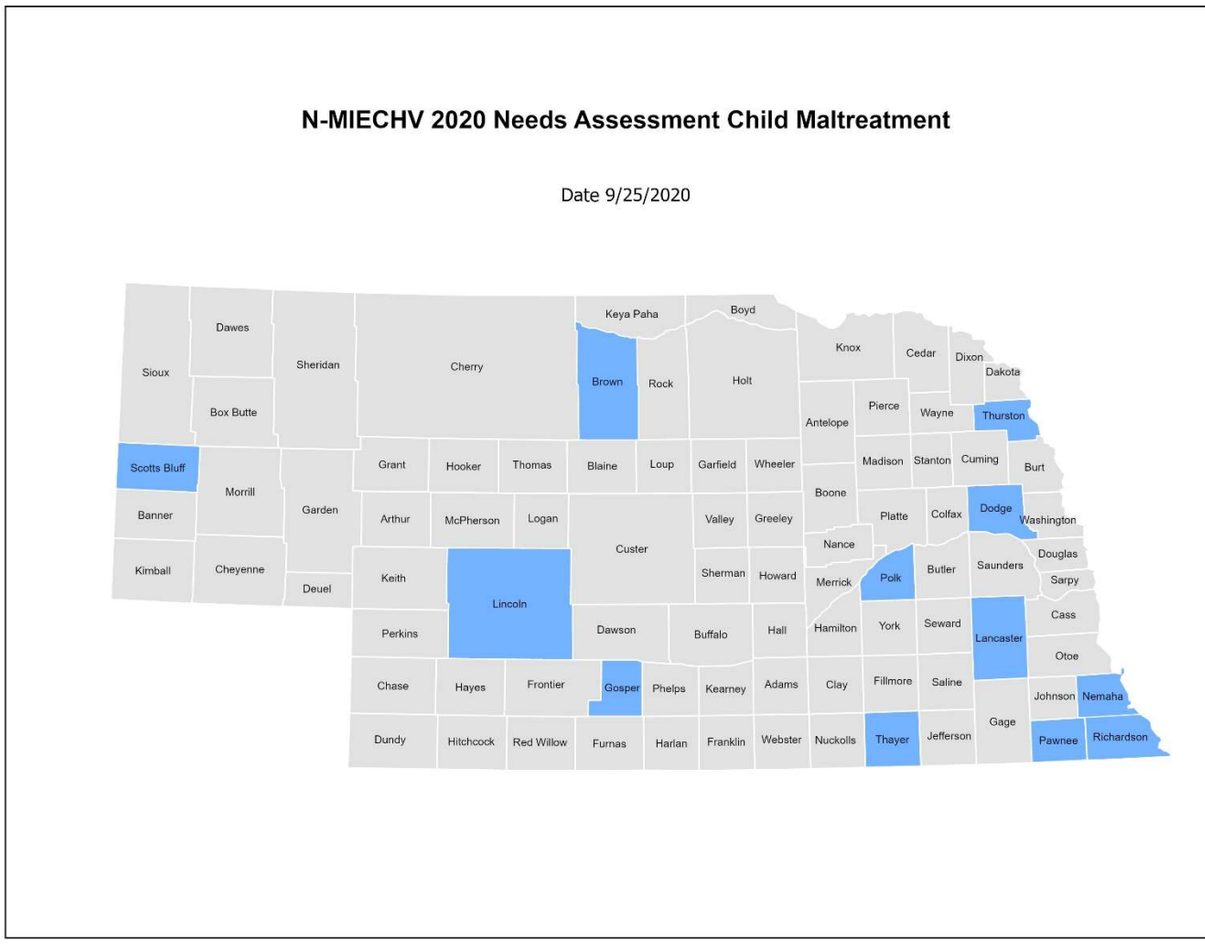
☐ No

What other information would you like to provide about home visiting programs in your area?

THANK YOU FOR COMPLETING THIS SURVEY!

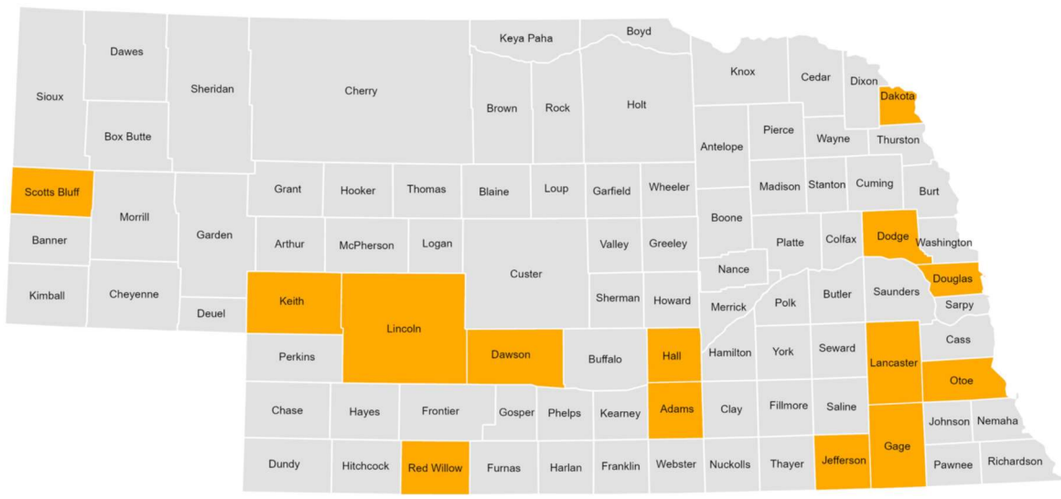
Your responses will be aggregated with those of other agencies to complete the required capacity assessment. This information will also inform possible future expansion of home visiting programs throughout Nebraska. Results will be available from N-MIECHV (http://dhhs.ne.gov/Pages/Maternal-Infant-Early-Childhood-Home- Visiting.aspx) in October, 2020.

Attachment 3: Domain Maps



N-MIECHV 2020 Needs Assessment Crime

Date 7/10/2020

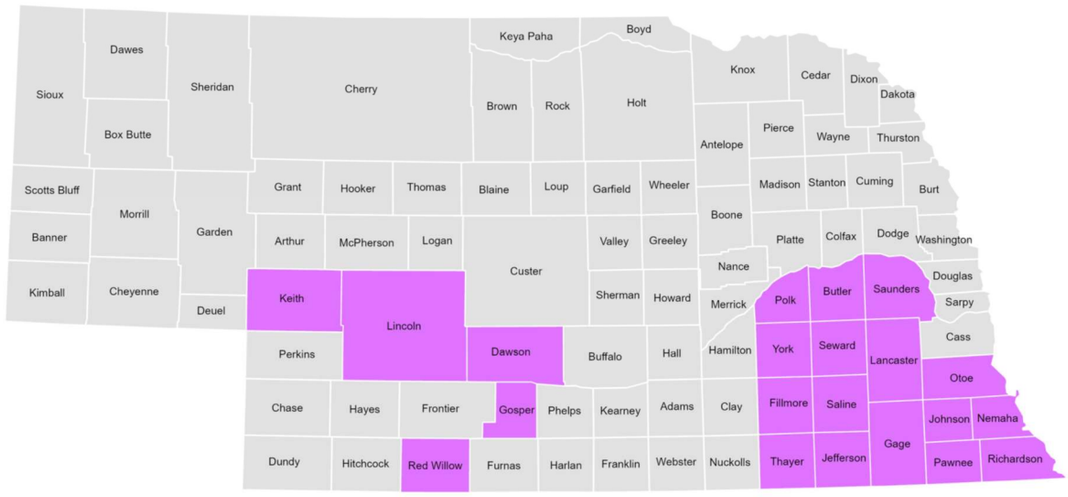


N-MIECHV 2020 Needs Assessment Socioeconomic Status

Date 7/10/2020

N-MIECHV 2020 Needs Assessment Substance Use Disorder

Date 7/10/2020



N-MIECHV 2020 Needs Assessment Adverse Perinatal Outcomes

Date 7/10/2020