


The Youngest Nebraskans:

A Statistical Look at Infants and Toddlers in Nebraska

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Child TRENDS

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Introduction

Like all states, Nebraska faces distinct challenges in how it allocates resources to meet the most immediate needs of its citizens while investing responsibly in long-term social and economic growth. Very often, this is a balancing act between competing priorities that policymakers must negotiate using the best available information to make their decisions. In the realm of public policy, any significant commitment represents a trade-off: we can do this, but only if we do less of that.

Given that public resources are finite, investments that address a wide range of pressing concerns while simultaneously anticipating Nebraska's social and economic needs for years to come should be given attention. The purpose of this report is to explore whether investments in children during the first 3 years of life meet that criterion.

The period of infancy and toddlerhood (birth to age 3) is a time of enormous potential. Development during this stage of life is rapid, dynamic, and keenly sensitive to inputs from children's social, physical, and biological environments.

Our growing understanding of brain development and of the complex interplay of genetics and experience has heightened appreciation of the first few years of life as the time when fundamental predispositions regarding health, cognition, and patterns of behavior, for better and worse, become established. These patterns can create pathways that become increasingly resistant to change as children reach school age, adolescence, and adulthood. The infant-and-toddler period is increasingly seen as the time during which opportunities to help set children on a path to flourish are greatest.

In recent years, an expanding body of research shows that, from a "dollars-and-cents" perspective, few investments yield monetary returns to society equal to those derived from high-quality care of our youngest children. These returns include (but are not limited to) cost savings from reduced special education placement, grade retention and dropout, rising healthcare expenses, prosecution and incarceration of criminal offenders, lower reliance on systems of public support, increased workforce participation, and higher individual earnings. While it is true that later interventions can also be cost-effective, they are often addressing or mitigating problems arising from inadequate investment earlier in life, and so produce a lower net return.[1]

The optimal development of young children is often framed as a matter of their readiness to enter formal schooling with the attitudes, knowledge, and skills that will set them up for academic success—and, more generally, on a path for positive life outcomes. The "achievement gap," variously identified as threatening our national performance in higher education, high school graduation, third-grade reading achievement, kindergarten readiness, and so on, in fact begins much earlier—in infancy.[2]

[1]Kilburn, M. R., & Karoly, L. A. (2008). What does economics tell us about early childhood policy? Rand Corporation Research Brief. Retrieved from http://www.rand.org/pubs/research_briefs/RB9352.html.
Lynch, R. (2004). Exceptional returns: Economic, fiscal, and social benefits of investment in early childhood development. Economic Policy Institute. Retrieved from http://www.unicef.org/lac/spbarbados/Finance/Global/exceptional_returns_ECD_2004.pdf. Heckman, J. (2000).
[2]Halle, T., Forry, N., Hair, E., Perper, K., Wandner, L., Wessel, J., & Vick, J. (2009). Disparities in early learning and development: Lessons from the Early Childhood Longitudinal Study-Birth Cohort (ECLS-B). Washington, DC: Child Trends. Retrieved from http://www.childtrends.org/?publications=disparities-in-early-learning-and-development-lessons-from-the-early-childhood-longitudinal-study-birth-cohort-ecls-b

It would be a mistake to limit our focus to children's cognitive preparedness for school entry at the expense of a broader appreciation of the multidimensional and interdependent aspects of early development, health, and socioeconomic status. The predominant chronic health conditions of our era (including overweight, asthma, and depression, among others) frequently originate in early childhood, and contribute to ongoing disparities in school achievement and families' economic security.[3] Likewise, excessive or unrelieved exposure to environmental stressors in early childhood, such as violence in the home or community, neglect, and other factors, can yield profound physiological and behavioral outcomes affecting school performance, incidence of antisocial behavior, and even chronic health conditions later in life.[4]

While it is critical to acknowledge the effects of inadequate or negative early experiences, it is not sufficient to simply compensate for these factors if children are to truly thrive. In recent years, the field of developmental science has widened its focus beyond the attributes of the "normally developing" (or struggling) child to examine the indicators of well-being that describe children who "flourish."[5]

[3]Center on the Developing Child at Harvard University. (2010). The foundations of lifelong health are built in early childhood. Retrieved from http://developingchild.harvard.edu/resources/reports_and_working_papers/foundations-of-lifelong-health/
[4]Ibid.
[5]Moore, K. A. & Lippman, L. H. (Eds.) (2005). What do children need to flourish? Conceptualizing and measuring indicators of positive development. NY: Springer.

Structure of the Report

What indicators can (and can't) do

Because indicators deal with populations rather than individuals, they both reveal and conceal important features. On the one hand, indicators can by no means account for the unique circumstances and stories of individuals, any one of which may diverge markedly from the picture conveyed by aggregate data. On the other, a different order of information emerges because larger numbers can illuminate trends not necessarily apparent in the experiences of individuals. So, indicators often confirm, but sometimes challenge, what is "common knowledge." Indicators cannot tell "why" or "how," but rather "who" and "what" (and sometimes "when"). Indicators are ideal for laying the foundation for an informed conversation, and for further investigation. Despite their imperfections, indicators help keep us—all those with a stake in expanding well-being—honest with respect both to our shortcomings and our progress.

This is an indicators report on infants and toddlers that also addresses multiple aspects of children's earliest environments in Nebraska. A major challenge is to preserve, in what is necessarily a focus on numbers and trends, the knowledge that we are talking about diverse, complex lives with very real joys and sorrows. Every parent knows their infant is remarkably unique, and even those who are not parents can appreciate how each individual represents a particular combination of genes and experiences not to be duplicated. Readers are urged to keep in mind that behind the tables and charts, there are lives rich in promise and expectation.

Data on infants and toddlers

As recently as 10 or even 5 years ago, there was a lack of information on Nebraska's youngest children. Several groundbreaking surveys have significantly expanded the scope of these data. Prominent among these are the U.S. Census Bureau's American Community Survey and the National Survey of Children's Health, sponsored by the Maternal and Child Health Bureau.

In this report, we present selected indicators that describe the status of infants and toddlers in Nebraska; we often show the comparable data for the U.S. as a whole. Where the data allow, we show trends for up to 10 years to display a fuller picture of their direction. Of course, children in this group cannot report on their own well-being, so apart from physiological measures, we must rely heavily on measures that are indirect—for instance, information provided by parents.

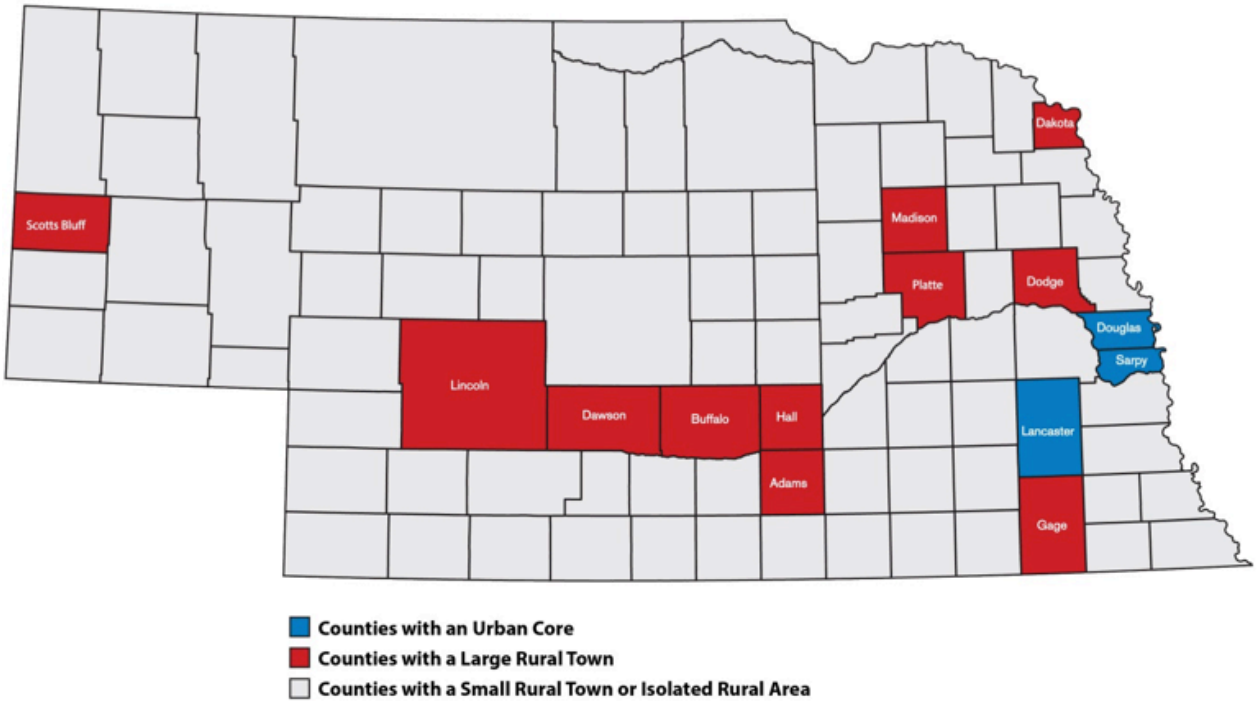
National- and state-level data, however, if not further disaggregated, can obscure important differences among subgroups of the population. These divides may fall along several lines—race, ethnic origin, immigration status, income, education, gender, region of the country, and so on. Understanding these is critical to understanding the origins, and perseverance, of various well-being disparities.

In Nebraska, a primary concern is how its youngest children are faring across the urban-rural spectrum of communities. While Nebraska is considered a primarily rural state, it does have several counties (Douglas, Lancaster, and Sarpy) that are quite urban, and others that include at least 1 large town. For this report, we disaggregate the data whenever possible by the following categories:

- Counties with an urban core[6] (Douglas, Lancaster, Sarpy)
- Counties with a large rural town[7] (Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff)
- Counties with a small rural town[8] or isolated rural area[9] (all others)

For some indicators, the data do not permit a breakdown at all 3 levels. When we refer, in these cases, to "urban" versus "non-urban" Nebraska counties, we include in "non-urban" all those without an urban core.

Nebraska Counties Classified by Community Type



Urban Core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.
Large Rural Town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at least one micropolitan community, but no metropolitan communities.
Small Rural Town is defined as a community with a population between 2,500 and 9,999. Isolated Rural Area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.

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[9]Isolated Rural Area is defined as a region with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.

In some cases, even state-level data are not available, primarily due to insufficient sample size within a survey. For those indicators, national-level data provide the best-available estimates, and may still be useful to states' understanding of the issues affecting their own youngest residents.

We set the stage for understanding Nebraska's infants and toddlers by laying out the landscape of Nebraska's infants and toddlers and their families. Here we include data on the circumstances of birth, as well as the prenatal and postpartum periods.

Next, we consider the interrelated roles of family structure and economic well-being in the families of Nebraska's infants and toddlers. Included here are also characteristics such as parental education, language spoken at home, and availability of parental leave.

The 2 sections that follow have to do with the early health and development of the youngest Nebraskans. Growth is rapid during this time, and proceeds on many fronts, so there are critical opportunities here for parents and other caregivers to help set infants and toddlers on a path to optimal well-being.

The final section deals specifically with the workforce that cares for Nebraska's infants and toddlers. This group is experiencing rapid change, as policymakers are recognizing their needs for professional development and improved career potential. The qualifications of this workforce will have much to do with seeing that the youngest Nebraskans get off to a good start.

Notes on terminology

When we state that a data point for one group is higher (or lower) than the corresponding point for another group (for example, males and females, urban and non-urban), the difference is statistically significant. If differences are not so described, the reader may assume they are not statistically significant, or that we lacked sufficient information to perform this test.

We use the term "Hispanic" to refer to the group also known as Latinos. Hispanics can be of any race; however, we have chosen to represent categories that are mutually exclusive. In this report, except where otherwise indicated, "white," "black," "Asian/Pacific Islander" and "American Indian/Alaska Native" refer to the members of those groups not also identified as Hispanic. Each of these labels of convenience, of course, can obscure the diversity typical of all of these broad categories. For instance, "black" families include African-Americans who have lived in this country for generations as well as those whose roots are in the Caribbean region but who do not identify as Hispanic, and more recent immigrants. Likewise, Hispanic families are likely to identify their heritage with any of a number of Central and South American nations.

For readers interested in more detail, the Appendix tables include all data points represented by the report charts, as well as additional subgroup data for many of the indicators.

Key Findings

We have included some observations about the composite picture that emerges in this report, identifying some common themes in the data. It is always a challenge to assemble puzzle pieces that were not necessarily designed to fit together neatly, but we provide a few key findings in an attempt to do so.

- **Nebraska's population is dispersed across a geographically diverse state:** Nebraska infants and toddlers are estimated at 77,688. Fifty-six percent live in Nebraska's urban counties, 20 percent in counties with a large rural town, and 24 percent in counties with a small rural town or isolated rural area.
- **Current investments in high-quality early childhood education reach all 3 geographic areas:** Investments in some form of high-quality early childhood education reach at-risk infants and toddlers in 100 percent of counties with an urban core or a large rural town, and 80 percent of counties with a small rural town or isolated rural area.
- **High-quality early childhood programs such as Educare and Sixpence demonstrate that interventions targeting infants and toddlers at risk better prepare these children to succeed in Nebraska's classrooms:** Evaluation data indicate that children in high-quality programs experienced gains in foundational cognitive, social, and behavioral skills as they approached school age. A follow-up study of children who attended the Educare of Omaha program for multiple years also showed persistent gains in reading, writing, and math well into the K-12 system, as well as a 50 percent reduction in the need for special education.
- **Yet, early childhood programs known to meet high-quality standards serve only a fraction of Nebraska's infants and toddlers at risk:** Only 7 percent of Nebraska's "at-risk" infants and 8 percent of Nebraska "at-risk" toddlers participate in programs recognized as meeting quality standards known to actively advance healthy cognitive, social, and emotional development.
- **Nearly two-thirds of infants and toddlers (65 percent) are in homes where all resident parents are employed, compared with 55 percent nationwide:** Because of this relatively high number, a need exists to ensure that early childhood opportunities available to parents meet the high-quality standards that prepare children to succeed in school, especially for those children most at risk. To meet this need, Nebraska requires an additional 6,314 qualified early childhood professionals who understand infant-toddler development and pursue early childhood careers across the state.
- **Nebraska families appear to lag behind national averages in key ways that support young children's development at home:** Reading, singing, and telling stories with children from birth is fundamental to cognitive and linguistic development, and sets the stage for emerging literacy skills. Nevertheless, recent survey data indicate that fewer Nebraska families read, sing, and tell stories to infants and toddlers on a daily basis than national averages, suggesting that there are gaps in caregivers' knowledge about young children's developmental needs.
- **Just over a third of Nebraska's youngest children are screened for developmental delays during the first 3 years, when interventions are most effective and least costly:** Only 35 percent of infants and toddlers in Nebraska receive developmental screenings, often resulting from parent-reported concerns about their children's physical, linguistic, and social-emotional growth. Developmental screenings are effective at identifying health or behavioral problems in young children, and better enable families to apply for and receive early intervention services that can make a difference in the life trajectories of infants and toddlers at risk.

- **Food insecurity threatens the healthy early development and life outcomes of many Nebraska infants and toddlers:** According to recent data, more than a third of Nebraska's infants and toddlers live in households that are not food secure. Lack of proper nutrition at this stage of development leads to higher rates of hospitalization, a greater incidence of chronic health conditions, and an increased likelihood of behavioral problems.

By the Numbers

Section I: Nebraska's Landscape of Infants and Toddlers and Their Families

The population of Nebraska infants and toddlers is estimated at 77,688.[10] Fifty-six percent live in Nebraska's urban counties, 20 percent in counties with a large rural town, and 24 percent in counties with a small rural town or isolated rural area.[11]

As of 2013, 7 in 10 (70 percent) Nebraska infants and toddlers are white. Just 1 in 17 (6 percent) is black, but 1 in 6 (17 percent) is Hispanic. Four percent of Nebraska infants and toddlers are identified as being of more than 1 race. There are small populations of Asian (about 1,700 statewide), American Indian (about 800 statewide), and Pacific Islander (fewer than 100 statewide) infants and toddlers.[12]

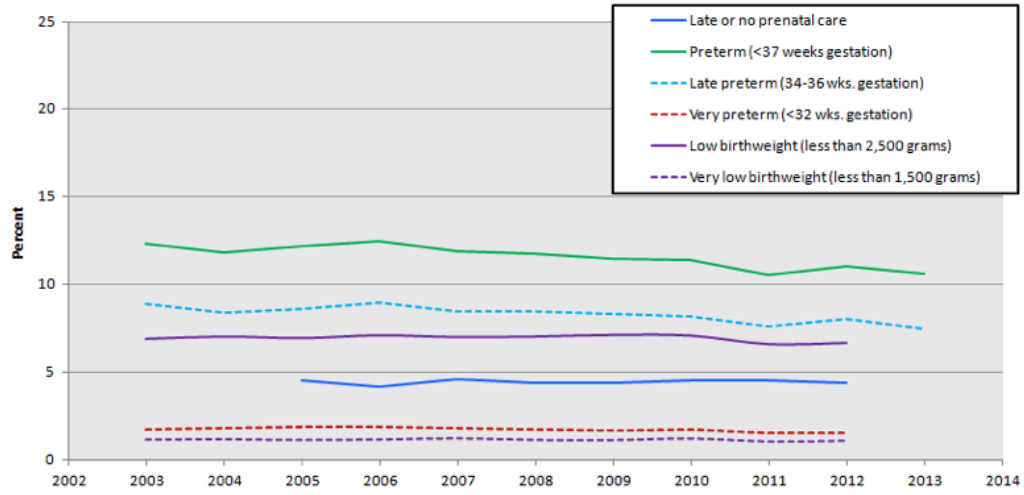
Prenatal care

For the most recent year available (2012), 4.4 percent of pregnant Nebraska women received late or no prenatal care, compared with 6.0 percent of women nationally. In recent years, Nebraska's overall record on prenatal care has been better than the nation's. However, the rate for black Nebraska women was 5.9 percent, and, for Hispanic women, 8.4 percent. In recent years, there is a consistent pattern showing slightly higher rates of late or no care for women living in Nebraska's non-urban counties.[13]

The shared well-being of mother and child begins with prenatal care. Pregnant women who receive no prenatal care, or whose care begins only in the last trimester of pregnancy, are more likely to have infants with health problems. Mothers who do not receive prenatal care are 3 times more likely to give birth to a low-weight infant, and their infant is 5 times more likely to die. However, in addition to the initiation of care, its frequency and timing are important, especially to respond effectively to specific maternal risk factors.[14]

[10]U.S. Census Bureau; Estimates derived from American Community Survey, 2013 American Community Survey 5-Year Estimates, Tables B09001 & B17024; generated by First Five Nebraska; using American Factfinder; <http://factfinder2.census.gov>; (4 December 2014).
[11]Ibid.
[12]Child Trends' calculations from the 2013 intercensal population estimates from the Census Bureau, retrieved from http://www.census.gov/popest/data/state/asrh/2013/index.html.
[13]National Center for Health Statistics, CDC WONDER online tool. Retrieved from: http://wonder.cdc.gov/.
[14]Child Trends DataBank. (2014). Late or no prenatal care. Retrieved from http://www.childtrends.org/?indicators=late-or-no-prenatal-care

Of Nebraska births, percentages with late* or no prenatal care; preterm, late preterm, or very preterm; and low or very low birthweight: 2003-2013**



* Late care means that the mother received care only in the third trimester.
**Data for 2013 is preliminary.
Sources: Data for prenatal care 2005-2006:Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm. All other data 2003-2012: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/. Data for 2013:Hamilton B. E., Martin J. A., Osterman, M. J. K., & Curtin, S. C. (2014). Births: Preliminary data for 2013. National Vital Statistics Reports, 63(2). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_02.pdf

Preterm births

Currently, about 1 in 9 Nebraska infants is born preterm, about the same as in the U.S. as a whole.

The causes of preterm birth are not all understood, but among the contributing factors are multiple pregnancy (twins, triplets, etc.), mother's smoking or use of alcohol and other drugs during pregnancy, and high levels of maternal stress, including experiencing domestic violence.[15]

Infants born preterm (before the 37th week of pregnancy) are at risk for a number of negative outcomes. Preterm birth is the leading cause of infant mortality. Infants born preterm have higher rates of health complications and lifelong disabilities, including mental illness, learning and behavioral problems, cerebral palsy, lung problems, vision and hearing loss, diabetes, high blood pressure, and heart disease. Children born preterm may also have increasing difficulties with the more complex cognitive functioning called upon as they grow older, even before they enter school.[16]

[15]Child Trends DataBank. (2014). Preterm births. Retrieved from http://www.childtrends.org/?indicators=preterm-births
[16]Ibid.

Low birthweight

Nebraska's recent rates of low birthweight infants are consistently lower than the national figure. Differences between Nebraska's urban/non-urban counties are not significant. However, black infants in Nebraska are much more likely than white or Hispanic infants to be born with low weight.[17]

Low birthweight (defined as less than 5.5 pounds) is an indicator strongly associated with poor developmental outcomes in infancy, and even into adult life. Low weight is often associated with infants delivered preterm, but also can occur with full-term births. According to research, a number of factors appear to contribute to the likelihood of low weight at birth, including mothers' smoking during pregnancy; mothers' low weight gain during pregnancy or low pre-pregnancy weight; and mothers' stress during pregnancy.[18]

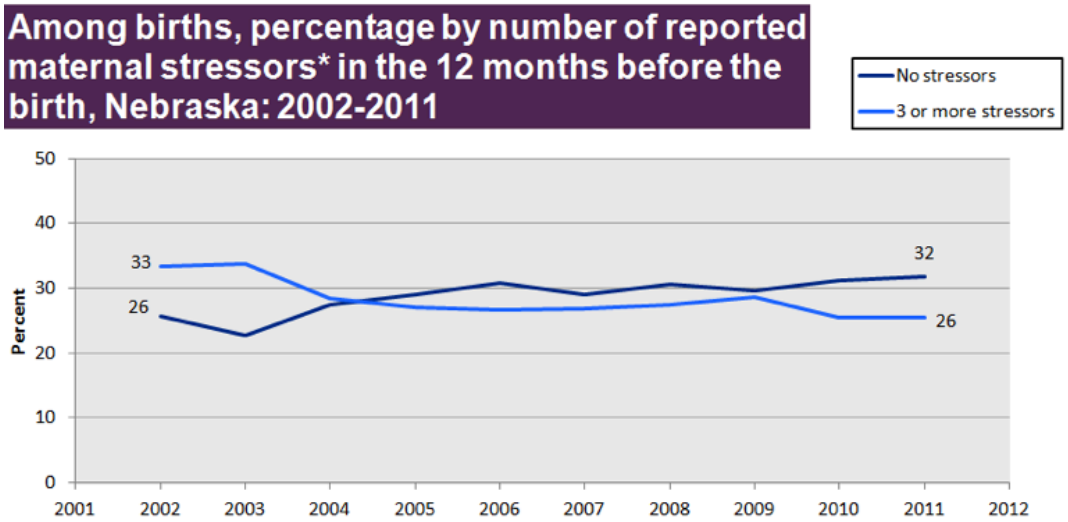
Both the U.S. and Nebraska rates of low birthweight are high by the standards of other highly developed nations. For instance, South Korea, Iceland, Norway, and Lithuania all have lower rates.[19]

Stress during pregnancy

A majority of recent mothers in Nebraska report they experienced at least 1 source of stress during the year before their child's birth, and a quarter of them say they experienced 3 or more.[20]

The role of stress during pregnancy is incompletely understood,[21] but it is known that psychological and physiological systems are tightly interrelated, and each are influenced, in part, by levels of circulating neurotransmitters and hormones that can be affected by events. Toxic effects are more likely if one has experienced multiple stressors, simultaneously or over time, particularly in the absence of social support.

[17]National Center for Health Statistics, CDC WONDER online tool. Retrieved from http://wonder.cdc.gov/.
[18]Child Trends DataBank. (2014). Low and very low birthweight infants. Retrieved from http://www.childtrends.org/?indicators=low-and-very-low-birthweight-infants
[19]UNICEF. (2008). The state of the world's children 2008. Retrieved from http://www.unicef.org/publications/files/The_State_of_the_Worlds_Children_2008.pdf
[20]Pregnancy Risk Monitoring System (PRAMS), CPONDER online tool. Retrieved from http://apps.nccd.cdc.gov/cPONDER.
[21]Rosin-Slater, M. & Brellochs, C. (2012). Preconception health and health care and early childhood comprehensive systems: Opportunities for collaboration. New York: National Center for Children in Poverty.



*Stressors include: A close family member was very sick and had to go into the hospital; Someone very close to the mother died; Someone very close to the mother had a bad problem with drinking or drugs; the mother argued with her husband or partner more than usual;she got separated or divorced from her husband or partner; she had a lot of bills she could not pay; she lost her job even though she wanted to go on working; she moved to a new address; she or her husband or partner went to jail; she was homeless; she was in a physical fight; her husband or partner lost his job; and her husband or partner said he did not want her to be pregnant.
Source: Pregnancy Risk Monitoring System (PRAMS), CPONDER online tool. Available at: http://apps.nccd.cdc.gov/cPONDER.

The potentially stressful events listed in the survey were:

- having a close family member in the hospital
- having someone very close die
- having someone very close who had a drug or drinking problem
- arguing more than normal with partner or spouse
- separation or divorce from one's partner
- having lots of bills you were unable to pay
- involuntary loss of employment
- moving to a new address
- time in jail for oneself or one's partner
- homelessness
- a physical fight
- having one's husband or partner lose a job, and
- having one's husband or partner say they didn't want the pregnancy.

There is a strong association between family income and the likelihood of reporting either no stressors, or 3 or more stressors.

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

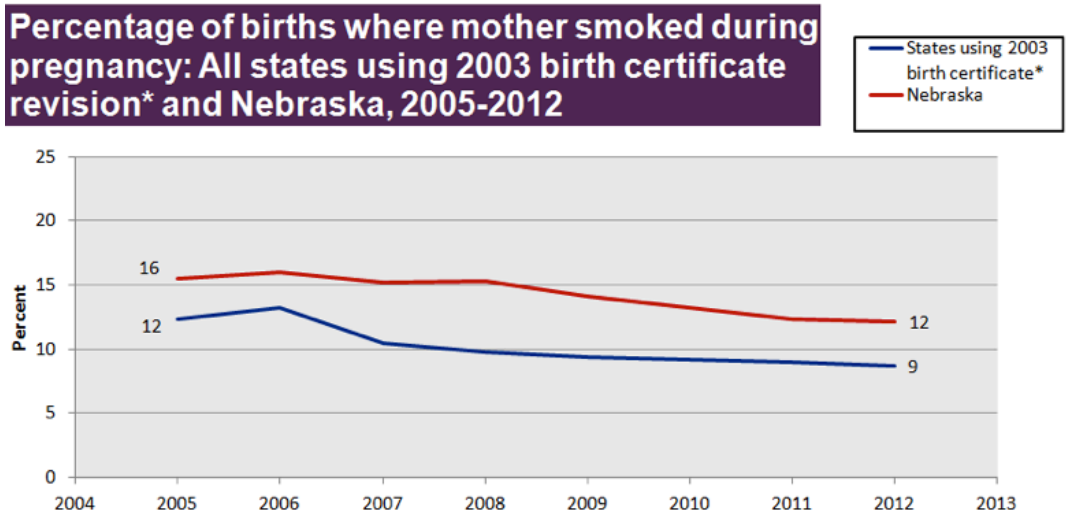
Smoking during pregnancy

One in 8 pregnant Nebraska women (12 percent) reports they smoked during their pregnancy, as of 2012—a proportion higher than in many states. Smoking during pregnancy (like cigarette smoking generally) is disproportionately associated with race/ethnicity and socioeconomic status. In Nebraska, the highest rates of smoking in pregnancy are reported by white women (14 percent, in 2012) and women living in non-urban counties of the state (15 percent). The lowest rates are among Hispanic women (4 percent) and those living in urban counties (10 percent). Between 2005 and 2012 (the most recent year available), these rates have declined by a few percentage points.[22]

There also are large differences in the prevalence of smoking during pregnancy, by mother's level of education. The highest rates of smoking during pregnancy are among Nebraska women with only a high school education; they are 13 times more likely to smoke than are pregnant women who have completed 4 years of college. Younger women also are more likely than older women to smoke while pregnant.[23]

If a pregnant women smokes, or even if she is exposed to "second-hand" (environmental) cigarette smoke, the harmful effects of smoking extend to the developing infant in utero. Infants born to mothers who smoke are more likely to be born with low weight, to develop asthma, and to become overweight in early childhood. They are 3 times more likely than infants whose mothers do not smoke during pregnancy to die from sudden infant death syndrome (SIDS).[24]

[22]Data for 2005-2006:Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm. Data for 2007-2012: National Center for Health Statistics, CDC WONDER online tool. Retrieved from http://wonder.cdc.gov/.
[23]Ibid.
[24]Child Trends DataBank. (2014). Mothers who smoke while pregnant. Retrieved from http://www.childtrends.org/?indicators=mothers-who-smoke-while-pregnant.



*The number of states using the 2003 version of the birth certificate has varied over time, so US trends in this measure should be interpreted with caution.

Sources: Data for 2005-2006:Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm. Data for 2007-2012: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/.

Maternal mortality

Maternal mortality—women's deaths associated with pregnancy and birth—is a longstanding measure of health system adequacy. It is generally not well known that U.S. maternal mortality rates are comparatively high: 42 countries, including Bulgaria, Spain, and Lithuania, have rates lower than ours.[25] Moreover, U.S. rates have more than doubled since 1987.[26]

Explanations for this unenviable record refer to a growing number of women entering pregnancy with chronic health conditions such as hypertension, diabetes, and heart disease, as well as more complete reporting.[27] However, marked disparities, particularly by age group and by race, are additional drivers of the overall high rate. Women ages 35 and older have rates of maternal mortality that are 4 times that of women in their early 20s, and more than twice that of women ages 25 to 34. Maternal mortality among black women is 2.5 times the rate for white women.[28] According to the Centers for Disease Control and Prevention, about half of maternal deaths in the U.S. are preventable.[29]

Nebraska's maternal mortality numbers are too small to detect interpretable trends. There were only 32 Nebraska pregnancy-related deaths in the past decade, 26 of which were of white women, and 18 of which were of urban women.[30]

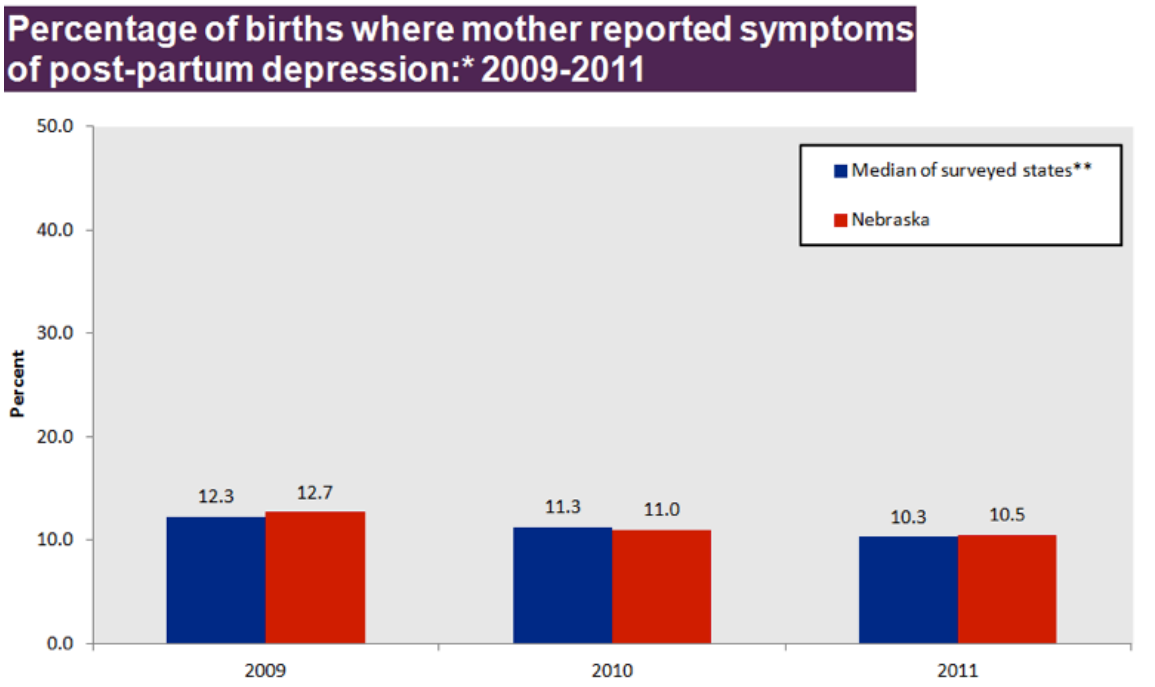
[25]World Health Organization. (2012). Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA and the World Bank estimates. Retrieved from http://www.unfpa.org/publications/trends-maternal-mortality1990-2010
[26]Amnesty International. (2010). Deadly delivery: The maternal health care crisis in the USA. Retrieved from http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf
[27]Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. Retrieved from http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html
[28]U.S. Department of Health and Human Services. (2013). Healthy People 2020. Objective MICH-5. Retrieved from http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives
[29]Bacak, S. J., Berg, C. J., Desmarais, J., Hutchins, E., & Locke, E. (Eds.) (2006). State maternal mortality review: Accomplishments of nine states. Centers for Disease Control and Prevention. Retrieved from http://www.cdph.ca.gov/data/statistics/Documents/MO-CDC-ReportAccomplishments9States.pdf
[30]Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2012 on CDC WONDER Online Database, released 2014. Data are from the Multiple Cause of Death Files, 1999-2012, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Postpartum depression

In 2011, more than 1 in 10 new mothers in Nebraska reported symptoms of postpartum depression.[31] While a mother's (or father's) symptoms of depression following soon after the birth of a child are not typical, they are relatively common—and treatable.[32]

A number of factors can lead parents to experience feelings of depression following a birth. These include adjustments in levels of circulating hormones, sleep deprivation, loss of social support, and financial worries. Regardless of the underlying reasons, parental depression is a serious problem because it can negatively affect the infant's development as well as the adult's well-being.[33]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.



*Post-partum depression symptoms were defined by the frequency of feeling down, depressed, or sad; feeling hopeless; and feeling slowed down.
**The number of states using this question on the survey has varied over time, so interpret trend data with caution.
Source: Pregnancy Risk Monitoring System (PRAMS), CPONDER online tool. Available at: http://apps.nccd.cdc.gov/cPONDER.

[31]Pregnancy Risk Monitoring System (PRAMS), CPONDER online tool. Retrieved from http://apps.nccd.cdc.gov/cPONDER.
[32]Earls, M. F. (2010). Clinical report: Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. American Academy of Pediatrics, The Committee on Psychosocial Aspects of Child and Family Health. Retrieved from http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348.full.pdf+html
[33]Onunaku, N. (2005). Improving maternal and infant mental health: Focus on maternal depression. National Center for Infant and Early Childhood Health Policy. Retrieved from http://main.zerotothree.org/site/DocServer/maternaldep.pdf

Parental aggravation

As measured in a nationally representative survey, children's parents are considered to be aggravated if they responded "usually" or "always" to 1 or more of 3 questions about how they felt during the past 30 days: their child was much harder to care for than other children; they were often bothered a lot by their child's behavior; and/or they were angry with their child. While potentially related to parental stress, this measure does not directly assess stress. Nationally, 7 percent of infants and toddlers have a parent who reports aggravation.[34]

Parents who experience inordinate stress in meeting the demands of their role may be at risk for poor health, and may be more likely to use coercive discipline, putting their children at increased risk for maltreatment and behavior problems.[35]

According to national data, toddlers (age 1 or older) are more likely to have parents reporting aggravation than are parents of infants. Young children with special health care needs also are more likely than children without such needs to have parents reporting aggravation. Infants and toddlers living in poverty are more than twice as likely as their counterparts in more economically secure families to have parents who report aggravation. Parental aggravation is also more prevalent in the case of Hispanic infants and toddlers than it is for their black peers, who in turn are more likely than white infants and toddlers are to live with parents with aggravation.[36]

Because of a small sample size, Nebraska data are not available for this indicator.

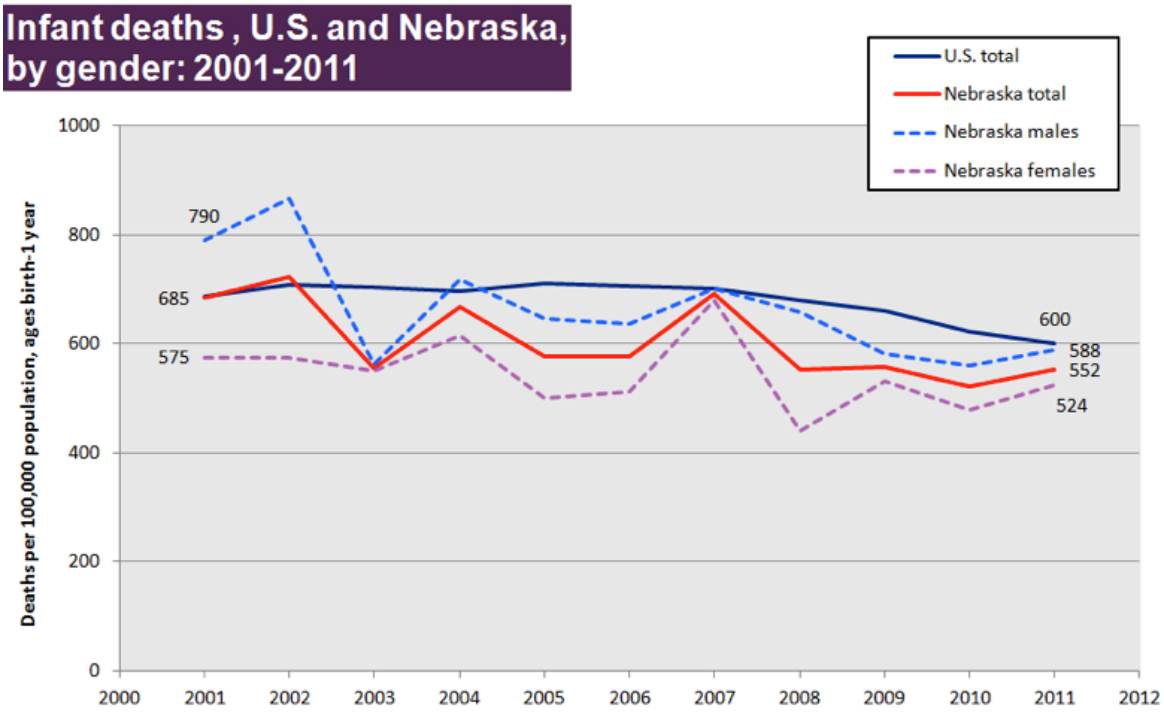
Deaths among infants and toddlers

In 2011, Nebraska's rate of infant deaths was similar to the nation's overall. Rates of both infant and toddler deaths have declined over the past 10 years.[37] Current Nebraska data show no significant differences between urban/non-urban counties on this indicator.

A high rate of death can reflect underlying problems, such as poor access to prenatal care, violent neighborhoods, or inadequate child supervision. It also can point to inequities: for example, in access to health care or safe places to play, or exposure to environmental toxins.

[34]Child Trends' analysis of the 2011-12 National Survey of Children's Health.
[35]McGroder, S. (2000). Parenting among low-income African American single mothers with preschool age children: Patterns, predictors, and developmental correlates. Child Development, 71(3), 752-771.
[36]Child Trends' analysis of the 2011-12 National Survey of Children's Health.
[37]National Center for Health Statistics, CDC WONDER online tool. Retrieved from http://wonder.cdc.gov/.

Among infants, the leading causes of death include congenital and chromosomal abnormalities, problems related to short gestation and low birthweight, and sudden infant death syndrome (SIDS).[38]



Source: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/.

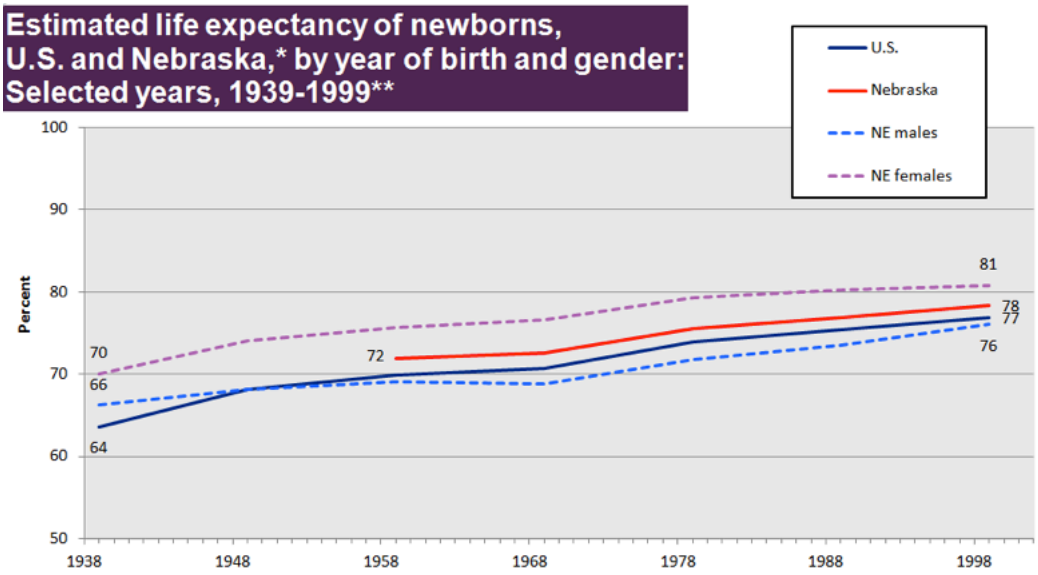
Life expectancy

In Nebraska, female infants in 2000 (the most recent year available) were expected to live nearly 5 years longer than male infants.[39] Life expectancy at birth is considered one of the fundamental indicators of a society's ability to provide for the health of its members. Overall, mortality rates for infants and for children older than age 1 fell considerably during the twentieth century, due largely to advances in medical technology, improved socioeconomic conditions, progress in water and food safety, and sanitation practices.[40]

Despite this progress, children in the U.S. have a shorter life expectancy than those in 25 other developed countries. Additionally, there are large differences by gender, race, education, and income—further evidence of room for improvement.[41]

[38]Child Trends DataBank. (2013). Infant, child, and teen mortality. Retrieved from http://www.childtrends.org/?indicators=infant-child-and-teen-mortality
[39]National Center for Health Statistics. U.S. decennial life tables. Retrieved from http://www.cdc.gov/nchs/products/life_tables.htm#decennial.
[40]Child Trends DataBank. (2012). Life expectancy. Retrieved from http://www.childtrends.org/?indicators=life-expectancy
[41]Ibid.

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.



Note: Total data for Nebraska prior to 1959 were not calculated because of limited computing power at the time of the report.
*Nebraska data by gender prior to 1969 only include white infants.
** Each data point is the average of three years of data, starting with the listed year.
Sources: National Center for Health Statistics. *U.S. decennial life tables*. Available at http://www.cdc.gov/nchs/products/life_tables.htm#decennial.

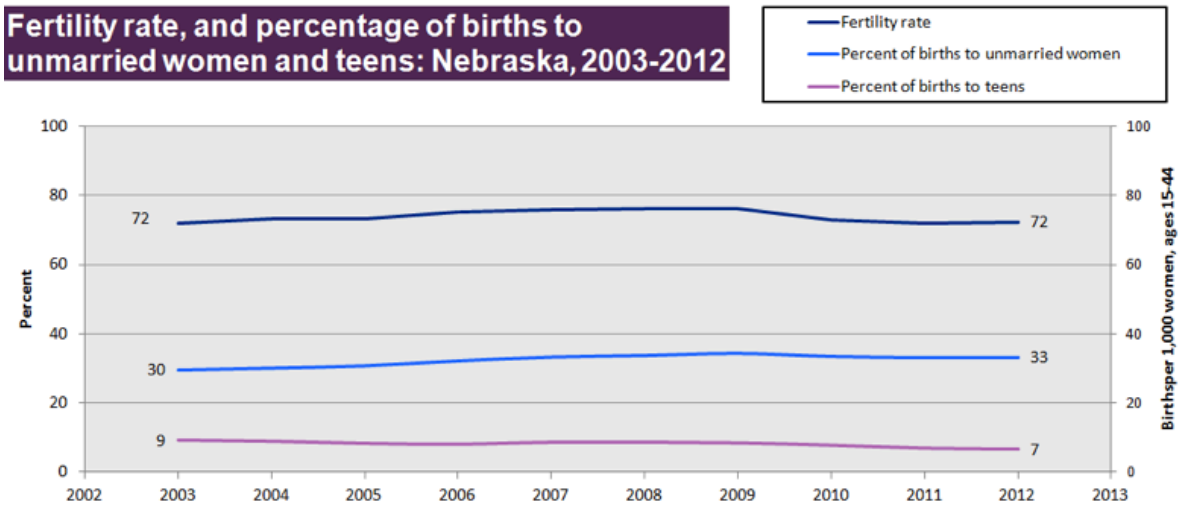
Fertility

Nebraska data show that the state's fertility rate over the previous 10 years has consistently been about 10 percent higher than the national rate.[42] In 2013, for example, Nebraska had 72 births per 1,000 women of childbearing age, compared with the overall national figure of 63 births per 1,000.[43] There has been no clear pattern over this time period differentiating urban/non-urban Nebraska counties on this indicator.

The U.S. fertility rate—the number of births per 1,000 women of childbearing age—is lower than at any time these data have been recorded. With fewer infants born, there are implications in a number of areas, not the least of which is a future workforce that will be smaller and responsible for supporting the needs of a growing elderly population.[44]

Nebraska's non-white population, while small in comparison with many states', accounts for a disproportionate share of the state's births. Fertility rates for black and Hispanic women are each about 40 percent higher than they are for white women.[45] Nebraska—like the rest of the U.S.—is likely to experience increasing diversity in its future generations.

[42]Births: Child Trends' calculations from CDC WONDER, Retrieved from http://wonder.cdc.gov/natality.html. Population of women ages 15-44: Child Trends' calculations from Intercensal and postcensal population estimates from the Census Bureau. Retrieved from http://www.census.gov/popest/data/state/asrh/2013/index.html and http://www.census.gov/popest/data/intercensal/national/nat2010.html.
[43]Ibid.
[44]Ibid.
[45]Ibid.



Source: Child Trends' calculations from CDC WONDER, available at: http://wonder.cdc.gov/natality.html.

Births to unmarried women

Nebraska consistently has a lower proportion of births that occur to unmarried women than the national average. In 2012, unmarried women accounted for 1 in 3 Nebraska births, and for 4 in 10 births nationally. In Nebraska, there are marked disparities by race/ethnicity in the percentage of births to unmarried women. Among white women, about 1 in 4 births are non-marital; among black women, the proportion is closer to 7 in 10, and among Hispanics it is about half.[46] There are no significant differences between Nebraska's urban/ non-urban counties on this indicator.

The percentage of births occurring outside of marriage is rising in Nebraska—but, again, the rate of increase is less than the national figure. More than ever before, women are having births outside of marriage. Infants born to unmarried mothers are statistically at greater risk for economic hardship and other poor outcomes.[47] Contrary to what some expect, the great majority of these births (according to national data) occur to women in their 20s and 30s, not to teens. In about 6 out of 10 of cases, the mother, though unmarried, is cohabiting at the time of the birth. However, relatively few of these cohabiting relationships will be sustained throughout the child's early years.[48]

More so than age, mothers' education is strongly associated with the probability that a birth will occur outside marriage. Nationally, for women with less than a high school education, 83 percent of first births occur in the absence of marriage; for women with a high school diploma or some college that number drops to 58 percent; and for college graduates, it drops further, to 12 percent.[49]

[46]Child Trends' calculations from CDC WONDER, Retrieved from http://wonder.cdc.gov/natality.html.
[47]Child Trends DataBank. (2014). Births to unmarried women. Retrieved from http://www.childtrends.org/?indicators=births-to-unmarried-women
[48]Copen, C. E., Daniels, K., & Mosher, W. D. (2013). First premarital cohabitation in the U.S.: 2006-2010 National Survey of Family Growth. National Health Statistics Reports, no. 64. Retrieved from http://www.cdc.gov/nchs/data/nhsr/nhsr064.pdf
[49]Hymowitz, K., Carroll, J. S., Wilcox, W. B., Kaye, K. (2013). Knot yet: The benefits and costs of delayed marriage in America. National Campaign to Prevent Teen and Unplanned Pregnancy. Retrieved from http://twentysomethingmarriage.org/

Births to teens

Birth rates among Nebraska teens have fallen in recent years, though somewhat less than in the nation as a whole. Nebraska's teen birth rate is about the same as the nation's. Rates among black and Hispanic Nebraska teens are more than triple the rate among white teens. However, over the past 10 years, teen birth rates for these minority groups have declined faster than for white teens. Recent teen birth rates are somewhat higher in non-urban Nebraska counties compared to urban counties.[50]

The number of infants born to teens is relatively small and, as a proportion of all births, has declined substantially in the past 20 years. However, these are infants who face inordinate risks.

National data show that children born to teen mothers are more likely to be born prematurely, to be born at a low birthweight and to die as infants, compared with children born to mothers in their 20s and early 30s. In addition, their mothers are likely to be at a disadvantage, both educationally and economically.[51] These circumstances make it difficult to pinpoint what role age, as opposed to other maternal characteristics, account for risks their children face.

[50]Births: Child Trends' calculations from CDC WONDER, Retrieved from http://wonder.cdc.gov/natality.html. Population of women ages 15-44: Child Trends calculations from Intercensal and postcensal population estimates from the Census Bureau. Retrieved from http://www.census.gov/popest/data/state/asrh/2013/index.html and http://www.census.gov/popest/data/intercensal/national/nat2010.html.
[51]Child Trends DataBank. (2014). Teen births. Retrieved from http://www.childtrends.org/?indicators=teen-births

Section II: Nebraska's Family Structure and Economic Well-Being

Family structure

With minor exceptions, trends in family structure among Nebraska families closely parallel the national data. As of 2013, 8 in 10 Nebraska infants and toddlers resided with 2 parents; about 1 in 6 were living with their mother only and small percentages with their father only or with no parent. Nebraska children residing in urban/non-urban counties were about equally likely to live with 2 parents.[52]

Both mothers and fathers play important roles in the growth and development of children. Strongly linked to a child's well-being are the number and the type of his or her parents (e.g., biological, step) in the household, as well as parents' relationship with each other. More so than at any time in recent history, young children are raised outside of marriage, and often by one parent only.[53]

Young children who live with no biological parents or in single-parent households are less likely than children with 2 biological parents to exhibit behavioral self-control, and more likely to be exposed to high levels of aggravated parenting than are children living with 2 biological parents.[54] Single-parent families have much lower incomes, on average, than do 2-parent families, while families headed by cohabiting partners fall in-between. Research finds, however, that the income differential only partially accounts for the negative effects in many areas of child and youth well-being (including health, educational attainment and assessments, behavior problems, and psychological well-being) associated with living outside of a married, 2-parent family.[55]

For today's young adults, marriage is increasingly separated from parenthood.[56] As noted previously, family structure and family income are strongly associated. In Nebraska the proportion of families with an infant or toddler that are headed by single mothers is more than 7 times as high among low-income families as among more affluent families.[57]

Although 7 in 10 Nebraska infants and toddlers are in households headed by 2 married adults, 1 in 8 (13 percent) lives with parents who are cohabiting rather than are married. Nationally, among young children living with cohabiting parents, nearly half are in poverty; a third have parents who have not finished high school, while the parents of another third have only a high school education.[58]

[52]Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS).
[53]Child Trends DataBank. (2014). Family structure. Retrieved from http://www.childtrends.org/?indicators=family-structure
[54]This body of research draws on data that assess the marital and cohabiting relationships of heterosexual couples with children and single-parent families, where the children are the biological offspring of at least one of the adults in the residential, romantic relationship or of the single parent. These studies did not identify adoptive or same-sex parents.
[55]Ibid.
[56]Hymowitz, K., Carroll, J. S., Wilcox, W. B., Kaye, K. (2013). Knot yet: The benefits and costs of delayed marriage in America. National Campaign to Prevent Teen and Unplanned Pregnancy. Retrieved from http://twentysomethingmarriage.org/
[57]Child Trends' calculations from the 2012 American Community Survey Public Microdata Sample (ACS PUMS).
[58]Child Trends DataBank. (2014). Family structure. Retrieved from http://www.childtrends.org/?indicators=family-structure

Grandparent-headed households

As of 2012, about 1 in 14 Nebraska infants and toddlers (7 percent) lived in households headed by grandparents.[59] Nationally, closer to 1 in 6 did so. Nebraska's Hispanic infants and toddlers are more than twice as likely as their white peers to live in a grandparent-headed household; numbers for black infants and toddlers were too small to yield reliable estimates.[60]

In recent years, more U.S. children are living with grandparents who may additionally have primary responsibility for their care. The circumstances surrounding children's residence with grandparents are diverse, influenced by families' economic security, family structure, health conditions of parents and/or children, and cultural norms. There can be both advantages and disadvantages associated with children living with grandparents, but a disproportionate share of grandparent-headed families have incomes below poverty level.[61]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

Children in foster care

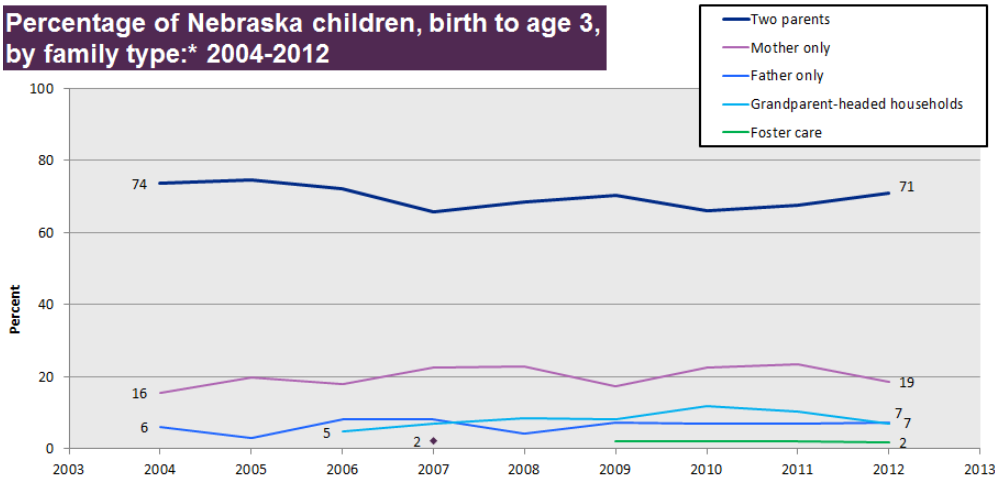
In 2012, 1,460 Nebraska infants and toddlers were in foster care. That number represents about 18 percent of all Nebraska children in foster care, compared with national data that show about 25 percent of all foster children are younger than age 3. Due to reporting requirements to protect privacy, data are not available at the country level. About 4 in 10 Nebraska children in foster care are white, about 3 in 10 are black, and about 2 in 10 are Hispanic.[62]

On a national basis, infants are more likely than children in any other age group to be placed in foster care—about 1 in 4 children admitted to foster care for the first time. On average, they will spend more of their childhood years in foster care than will older children who enter care. However, infants are adopted at higher rates than are older children.[63]

The annual placement rate for infants is about 9 per 1,000; by comparison, for older children it is about 2 per 1,000. The best available national data show that black infants comprise the single largest share of infants in foster care (39 percent), followed by white and Hispanic infants. As a group, compared with older children in foster care, infants in foster care have poorer health.[64]

Because infancy is the period in which attachment relationships—which have long-term implications for social-emotional well-being—are established, foster care poses an exceptional risk for infants. Almost by definition, infants in foster care have experienced multiple traumas.[65]

[59]Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS).
[60]Ibid.
[61]Murphey, D., Cooper, M., & Moore K. A. (2012). Grandparents living with children: State-level data from the American Community Survey. Child Trends Research Brief. Retrieved from http://www.childtrends.org/?publications=grandparents-living-with-children-state-level-data-from-the-american-community-survey
Murphey, D., Cooper, M., & Moore K. A. (2012). Children living with and cared for by grandparents: State-level data from the American Community Survey. Child Trends Research Brief. Retrieved from http://www.childtrends.org/?publications=children-living-with-and-cared-for-by-grandparents-state-level-data-from-the-american-community-survey
[62]Foster children: Child Trends' calculations from the Adoption and Foster Care Analysis and Reporting System (AFCARS).
[63]Wulczyn, F., Ernst, M., & Fisher, P. (2011). Who are the infants in out-of-home care? An epidemiological and developmental snapshot. Chapin Hall Issue Brief. Retrieved from http://www.chapinhall.org/sites/default/files/publications/06_08_11_Issue%20Brief_F_1.pdf
[64]Ibid.
[65]Child Trends DataBank. (2014) Foster care. Retrieved from http://www.childtrends.org/?indicators=foster-care



*Data may not sum to 100 percent because categories are not exhaustive or mutually exclusive.
Sources: Number of foster children: Child Trends' calculations from the Adoption and Foster Care Analysis and Reporting System (AFCARS). Population of Nebraska: Child Trends' calculations from Intercensal and postcensal population estimates from the Census Bureau, available at: http://www.census.gov/popest/data/state/asrh/2013/index.html and http://www.census.gov/popest/data/intercensal/national/nat2010.html. All other data: Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS)

Income and poverty

Children are the age group most likely to live in poverty, and the youngest children are even more likely to be poor, in part because their parents are often younger adults at the outset of their earnings careers. As a group, Nebraska infants and toddlers are considerably less poor than the national average: in 2012 (the most recent year available), about 1 in 6 (16 percent) lived in families in poverty,[66] compared with 1 in 4 nationally.[67]

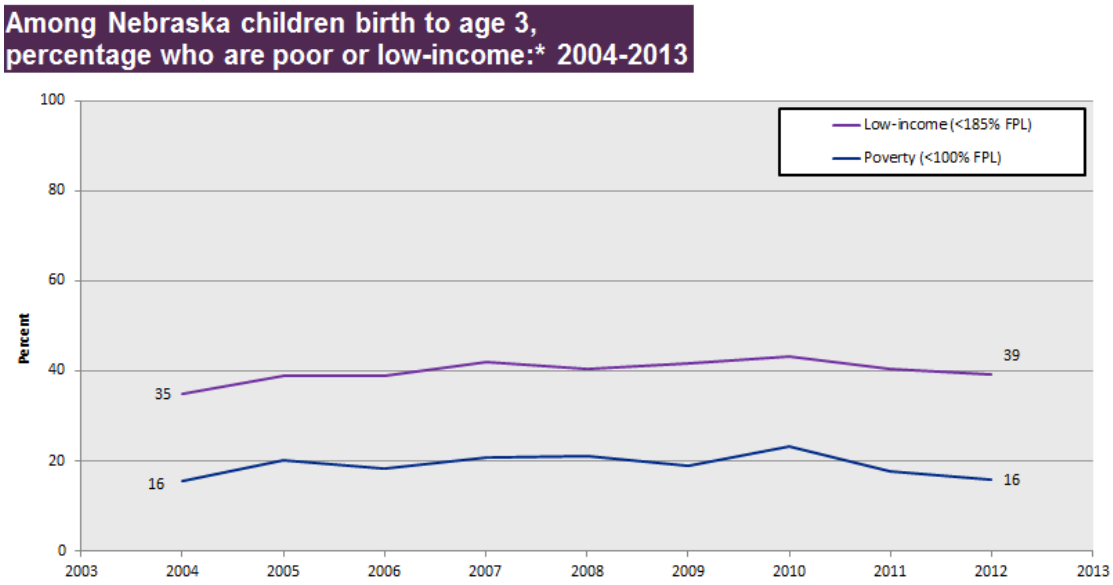
Similarly, 45 percent of infants and toddlers nationwide lived in families with "low income" (less than 185 percent of the poverty level), compared with 39 percent of Nebraska infants and toddlers.[68]

Nebraska infants and toddlers living in urban counties are as likely to be poor or low-income as those living in non-urban counties.[69]

Infants and toddlers living in Nebraska families headed by single mothers are nearly 9 times more likely to be in poverty than those who are living with 2 parents. In fact, poverty is a reality for the majority (54 percent) of single mothers with toddlers or infants.[70]

There are also stark differences between whites and Hispanics in these figures. Hispanic infants and toddlers in Nebraska are nearly 3 times as likely to be in poverty as their white peers. More than half (56 percent) of the youngest Hispanic Nebraskans are in low-income families, compared with less than 1 in 3 (30 percent) among their white counterparts. In the case of other racial groups, sample numbers are too small to provide reliable estimates.[71]

[66]Poverty is defined by the federal poverty threshold. In 2012, for a family of two adults and two dependent children, this was $22,283.
[67]Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS).
[68]Ibid.
[69]Ibid.
[70]Ibid.
[71]Ibid.



* Poor is defined as a family income below the federal poverty level. Low-income is defined as a family income below 185% of the federal poverty level.
Source: Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS).

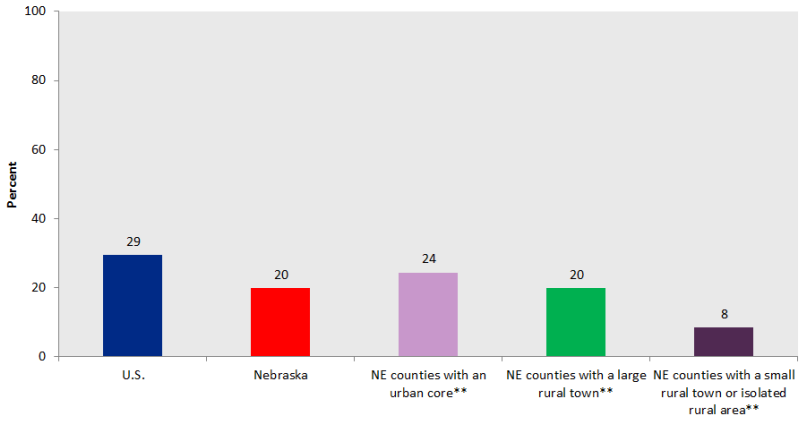
Poverty constrains more than material resources. Sustained poverty imposes chronic stress on families, affecting parental health and functioning, and likely harming the relationships between parents and between parent and child. The list of negative child outcomes associated with poverty is long, including increased likelihood of illness and injuries, psychological and behavioral problems, diminished cognitive development and school achievement, and shorter life expectancy.[72]

One in 5 (20 percent) of Nebraska's infants and toddlers lives in an area of concentrated poverty. Concentrated poverty for infants and toddlers occurs most frequently in counties with an urban core and occurs least often in counties with a small rural town or isolated rural area.[73]

Beyond the damaging effects of family-level poverty on young children, research finds that living in communities where there are large proportions of residents living in poverty confers additional disadvantages. For example, there are worse outcomes in the areas of physical and mental health, such as asthma, diabetes and depression; crime rates are higher in neighborhoods of concentrated poverty; and the quality of housing and schools is lower than in other communities.[74] Here, areas with concentrated poverty are defined as U.S. Census tracts where 20 percent or more of residents are poor.

[72]Evans, G. W. & Schamberg, M. A. (2009). Childhood poverty, chronic stress, and adult working memory. PNAS, 106(16), 6545-6549.
Melchior, M., Moffitt, T. E., Milne, B. J., Poulton, R., & Caspi, A. (2007). Why do children from socioeconomically disadvantaged families suffer from poor health when they reach adulthood? A life-course study. American Journal of Epidemiology, 166(8), 3966-974.
Conroy, K., Sandel, M., & Zuckerman, B. (2010). Poverty grown up: How childhood socioeconomic status impacts adult health. Journal of Developmental & Behavioral Pediatrics, 31, 154-160.
Singh, G. K. & Siahpush, M. (2006). Widening socioeconomic inequalities in U.S. life expectancy, 1980-2000. International Journal of Epidemiology, 35, 969-979.
[73]Child Trends' calculations from the American Community Survey.
[74]Bishaw, A. (2011). Areas with concentrated poverty: 2006-2010. American Community Survey Brief. U.S. Census Bureau. Retrieved from http://www.census.gov/prod/2011pubs/acsbr10-17.pdf

Among children birth to age 3, percentage living in areas of concentrated poverty,* U.S. and Nebraska: Average, 2007-12



* Concentrated poverty is defined as a census tract where 20 percent or more of the population has incomes below the poverty line.
**Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community. Large rural town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at leas one micropolitan community, but no metropolitan communities. Small rural town is defined as a community with a population between 2,500 and 9,999. Isolated rural area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.
Source: Child Trends' calculations from the American Community Survey.

All available parents in the labor force

In Nebraska, according to 2013 estimates, 73.4 percent of children birth to age 6 had all available parents in the labor force.[75] Included in the labor force numbers are persons both employed and unemployed (defined as those who are "jobless, looking for a job and available for work").[76]

Counties with an urban core ranged from 71.7 to 76.6 percent. Counties with a small rural town or isolated rural area had a much larger range (30.4 to 100 percent), while counties with a large rural town had a range of 69.8 to 80.9 percent.[77]

A comparison of Nebraska's infants and toddlers is not available for this indicator.

Mothers in the labor force

According to 2013 estimates, 75 percent of Nebraska mothers with children birth to age 6 were in the labor force.[78] On this indicator, Nebraska ranks eleventh among the states.[79]

Data specific to Nebraska families with infants and toddlers are not available for this indicator.

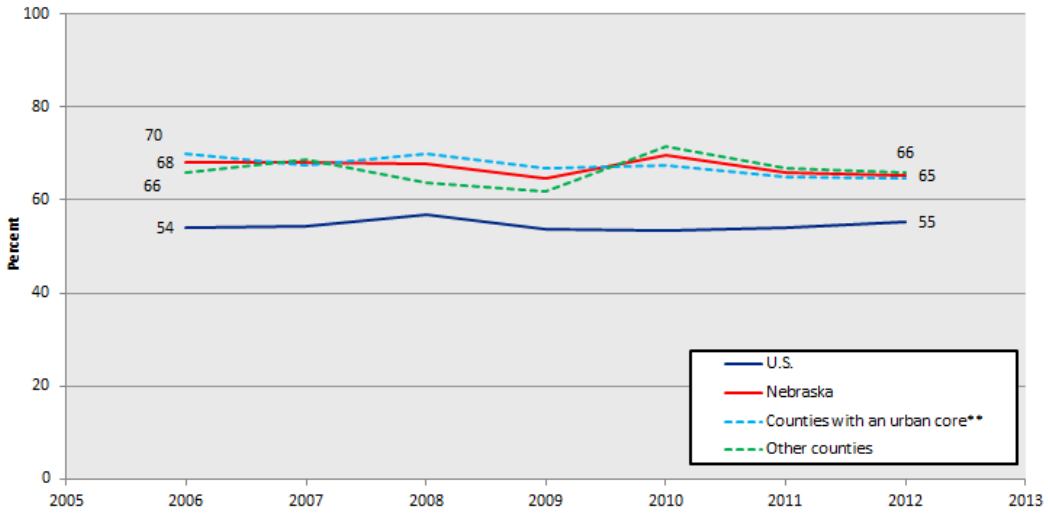
[75]U.S. Census Bureau; American Community Survey, 2013 American Community Survey 5-Year Estimates, Table GCT2302; generated by First Five Nebraska; using American Factfinder; <http://factfinder2.census.gov>; (4 December 2014).
[76]Labor force statistics from the current population survey. (2014, June 12). Retrieved November 24, 2014, from U.S. Department of Labor: Bureau of Labor Statistics website: http://www.bls.gov/cps/cps_htgm.htm#nilf.
[77]U.S. Census Bureau; American Community Survey, 2013 American Community Survey 5-Year Estimates, Table GCT2302; generated by First Five Nebraska; using American Factfinder; <http://factfinder2.census.gov>; (4 December 2014).
[78]U.S. Census Bureau; American Community Survey, 2013 American Community Survey 1-Year Estimates, Table B23003; generated by University of Nebraska at Omaha Center for Public Affairs Research; using American Factfinder; <http://factfinder2.census.gov>; (5 December 2014). Included in the labor force numbers are persons both employed and unemployed (defined as those who are "jobless, looking for a job and available for work").
[79]Ibid.

Young children with all resident parents employed

Another key indicator when considering the parental employment of children is whether they are in homes where all resident parents are employed. In Nebraska, as of 2012, nearly two-thirds of infants and toddlers (65 percent) fell into this category.[80]

This compares with the corresponding U.S. average of 55 percent. There is no significant difference in this indicator between young children living in Nebraska's urban/non-urban counties. However, Hispanic children are less likely to have all parents working than are non-Hispanic whites. Infants and toddlers in low-income families are less likely than those in more affluent families to have all parents working.[81]

Percentage of children,* birth to age 3, living in homes where all resident parents are employed: 2006-2012



* Does not include children who do not live with either parent.
**Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.
Source: Child Trends' calculations from the American Community Survey.

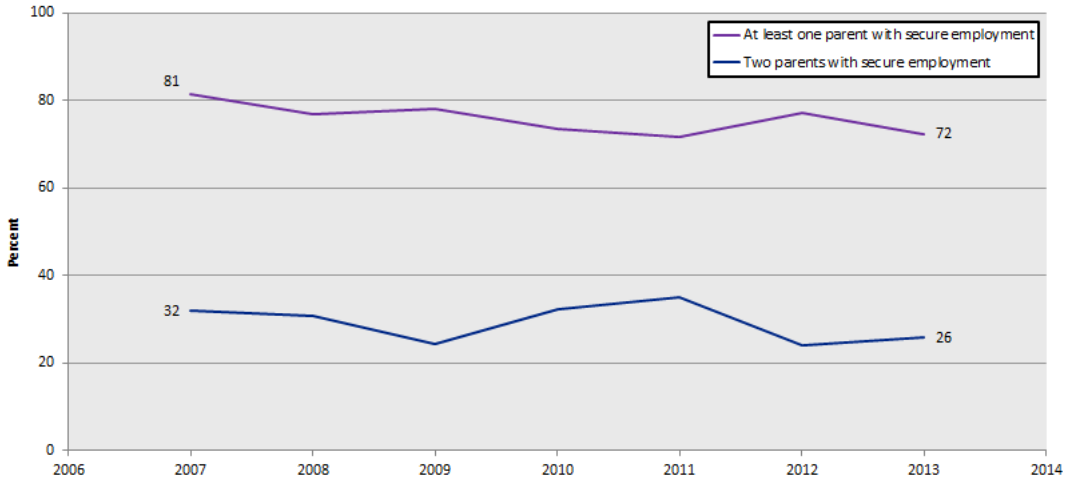
While Nebraska's average for homes where all available parents are working has consistently been higher than the U.S. average (implying a strong work ethic and perhaps contributing to lower rates of poverty), this also may limit parents' time to interact with their young children in ways that support their healthy development.

Secure parental employment

As of 2013, 7 in 10 (72 percent) of Nebraska infants and toddlers lived with at least 1 parent who was employed full-time, year-round. This is about the same as the national average, but for Nebraska it is the second-worst figure recorded over the past 7 years, and a drop of about 9 percentage points since 2007.[82] Infants and toddlers living in Nebraska's urban counties are less likely to have parents with secure

[80]Child Trends' calculations from the American Community Survey.
[81]Ibid.
[82]Child Trends' calculations from the March Current Population Survey (CPS).

Among Nebraska children birth to age 3, percentage living with at least one parent with secure employment: 2004-2013**



* Secure employment is defined as having worked full-time for 50 to 52 weeks in the past year. Only includes children living with at least one parent.
Sources: Child Trends' calculations from the March Current Population Survey (CPS).

employment. Six in 10 of children in 2-parent families, and only 3 in 10 of children with single mothers, living in urban regions, had parents with secure employment in 2013.[83]

For nearly all families with young children, parental employment is a necessity for meeting basic needs. For low-income families, it is not a guarantee of escape from poverty, but it is associated with higher family income and greater access to private health insurance. In some cases, long hours of employment among mothers with very young children have been associated with modestly negative child outcomes.[84]

More recently, research links parental (particularly fathers') permanent job loss to increased likelihood of parental divorce, family relocation, and children's repeating a grade; and to decreased earnings for children themselves when they enter the labor force. The scarring effects of parental unemployment may be multigenerational.[85]

[83]Ibid.
[84]Child Trends DataBank. (2013). Secure parental employment. Retrieved from http://www.childtrends.org/?indicators=secure-parental-employment
[85]Ibid.

Parents' age

As of 2013, about half of Nebraska infants and toddlers living with parents had at least 1 resident parent who was 30 or older. Older parents are more prevalent in Nebraska's urban counties than in non-urban counties.[86]

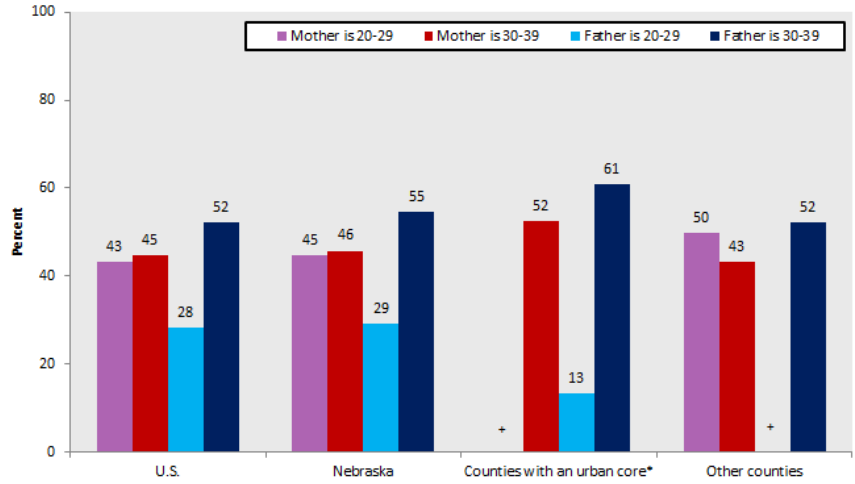
Men and women are starting families at increasingly older ages. Advancing age is associated with declining fertility and increased risk of genetic mutations in sperm and egg cells. Use of fertility-enhancing treatments increased in recent years, particularly among older women. These developments, which may raise health risks for parents and/or their infants, account for a trend of older parenting. The proportion of all U.S. births that were to women ages 30 and older doubled between 1980 and 2004, tripled for women 35 and older, and quadrupled for women 40 and older.[87]

Research has shown that increasing mothers' age, and to a lesser extent, increasing age among fathers, is linked with a greater risk for pregnancy complications and other negative outcomes, including infant mortality and autism spectrum disorders.[88]

The implications of "mid-life" parenting for infants and toddlers are not well studied. Intuitively, older parents may have, on average, the advantages of greater economic resources, more stability in life circumstances, and the wisdom stemming from higher educational attainment as well as life experience, compared with younger parents. On the other hand, older parents may be more challenged by the physical demands of caring for young children.

[86]Child Trends' calculations from the March Current Population Survey (CPS).
[87]Luke, B. & Brown, M. B. (2007). Elevated risks of pregnancy complications and adverse outcomes with increasing maternal age. Human Reproduction, 22(5), 1264-1272.
[88]Croen,L. A., Najjar, D. V., Fireman, B., & Grether, J. K. (2007). Maternal and paternal age and risk of autism spectrum disorders. Archives of Pediatric & Adolescent Medicine, 161, 334-340.

Children birth to age 3, percentages by age of parents, U.S. and Nebraska: 2013



+ Estimate unreliable, due to fewer than 20 sample cases in one or more cells.
*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.
Source: Child Trends' calculations from the March Current Population Survey (CPS).

Parental leave

The people most important in a young child's life are his or her parents. Particularly in the earliest months after birth, when an attachment bond is forming, infants and their parents need time together to learn a set of routines, responsibilities, and expectations new to them both. This relationship-building period is foundational for the child's optimal social, emotional, and cognitive development.

Workplace demands can threaten parents' ability to follow this agenda. Nearly all developed countries acknowledge the critical importance to society of the early parenting period by ensuring that new parents, or at least mothers, can take a temporary leave from work without jeopardizing their employment.[89]

Policies on parental leave in the U.S. are markedly different. When such leave is offered, it is usually unpaid, which makes it an untenable option for many new parents.[90] The Family and Medical Leave Act of 1993 (FMLA) guarantees—for qualifying employees[91]—up to 12 weeks of unpaid leave for specified reasons (that include the birth of a child). However, a recent survey finds that many FMLA-covered employers are not complying with its provisions.[92]

[89]International Labor Organization. (2014). Maternity and paternity at work: Law and practice across the world. Retrieved from www.ilo.org/maternityprotection
[90]Winston, P. (2014). Work-family supports for low-income families: Key research findings and policy trends. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from http://aspe.hhs.gov/hsp/14/WorkFamily/rpt_workfamily.cfm
[91]Employees must be part of a firm with at least 50 workers within 75 miles of the worksite; must have worked at least twelve months with the firm, and have worked 1,250 hours during the past year.
[92]Matos, K. & Galinsky, E. (2012). 2012 National Study of Employers. Families and Work Institute. Retrieved from http://familiesandwork.org/site/research/reports/NSE_2012.pdf

U.S. data from 2006-10 show that, among women who had a recent birth, two-thirds worked during their pregnancy; the percentage working was highest among white women and lowest among Hispanics. Of those who worked during their pregnancy, about two-thirds took maternity leave; of this group, the majority received some paid leave; however, more than a third received no pay while on leave. About 1 in 6 of those taking any maternity leave received at least 9 weeks of paid leave. Hispanics were less likely than black or white women to receive 9 or more weeks of paid leave.[93]

Paternity leave is much less available and less likely to be reimbursed than is maternity leave.[94]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

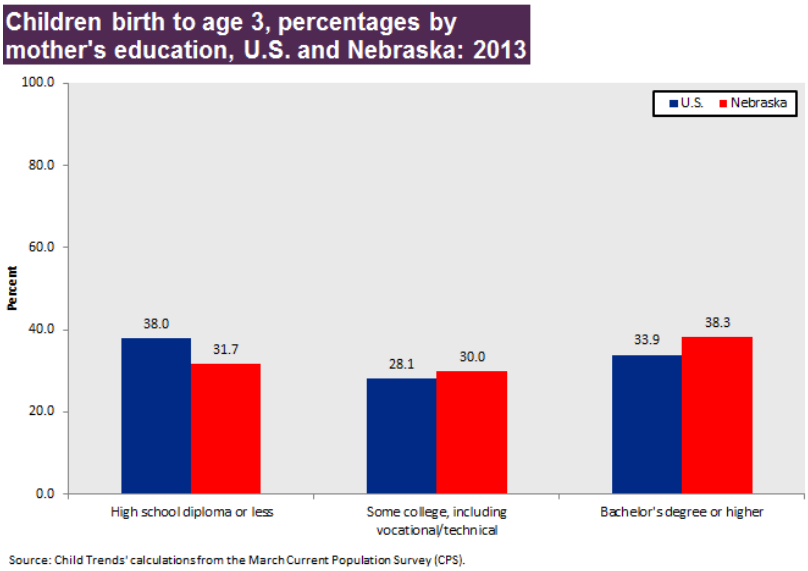
Parental education

As a group, Nebraska's parents are more educated than they were just 6 years ago. As of 2013, more than 4 in 10 Nebraska children younger than age 3 have at least 1 resident parent with a bachelor's degree or higher (38 percent of mothers, 31 percent of fathers). Nearly three-quarters of their parents have at least some years of college or other post-secondary training (68 percent of mothers, 63 percent of fathers).[95]

The education level of parents is one of the most powerful predictors of child well-being, beginning in the prenatal period. Higher levels of education are associated with greater financial, material, and social resources, but also with better parental health, and with parenting that is more sensitive to children's developmental needs.[96]

Higher levels of parental educational attainment are also strongly associated with positive outcomes for children in many areas, including incidence of low birthweight, school readiness, and educational achievement.[97]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.



Source: Child Trends' calculations from the March Current Population Survey (CPS).

[93]U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2013). Child Health USA 2013. Rockville, Maryland: U.S. Department of Health and Human Services. Retrieved from http://mchb.hrsa.gov/chusa13/
[94]National Partnership for Women & Families. (2012). Dads expect better: Top states for new dads. Retrieved from http://www.nationalpartnership.org/site/DocServer/Dads_Expect_Better_June_2012.pdf?docID=10581
[95]Child Trends' calculations from the March Current Population Survey (CPS).
[96]Child Trends DataBank. (2014). Parental education. Retrieved from http://www.childtrends.org/?indicators=parental-education.
[97]Ibid.

English proficiency

About 1 in 15 Nebraska infants and toddlers (7 percent) lives in a family where no one over age 14 speaks English only or very well. This is about the same proportion as the national average.[98]

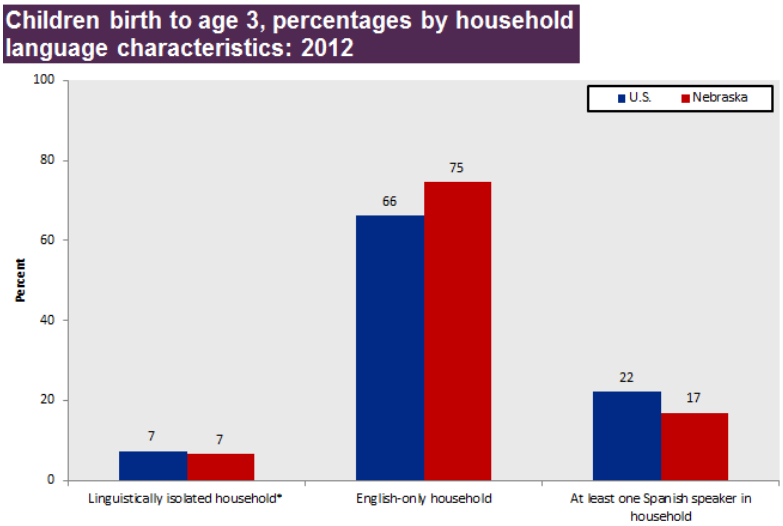
In 2012, three-quarters of Nebraska households with an infant or toddler were ones where only English was spoken, compared with two-thirds nationally.[99] About 1 in 7 Nebraska infants and toddlers lives in a household where someone speaks Spanish. However, among those in urban counties, 1 in 5 does so. Young Nebraskans living in poverty are also more likely to have a Spanish-speaker in their household: 1 in 4, compared with 1 in 8 in households with incomes at least twice the poverty level.[100]

In addition to Nebraska's Spanish-speaking population, public schools across the state represent over 100 different languages.[101] Aside from English, the most dominant languages spoken in Nebraska are Spanish, Karen, Vietnamese, Arabic, Nilo-Saharan (Other), and Somali, in that order.[102] Two-thirds of Nebraska counties with an urban core have 1,000 or more English language learner (ELL) students enrolled. The remaining county with an urban core (Sarpy) enrolls between 100 and 499 ELL students.[103] Among Nebraska counties with a large rural town, just over one-third enroll greater than 500 students, while an equal number of counties enroll between 100 and 499 students.[104] In contrast, Nebraska counties with a small rural town or isolated rural area enroll far fewer, if any, ELL students. Forty-nine percent of these counties enroll between 1 and 99 ELL students, while an additional 47 percent enroll no ELL students at all.[105]

Perhaps nowhere is the growing diversity of American culture more apparent than in the language environment of infants and toddlers. Research supports the cognitive and other benefits for children growing up in a multilingual environment.[106] However, young children's parents who have limited English proficiency may face difficulty in navigating the various service systems associated with meeting their own and their children's needs. For example, families with 1 or more parents who have limited English proficiency are less likely to receive a child care subsidy.[107]

Learning language is one of the most important accomplishments of the infant-toddler period. Young children who are exposed to a language-rich environment reap advantages in later cognitive and social development. For children who are not English-language speakers, research supports the effectiveness of direct dual-language instruction.[108]

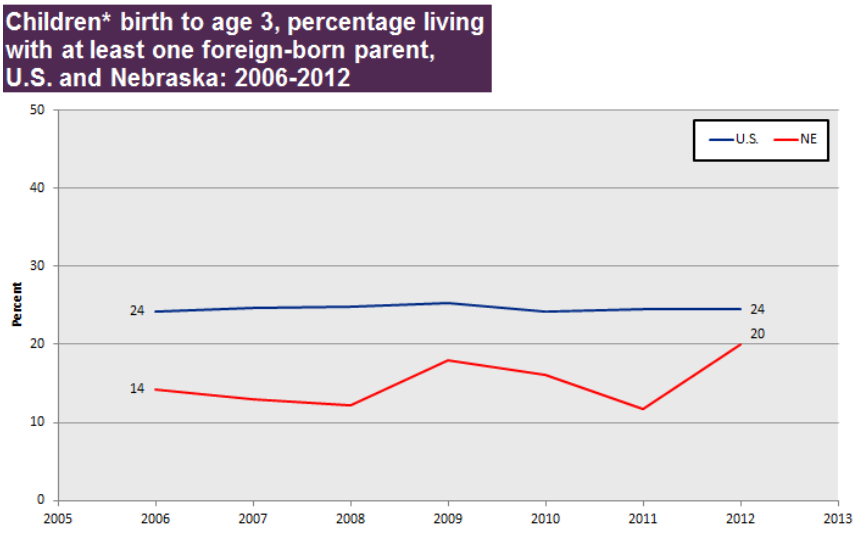
[98]Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS).
[99]Child Trends' analysis of the American Community Survey, Public Use Microdata Sample.
[100]Ibid.
[101]Nebraska Department of Education. (n.d.). Limited English speaking students in Nebraska schools 2012-2013. Retrieved from http://www.education.ne.gov/NATLORIGIN/PDF/LEP%20Data/Languages%20Spoken%20by%20ELL%20Students%20201213.pdf.
[102]Ibid.
[103]Nebraska Department of Education. (n.d.). English language learners 2012-2013. Retrieved from http://www.education.ne.gov/NATLORIGIN/PDF/Maps/20122013%20map.pdf.
[104]Ibid.
[105]Ibid.
[106]Office of Head Start. National Center on Cultural and Linguistic Responsiveness. (2013). The benefits of being bilingual. Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/cultural-linguistic/fcp/docs/benefits-of-being-bilingual.pdf
[107]Firgens, E. & Matthews, H. (2012). State child care policies for limited English proficient families. Center for Law and Social Policy. Retrieved from http://files.eric.ed.gov/fulltext/ED538051.pdf
[108]Beltrán, E. (2012). Preparing young Latino children for school success: Best practices in language instruction. Issue Brief No. 25. National Council of La Raza. Retrieved from



*A linguistically isolated household is one in which no one age 14 and over speaks English only or speaks English "very well."
Source: Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS)

Ours has always been a nation of immigrants. As of 2012, 1 in 5 Nebraska infants and toddlers had at least 1 parent who was born outside the U.S. About a third of these young children live with 2 foreign-born parents. Immigrant children are about equally likely to live in urban/non-urban Nebraska counties.[109]

Nebraska has 3 refugee resettlement agencies,[110] and many of the families that relocated to Nebraska end up permanently settling in the state.



*Includes only children who live with at least one parent.
Source: Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS)

[109]Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS).
[110]Nebraska Department of Health & Human Services. (2011, October 23). Refugee resettlement program: Program overview. Retrieved September 25, 2014, from http://dhhs.ne.gov/children_family_services/Pages/refugees_overview.aspx.

Section III: Early Childhood Health

Preventive care

In Nebraska, more than 9 in 10 infants and toddlers receive preventive medical care. However, with respect to preventive *dental* care, 36 percent of Nebraska infants and toddlers, compared with a national average of 25 percent, had a visit within the past year.[111]

Preventive medical care (also known as "well-child care") is a critical opportunity to detect a possible developmental delay or disability, early treatment of which can lessen the future impact on both the child and family. In addition, well-child visits allow physicians to promote behaviors conducive to healthy development, and to give age-appropriate counseling or anticipatory guidance. For example, physician guidance has been found to increase the likelihood that parents will read to their child, or that a child will be breastfed.[112]

According to data from a 2011 national survey, more than 9 in 10 infants and toddlers had at least 1 preventive pediatric visit in the past 12 months. However, children in poor families, and black and Hispanic children, were less likely to get well-child care.[113]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

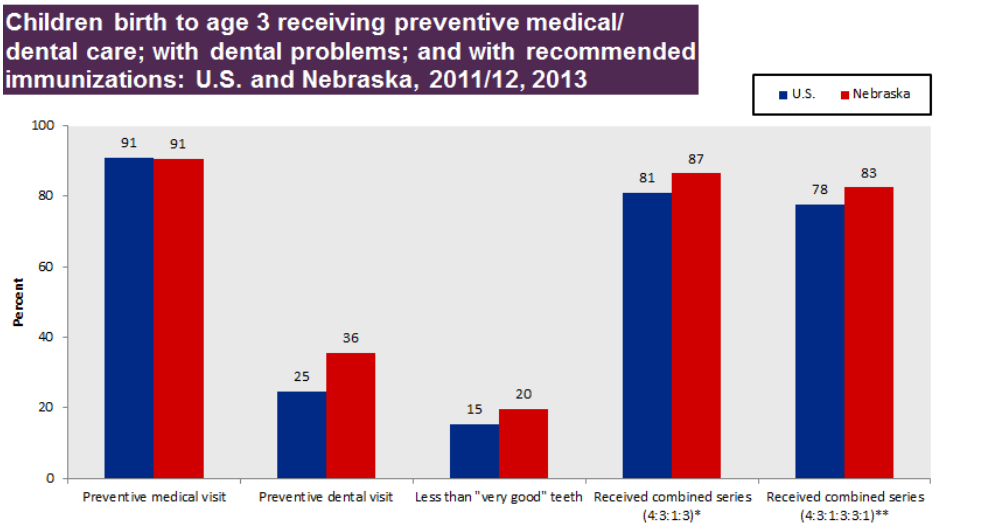
Immunizations

About 1 in 5 Nebraska infants and toddlers lack 1 or more of the recommended vaccines.[114]
Immunizations are a highly cost-effective preventive strategy to protect against many illnesses that can be life-threatening to infants and toddlers. Vaccines are given early in life because many of the diseases they prevent are more common, and more deadly, among infants and small children. Additionally, childhood immunization is an important step in maintaining high vaccination levels within the population, which prevent outbreaks of such diseases.[115]

The U.S. Centers for Disease Control and Prevention (CDC) issues specific recommendations for vaccines children should receive before they reach age 3. These include 4 doses of the diphtheria, tetanus and pertussis (DTP) vaccine, 3 or more doses of polio vaccine, 1 or more doses of the measles-mumps-rubella (MMR) vaccine, 3 or more doses of the Haemophilus influenza type b (Hib) vaccine, the hepatitis B vaccine, and the varicella (chickenpox) vaccine. The DTP, polio, MMR and Hib vaccines are collectively referred to as the combination or 4:3:1:3 series.[116]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

[111]Child Trends' analysis of the National Survey of Children's Health.
[112]Child Trends DataBank. (2014). Well-child visits. Retrieved from http://www.childtrends.org/?indicators=well-child-visits
[113]Child Trends' analysis of the National Survey of Children's Health.
[114]Centers for Disease Control and Prevention, National Immunization Program, NIS data, tables, Jan-Dec . http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/data/tables-2013.html
[115]Child Trends DataBank. (2014). Immunization. Retrieved from http://www.childtrends.org/?indicators=immunization
[116]Ibid.



Note: Data on preventive dental care and dental problems refer only to children ages 1 to 3. Data on immunizations refer to children ages 19-35 months. Data on preventive visits and dental problems were collected in 2011-12, while data on immunization were collected in 2013.
*The 4:3:1:3 combined series measures the number of children who have received 4 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine, 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, and 3 or more doses of Haemophilus influenzae type b vaccine (Hib)
**The 4:3:1:3::3:1 combined series measures the number of children who have received 6 key immunizations: the 4:3:1:3 series and also three or more doses of hepatitis B vaccine (HepB), and one or more doses of varicella.
Sources: Preventive visits and dental health data: Child Trends calculations from the National Survey of Children's Health (NSCH). Vaccination data: Centers for Disease Control and Prevention, National Immunization Program, NIS data, tables, Jan-Dec. www.cdc.gov/vaccines/statsurv/imz-coverage.htm#nis

Oral health

According to 2011-12 data from a representative survey, about 8 in 10 (80 percent) of Nebraska infants and toddlers have teeth that are in "excellent" or "very good" condition, as reported by their parents, compared with 85 percent nationally.[117]

Oral health (which includes dental health) is a dimension of care and well-being that is sometimes overlooked. However, dental caries (tooth decay) can be considered to be a chronic disease of childhood, with prevalence rates higher than those for asthma or allergies.[118] Untreated oral diseases can lead to problems in eating, speaking, and sleeping. Poor oral health among children has been tied to poor performance in school and poor social relationships. For example, children with chronic dental pain may have difficulty concentrating, poor self-image, and problems completing schoolwork. Children with early childhood dental problems also often weigh less.[119]

The American Academy of Pediatric Dentistry recommends that all children visit the dentist within 6 months of the eruption of their first primary tooth, or no later than their first birthday.[120]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

[117]Child Trends' calculations from the National Survey of Children's Health (NSCH).
[118]Ramos-Gomez, F., Crystal, Y. O., Ng, M. W., Tinanoff, N., & Featherstone, J. D. (2010). Caries risk assessment, prevention, and management in pediatric care. General Dentistry, November/December, 2010, 505-517. Child Trends DataBank. (2013). Unmet dental needs. Retrieved from http://www.childtrends.org/?indicators=unmet-dental-needs
[119]Child Trends DataBank. (2013). Unmet dental needs. Retrieved from
[120]Ibid.

Developmental screening

In 2011, just over a third (35 percent) of Nebraska infants and toddlers were screened, compared with 1 in 5 (20 percent) in 2007.[121] Clear progress has been made in improving rates of developmental screening among the youngest children. National-level data show inequities by race/Hispanic origin seen in earlier years are now non-significant. However, children identified as having a special health care need were more likely to receive a screening than were children without such need.[122]

Developmental screening of young children is an efficient, cost-effective way to identify potential health or behavioral problems. In primary health care settings, the most effective screening tools rely on parent-reported information.[123] Research has found that children who get a screening are more likely to be identified with developmental delays, referred for early intervention, and be determined eligible for early intervention services.[124] The American Academy of Pediatrics recommends that children, before their third birthday, receive developmental screening from their physicians at least 3 times.[125]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

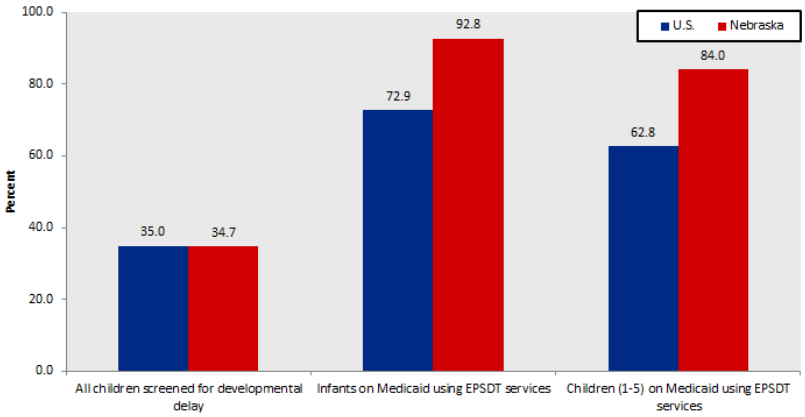
Early Periodic Screening, Diagnostic and Treatment

Early Periodic Screening, Diagnostic and Treatment (EPSDT) services are comprehensive and preventive health care services available to all Medicaid-eligible children through age 20. These services include vision, hearing and dental care, physical exams, developmental and behavioral screening, and all coverable, medically necessary treatments for any health conditions identified.[126]

The most recent data available show that in 2011, about 9,000 Nebraska infants received EPSDT services, as well as an estimated 22,000 toddlers and preschoolers (through age 5).[127]

[121]Child Trends' calculations from the National Survey of Children's Health (NSCH).
[122]Ibid.
[123]Glascoe, F. P. (2000). Early detection of developmental and behavioral problems. Pediatrics in Review, 21(8), 272-280.
[124]Guevara, J. P., Gerdes, M., Localio, R., Huang, Y. V., Pinto-Martin, J., Minkovitz, C. S., Hsu, D., Kyriakou, L, Baglivo, S., Kavanagh, J., & Pati, S. (2013). Effectiveness of developmental screening in an urban setting. Pediatrics, 131(1), 30-37.
[125]American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. Pediatrics, 118(1), 405-420.
[126]Health Resources and Services Administration, Maternal and Child Health. EPSDT & Title V Collaboration to Improve Child Health. Retrieved from http://mchb.hrsa.gov/epsdt/
[127]Child Trends' calculations based on the Medicaid Statistical Information System (MSIS) State Summary Datamarts, quarterly cubes. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html

Percentage of all children, ages 10 months to 3 years, screened for developmental delay,* and percentage of Medicaid-covered infants and children (to age six) who used EPSDT services: U.S. and Nebraska**



Note: Developmental delay screening data were collected in 2011-12, while data for ESPDT utilization are for 2010.
*Using a Standardized Developmental Screening tool.
**Early Periodic Screening, Diagnostic, and Treatment
Sources: Screening for developmental delay data: Child Trends' calculations from the National Survey of Children's Health (NSCH). Medicaid usage data: Child Trends calculations based on the Medicaid Statistical Information System (MSIS) State Summary Datamarts, quarterly cubes. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html

Parental concerns about development

In 2011-12, 1 in 8 Nebraska infants and toddlers (13 percent) had parents who expressed concern about 1 or more items that are considered predictive of developmental delays. This rate is considerably lower than the corresponding national figure of 22 percent.[128]

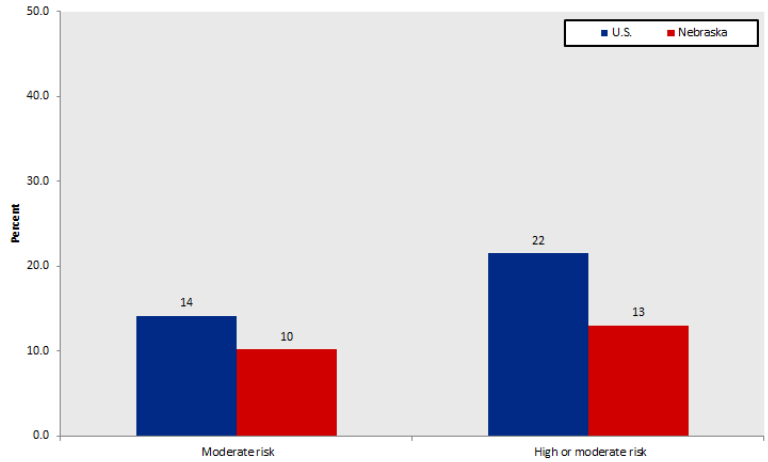
For children in this age group, these items included receptive and expressive language, and socio-emotional development. Research indicates that when parents express 1 or more concerns, their child's risk for disabilities is 8 times as great as for those whose parents have no concerns; when parents express 2 or more concerns, the risk is 20 times as high.[129]

Developmental delays among young children can signal the presence of serious physical or psycho-social problems. Screenings—which may be conducted by pediatricians or through parent questionnaires—can help identify children who are not meeting expected developmental milestones.[130] Because development during infancy and toddlerhood is rapid and cumulative, the success of early intervention depends on early identification. Delayed development (sometimes termed "failure to thrive") can also indicate the presence of serious neglect or maltreatment.[131]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

[128]Child Trends' calculations from the National Survey of Children's Health (NSCH).
[129]Glascoe, F. P. (2000). Early detection of developmental and behavioral problems. Pediatrics in Review, 21(8), 272-280.
[130]Ibid.
[131]MedlinePLus. (2013). Failure to thrive. U.S. National Library of Medicine, National Institutes of Health. Retrieved from http://www.nlm.nih.gov/medlineplus/ency/article/000991.htm

Percentage of children, 4 months to age 3, with developmental risk,* according to parental report: 2011-12



*Risk assessment is based on one or more age-specific parental concerns that are predictive of delay. Moderate risk is defined as one such concern, high risk as two or more such concerns.
Source: Child Trends' analysis of National Survey of Children's Health.

Early intervention services

In 2011, approximately 1,500 Nebraska infants and toddlers were served by early intervention services, representing about 2 percent of the total population.[132] Also known as the Program for Infants and Toddlers with Disabilities, it was established in 1986 as part of the Individuals with Disabilities Act. Funding provided by the program varies from year to year, depending upon U.S. Census-based estimates of the number of infants and toddlers in the general population.[133]

The purpose of the program is to improve outcomes for infants and toddlers with disabilities through provision of direct services to the child as well as services to the family.[134] Early intervention services are offered, through states and territories, to children with identified disabilities or, in some states, to those who are at risk for developing a disability, from birth to age 3. States' eligibility criteria for early intervention services vary,[135] as do the services they offer.

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

[132]ECTA Center. (2014). Annual Appropriations and Number of Children Served Under Part C of IDEA Federal Fiscal Years 1987-2012. Retrieved December 9, 2014 from http://ectacenter.org/partc/partcdata.asp
[133]U.S. Department of Education. (2014). Programs: Early Intervention Program for Infants and Toddlers with Disabilities. Retrieved from http://www2.ed.gov/programs/osepeip/index.html
[134]Ibid.
[135]Ringwalt, S. (2012). Summary table of states' and territories' definitions of /criteria for IDEA Part C eligibility. ECTA Center. Retrieved from http://ectacenter.org/~pdfs/topics/earlyid/partc_elig_table.pdf

Special health care needs

In 2011-12, about 1 in 20 Nebraska children younger than age 3 was reported by their parent to have a special health care need.[136] There is no consensus on how to define disabilities or "special health care needs" among children. Both terms encompass a broad range of chronic health conditions, from major physical or developmental disabilities to conditions that are often less limiting, such as autism spectrum disorder or asthma.

National data show a significantly higher percentage of black infants and toddlers had a special health care need (13 percent) compared with their white counterparts (8 percent).[137]

Coordination of care, involving doctors, teachers, and community resources, can be challenging for parents of children with special health care needs. Nationally, about two-thirds of infants and toddlers with special health care needs who received 2 or more services got help with coordination of care or services, according to their parents.[138]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

Autism spectrum disorders

The identification of autism spectrum disorders (ASD) in young children has risen in recent years. Although most children with ASD are not identified before age 4, symptoms usually are evident between ages 1 and 3.[139] Children with ASD exhibit a wide range of characteristics, but have problems with social and communication skills in common. Other features typical of children with ASD are unusual patterns of learning, paying attention, and reacting to sensory stimuli.[140]

In 2011, 1.6 percent of U.S. children ages 2 through 5 had ever been diagnosed with ASD. Boys are 3 times as likely as girls to have received the diagnosis: in 2011, the estimated prevalence among boys was 2.4 percent, compared to 0.8 percent among girls. Low-income children are more likely than those in higher-income families to have been diagnosed with ASD.[141]

Early identification and intervention are important for children with ASD, so that they can gain access to programs and services that address the disabilities associated with this disorder. According to 2011 data, about 1 in 4 children ages 2 through 17 with ASD received the diagnosis before age 3. Girls were more likely than boys, and black children more likely than white or Hispanic children, to receive early diagnosis.

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

[136]Child Trends' calculations from the National Survey of Children's Health (NSCH).
[137]Child Trends DataBank. (2012). Children with special health care needs. Retrieved from http://www.childtrends.org/?indicators=children-with-special-health-care-needs
[138]Ibid.
[139]Centers for Disease Control and Prevention. (2012). Prevalence of autism spectrum disorders—Autism and Developmental Disabilities Monitoring Network, 14 sites, U.S., 2008. MMWR Surveillance Summaries, 61(3). Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6103a1.htm?s_cid=ss6103a1_w
[140]Child Trends DataBank. (2013). Autism spectrum disorders. Retrieved from http://www.childtrends.org/?indicators=autism-spectrum-disorders
[141]Ibid.

Health insurance

In Nebraska, infants and toddlers are about as likely to lack health insurance as those nationwide. Nebraska had a 2012 rate of 5 percent, the same as the national rate.[142] A smaller percentage of Nebraska infants and toddlers are covered by public health insurance than is the case nationally (32 percent and 46 percent, respectively). The proportion covered by private insurance is higher in Nebraska than in the U.S. (66 percent and 53 percent, respectively).[143]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

Breastfeeding

Breastfeeding rates in Nebraska are comparable with those for the nation as a whole. For infants born in 2011 (the latest data available), 82 percent of mothers reported ever breastfeeding, 46 percent reported still breastfeeding at 6 months, and 26 percent reported breastfeeding at 12 months.[144]

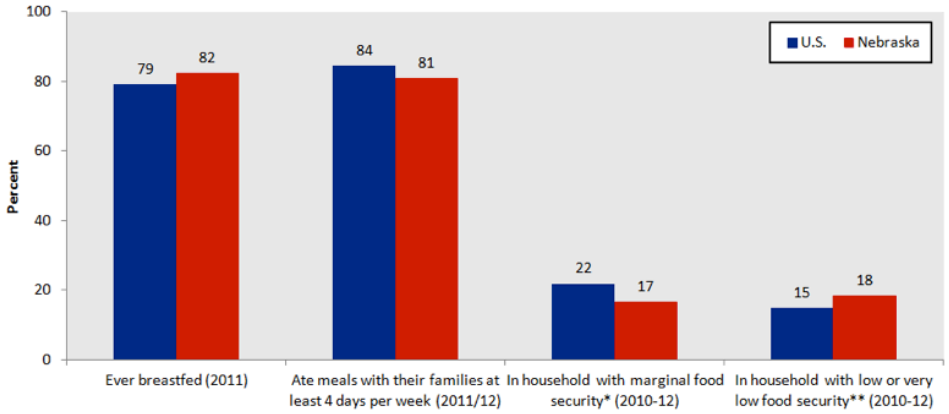
Breastfeeding supports infants' immunologic, nutritional, physical, and cognitive development. Research shows that breastfeeding is associated with a number of benefits to children, including reduced rates of infectious diseases, Sudden Infant Death Syndrome (SIDS), type 1 and type 2 diabetes, lymphoma, leukemia, Hodgkin's disease, overweight, and obesity. Children who are breastfed during early infancy are less likely to suffer from diarrhea, ear infections, lower respiratory infections, urinary tract infections, and bacterial meningitis. Breast milk may also help protect against allergies and digestive disorders.[145]

In addition to benefitting infants, breastfeeding is associated with positive outcomes for mothers. Studies demonstrate a number of maternal health benefits, including earlier return to pre-pregnancy weight, reduced rates of breast and ovarian cancers, and decreased risk of hip fractures and osteoporosis later in the mother's life. Breastfeeding mothers also report higher rates of mother-infant attachment and bonding, feelings of maternal empowerment, and confidence.[146]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

[142]Child Trends' analysis of the American Community Survey, Public Use Microdata Sample.
[143]Ibid.
[144]U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Breastfeeding Practices: Results from the National Immunization Survey. Available online at http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm.
[145]Child Trends DataBank. (2014). Breastfeeding. Retrieved from http://www.childtrends.org/?indicators=breastfeeding
[146]Ibid.

Infant breastfeeding; family meals; food security: U.S. and Nebraska



*Marginal food security is when the household has one or two reported indications of food insecurity--typically anxiety over food sufficiency or shortage of food in the house. There is little or no indication of changes in diets or food intake.
**Low food security is when the household reports reduced quality, variety, or desirability of diet. There is little or no indication of reduced food intake. Very low food security is when the household reports multiple indications of disrupted eating patterns and reduced food intake.
Source: Breastfeeding data: U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Breastfeeding Practices: Results from the National Immunization Survey. Available online at http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm. Data on family meals: Child Trends' calculations from the National Survey of Children's Health (NSCH). Data on food security: Child Trends' analysis of the Current Population Survey: Food Security Supplement.

Family meals

Data from 2011-12 show that 8 in 10 (81 percent) Nebraska infants and toddlers ate meals with their families at least 4 days per week, about the same as the national figure. Nationally, young children in families who are in poverty are slightly less likely to share family meals than children in families with higher incomes. Regardless of race/Hispanic origin, large majorities of children frequently eat meals with family, though black children are slightly less likely to do so than are white or Hispanic children.[147]

Having an infant or toddler eat with other family members may not always be practical, but research finds that shared mealtimes are associated with a number of benefits. Among those most relevant to the youngest children are increased vocabulary, and exposure to a wider variety of foods that may lead to their adopting healthier eating habits. Research suggests that having a television on during mealtimes does not substitute for shared family conversations, and may promote unhealthy eating.[148]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

[147]Child Trends' calculations from the National Survey of Children's Health (NSCH).
[148]Child Trends DataBank. (2013). Family meals. Retrieved from http://www.childtrends.org/?indicators=family-meals

Food insecurity

In 2010-12, 18 percent of Nebraska infants and toddlers lived in households with marginal food security, 13 percent lived with low food security, and 4 percent lived in a household with very low food security. That means that more than a third lived in households that were not food-secure. Low-income families were more likely than their more affluent counterparts to experience any of these types of food insecurity.

No parent wants to have their infant grow hungry. Indeed, parents will sacrifice their own nutritional needs before they let their children's go unmet. Inadequate food intake in children is associated with a number of serious health, behavior and cognitive deficits. Children who are food-insecure are in poorer health than children who are in food-secure households (defined by the U.S. Department of Agriculture as having "access at all times to enough food for an active, healthy life for all household members."[149]). Higher rates of hospitalization, iron deficiency anemia, and chronic health conditions are reported among food-insecure children. Paradoxically, food insecurity is also associated with children's greater risk for being overweight.[150]

Studies also report that food insecurity is associated with higher rates of behavioral problems in 3-year-olds. Food insecurity, particularly when experienced in the earliest primary grades, also has a significant detrimental effect on young children's interpersonal skills, self-control, and the group of competencies (including attentiveness, persistence and flexibility) termed "approaches to learning." Recent research shows that even "marginal" food insecurity can have negative effects on health.[151]

The measurement of food insecurity is somewhat complex, relying on a series of survey questions. All members of a household that is having difficulty obtaining enough healthy food are considered "food-insecure." However, because adults generally do all they can to see that children are the last to suffer food-related hardship, a more sensitive indicator of serious risk is the percentage of households reporting that children are going without sufficient healthy food.[152]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

Overweight

The widespread problem of overweight in our society extends to the youngest children. Children who are overweight or obese are at increased risk for health and socio-emotional problems, and overweight in the preschool years is highly predictive of being overweight later in childhood. Overweight children are more likely than their peers to develop cardiovascular disease, type 2 diabetes, liver disease, sleep apnea, high cholesterol, and asthma. There is increasing evidence that the problem of overweight in our population may begin in the earliest years of life.[153] While there is a lack of nationally representative data on the weight status of infants and toddlers, the best available data (from 2009-10) show that, among children ages 2 to 5, more than 1 in 4 is overweight, and 1 in 8 is obese.[154]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

[149]Nord, M, Andrews, M, and Carlson, S. (2007). Household food security in the U.S. 2006. Economic Research Report No. ERR-49. Retrieved from http://www.ers.usda.gov/publications/err-economic-research-report/err49.aspx
[150]Child Trends DataBank. (2014). Food insecurity. Retrieved from http://www.childtrends.org/?indicators=food-insecurity
[151]Cook, J. T., Black, M., Chilton, M., Cutts, D., Ettinger de Cuba, S., Heeren, T., Rose-Jacobs, R., Sandel, M., Casey, P. H., Coleman, S., Weiss, I., & Frank, D. A. (2013). Are food insecurity's health impacts underestimated in the U.S. population? Marginal food insecurity also predicts adverse health outcomes in young U.S. children and mothers. Advances in Nutrition, 4, 51-61.
[152]U.S. Department of Agriculture, Economic Research Service. (2014). Food & Nutrition Assistance: Overview: Measurement. Retrieved December 9, 2014 from: http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement.aspx
[153]Child Trends DataBank. (2014). Overweight children and youth. Retrieved from http://www.childtrends.org/?indicators=overweight-children-and-youth
[154]Ogden C. L., Carroll, M. D., Kit, B. K., Flegal, K. M., (2012). Prevalence of obesity and trends in body mass index among US children and adolescents, 1999-2010, JAMA 307 (5). pp 483-490. Retrieved from http://jama.jamanetwork.com/article.aspx?volume=307&issue=5&page=483

WIC

More than 30,000 Nebraska infants and toddlers were served by the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) in 2013, about half (56 percent) of the estimated eligible population.[155] WIC was developed in 1974 to improve the nutrition of low-income (≤ 185 percent of the federal poverty level) pregnant women and new mothers, and their infants and children (birth to age 4).[156]

WIC provides nutritious foods (via vouchers that can be used at participating food stores), nutrition information, and screenings and referrals to health, welfare, and social services.[157] WIC services are provided through county health departments and community-based agencies, including hospitals, mobile and migrant health clinics, community centers, schools, and public housing sites.[158]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator; however, services are reaching out across the state.[159]

Supplemental Nutrition Assistance Program

In 2012, about 30,000 Nebraska children younger than age 5 received benefits from the Supplemental Nutrition Assistance Program (SNAP, formerly known as the food stamp program). Using 125 percent of the federal poverty level as a conservative proxy for eligibility, these data suggest that around three-quarters of this most-vulnerable group of Nebraskans are receiving SNAP benefits.[160]

Nationally, 96 percent of eligible poor households with children receive assistance from SNAP, a benefit designed to increase the food purchasing power of low-income households. Receiving SNAP benefits increases what households spend on food, and the availability of calories and protein.[161] Also, when controlling for other relevant factors, several studies suggest SNAP receipt increases food security,[162] defined by the U.S. Department of Agriculture as having "access at all times to enough food for an active, healthy life for all household members."[163]

According to a nationally representative study, women with access to SNAP in the last 3 months of pregnancy had improved birth outcomes, as measured by birthweight. Additionally, there is evidence that SNAP benefits substantially reduce poverty among children.[164]

A comparison between Nebraska's urban/non-urban counties on participation in SNAP is available only for children ages birth through 17. This analysis shows that participation rates are lowest in counties with a small rural town or isolated rural area, and highest in counties with an urban core.[165]

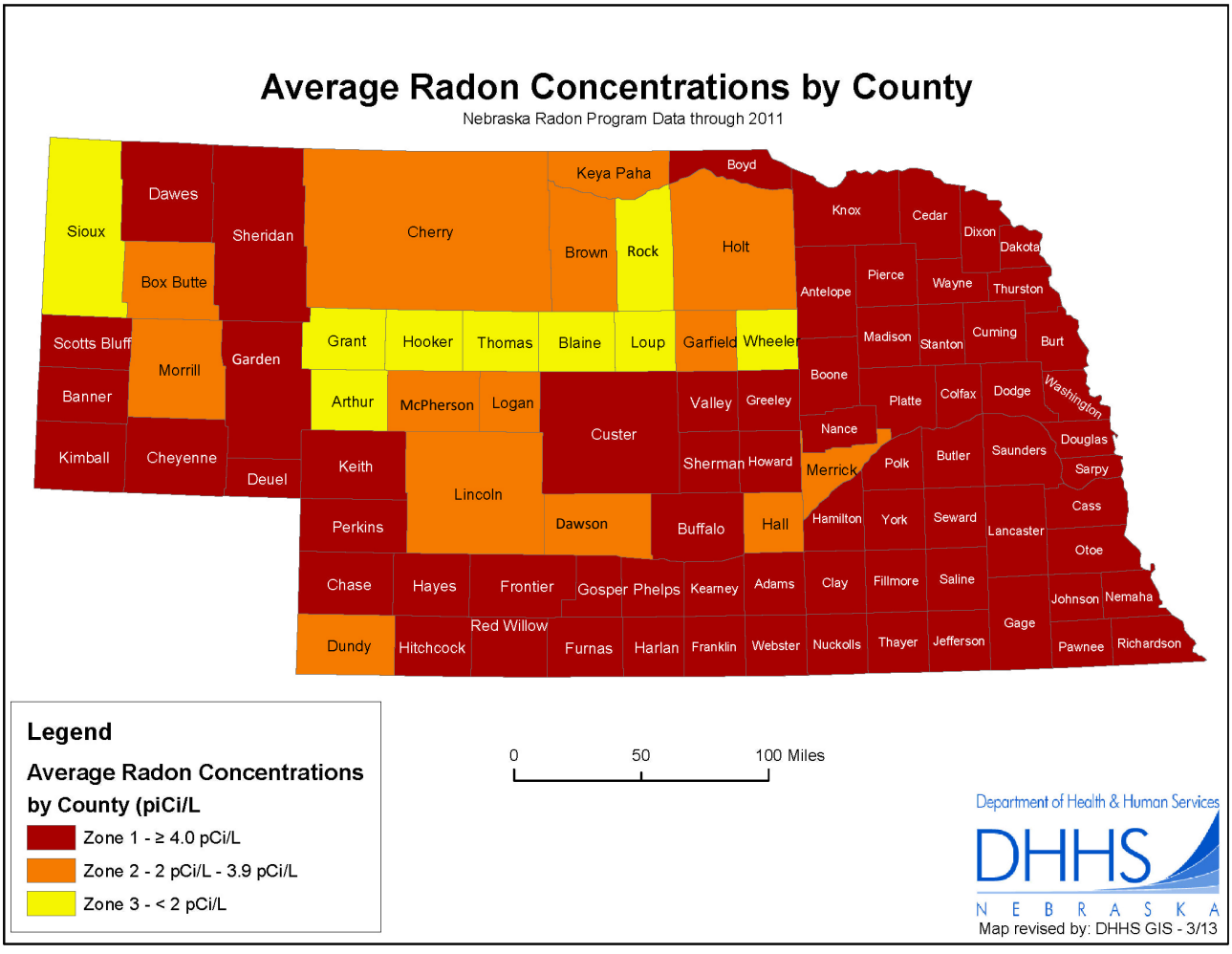
[155]U.S. Department of Agriculture, Food and Nutrition Service. (2014).Program data: WIC program. Retrieved December 9, 2014 from http://www.fns.usda.gov/pd/wisummary.htm At-risk population data: Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS).
[156]U.S. Department of Agriculture, Food and Nutrition Service. (2014).Women, Infants and children (WIC): Frequently asked questions about WIC. Retrieved December 9, 2014, from http://www.fns.usda.gov/wic/frequently-asked-questions-about-wic
[157]U.S. Department of Agriculture, Food and Nutrition Service. (2014). Women, Infants and children (WIC): About WIC – WIC at a glance. Retrieved December 9, 2014, from http://www.fns.usda.gov/wic/about-wic-wic-glance
[158]Ibid.
[159]Nebraska WIC Program. Retrieved December 17, 2014, from http://dhhs.ne.gov/publichealth/Pages/wic_outreach_find-a-wic-clinic_index.aspx
[160]U.S. Department of Agriculture, Food and Nutrition Service. {various years}. Characteristics of Supplemental Nutrition Assistance Program housholds. Retrieved from http://www.fns.usda.gov/ops/wic-studies. Population data: Child Trends analysis of March Current Population Survey Data.
[161]Fox, M.K., Hamilton, W., Lin, B. (2004). Effects of food assistance and nutrition programs on nutrition and health: Volume 4, Executive summary of the literature review. Economic Research Service/USDA. p. 11. Retrieved from http://www.ers.usda.gov/publications/fanrr-food-assistance-nutrition-research-program/fanrr19-4.aspx .
[162]Ibid, p. 12.
[163]Nord, M, Andrews, M, and Carlson, S. (2007). Household food security in the U.S. 2006. Economic Research Report No. ERR-49. Retrieved from http://www.ers.usda.gov/publications/err-economic-research-report/err49.aspx
[164]Tiehen, L, Joliffe, D., and Gundersen, C. (2012). Alleviating poverty in the U.S.: The critical role of SNAP benefits. U.S. Department of Agriculture, Economic Research Service. Retrieved from http://www.ers.usda.gov/publications/err-economic-research-report/err132.aspx
[165]Sources: SNAP data: Tonkinson, C. (2014). Kids Count in Nebraska 2013 report. Ralston, NE: Voices for Children in Nebraska. Retrieved from: http://voicesforchildren.com/wp-content/uploads/2014/01/Kids-Count-2013-FINAL2.pdf. Poverty data: American Factfinder, Table B17024: Age by ratio of income to poverty level in the past 12 months, 2008-2012 American Community Survey 5-year estimates.

Exposure to radon

Radon is a naturally occurring but potentially deadly environmental health hazard. A radioactive gas originating in rock, soil, and water, radon is estimated to cause thousands of cancer deaths per year in the U.S..[166]

The Nebraska Department of Health and Human Services has published the following map of Nebraska counties divided into 3 zones with the average radon concentrations. Information is based on data provided by the U.S. Environmental Protection Agency (EPA). According to this map, 100 percent of counties with an urban core fall into zone 1 (which has the highest radon concentrations); 73 percent of counties with a large rural town are also in zone 1, with the remaining in zone 2. Counties with a small rural town or isolated rural area are split as follows: 75 percent in zone 1, 14 percent in zone 2, and 11 percent in zone 3.[167]

According to NDHHS, "this map is not intended to be used to determine if a home in a given zone should be tested for radon. Homes with elevated levels of radon have been found in all 3 zones. All homes should be tested regardless of geographic location."[168]



[166]U.S. Environmental Protection Agency. (2014). Radon (Rn). Retrieved from http://www.epa.gov/radon/index.html
[167]Nebraska Department of Health & Human Services. (2013, January 11). Average radon concentrations by county in Nebraska. Retrieved September 24, 2014, from http://dhhs.ne.gov/publichealth/Pages/radon_2010data_averages.aspx.
[168]Ibid.

Asthma

Asthma is the most prevalent chronic condition of childhood in the U.S. Survey data do not include sufficient numbers of cases to provide reliable Nebraska-specific estimates of asthma prevalence for this age group; however, among children birth to age 18, rates of current asthma for Nebraska are somewhat lower than the national average.[169]

Research implicates multiple underlying causes for asthma; however, it is clear that a number of environmental triggers can set off an asthma attack. Many of these are associated with poor housing and with exposure to pollutants that are disproportionately found in poor neighborhoods.[170]

Among children younger than age 3, about 1 in 18 (5.5 percent) have current asthma, a proportion that has changed little over the past 10 years. Rates among young black children are more than twice as high as among white children, while rates for Hispanics fall in-between. Infants and toddlers living in poverty are three times more likely to have asthma as are those with family incomes at least double the poverty level. Boys are more likely than girls to have asthma.[171]

Lead poisoning

Public awareness of the dangers to young children posed by environmental exposure to lead has contributed to marked declines in blood lead levels among tested children. Nevertheless, there are also disturbing facts: first, it is becoming clear that there is no safe level of lead exposure, so even minute amounts may pose risks, particularly for infant development; second, lead exposure increasingly affects disproportionately the most disadvantaged children—those who live in older, poorer urban areas.[172]

No Nebraska data are available on infants and toddlers tested for lead poisoning.

Adverse childhood experiences

Evidence is growing that highlights the importance of cumulative stress in affecting a number of health and other life-course outcomes. While a degree of stress is unavoidable, when stress reaches "toxic" levels it interferes with the normal development of the body's neurological, endocrine, and immune systems, leading to increased susceptibility to disease. Infants and toddlers, because their brains are developing rapidly, may be especially vulnerable, and damage may be long-lasting.[173]

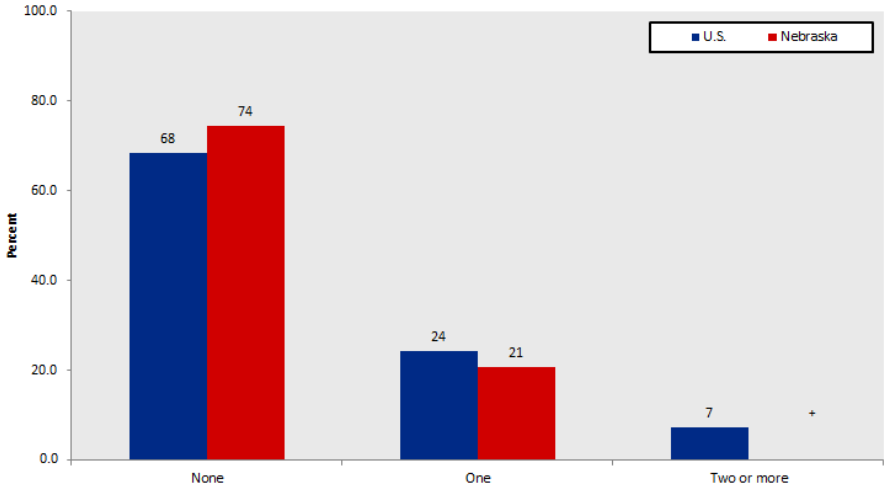
Research has focused on adverse experiences in childhood that may be traumatic, depending in part on whether there are supportive caretakers who can buffer the level of stress. Recently, this list has been adapted for use in a nationally representative survey of U.S. parents. Survey items asked parents to indicate whether their child had ever experienced one or more of the following: economic hardship, divorce/separation of parent, death of a parent, a parent who served time in jail, witness to domestic violence, victim of or witness to neighborhood violence, lived with someone who was mentally ill or suicidal, lived with someone with an alcohol/drug problem or was treated or judged unfairly due to race/ethnicity.[174]

[169]2011-12 National Survey of Children's Health. Data Resource Center for Child & Adolescent Health. www.childhealthdata.org
[170]Child Trends DataBank. (2013). Asthma. Retrieved from http://www.childtrends.org/?indicators=asthma
[171]Child Trends' analysis of National Health Interview Survey.
[172]Child Trends DataBank. (2014). Lead poisoning. Retrieved from http://www.childtrends.org/?indicators=lead-poisoning.
[173]Shonkoff, J. P., Garner, A. S., and the Committee on Psychosocial Aspects of Child and Family Health. (2012). The lifelong effects of early childhood adversity and toxic stress. American Academy of Pediatrics Technical Report. Retrieved from http://pediatrics.aappublications.org/content/129/1/e232.full.pdf
[174]Centers for Disease Control and Prevention. (2013). State and local area integrated telephone survey: National Survey of Children's Health. Retrieved December 9, 2014 from: http://www.cdc.gov/nchs/slaits/nsch.htm#2011nsch

Most Nebraska infants and toddlers have experienced none of these adverse events. However, 21 percent have experienced at least one; the most prevalent is the experience of economic hardship "very" or "somewhat" frequently. The sample size for Nebraska is too small to yield a reliable estimate of the percentage with 2 or more of these experiences.[175]

National data show the prevalence of 2 or more adverse experiences (excluding economic hardship) is more than 4 times as high among infants and toddlers living in poverty as it is among those in families with incomes at least twice the poverty level. Boys are less likely than girls to have had no adverse experiences, and are more likely to have a single such experience; boys and girls are equally likely to have had 2 or more. Children with special health care needs are more than twice as likely as those without such needs to have had 2, and more than 3 times as likely to have had 3 or more, adverse experiences.[176]

Among children birth to age 3, percentages who have had no, 1, or more adverse experiences:* U.S. and Nebraska, 2011-12



+Estimate unreliable, due to fewer than 20 sample cases in one or more cells.
*Adverse experiences (reported by parent or other responsible adult) include: frequent economic hardship, parental divorce or separation, parental death, parental incarceration, witnessing domestic violence, witnessing or being a victim of violence in the neighborhood, living with someone who is mentally ill or suicidal, living with someone who has problems with substance abuse, and racial or ethnic descrimination.
Source: Child Trends' analysis of National Survey of Children's Health.

[175]Child Trends' analysis of the 2011-12 National Survey of Children's Health data.
[176]Ibid.

Section IV: Early Childhood Development

Reading, telling stories and singing songs to young children

About 4 in 10 Nebraska children birth to age 3 (43 percent) were read to by a family member every day during the past week, compared with 46 percent nationwide. Nationally, white children are about twice as likely as Hispanics to have family members read to them frequently; black children fall between.[177]

Children develop literacy skills and an awareness of language long before they are able to read. Since language development is fundamental to many areas of learning, skills developed early in life help set the stage for later school success. By reading aloud to their young children, parents help them acquire the skills they will need to be ready for school.[178]

Young children who are regularly read to have a larger vocabulary, higher levels of phonological, letter name and sound awareness, and better success at decoding words. The number of words in a child's vocabulary can be an important indicator of later academic success. Children's vocabulary use at age 3 is a strong predictor of language skills and reading comprehension at ages 9 to 10.[179]

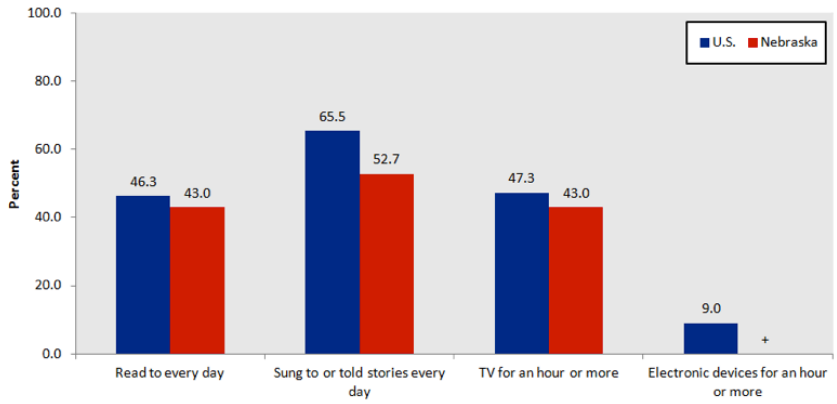
Another shared activity that promotes early literacy skills and provides opportunities for closeness between young children and other family members is singing songs or telling stories together.

In 2011-12, about half of Nebraska infants and toddlers (53 percent) were sung to or told stories every day—lower than the national average of 66 percent.[180]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

[177]Child Trends' analysis of the 2011-12 National Survey of Children's Health data.
[178]Child Trends DataBank. (2013). Reading to young children. Retrieved from http://www.childtrends.org/?indicators=reading-to-young-children
[179]Ibid.
[180]Child Trends' analysis of the National Survey of Children's Health taken from the Data Resource Center for Child and Adolescent Health at www.childhealthdata.org

Percentages of infants and toddlers whose family members read to, or sing or tell stories to them; and who spend time with television* or other electronic devices: U. S. and Nebraska, 2011/12**



+ Estimate unreliable, due to fewer than 20 sample cases in one or more cells.
*Time in front of a television includes one or more hours per weekday watching TV or videos, or playing video games.
**Usage of electronic devices includes one or more hours per weekday with computers, cell phones, handheld video games, and other electronic devices.
Source: Child Trends' calculations from the National Survey of Children's Health (NSCH) (all data parent-reported)

Use of television and handheld electronic devices

Technology is very much a common part of the typical American day, but we know that infants and toddlers learn through interactions with adults (and other children), so careful attention should be given to use of electronic devices at a young age. When used to support healthy adult-child interactions, electronic devices can be helpful tools.

Four in 10 Nebraska infants and toddlers (according to parents' reports) spend an hour or more per weekday in front of a television, either watching programs or playing video games. About 1 in 3 is reported to watch "none" on a typical weekday. According to national data, black infants and toddlers and those living in poverty are more likely than their counterparts to watch an hour or more.[181]

[181]Child Trends' analysis of the 2011-12 National Survey of Children's Health data.

The American Academy of Pediatrics discourages the use of television and other electronic media for children younger than age 2, and for older children recommends no more than 2 hours per day.[182] Nevertheless, data from a number of surveys show that U.S. infants and toddlers are exposed to a great deal of these media, starting in the earliest months of life. A 2011 report says nearly half (47 percent) of children in this age group watch TV or DVDs on a typical day, with average viewing at nearly 2 hours for those who do so. Forty-three percent watch TV at least daily. Nearly a third (29 percent) of infants and toddlers have a television in their bedroom.[183] A third of infants and toddlers live in homes where television is on constantly, regardless of whether anyone is watching it.[184]

Other 2011-12 data supplement these by reporting on use of computers, cell phones, video games, and "other handheld electronic devices." About 1 in 5 Nebraska infants and toddlers use these for some amount of time on an average weekday.[185] National data show that young black children are more than 3 times as likely as their white counterparts to be "heavy" users of these media (an hour or more on a typical weekday). Young children in poverty are about half again as likely to be "heavy" users as those in families with incomes at least twice the poverty level.[186]

A comparison of Nebraska's urban/non-urban counties is not available for this indicator.

High-quality early childhood environments

An estimated 32,753 Nebraska children birth to age 3 face risk factors that stand in the way of their cognitive, linguistic, social-emotional, behavioral and physiological development.[187] Numerous studies have documented a strong association between high-quality early childhood environments and a wide range of positive developmental, academic, and social outcomes for the children. This is particularly evident in high-quality programs that target young children with risk factors. The strongest evidence of positive long-term outcomes for vulnerable children comes from studies of model early childhood programs that offer intensive, comprehensive services addressing the major domains of early development.[188] Recent research suggests that a relatively high level of quality is needed to meaningfully affect child outcomes.[189]

High-quality early childhood programs can vary in structure and scope; however, there are common characteristics that indicate quality environments. These include, but are not limited to:

- program staff with a high degree of knowledge about child development, and have sufficient opportunities to increase their professional caliber through training;
- small class sizes and low child-to-teacher ratios;

[182]American Academy of Pediatrics, Council on Communications and Media. (2011). Media use by children younger than two years. Policy Statement. Pediatrics, 128(5), 1040-1045.
[183]Common Sense Media. (2011). Zero to Eight: Children's media use in America. Retrieved from http://www.commonsensemedia.org/sites/default/files/research/zerotoeightfinal2011.pdf
[184]Rideout, V. & Hamel, E. (2006). The media family: Electronic media in the lives of infants, toddlers, preschoolers, and their parents. Kaiser Family Foundation. Retrieved from http://kff.org/other/the-media-family-electronic-media-in-the/
[185]Child Trends' analysis of the 2011-12 National Survey of Children's Health data.
[186]Ibid.
[187]U.S. Census Bureau; Estimates derived from American Community Survey, 2013 American Community Survey 5-Year Estimates, Tables B09001 & B17024; generated and analyzed by First Five Nebraska; using American Factfinder; <http://factfinder2.census.gov>; (4 December 2014).
[188]Burger, K. (2010). How does early childhood care and education affect cognitive development? An international review of the effects of early interventions for children from different social backgrounds. Early Childhood Research Quarterly, 25, 140-165; Reynolds, A. J., Magnuson, K. A., & Ou, S.-R. (2010). Preschool-to-third grade programs and practices: A review of research. Children and Youth Services Review, 32, 1121-1131.
[189]Burchinal, M., Vandergrift, N., Pianta, R., & Mashburn, A. (2010). Threshold analysis of association between child care quality and child outcomes for low-income children in prekindergarten programs. Early Childhood Research Quarterly, 25(2), 166-176. DOI: http://dx.doi.org/10.1016/j.ecresq.2009.10.004

- communication between staff and parents, and actively build parents' capacity to guide the healthy development of their youngest children;
- safe, clean environments with an abundance of tools that stimulate development of foundational skills; and
- consistently affectionate, supportive and encouraging interactions between adults and children modeling appropriate behaviors and respond to the needs of individual children.[190]

Recent calculations suggest that only 7 percent of infants (about 1,100) and 8 percent of toddlers (about 1,300) at risk in Nebraska receive services in environments known to meet high-quality standards.[191]

Sixpence

Sixpence[192] (officially named the Nebraska Early Childhood Education Endowment Cash Fund) was established in 2006 as an innovative partnership that brought together state agencies and private philanthropy to increase the availability of high-quality early developmental experiences for Nebraska's infants and toddlers at risk of failure in school. The program currently supports high-quality family engagement and center-based programs in 25 locations throughout the state.

The dedicated funding stream flows through local public school systems to community providers who deliver high-quality services to infants and toddlers.

[190]Bredekamp, S. & Copple, C. (Eds.). (1997). Developmentally appropriate practice in early childhood programs. Rev. ed. Washington, D.C.: National Association for the Education of Young Children.
[191]Children at risk were estimated from ACS 5-year estimates. Children in high-quality programs were calculated from NDE Preschool, Sixpence, Educare, EDN, Early Steps to School Success and Head Start programs, as well as children receiving subsidized care from either an accredited or Step Up to Quality Step 3-Step 5 provider. For further information contact First Five Nebraska.
[192]See Step Up to Quality at the Nebraska Department of Education for more information, at www.education.ne.gov/StepUpToQuality/.

Each program is uniquely determined by its community; some programs provide center-based child care services, and others focus on parent coaching skills—helping parents become better parents. Of the 25 Sixpence locations, 68 percent are located in counties with a small rural town or isolated area, 24 percent are located in counties with a large rural town, and 8 percent are in counties with an urban core. However, many programs reach across county lines. Sixpence programs reach 66 percent of the counties with an urban core (2 counties), 55 percent with a large rural town (6 counties), and 22 percent with a small rural town or isolated area (17 counties).[193]

Programs target different risk factors for participation eligibility. For example, programs in counties with an urban core have a greater focus on teen pregnancies (58.6 percent of participants) and parents without a high school diploma (57.7 percent of participants),[194] while counties with a large rural town have a greater focus on English language learners (46.3 percent of participants). The poverty rate was higher in counties with a small rural town or isolated rural areas than in counties with an urban core, but exceeded 72 percent across 2 years in both settings.[195]

Independent evaluations conducted by researchers at the University of Nebraska's Munroe Meyer Institute indicate that Sixpence programs are delivering positive results for children subject to significant risk factors. According to 2013-14 assessments, 90 percent of participating children were gaining skills at the expected growth rate across the major developmental domains.[196]

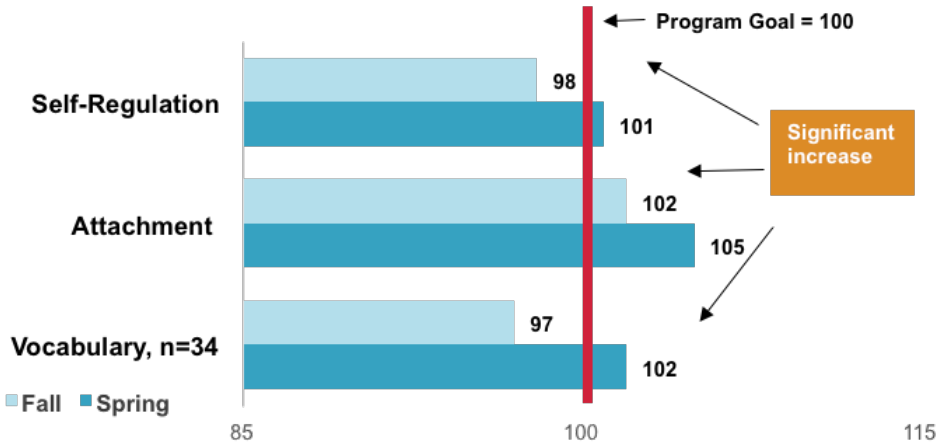
Children showed particularly strong gains in social-emotional competencies such as initiative, attachment, and self-regulation, all of which are known to influence a child's ability to function productively in more formal classroom settings.[197] Devereux Early Childhood Assessment (DECA[198]) scores in 2013-14 showed gains in social and emotional health over 2012-13, with 94.7 percent of infants and toddlers statewide scoring in the average range in the most recent year. Results were comparable in all geographic regions across the state.[199]

Similarly, parents participating in Sixpence saw gains in their ability to build stronger relationships with their infants and toddlers,[200] and improved significantly in their ability to promote effective learning and support their children's confidence.[201] Statewide results from the Keys to Interactive Parenting Scale (KIPS[202]) showed significant improvement during the program year for parent-child interactions specifically related to learning and building confidence.[203] Approximately half of the parents met the program's goal in the area of parent-child interaction by the spring of the program's academic year.[204]

Sixpence families also succeeded in ensuring that nearly all infants and toddlers met the health indicators identified by the program as important to positive development in these early years.[205]

[193]Sixpence grantee status report [Microsoft Word]. (2014, November). Unpublished raw data
[194]Jackson, B., & Zweiback, R. (2014, October 8). [Summary of data for Sixpence programs] [Microsoft Word]. Unpublished raw data, Munroe-Meyer Institute, University of Nebraska Medical Center, Omaha, NE.
[195]Ibid.
[196]Jackson, B.; Zweiback, R.' Alvarez, L. (2014). "Sixpence Annual Report 2013-2014." Omaha: University of Nebraska Medical Center, 11.
[197]Ibid.
[198]LeBuffe, P. (1999). The Devereux Early Childhood Assessment (DECA): A measure of within-child protective factors in preschool children. National Head Start Association Dialog, 3, 75-80.
[199]Jackson & Zweiback, Summary of data for Sixpence programs.
[200]Jackson, Zweiback, Alvarez, "Sixpence Annual Report 2013-2014", 14.
[201]Jackson & Zweiback, Summary of data for Sixpence programs.
[202]Comfort, M., Gordon, P., & Naples, D. (2011). KIPS: An evidence-based tool for assessing parenting strengths and needs in diverse families. Infants & Young Children: An Interdisciplinary Journal of Early Childhood Intervention, 24(1), 56-74. http://dx.doi.org/10.1097/iyc.0b013e3182001bd3
[203]Jackson & Zweiback, Summary of data for Sixpence programs.
[204]Ibid.
[205]Jackson, Zweiback, Alvarez, "Sixpence Annual Report 2013-2014", 12.

Sixpence helped to close the gap in children's social-emotional and language skills.
On average, children scored above the program goal of 100.



Educare

Educare is a network of high-quality schools serving children birth to age 5 who come from low-income households and face risk factors associated with failure in school. The Educare model focuses not only on high-quality learning environments for children at risk, but emphasizes family engagement as the key to enabling parents to fulfill their roles as their children's most important teachers. In Nebraska, Educare serves children at 2 locations in Omaha, one location in Lincoln, and one location in Winnebago. The Omaha and Lincoln locations are in counties with an urban core, while the Winnebago Educare is in a county with a small rural town or isolated rural area. Individual Educare locations are made possible by collaborations between state agencies, private philanthropy, and local partners. Strong ties with the University of Nebraska System help Educare centers function as research centers for best practices in child care and development.[206]

At the individual site level, the Educare Schools collect data and ongoing child assessments in the areas of social-emotional development, language and literacy skills, and math—skill and knowledge competencies that children need to thrive in kindergarten. The first young Nebraskans who attended Educare are currently in fifth grade (2013-14 school year), and longitudinal analysis conducted by independent third-party evaluators finds evidence not only of significant early gains in these skill and knowledge areas,[207] but that these gains persist well into the K-12 system. Researchers at the Munroe Meyer Institute found that those who attended Educare of Omaha for 2 or more years scored significantly higher than children from similar backgrounds as measured by Omaha Public Schools districtwide Nebraska State Assessments (NeSA) in reading, writing, and math. Similarly, the same analysis found that students who attended the Educare of Omaha program for 2 or more years were 50 percent less likely to need special education in the 2013-14 school year than those students who attended 1 year or less.[208]

[206]See Educare at http://www.educareschools.org for more information.
[207]St. Clair, L. & Borer, M. (2013). "Section IV. Evaluation Report for Educare of Omaha, 2012-13." Omaha, NE: Educare.
[208]St. Clair, L (2014). "Educare of Omaha Follow Up Study: How are former Educare students performing in Omaha's urban school district?" Unpublished Report. Omaha, NE: Munroe Meyer Institute at the University of Nebraska Medical Center.

Early Steps to School Success

The Early Steps to School Success program targets rural areas where there are few other early childhood supports. The program is designed to assist children, from birth to age 5, with language, social, and emotional development; to equip parents with the skills and knowledge to successfully support their child's growth beginning in pregnancy; and to develop strong home-school connections. In Nebraska, Early Steps to School Success works with 12 partner sites in 7 counties, 1 of which is located in a county with an urban core, 4 in counties with a large rural town, and 2 in counties with a small rural town or isolated rural area.[209]

Based on 2 design approaches (quasi-experimental and regression discontinuity), annual evaluations of all sites nationwide, including those in Nebraska, consistently show greater than 80 percent of three-year-olds and 90 percent of 5-year-olds score at or above the normal range for vocabulary, a critical component of language development and pre-literacy skills.[210]

Early Head Start

In 2013, Early Head Start served nearly 1,700 Nebraska pregnant women, infants and toddlers.[211] Early Head Start (EHS) is a comprehensive child development and family support program for infants, toddlers and pregnant women in low-income families. EHS serves as a key partner in many of Nebraska's Sixpence programs, and is a community partner with both Sixpence and the public schools because of its comprehensive services and wide range of support.

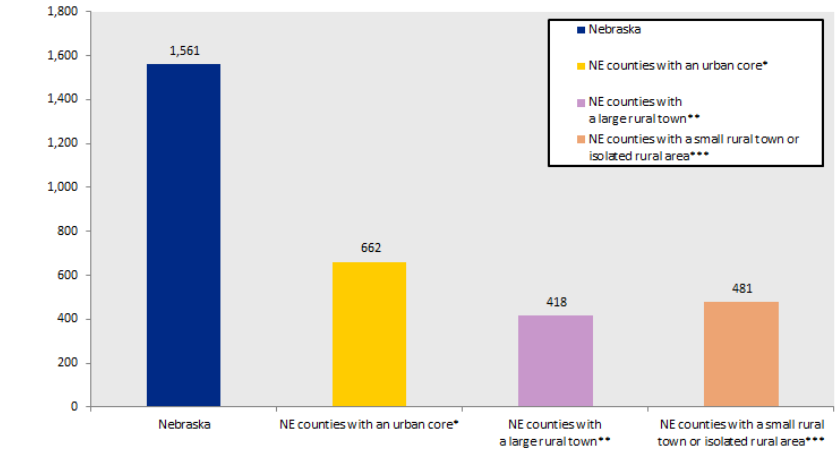
Apart from family income, each EHS program sets its own eligibility criteria, targeting their services to best meet the needs of families and children in their community. Services may be delivered in centers, family child care homes or individual family homes. In addition, EHS programs must allocate at least 10 percent of their enrollment slots to children with disabilities who are eligible for Part C services under the Individuals with Disabilities Education Act.[212]

Of Nebraska's EHS participants, about 42 percent are served in counties with an urban core, 26 percent in counties with a large rural town, and 33 percent in counties with a small rural town or isolated rural area.[213] EHS programs reach 100 percent of counties with an urban core, 82 percent with a large rural town (9 counties), and 49 percent with a small rural town or isolated area (39 counties).[214] Sixty-five percent are white, 11 percent are black, and 39 percent are Hispanic.[215]

EHS reports on a number of "progress" indicators, measures taken at the beginning and end of the enrollment year. In 2013, for example, 95 percent of enrolled children had health insurance at the start of the year, and 97 percent had it at year's end. These figures closely parallel the corresponding EHS national data.[216]

[209]Save the Children. (n.d.). Helping Nebraska children succeed. Retrieved from http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/HELPING%20NEBRASKA'S%20CHILDREN%20SUCCEED.PDF.
[210]Jerald, J., & O'Neil, N. V. (2010, November). 11-2010 ESSS overview updated . Retrieved from http://uscenter.savethechildren.org/Early%20Steps%20to%20School%20Success/11-2010%20ESSS%20Overview%20updated.pdf. See also Raikes, H., Richardson, L., Escalante, E., & Plata-Potter, S. (2012, April 25). Early Steps to School Success – Program and evaluation. Retrieved from http://cyfs.unl.edu/ecs/2012/downloads/Raikes_Early_Steps.pdf.
[211]Head Start Data: HHS/ACF/OHS. (2013). Program Information Reports. Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/mr/pir.
[212]Early Head Start National Resource Center. http://eclkc.ohs.acf.hhs.gov/hslc/standards/pc
[213]Head Start Data: HHS/ACF/OHS. (2013). Program Information Reports. Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/mr/pir.
[214]Ibid.
[215]Ibid.
[216]Ibid.

Number of children birth to age 3 in Early Head Start programs: School year 2012-13



*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.
**Large rural town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at least one micropolitan
***Small rural town is defined as a community with a population between 2,500 and 9,999. Isolated rural area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.
Sources: Early Head Start data: HeadStart Data: HHS/ACF/OHS. (2013). Program Information Reports. Available at: http://eclkc.ohs.acf.hhs.gov/hsdc/mr/pir

Home-visiting services

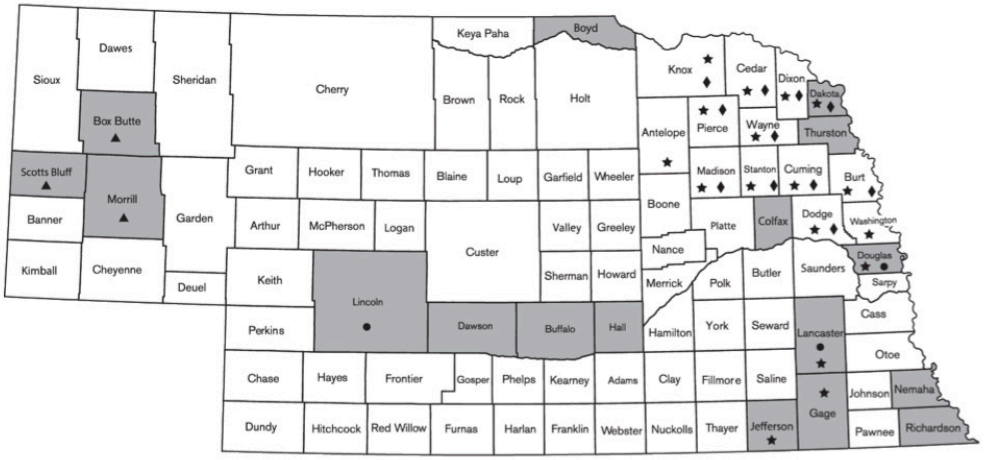
About 1 in 7 Nebraska parents and/or children received one or more home visits between pregnancy and the child's third birthday, according to 2011-12 data.[217] Evidence-based home-visiting services are among the most demonstrably effective models for strengthening the bond between parents and children, and educating parents about their children's developmental needs.

In home-visiting programs, early childhood specialists work closely with individual families, modeling techniques for healthy, language-rich parent-child interactions, educating parents about their children's developmental stages, and connecting families with a network of medical, dental, mental health, and other resources in the community. Benchmark research shows that evidence-based home-visiting programs improve maternal and newborn health, reduce child injuries, and lower the incidence of child abuse, neglect or maltreatment, and emergency department visits. Other gains associated with home-visiting services include improved school readiness and achievement, reduced incidence of crime and domestic violence, and stronger family economic self-sufficiency.[218]

The Nebraska Department of Health and Human Services (DHHS) has invested in home-visiting programs in 21 counties reaching 66 percent with an urban core (2 counties), 55 percent with a large rural town (6 counties), and 16 percent with a small rural town or isolated area (13 counties).[219]

[217]Child Trends' analysis of the 2011-12 National Survey of Children's Health data.
[218]NGA Center for Best Practices. (2011). Maximizing the impact of state early childhood home visitation programs. Washington, DC: Author.
[219]Maternal child adolescent health. (2014, September 18). Retrieved November 24, 2014, from http://dhhs.ne.gov/publichealth/pages/homevisitingmap.aspx.

Nebraska Maternal, Infant, and Early Childhood Home Visiting (N-MIECHV) Overview



Legend (DHHS Investments in Home Visiting)
- ▲ Federal MIECHV Formula Grant
- ● Federal MIECHV Development Grant
- ★ State Funds

Source: "Nebraska Maternal, Infant, and Early Childhood Home Visiting (N-MIECHV) Overview" Nebraska Department of Health and Human Services. Retrived from http://dhhs.ne.gov/publichealth/Pages/HomeVisitingMap.aspx. October 21, 2014

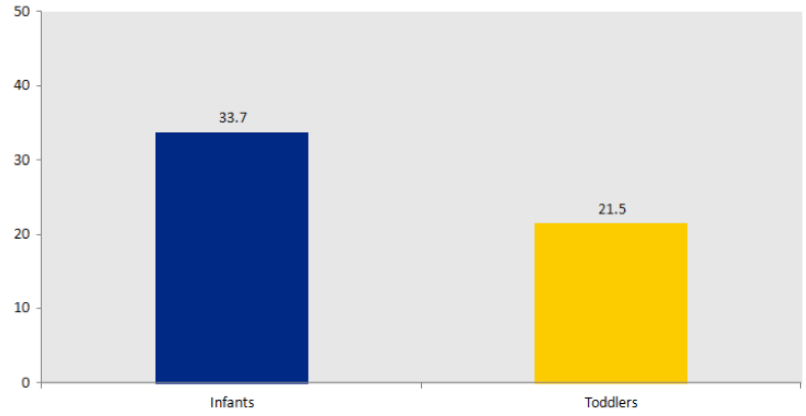
Child care

The largest funding source used to support early childhood settings is the federal child care subsidy program, called the Child Care and Development Fund (CCDF). CCDF served nearly 19,900 Nebraska infants and toddlers in 2012, representing 34 percent of infants and 22 toddlers in the state. In federal fiscal year 2013, $5.1 billion in federal funds was allocated to states, territories and tribes to administer this program to children birth to age 13. Nebraska received just under $34 million.[220] Combined with state funds, Nebraska spends just over $92 million annually on publicly subsidized child care.[221]

[220]Office of Child Care, Administration for Children and Families. (2012). Child Care and Development Fund fact sheet. Retrieved from http://www.acf.hhs.gov/programs/occ/resource/child-care-and-development-fund

[221]Nebraska Department of Health and Human Services. (2014, August 12). FY2013 subsidized child care expenditures. Unpublished raw data. Analysis provided by First Five Nebraska.

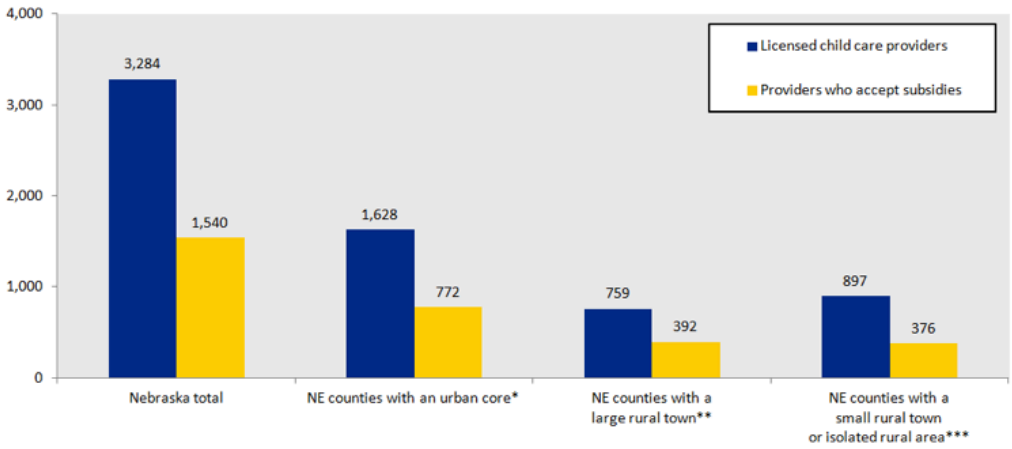
Percentage of low-income Nebraska infants and toddlers served by a child care subsidy:* Fiscal year 2012-13



*Low-income is defined as < 185% of the federal poverty level. Percentage is based on an estimate of population for the infant and toddler population from January through December, while the subsidy data are for July through June.
Children may receive more than one subsidy over the course of a year if they are cared for by more than one provider.
Sources: Child subsidy data from NDHHS. Population data for percentages: Child Trends' calculations from postcensal population estimates from the Census Bureau, available at: http://www.census.gov/popest/data/state/asrh/2013/index.html

As of October 2013, Nebraska had nearly 3,300 licensed child care providers and fewer than half (47 percent) accepted subsidy payments. Nearly half of licensed providers (49 percent) were located in counties with an urban core; 23 percent were in counties with a large rural town; and 27 percent were in counties with a small rural town or isolated rural area.[222]

Number of Nebraska licensed child care providers serving infants and toddlers, and number accepting subsidies, by urban/rural location: October 2013



*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.
**Large rural town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at least one micropolitan community, but no metropolitan communities.
***Small rural town is defined as a community with a population between 2,500 and 9,999. Isolated rural area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.
Source: Child Trends' calculations from the October 2013 roster of licensed providers maintained by NDHHS.

[222]Nebraska DHHS: Division of Public Health. (2013, October 11). Roster of licensed child care and preschool programs in Nebraska . Retrieved from http://dhhs.ne.gov/publichealth/Documents/ChildCareRoster.pdf.

As in other states, the quality of child care funded by CCDF is uncertain, yet low-income working parents depend heavily on that child care. National data show the types of care employed mothers predominantly use for their children (birth to age 5) have changed only slightly in the past 25 years. Between 1985 and 2011, the percent of these children whose primary caregiver during working hours was a parent has fluctuated between 22 percent and 29 percent. The proportion in center-based programs increased from 23 percent to 26 percent between 1997 and 2011. The percentage of children who were cared for by a relative has remained fairly steady for the past decade, between 25 percent and 27 percent. The strongest trend has been a consistent decrease in the percentage of children who are cared for by a non-relative at home, which declined from 28 percent to 14 percent between 1985 and 2011.[223]

The CCDF is administered through block grants by states, with guidance from the federal government. The stated goals of the Child Care and Development Fund subsidies are to promote parental employment among low-income families, and to promote the quality and accessibility of child care.[224] At the time of this writing, the Child Care and Development Block Grant (CCDBG) Act had been recently signed into law with provisions making high-quality early learning a requisite component of CCDF funding.[225]

With Nebraska's passage of an early childhood quality rating system in 2013, child care programs will be able to raise their level of quality through incentives for training, education, and coaching opportunities. Scholarships can be provided to pursue college coursework and bonuses are offered to providers who improve their quality.[226]

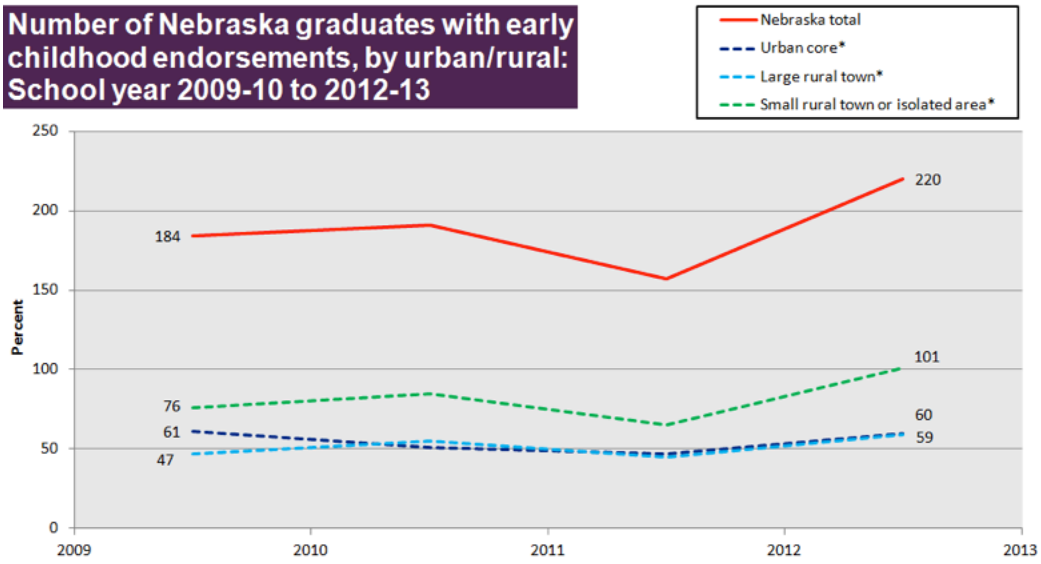
[223]Child Trends. (2013). Child care. Retrieved from http://www.childtrends.org/?indicators=child-care
[224]Office of Child Care, Administration for Children and Families. (2012). Child Care and Development Fund fact sheet. Retrieved from http://www.acf.hhs.gov/programs/occ/resource/child-care-and-development-fund
[225]Child Care and Development Block Grant Act of 2014, S.1086, 113th Cong., 2d Sess. (2014).
[226]Step Up to Quality Child Care Act, Neb. Rev. Stat. § 71-1953 (2013).

Section V: Early Childhood Workforce

Early Childhood Education endorsements

Cultivating and sustaining an early childhood workforce of sufficient size and quality to meet the developmental needs of infants and toddlers is necessary. **In Nebraska, this workforce requires a teaching certificate that includes an Early Childhood Education (ECE) endorsement.** Recent Nebraska data show that 4,007 individuals hold such an endorsement, while 1,022 hold an Early Childhood Unified/Inclusive endorsement, and an additional 133 hold an Early Childhood Special Education (SPED) endorsement.[227]

In the 2012-13 academic year, 220 new ECE endorsements were issues to Nebraska graduates. Of these, about equal numbers graduated from higher education institutions in counties with an urban core (60) and counties with a large rural town (59); 101 were in counties with a small rural town or isolated rural area.[228]



*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community. Large rural town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at least one micropolitan community, but no metropolitan communities. Small rural town is defined as a community with a population between 2,500 and 9,999. Isolated rural area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.
Source: Nebraska Department of Education.

[227]Nebraska Department of Education, Adult Program Services Administrator. (2014, August 26). Early childhood data [E-mail to First Five Nebraska].
[228]Nebraska Department of Education. (2014, February). Endorsements on initial certificates issued Sep 1, 2012-Aug 31, 2013. Retrieved from http://www.education.ne.gov/EducatorPrep/IHE/TitleIIReporting/TitleIIReports/2014Reports/2014_Endorsement_Report.pdf. Analysis provided by First Five Nebraska.

Infant-toddler workforce needs

Notwithstanding this addition of recent graduates with ECE endorsements to its workforce, Nebraska is confronted by a growing gap between the demand for high-quality services and a sufficient supply of qualified professionals to deliver them. As indicated previously, only about 6 percent of Nebraska's infants and 7 percent of toddlers at risk have access to care and education services that are known to meet the standards of quality associated with strong skills growth. Based on the size of existing age cohorts and recommended staff-to-child ratios, these programs employ less than 20 percent of the total workforce needed to deliver high-quality services to all children at risk from birth to age 3 in Nebraska. To staff a sufficient number of programs to fill that gap, Nebraska must increase the workforce by approximately 6,314 highly trained and qualified professionals for an estimated total of 6,823.[229]

This challenge is complicated by the fact that Nebraska's 6,200 center-based employees earn an average annual income of $18,410, which is less than the $21,320 earned by child care workers nationally.[230]

Initiatives like Nebraska's newly implemented early childhood quality rating system, Step Up to Quality, provide opportunities and incentives for child care workers to obtain additional professional training to enhance their quality as caregivers and instructors, raising the quality of the programs in which they are employed, and increasing their overall marketability in the field.[231]

Other efforts are also underway in Nebraska, such as the collaboration between the Nebraska Department of Health & Human Services and the Nebraska Department of Education in surveying the state's community colleges, 4-year colleges, and universities to determine specific majors that include coursework on Nebraska's early learning guidelines and management training.

Simultaneously, the Buffett Early Childhood Institute[232] at the University of Nebraska is conducting a survey in conjunction with the University of California-Berkeley on early childhood personnel preparation in Nebraska, and will hold a variety of state and national symposia on the workforce.

T.E.A.C.H. scholarships

T.E.A.C.H. Early Childhood® NEBRASKA provides scholarships for early care and education staff to work toward a degree in early childhood education. Through the scholarship components, T.E.A.C.H. addresses the issues of under-educated early childhood staff, poor compensation for early childhood professionals, and a high turnover rate within the early childhood workforce.[233]

[229]Calculations by First Five Nebraska based on U.S. Census and Nebraska Department of Education data.
[230]Child Care Aware of America (2014). Child Care in America: 2014 State Fact Sheets. Retrieved fromhttp://usa.childcareaware.org/sites/default/files/19000000_state_fact_sheets_2014_v04.pdf.
[231]Step Up to Quality Child Care Act, Neb. Rev. Stat. § 71-1953 (2013).
[232]See Buffett Early Childhood Institute at the University of Nebraska. Information at http://buffettinstitute.nebraska.edu/.
[233]See T.E.A.C.H. Early Childhood® NEBRASKA from the Nebraska Association for the Education of Young Children at http://nebraskaaeyc.simplepublish.com/t-e-a-c-h-early-childhood/.

Scholarship recipients complete college coursework in early childhood education and immediately use that knowledge in their child care setting. Children are the main beneficiaries of the scholarship program. They receive a higher quality of care and can bond more effectively with their teachers. Child care programs also benefit from employing more qualified staff who work longer for their program.[234]

From June 2013 to July 2014, 123 students actively participated in T.E.A.C.H., earning over 1,118 college credits. Sixty-eight of those individuals work with infants and/or toddlers. Six participants graduated with an associate degree in early childhood education and one student graduated with a bachelor's degree in the Unified Endorsement in Early Childhood.[235]

T.E.A.C.H. scholarship recipients may elect to pursue their professional education in any of the participating 8 community colleges and 5 universities operating throughout the state, representing a geographical and demographical cross section of Nebraska counties.[236]

Conclusion

The data contained in this report indicate the breadth and complexity of the challenges facing Nebraska's youngest children at an age when they are keenly sensitive to the experiences, environments, and relationships they encounter daily. Confronting the issues described in this report will require action on multiple levels. It is not the purpose of this report to offer answers to these or any of the pressing challenges referenced here. Rather, the intent of this document is to provide the groundwork of information necessary to better understand the dimensions and nuances of those challenges, as well as the policies, practices, and initiatives that are yielding strong results. Given a sufficiency of sound information and the insight to capitalize on it, Nebraska will be in a stronger position to ensure that its most vulnerable infants and toddlers have a stronger chance for lifelong success.

[234]The Nebraska Association for the Education of Young Children, Inc. data [E-mail to First Five Nebraska].
[235]Ibid.
[236]See T.E.A.C.H. Early Childhood® NEBRASKA from the Nebraska Association for the Education of Young Children at http://nebraskaaeyc.simplepublish.com/t-e-a-c-h-early-childhood/.

Appendix

Percentage of Births with Late* or No Prenatal Care, All States Using the 2003 Revision of the Birth Certificate** and Nebraska: 2005-2012								
	2005	2006	2007	2008	2009	2010	2011	2012
States Using 2003 Birth Certificate Revision**	7.8	8.0	7.1	7.0	6.6	6.2	6.0	6.0
Nebraska	4.5	4.2	4.7	4.4	4.4	4.6	4.5	4.4
Counties with an urban core***	4.3	3.8	4.3	4.2	4.1	4.3	4.0	3.7
Other counties	4.7	4.6	5.1	4.7	4.8	4.9	5.3	5.4
Non-Hispanic white	3.8	3.2	3.5	3.4	3.2	3.5	3.3	3.3
Non-Hispanic black	6.7	7.2	7.9	8.1	8.7	7.6	7.1	5.9
Hispanic	7.0	7.3	8.0	7.5	7.8	7.5	8.6	8.4
* Late care means that the mother received care only in the third trimester.								
**The number of states using the 2003 version of the birth certificate has varied over time, so US trends in this measure should be interpreted with caution.								
***Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.								
Sources: Data for 2005-2006:Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm. Data for 2007-2012: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/.								

Among Births, Percentage by Number of Reported Maternal Stressors* in the 12 Months Before the Birth: 2002-2011										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Median among participating states**										
No stressors	25.0	24.2	27.3	27.7	28.8	29.2	29.8	27.3	29.1	31.0
1 to 2	41.4	40.8	42.5	42.2	42.4	41.1	40.9	41.7	42.8	42.5
3 to 5	26.2	26.0	23.7	23.3	22.1	22.8	22.7	23.9	22.9	20.8
6 to 13	6.5	8.0	6.4	5.9	5.6	6.1	6.0	6.0	5.2	5.2
Nebraska										
No stressors	25.6	22.7	27.4	29.0	30.9	29.1	30.6	29.6	31.2	31.7
1 to 2	41.1	43.6	44.3	43.9	42.4	44.1	42.0	41.8	43.3	42.9
3 to 5	24.5	25.3	22.0	21.1	20.9	21.9	22.5	23.8	21.3	20.2
6 to 13	8.8	8.5	6.4	6.0	5.8	4.9	5.0	4.9	4.2	5.3
*Stressors include: A close family member was very sick and had to go into the hospital; Someone very close to the mother died; Someone very close to the mother had a bad problem with drinking or drugs; the mother argued with her husband or partner more than usual;she got separated or divorced from her husband or partner; she had a lot of bills she could not pay; she lost her job even though she wanted to go on working; she moved to a new address; she or her husband or partner went to jail; she was homeless; she was in a physical fight; her husband or partner lost his job; and her husband or partner said he did not want her to be pregnant.										
**The number of states using this question on the survey has varied over time, so interpret trend data with caution.										
Source: Pregnancy Risk Monitoring System (PRAMS), CPONDER online tool. Available at: http://apps.nccd.cdc.gov/cPONDER.										

Stressor	Percent
You moved to a new address	33.9
You argued with your husband or partner more than usual	22.2
A close family member was very sick and had to go into the hospital	21.3
You had a lot of bills you could not pay	21.3
Someone very close to you died	16.6
Your husband or partner lost his job	10.0
Someone very close to you had a bad problem with drinking or drugs	9.9
You lost your job even though you wanted to go on working	9.7
You got separated or divorced from your husband or partner	8.0
Your husband or partner said he did not want you to be pregnant.	7.7
You or your husband or partner went to jail	3.5
You were homeless	3.5
You were in a physical fight	3.0

Source: Pregnancy Risk Monitoring System (PRAMS), CPONDER online tool. Available at: http://apps.nccd.cdc.gov/cPONDER.

Percentage of Births Where Mother Smoked During Pregnancy: All States Using 2003 Birth Certificate Revision* and Nebraska, 2005-2012

	2005	2006	2007	2008	2009	2010	2011	2012
States using 2003 birth certificate*	12.4	13.2	10.4	9.7	9.3	9.2	9.0	8.7
Nebraska	15.5	16.0	15.2	15.3	14.1	13.3	12.4	12.1
Counties with an urban core**	13.1	13.4	12.6	12.7	11.4	11.1	9.9	9.9
Other counties	19.0	19.4	18.6	18.7	17.8	16.2	15.7	15.3
Non-Hispanic white	17.7	18.2	17.5	17.7	16.5	15.4	14.1	13.9
Non-Hispanic black	14.3	13.9	12.1	14.5	12.5	12.4	10.4	12.0
Hispanic	5.6	5.3	5.0	4.0	4.2	3.9	4.6	3.9
15-19 years	24.4	22.4	22.1	21.1	19.6	18.5	17.2	17.4
20-24 years	24.1	25.2	22.8	23.6	22.0	21.0	19.2	19.8
25-29 years	13.4	14.2	13.5	14.0	13.1	12.0	12.1	11.4
30-34 years	8.9	9.3	9.3	9.2	8.6	8.5	8.0	7.8
35-39 years	9.7	8.7	9.4	9.4	7.7	8.0	6.7	6.9
40-54 years	9.9	13.0	8.2	6.6	9.0	5.6	7.4	8.1
No high school diploma	19.7	20.7	18.4	18.4	16.2	16.7	16.3	15.4
High school diploma or GED	29.1	28.7	28.1	28.4	26.2	24.8	23.3	23.5
Some college or associate's degree	17.0	18.0	16.9	17.3	16.8	15.8	15.2	15.0
BA or more	2.4	2.4	2.4	2.2	2.0	2.0	1.7	1.7

*The number of states using the 2003 version of the birth certificate has varied over time, so US trends in this measure should be interpreted with caution.

**Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.

Sources: Data for 2005-2006:Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm. Data for 2007-2012: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/.

Percentage of Births Where Mother Reported Symptoms of Post-Partum Depression:* 2009-2011			
	2009	2010	2011
Median of surveyed states**	12.3	11.3	10.3
Nebraska	12.7	11.0	10.5
Maternal education			
less than 12 years	16.5	11.0	13.7
12 years	16.8	12.5	11.6
more than 12 years	10.6	10.6	9.6
Income			
Less than $10,000	20.6	12.5	18.7
$10,000 to $24,999	17.3	15.1	11.3
$25,000 to $49,999	14.9	13.0	7.9
$50,000 or more	6.4	7.2	7.9
*Post-partum depression symptoms were defined by the frequency of feeling down, depressed, or sad; feeling hopeless; and feeling slowed down.			
**The number of states using this question on the survey has varied over time, so interpret trend data with caution.			
Source: Pregnancy Risk Monitoring System (PRAMS), CPONDER online tool. Available at: http://apps.nccd.cdc.gov/cPONDER.			

Deaths per 100,000 Population, Infants and Children Under 5 Years: U.S. and Nebraska, 2001-2011											
	2001	2010	2003	2004	2005	2006	2007	2008	2009	2010	2011
Infants											
U.S.	687.0	709.5	704.9	695.9	710.2	705.8	702.5	678.9	659.7	623.4	600.1
Nebraska	685.2	723.7	556.2	669.2	575.9	577.0	691.0	553.1	557.0	521.4	552.0
Counties with an Urban Core**	687.7	790.5	602.6	651.6	602.8	619.2	720.8	543.2	516.3	556.7	501.1
Other counties	682.2	642.0	498.0	691.0	541.8	522.6	652.5	566.0	609.2	475.7	621.6
Males	790.4	866.6	562.6	719.5	645.8	638.0	701.8	659.2	581.3	560.9	588.4
Females	575.4	574.2	549.5	615.7	501.5	512.0	679.6	439.4	531.6	479.9	523.7
Non-Hispanic white	665.7	644.8	492.5	584.9	505.1	535.3	681.1	497.6	517.0	469.6	554.2
Non-Hispanic black	764.3*	1857.6	1306.8	1431.7	998.3*	1010.6	1228.4	1257.3	980.4	1325.9	920.4*
Hispanic	643.0	628.4	464.5*	741.3	614.8	536.8	434.7	482.1	553.2	428.8	380.8*
Children ages 1-4											
U.S.	33.4	31.4	31.8	30.3	29.9	29.1	29.4	29.3	27.4	26.5	26.3
Nebraska	33.3	30.7	40.5	37.6	23.8	26.5	26.3	36.6	24.8	27.4	23.7
Counties with an urban core**	32.7*	31.8*	30.9*	35.5*	23.6*	25.1*	24.6*	36.4	22.3*	20.4*	23.7*
Other counties	33.8*	29.4*	51.5	40.1*	24.1*	28.4*	28.3*	36.9*	28.1*	36.2*	23.7*
* Rate is based on fewer than 20 deaths.											
**Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.											
Source: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/.											

Estimated Life Expectancy (in Years) of Newborns in the U.S., and Nebraska, by Race and Gender, Selected Years 1939-2001							
	1939-41	1949-51	1959-61	1969-71	1979-81	1989-91	1999-2001
U.S.	63.6	68.1	69.9	70.8	73.9	75.4	76.9
Nebraska	-	-	72.0	72.6	75.5	76.9	78.4
Males	-	-	-	68.9	71.7	73.6	76.0
Females	-	-	-	76.6	79.3	80.2	80.8
Nebraska white*	-	-	-	72.9	75.7	77.2	78.6
Males*	66.3	68.2	69.1	69.1	72.0	73.9	76.2
Females*	70.0	74.0	75.7	76.9	79.5	80.4	81.1
Overall state rank	-	2	1	5	6	7	14
* Data for whites include Hispanics.							
National Center for Health Statistics. U.S. decenial life tables. Available at http://www.cdc.gov/nchs/products/life_tables.htm#decennial.							

Fertility Rates (Births per 1,000 Women, Ages 15-44), U.S. and Nebraska: 2003-2012										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
U.S.	66.1	66.4	66.7	68.6	69.3	68.1	66.2	64.1	63.2	63.0
Nebraska	71.9	73.4	73.1	75.1	76.0	76.3	76.1	73.0	72.0	72.4
Counties with an urban core*	72.4	74.5	75.0	75.2	75.8	75.1	74.8	71.9	70.7	71.5
Other counties	71.2	71.9	70.7	74.9	76.1	77.9	77.8	74.6	73.9	73.6
White	64.1	65.7	66.8	68.4	69.4	69.9	70.0	68.3	68.6	68.1
Black	86.1	90.6	89.4	99.5	103.4	99.8	98.2	95.3	93.9	97.9
Hispanic	128.6	123.1	130.3	129.0	124.9	124.7	118.1	103.5	93.2	95.6
*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.										
Sources: Births: Child Trends' calculations from CDC WONDER, available at: http://wonder.cdc.gov/natality.html. Population of women ages 15-44: Child Trends' calculations from Intercensal and postcensal population estimates from the Census Bureau, available at: http://www.census.gov/popest/data/state/asrh/2013/index.html and http://www.census.gov/popest/data/intercensal/national/nat2010.html.										

Children Birth to Age 3, U.S. and Nebraska, Percentages by Family Structure: 2004-2012									
	2004	2005	2006	2007	2008	2009	2010	2011	2012
Two parents									
U.S.	65.8	65.3	64.6	64.3	63.4	61.8	60.9	60.8	60.9
Nebraska	73.6	74.5	72.0	65.8	68.6	70.4	65.9	67.5	71.0
Counties with an urban core*	-	75.5	72.3	67.2	71.3	70.8	70.2	67.3	73.8
Other counties	-	73.4	71.6	67.3	67.8	59.3	69.9	63.5	63.7
Father only									
U.S.	6.6	6.8	7.5	7.4	7.8	7.7	7.9	8.1	8.1
Nebraska	6.0	3.1	8.1	8.2	4.3	7.2	7.0	7.0	7.3
Counties with an urban core*	-	-	-	-	-	-	-	-	-
Other counties	-	-	10.1	12.6	6.5	10.2	10.3	4.8	9.4
Mother only									
U.S.	23.2	23.5	23.5	24.0	24.8	27.0	27.5	27.8	27.6
Nebraska	15.6	19.8	18.1	22.6	22.9	17.3	22.5	23.3	18.7
Counties with an urban core*	-	16.8	19.6	22.6	22.5	20.0	20.0	23.2	20.4
Other counties	-	22.9	16.2	16.4	23.5	26.5	13.5	23.7	22.5
No parents									
U.S.	4.4	4.3	4.4	4.3	4.1	3.4	3.6	3.4	3.4
Nebraska	4.8	2.7	1.8	3.4	4.2	5.1	4.5	2.2	3.1
Counties with an urban core*	-	3.2	1.6	2.7	2.1	4.2	4.9	2.1	2.6
Other counties	-	2.1	2.1	3.7	2.2	4.0	6.4	8.0	4.5

*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.

"-" based on fewer than 20 cases in the sample, or not available.

Source: Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS)

U.S. and Nebraska Children, Birth to Age 3: Percentage Who are Poor or Low-Income, 2004-2012									
	2004	2005	2006	2007	2008	2009	2010	2011	2012
Poverty (<100% FPL)									
U.S.	21.4	21.7	21.0	21.1	21.3	23.3	25.1	25.5	25.2
Nebraska	15.5	20.3	18.3	20.7	21.0	18.8	23.4	17.7	15.9
Counties with an urban core*	-	18.0	18.0	20.0	19.1	17.4	19.9	15.5	18.7
Other counties	-	22.9	17.9	20.1	21.6	18.4	25.4	19.4	11.0
Living with two parents	-	9.0	8.6	6.6	8.0	9.9	10.4	8.8	6.2
Mother only	53.7	59.2	54.7	58.4	56.6	54.1	56.0	41.6	54.1
Non-Hispanic white	9.7	12.7	12.9	13.1	15.2	13.9	15.8	12.5	9.7
Hispanic	-	38.6	35.1	37.0	32.4	28.0	31.8	35.1	27.6
Low-Income (<185% FPL)									
U.S.	40.3	40.8	40.1	40.3	40.8	43.0	45.1	45.1	44.6
Nebraska	34.9	39.0	38.9	42.1	40.5	41.6	43.1	40.4	39.3
Counties with an urban core*	-	32.7	35.8	38.1	36.6	34.7	33.3	36.6	37.5
Other counties	-	45.9	41.0	44.1	42.3	45.1	51.2	43.1	38.9
Living with two parents	24.7	26.6	26.2	23.1	23.5	29.0	26.2	28.6	27.1
Mother only	68.8	78.5	88.0	77.9	83.3	82.0	87.4	66.4	82.7
Non-Hispanic white	26.5	28.2	31.0	33.2	30.4	30.1	30.6	31.6	29.9
Hispanic	67.0	69.8	59.6	-	70.0	76.2	-	-	55.8
"-" fewer than 20 cases in the sample, or not available.									
*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.									
Note: FPL is the Federal Poverty Level.									
Source: Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS)									

Of U.S. and Nebraska Children Birth to Age 3, Percentage Living in Areas with Various Levels of Concentrated Poverty: 2007-2012

	<13.8% in poverty	13.8 to <20% in poverty	20 to <40% in poverty	40% or more in poverty	Concentrated poverty
U.S.	53.5	17.1	24.2	5.2	29.4
Nebraska	66.1	14.0	17.6	2.3	19.9
Counties with an urban core*	64.6	11.1	20.2	4.1	24.3
Counties with a large rural town**	62.7	17.5	19.9	0.0	19.9
Counties with a small rural town or isolated rural area***	73.4	18.2	8.4	0.0	8.4

1 Concentration is defined by the percentage of a census-tract population living in poverty; conventionally, 20% and above is considered "concentrated poverty."

*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.

**Large rural town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at least one micropolitan community, but no metropolitan communities.

***Small rural town is defined as a community with a population between 2,500 and 9,999. Isolated rural area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.

Source: Child Trends' calculations from the American Community Survey

Of U.S. and Nebraska Children,* Birth to Age 3, Percentage Living with at Least one Parent with Secure Employment, 2007-2013**

	2007	2008	2009	2010	2011	2012	2013
At least one parent with secure employment							
U.S.	74.7	74.2	71.7	67.3	66.6	69.3	70.4
Nebraska	81.4	76.8	78.2	73.4	71.5	77.2	72.3
Counties with an urban core***	-	-	-	-	-	-	-
Other counties	78.2	76.9	76.8	67.6	68.4	77.3	78.5
Two parents with secure employment							
U.S.	19.6	19.4	18.3	17.6	17.8	18.9	19.6
Nebraska	32.0	30.6	24.2	32.2	35.1	24.0	25.9
Counties with an urban core***	-	-	-	-	-	-	-
Other counties	32.8	26.4	21.4	33.3	39.1	21.5	24.8

*Includes only children living with parents.

**Secure employment is defined as having worked full-time for 50 to 52 weeks in the past year.

***Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.

"-" based on fewer than 20 cases in the sample.

Children Birth to Age 3, Percentages by Parental Age, U.S. and Nebraska: 2007-2013							
	2007	2008	2009	2010	2011	2012	2013
Mother's age							
Ages 20-29							
U.S.	46.4	46.2	45.9	46.9	45.8	45.0	43.2
Nebraska	43.6	52.9	43.5	50.8	50.5	47.6	44.8
Counties with an urban core*	-	-	-	47.4	-	-	-
Other counties	45.7	56.4	47.2	52.3	52.1	49.7	49.7
Ages 30-39							
U.S.	43.5	43.7	44.1	43.3	43.3	44.8	44.6
Nebraska	48.2	42.9	49.7	41.8	47.1	44.8	45.8
Counties with an urban core*	-	-	60.4	45.9	51.4	-	52.4
Other counties	45.5	39.3	45.4	40.0	45.5	43.5	43.3
Father's age							
Ages 20-29							
U.S.	31.5	32.2	31.3	30.3	30.2	29.2	28.3
Nebraska	33.5	32.4	30.2	31.5	25.9	28.8	29.0
Counties with an urban core*	32.2	27.2	21.2	22.0	26.4	5.9	13.3
Other counties	-	-	-	-	-	-	-
Ages 30-39							
U.S.	50.7	50.1	51.9	51.3	51.2	52.9	52.2
Nebraska	51.8	58.9	60.4	58.9	63.2	59.8	54.6
Counties with an urban core*	60.4	61.0	68.3	70.4	61.0	79.5	60.9
Other counties	-	-	56.7	53.7	64.0	54.3	52.3

"-" based on fewer than 20 cases in the sample.

*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.

Source: Child Trends' calculations from the March Current Population Survey (CPS).

Children Birth to Age 3, Percentage by Parental Education, U.S. and Nebraska: 2007-2013							
	2007	2008	2009	2010	2011	2012	2013
Highest parental education in family							
High school diploma or less							
U.S.	36.8	36.5	35.2	34.9	34.0	33.7	32.9
Nebraska	22.3	28.7	38.3	26.5	36.9	24.2	28.0
Counties with an urban core*	-	-	-	-	-	-	-
Other counties	25.4	31.3	40.0	29.8	39.1	25.6	24.1
Some college, including vocational/ technical							
U.S.	26.6	27.8	28.0	28.3	28.1	27.7	28.1
Nebraska	33.3	39.6	24.1	27.0	29.7	27.6	29.3
Counties with an urban core*	-	-	-	-	-	-	-
Other counties	34.0	44.2	25.9	29.2	33.6	28.2	33.0
Bachelor's degree or higher							
U.S.	36.6	35.8	36.9	36.8	37.9	38.6	39.1
Nebraska	44.4	31.7	37.6	46.6	33.5	48.2	42.7
Counties with an urban core*	-	-	46.0	59.7	50.8	55.0	-
Other counties	40.7	24.5	34.1	41.0	27.4	46.2	42.9
	2007	2008	2009	2010	2011	2012	2013
Mother's education							
High school diploma or less							
U.S.	42.7	42.2	40.6	40.4	39.2	39.0	38.0
Nebraska	27.5	30.5	41.6	33.0	41.3	29.7	31.7
Counties with an urban core*	-	-	-	-	-	-	-
Other counties	32.2	33.9	43.5	36.0	43.0	30.3	26.2
Some college, including vocational/ technical							
U.S.	26.6	27.3	27.9	27.5	27.6	27.7	28.1
Nebraska	38.6	41.7	26.3	26.6	28.0	33.3	30.0
Counties with an urban core*	-	-	-	-	-	-	-
Other counties	37.9	44.8	29.6	29.0	31.4	33.1	33.1
Bachelor's degree or higher							
U.S.	30.7	30.5	31.5	32.1	33.3	33.3	33.9
Nebraska	33.9	27.9	32.2	40.4	30.7	37.0	38.3
Counties with an urban core*	-	-	44.9	52.9	-	-	-
Other counties	30.0	21.3	26.9	35.0	25.6	36.5	40.8

Children Birth to Age 3, Percentage by Parental Education, U.S. and Nebraska: 2007-2013							
	2007	2008	2009	2010	2011	2012	2013
Father's Education							
High school diploma or less							
U.S.	42.9	43.0	41.9	42.5	41.2	39.4	39.1
Nebraska	37.8	46.2	35.8	36.2	42.6	33.3	37.0
Counties with an urban core*	-	-	-	-	-	-	-
Other counties	44.0	55.1	36.5	39.8	42.1	37.8	37.9
Some college, including vocational/ technical							
U.S.	23.8	23.9	24.5	24.3	24.8	25.7	25.7
Nebraska	24.4	20.3	26.6	32.5	24.8	27.0	31.9
Counties with an urban core*	-	-	-	-	-	-	-
Other counties	24.4	-	30.1	33.1	28.8	29.0	35.8
Bachelor's degree or higher							
U.S.	33.3	33.1	33.6	33.2	34.0	34.9	35.3
Nebraska	37.8	33.5	37.6	31.3	32.6	39.7	31.1
Counties with an urban core*	-	-	46.5	40.6	-	-	-
Other countries	31.6	23.4	33.4	27.1	29.0	33.3	26.3
"-" based on fewer than 20 cases in the sample							
*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.							
Source: Child Trends' calculations from the March Current Population Survey (CPS).							

Children Birth to Age 3, Percentages by Household Language Characteristics: 2004-2012									
	2004	2005	2006	2007	2008	2009	2010	2011	2012
Linguistically isolated household*									
U.S.	8.8	8.9	9.2	9.2	9.2	9.0	8.3	8.1	7.4
Nebraska	6.8	8.7	8.2	7.5	-	7.6	8.0	-	6.6
English-only household									
U.S.	69.5	68.3	67.7	67.1	66.7	66.0	66.6	66.2	66.2
Nebraska	81.8	79.5	81.0	83.5	82.8	77.6	80.7	85.2	74.7
Counties with an urban core**	-	78.9	82.0	80.1	82.2	78.0	77.2	83.1	74.3
Other counties	-	80.2	79.7	88.0	-	77.1	85.2	87.7	75.1
Income as a ratio of federal poverty level									
<100% FPL	69.2	64.0	67.6	74.0	69.3	65.2	68.6	-	65.2
100%-184% FPL	73.1	64.7	79.3	78.9	72.5	58.4	66.3	-	64.2
185%+ FPL	87.9	90.1	85.8	88.1	91.3	89.2	90.2	88.7	80.9
At least one Spanish speaker in household									
U.S.	20.8	21.5	22.0	22.5	23.0	23.2	22.4	22.5	22.2
Nebraska	14.0	14.4	14.6	10.8	12.0	15.8	13.5	12.3	17.0
Counties with an urban core**	-	13.5	12.1	12.6	11.7	13.5	14.0	13.2	13.0
Other counties	-	15.3	17.4	8.5	12.5	18.6	12.9	11.3	22.2
Income as a ratio of federal poverty level									
<185% FPL	24.0	26.0	19.8	19.6	20.1	30.5	25.5	14.8	24.2
185%+ FPL	7.9	-	11.3	-	-	5.4	-	-	12.8
*A linguistically isolated household is one in which no one age 14 and over speaks English only or speaks English 'very well.'									
**Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.									
"-" based on fewer than 20 cases in the sample or not available.									
Source: Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS)									

U.S. and Nebraska Children* Birth to Age 3, Percentage Living with at Least One Foreign-Born Parent: 2006-2012							
	2006	2007	2008	2009	2010	2011	2012
At least one foreign-born parent							
U.S.	24.2	24.7	24.8	25.3	24.2	24.5	24.4
Nebraska	14.3	12.9	12.2	18.0	16.2	11.7	20.0
Counties with an urban core**	14.7	16.9	13.6	19.7	21.1	13.4	19.4
Other counties	13.8	-	9.8	15.8	10.0	-	20.8
Two foreign-born parents							
U.S.	12.3	12.5	12.5	12.1	11.7	11.5	11.2
Nebraska	7.0	7.5	-	8.7	7.4	-	6.5
One foreign-born parent, one native-born parent							
U.S.	6.5	6.7	6.5	6.7	6.4	6.7	7.0
Nebraska	3.0	-	-	3.5	4.1	-	7.2
Single parent, foreign-born							
U.S.	5.4	5.4	5.7	6.5	6.1	6.4	6.3
Nebraska	-	-	-	-	-	-	-
*Includes only children who live with at least one parent.							
**Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.							
"-" Estimates unreliable, due to fewer than 20 sample cases in one or more cells.							
Source: Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS)							

Percentage of Children, Ages 19-35 Months, Receiving Vaccinations, by Vaccine, 2013								
	DTP/DT/ DTaP (4 doses or more)+	Polio (3 doses or more)	Measles-Mumps-Rubella	Hib (Primary Series)++	Hepatitis B	Varicella (Chicken-pox)	Combined series (4:3:1:3)*	Combined series (4:3:1:3:3:1)**
U.S.	83.1	92.7	91.9	93.7	90.8	91.2	81.1	77.7
Nebraska	88.3	95.9	92.5	95.7	94.5	92.2	86.5	82.5
Counties with an urban core	89.6	94.7	92.2	94.4	92.1	94.3	87.3	83.4
At or above poverty	90.0	95.3	92.4	95.5	94.6	90.2	87.9	84.2
Below poverty	-	97.5	92.2	96.1	95.1	97.5	-	-
*The 4:3:1:3 combined series measures the number of children who have received 4 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine, 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, and 3 or more doses of Haemophilus influenzae type b vaccine (Hib)								
**The 4:3:1:3::3:1 combined series measures the number of children who have received 6 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine (DTP), 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, 3 or more doses of Haemophilus influenzae type b vaccine (Hib), three or more doses of hepatitis B vaccine (HepB), and one or more doses of varicella.								
+ Diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids, and diptheria and tetanus toxoids and acellular pertussis vaccine.								
++ Haemophilus influenzae type b vaccine (Hib).								
Source: Centers for Disease Control and Prevention, National Immunization Program, NIS data, tables, Jan-Dec . www.cdc.gov/vaccines/statssurv/imz-coverage.htm#nis								

Among Children Under 6 Covered by Medicaid, Number and Percent Who Used EPSDT Services: 2002-2011										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Number of beneficiaries in Nebraska										
Infants (<1 year)	7,652	7,913	7,983	8,330	8,646	8,645	8,905	8,617	8,994	8,785
Children ages 1 to 5 years	24,207	24,560	23,908	26,722	27,396	28,202	29,388	30,690	31,401	22,251
Rate of usage										
Infants (<1 year)										
Nebraska	99.0	98.9	98.8	87.2	88.3	86.2	86.0	84.6	92.8	96.2
U.S.	87.3	87.8	87.7	88.4	86.6	82.5	78.9	73.9	72.9	-
Children ages 1 to 5 years										
Nebraska	97.6	97.7	97.7	84.0	83.5	84.4	84.4	83.5	84.0	64.8
U.S.	80.9	79.1	78.4	79.8	76.3	74.5	68.6	64.3	62.8	-
Source: Child Trends' calculations based on the Medicaid Statistical Information System (MSIS) State Summary Datamarts, quarterly cubes. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html										

Percentage of Children, 4 Months to Age 3, With Developmental Risk,* according to Parental Report: 2011-12		
	Moderate Risk	High or Moderate Risk
U.S.	14.2	21.6
Nebraska	10.2	13.0
*Risk assessment is based on one or more age-specific parental concerns that are predictive of delay. Moderate risk is defined as one such concern, high risk as two or more such concerns.		
Source: Child Trends' calculations from the National Survey of Children's Health (NSCH)		

Percentage of Infants Whose Mothers Breastfed, by Duration: U.S. and Nebraska, 2000-2011												
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009*	2010*	2011*
Ever breastfed												
U.S.	70.9	71.6	71.4	72.6	73.1	74.1	74.0	75.6	74.6	76.1	76.7	79.2
Nebraska	63.0	71.1	64.9	75.5	78.2	81.3	74.4	75.5	-	77.0	83.4	82.4
Breastfed for 6 months												
U.S.	34.2	37.3	37.9	39.1	42.1	42.9	43.5	43.8	44.4	46.6	47.5	49.4
Nebraska	40.4	32.9	39.1	43.5	46.9	53.1	48.3	47.0	-	47.0	54.4	46.1
Breastfed for 12 months												
U.S.	15.7	18.5	19.2	19.6	21.4	21.5	22.7	22.7	23.4	24.6	25.3	26.7
Nebraska	11.9	16.1	20.1	23.8	22.5	24.0	24.4	23.9	-	23.5	20.9	25.8
*Cellphones were included in the sample beginning in 2009.												
Source: U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Breastfeeding Practices: Results from the National Immunization Survey. Available online at http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm.												

Children, Birth to 18, Who Received Food Stamps/SNAP, Total, and as a Percentage of All Poor Children,* Fiscal Years 2008 and 2012		
	2008	2012
SNAP Participants, 0-17		
Nebraska	62,380	88,838
Counties with an urban core*	35,317	51,222
Counties with a large rural town**	14,875	20,909
Counties with a small rural town or isolated rural area***	12,188	16,707
Participation rate****		
Nebraska	62.4	88.8
Counties with an urban core*	66.7	96.7
Counties with a large rural town**	65.2	91.7
Counties with a small rural town or isolated rural area***	50.2	68.8
*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.		
**Large rural town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at least one micropolitan community, but no metropolitan communities.		
***Small rural town is defined as a community with a population between 2,500 and 9,999. Isolated rural area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.		
****Defined as living in families with incomes below 125 percent of federal poverty level. The population is based on an average between 2008 and 2012.		
Sources: SNAP data: Tonkinson, C. (2014). Kids Count in Nebraska 2013 report. Ralston, NE: Voices for Children in Nebraska. Retrieved from: http://voices-forchildren.com/wp-content/uploads/2014/01/Kids-Count-2013-FINAL2.pdf. Poverty data: American Factfinder, Table B17024: Age by ratio of income to poverty level in the past 12 months, 2008-2012 American Community Survey 5-year estimates.		

Percentage of Children, Birth to Age 3, Who Ate Meals with Their Families at least 4 days in the Past Week: 2003, 2007, and 2011-12			
	2003	2007	2011-12
U.S.	79.6	81.8	84.4
Nebraska	84.2	87.2	80.9
Source: Child Trends' calculations from the National Survey of Children's Health (NSCH)			

Percentage of Nebraska Children, Birth to Age 3, in Food-Insecure and Marginally Food-Secure Households: 2004-2012			
	2004-2006	2007-2009	2010-2012
Marginal food security*	-	14.9	18.3
Poverty			
Below 185% poverty	-	26.6	28.9
Above 185% poverty or income not reported	-	-	-
SNAP receipt			
Family received SNAP in past 12 months	-	-	-
Family did not receive SNAP in past 12 months	-	24.5	25.8
WIC receipt			
Family received WIC in past 30 days	-	-	-
Family did not receive WIC in past 30 days	-	-	-
Low or very low food security**	16.4	24.0	16.7
Poverty			
Below 185% poverty	29.7	34.9	26.8
Above 185% poverty or income not reported	-	-	-
SNAP receipt			
Family received SNAP in past 12 months	45.8	65.1	-
Family did not receive SNAP in past 12 months	23.6	26.2	26.8
WIC receipt			
Family received WIC in past 30 days	40.9	44.7	-
Family did not receive WIC in past 30 days	-	34.2	29.0
"-" Rate is based on fewer than 20 sample children.			
Note: division by benefit receipt includes onlythose who are eligible for the program.			
*Marginal food security is when the household has one or two reported indications of food insecurity--typically of anxiety over food sufficiency or shortage of food in the house. There is little or no indication of changes in diets or food intake.			
**Low food security is when the household reports reduced quality, variety, or desirability of diet. There is little or no indication of reduced food intake. Very low food security is when the household reports multiple indications of disrupted eating patterns and reduced food intake.			
Source: Child Trends' analysis of the Current Population Survey: Food Security Supplement.			

Percentage of Nebraska Children, Birth to Age 3, by Percentage of Tested Homes in their Home County with Elevated Levels of Radon (above 4.0 pCi/L): 2011			
	Low (40% or less)	Medium (41 to 60%)	High (60% or more)
Nebraska Total	9.8	59.1	31.1
Counties with an urban core*	0.0	81.9	18.1
Counties with a large rural town**	33.4	36.6	30.0
Counties with a small rural town or isolated rural area***	11.6	22.7	65.7
*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.			
**Large rural town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at least one micropolitan community, but no metropolitan communities.			
***Small rural town is defined as a community with a population between 2,500 and 9,999. Isolated rural area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.			
Source: Radon testing data: Nebraska Radon Program. Radon information by county: Summary of radon test data through 12/2011. Available at http://dhhs.ne.gov/publichealth/Documents/RadonCountyDataTable2011.pdf. Population data: 2008-2012 American Community Survey, table B09001 located on AmericanFactfinder. Available at: http://factfinder2.census.gov			

Number of Adverse Experiences* Among Children, Birth to Age 3: 2011-12			
	None	One	Two or more
U.S.	68.4	24.3	7.3
Nebraska	74.5	20.6	
"-" Estimates unreliable, due to fewer than 20 sample cases in one or more cells.			
*Adverse experiences include: frequent socioeconomic hardship, parental divorce or separation, parental death, parental incarceration, witnessing domestic violence, witnessing violence in the neighborhood, living with someone who is mentally ill or suicidal, living with someone who has problems with substance abuse, and racial or ethnic descrimination.			
Source: Child Trends' analysis of National Survey of Children's Health.			

Among Children, Birth to Age 3, Percentage by Number of Days in the Past Week that A Family Member Read, Sang, or Told them Stories: 2011/12		
	Reading	Singing or telling stories
Less than 4 days		
U.S.	34.3	16.1
Nebraska	29.7	24.8
Poverty level		
Less than 185% FPL	39.6	36.9
185% FPL or more	22.8	16.2
Every day		
U.S.	46.3	65.5
Nebraska	43.0	52.7
Poverty level		
Less than 185% FPL	36.7	44.4
185% FPL or more	47.4	58.6
Note: FPL is the Federal Poverty Level.		
Source: Child Trends' calculations from the National Survey of Children's Health (NSCH)		

Among Children, Birth to Age 3, Percentages by Time, on an Average Weekday, In Front of the Television* and Using Electronic Devices:** 2011-12		
	TV	Electronic devices
An hour or more a day		
U.S.	47.3	9.0
Nebraska	43.0	-
None		
U.S.	30.4	78.0
Nebraska	32.7	82.9
"-" Estimates unreliable, due to fewer than 20 sample cases in one or more cells.		
*Time in front of a television includes time watching tv or videos, or playing video games.		
**Usage of electronic devices includes usage of computers, cell phones, handheld video games, and other electronic devices.		
Source: Child Trends' calculations from the National Survey of Children's Health (NSCH). All data are parent-reported.		

Enrollment in Nebraska Early Head Start and Migrant Head Start: 2007-2013							
	2007	2008	2009	2010	2011	2012	2013
Total enrollment	1,341	1,305	1,331	1,689	1,846	1,786	1,721
Pregnant women	159	167	124	232	238	196	148
Less than 1 year old	418	456	417	599	601	578	594
1 year old	364	338	375	413	492	513	491
2 years old	343	322	394	421	460	463	454
3 years old	57	22	21	24	55	36	34
Hispanic or Latino origin	411	419	468	518	630	669	675
Non-Hispanic/Non-Latino origin	930	886	863	1171	1216	1117	1,046
American Indian/Alaska Native	62	26	19	52	51	34	38
Asian	10	13	11	14	21	20	32
Black or African American	208	172	156	193	187	184	180
Native Hawaiian/Pacific Islander	4	59	8	5	11	5	4
White	740	717	770	1040	1152	1113	1112
Biracial or multi-racial	113	103	105	118	133	127	139
Other race	0	4	166	175	157	165	97
Unspecified race	204	211	96	92	134	138	119
Migrant Head Start enrollment to age four	31	49	45	34	40	31	31
Pregnant women	0	0	0	0	0	0	0
Less than 1 year old	6	9	10	5	7	5	6
1 year old	5	9	12	9	9	6	5
2 years old	11	17	11	12	12	7	11
3 years old	9	14	12	8	12	13	9
Counties with an urban core*	614	587	550	783	809	766	719
Pregnant women	51	58	48	84	83	66	33
Less than 1 year old	153	195	174	272	259	229	233
1 year old	175	161	148	190	222	225	212
2 years old	189	152	167	213	213	226	217
3 years old	46	21	13	24	32	20	24
Hispanic or Latino origin	122	140	150	215	246	238	242
Non-Hispanic/Non-Latino origin	492	447	400	568	563	528	477
American Indian/Alaska Native	41	10	10	16	11	10	5
Asian	10	7	7	11	18	17	30

Enrollment in Nebraska Early Head Start and Migrant Head Start: 2007-2013							
Black or African American	199	160	142	167	150	141	170
Native Hawaiian/Pacific Islander	1	1	1	19	30	33	3
White	226	248	238	258	301	273	344
Biracial or multi-racial	81	74	63	146	116	117	80
Other race	0	4	89	143	165	155	71
Unspecified race	56	83	0	0	21	20	16
Counties with a large rural town**	401	386	383	384	462	470	438
Pregnant women	42	44	39	46	50	38	39
Less than 1 year old	119	127	112	114	134	148	134
1 year old	114	96	114	102	126	137	124
2 years old	116	118	118	122	149	143	138
3 years old	10	1	0	0	3	4	3
Hispanic or Latino origin	193	175	187	185	212	256	238
Non-Hispanic/Non-Latino origin	208	211	196	199	250	214	200
American Indian/Alaska Native	5	6	1	5	7	6	7
Asian	0	4	3	3	4	3	2
Black or African American	5	8	3	3	3	2	3
Native Hawaiian/Pacific Islander	0	0	1	0	0	0	0
White	246	249	186	257	308	305	275
Biracial or multi-racial	17	11	24	24	33	24	34
Other race	0	0	75	6	0	20	23
Unspecified race	128	108	90	86	107	110	94
Counties with a small rural town or isolated rural area***	326	332	398	522	575	550	564
Pregnant women	66	65	37	102	105	92	76
Less than 1 year old	146	134	131	213	208	201	227
1 year old	75	81	113	121	144	151	155
2 years old	38	52	109	86	98	94	99
3 years old	1	0	8	0	20	12	7
Hispanic or Latino origin	96	104	131	118	172	175	195
Non-Hispanic/Non-Latino origin	230	228	267	404	403	375	369
American Indian/Alaska Native	16	10	8	31	33	18	26
Asian	0	2	1	0	0	0	0

Enrollment in Nebraska Early Head Start and Migrant Head Start: 2007-2013							
Black or African American	4	4	11	6	6	8	7
Native Hawaiian/Pacific Islander	3	2	6	3	7	4	1
White	268	276	346	459	487	477	493
Biracial or multi-racial	15	18	18	13	29	31	25
Other race	0	0	2	4	7	4	3
Unspecified race	20	20	6	6	6	8	9
*Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community.							
**Large rural town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at least one micropolitan community, but no metropolitan communities.							
***Small Rural Town is defined as a community with a population between 2,500 and 9,999. Isolated Rural Area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.							
Source: Head Start Data: HHS/ACF/OHS. (2013). Program Information Reports. Available at: http://eclkc.ohs.acf.hhs.gov/hslc/mr/pir.							

Number and Percent of Low-Income Infants and Toddlers Who Receive Child Care Subsidies: FY 2011-12 - 2013-14			
	2011-12	2012-13	2013-14
Total subsidies*			
Infants	9,446	8,705	8,041
Counties with an urban core***	6,317	5,983	5,609
Counties with a large rural town***	2,171	1,934	1,726
Counties with a small rural town or isolated rural area***	958	788	706
Toddlers	11,224	11,162	10,496
Counties with an urban core***	7,362	7,554	7,184
Counties with a large rural town***	2,554	2,497	2,314
Counties with a small rural town or isolated rural area***	1,308	1,111	998
Percentage of all infants and toddlers who receive subsidies**			
Infants	36.8	33.7	31.3
Toddlers	21.5	21.5	20.2
Percentage of low-income Infants and toddlers who receive subsidies**			
Infants		105.5	
Counties with an urban core***		150.7	
Other counties		63.5	
Toddlers		51.2	
Counties with an urban core***		59.2	
Other counties		40.0	
*Children may receive more than one subsidy over the course of a year if they are cared for by more than one provider			
**Percentage is based on an estimate of population for the infant and toddler population from January through December, while the subsidy data are for October through September			
***Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community. Large rural town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at least one micropolitan community, but no metropolitan communities. Small rural town is defined as a community with a population between 2,500 and 9,999. Isolated rural area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.			
Sources: Child subsidy data from NDHHS. Population data for percentages: Child Trends' calculations from the American Community Survey Public Microdata Sample (ACS PUMS)			

Number and Type of Licensed Early Childcare Providers in Nebraska that Serve Infants and Toddlers, by Type:* October 2013

	Total	Child Care Center	Family Child Care Home I	Family Child Care Home II	Preschool
Number of providers					
Nebraska total	3284	598	1993	665	28
Counties with an urban core***	1628	373	963	281	11
Counties with a large rural town***	759	119	478	155	7
Counties with a small rural town or isolated rural area***	897	106	552	229	10
Number of providers that serve infants					
Nebraska Total	3173	526	1986	660	1
Counties with an urban core***	1561	324	959	278	0
Counties with a large rural town***	734	106	475	153	0
Counties with a small rural town or isolated rural area***	878	96	552	229	1
Provide some weekend hours					
Nebraska Total	1028	141	629	258	0
Counties with an urban core***	512	84	303	125	0
Counties with a large rural town***	248	38	150	60	0
Counties with a small rural town or isolated rural area***	268	19	176	73	0
Provide some off-hours care**					
Nebraska Total	2565	512	1538	513	2
Counties with an urban core***	1223	317	690	216	0
Counties with a large rural town***	642	113	398	130	1
Counties with a small rural town or isolated rural area***	700	82	450	167	1
Accept Subsidies					
Nebraska Total	1540	483	712	342	3
Counties with an urban core***	772	303	323	145	1
Counties with a large rural town***	392	99	199	93	1
Counties with a small rural town or isolated rural area***	376	81	190	104	1
Accept Subsidies (percent)					
Nebraska Total	47%	81%	36%	51%	11%
Counties with an urban core***	47%	81%	34%	52%	9%
Counties with a large rural town***	52%	83%	42%	60%	14%
Counties with a small rural town or isolated rural area***	42%	76%	34%	45%	10%

* Family Child Care Home I are programs in the home of the provider; maximum capacity is eight children of mixed ages and two additional school age children during non-school hours. Family Child Care Home II are programs in the home of the provider or another site; maximum capacity is twelve with two providers. Child Care Centers are programs licensed for at least 13 children. Preschools are programs providing educational services where children do not nap and are not fed a meal.

**Open some hours between 6 pm and 7 am.

***Urban core is defined as a metropolitan community with a population of 50,000 or more. Counties in this group contain at least one metropolitan community. Large rural town is defined as a micropolitan community with a population between 10,000 and 49,999. Counties in this group contain at least one micropolitan community, but no metropolitan communities. Small rural town is defined as a community with a population between 2,500 and 9,999. Isolated rural area is defined as regions with a population less than 2,500. Counties in this group contain a small rural town or isolated rural areas, but do not contain a micropolitan or metropolitan community.

Source: Child Trends' calculations from the October 2013 roster of licensed providers maintained by NDHHS.

Number of Nebraska Graduates with Early Childhood Endorsements: SY 2009-10 - 2012-13				
	2009-10	2010-11	2011-12	2012-13
Total endorsements				
Nebraska total	184	191	157	220
Urban core*	61	51	47	60
Large rural town*	47	55	45	59
Small rural town or isolated area*	76	85	65	101
Early care and education				
Nebraska total	-	-	3	7
Urban core*	-	-	3	7
Large rural town*	-	-	0	0
Small rural town or isolated area*	-	-	0	0
Early childhood education				
Nebraska total	102	114	96	133
Urban core*	31	33	23	36
Large rural town*	14	20	22	17
Small rural town or isolated area*	57	61	51	80
Early childhood education unified				
Nebraska total	81	76	58	79
Urban core*	29	17	21	16
Large rural town*	33	35	23	42
Small rural town or isolated area*	19	24	14	21
Preschool disabilities				
Nebraska total	1	1	0	1
Urban core*	1	1	0	1
Large rural town*	0	0	0	0
Small rural town or isolated area*	0	0	0	0
SpEd - Early childhood				
Nebraska total	-	0	0	0
Urban core*	-	0	0	0
Large rural town*	-	0	0	0
Small rural town or isolated area*	-	0	0	0
'-' Program not available				

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Sources: Data from Nebraska Department of Education.

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