



# Early Childhood Iowa Statewide Needs Assessment 2019

*“Every child, beginning at birth, will be healthy and successful.”*



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## EXECUTIVE SUMMARY

Early Childhood Iowa's 2019 Needs Assessment reflects a legislatively prioritized statewide emphasis on collaborative, comprehensive approaches supporting young children and their families. It builds on investments over the last several decades in quality early care and education (ECE) systems, and capitalizes on recent development of a statewide integrated data system (IDS) that brings together relevant data from siloed systems of health, education, and child welfare to use for statewide strategic planning. Using an iterative, bi-directional process this Needs Assessment included seven data collection efforts and a series of stakeholder learning sessions with diverse partners including families, community members, executive leaders, private businesses, program managers, and providers. Findings were used to enhance ECI's companion Strategic Plan, *"We are ECI,"* by calling attention to needs for enhanced infrastructure, communications, workforce development, family access to care, and quality program improvement across our birth-to-five system.

Data collection for the 2019 Needs Assessment included administrative data from health, education, and child welfare that was integrated across the population of birth-to-five using our IDS; family and provider surveys to gather statewide perspectives on access and barriers to care; family and provider focus groups to understand voices of our community and the systemic strengths and disconnects that need addressed; and statewide community listening sessions that identified the top five critical issues facing Iowa communities' ability to thrive.

Findings from the 2019 ECI Needs Assessment identified four priority needs.

1. We have gaps in service utilization for vulnerable children including those in rural counties, low-income and minority families, and with identified risks at birth such as low maternal education and inadequate prenatal care. Our families face significant access challenges, including long waiting lists and out-of-reach costs that prevent many of them from receiving the care they need when they need it.
2. We have shortages in both the quantity and quality of our early childhood workforce. Staffing challenges are particularly acute in rural counties, which comprise 89% of Iowa counties.
3. We have identified gaps in communications that limit our ability to fully foster systems-wide change. Generating and improving bi-directional feedback loops with families and providers, as well as strategies to improve the content of communications, is needed.
4. We need to continue investments in building a "data culture" so that the information we collect to monitor the impact of our efforts is used in strategic planning and daily decision-making to improve our system.

These findings directly informed the development of a revised Strategic Plan for ECI in August of 2019. This Plan, *"We are ECI,"* identifies five goals and thirteen specific strategies to improve the overall coordination and quality of Iowa's mixed delivery birth-to-five system to address these prioritized needs.

## PART I: IOWA CONTEXT AND EARLY CHILDHOOD SYSTEMS DEVELOPMENT

The state of Iowa is home to nearly 250,000 children under the age of six. With 21% of these young children being non-white, they represent the most diverse age group in Iowa. Iowa also has one of the highest percentages of households with young children where all available parents are in the workforce (75% compared with 65% nationally). Recognizing the need for quality, coordinated services for young children in this context, Iowa has made significant investments in its early childhood system including being one of the first states to develop a comprehensive preschool program for low-income children and implement a two-generation approach for families living in poverty in the 1980s.

In 1998, the Iowa Legislature passed a law providing funding for early childhood services through local areas boards covering all 99 counties called *Iowa Community Empowerment*. It also authorized a State Board (similar to a Children’s Cabinet but with citizen and legislative members) to facilitate strategic planning, governance, program coordination, and accountability. In 2009 a Stakeholders Alliance (comprised of diverse members from across Iowa’s early care, health, and education systems) was designated as the State Advisory Council on Early Childhood Education and Care as required by the Head Start Act of 2007. This systems-building work culminated in 2010 when the Iowa Legislature designated *Early Childhood Iowa* (ECI) the new organizational umbrella for the local boards, State Board, and the Stakeholders Alliance, thus clarifying their purpose and functions in Iowa’s early childhood system. ECI is advised by a State Board comprised of 15 governor appointed citizens, six department directors, and four legislators. It is also supported by Component Groups tasked with fulfilling the organization’s mission. As a result of its comprehensive leadership, ECI is the only systemic voice to promote child wellbeing across multiple agencies and developmental domains and to emphasize system building through local level empowerment and state-level partnerships. The law directed that the same statewide vision, results areas, and strategic plan be used throughout the entire system, ensuring coordination of efforts – a critical step for our system to address the needs of young children and their families.

The governance structure and operational functions of ECI present a unique opportunity for interdisciplinary collaborations and accountability that foster improved services for children and families. The ECI State Office is situated within the Department of Management, providing access to the Governor’s office and a neutral space for departments to consider child and family needs because work is not directed solely from a health, child welfare, or educational lens. The deliberate incorporation of public and private members on local and state committees facilitates “top-down, bottom-up” communication and decision-making. Further, the structure of the Board, Stakeholder Alliance, Steering Committee, and Component Groups articulates routine processes to facilitate system-wide changes. Overall, this ECI system attempts to break down silos and hierarchies by assuring routine communication and accountability structures.

In 2013, ECI utilized funding from an Early Childhood Advisory Council Grant to conduct a statewide needs assessment and adopt its first joint strategic plan aimed at facilitating early childhood program coordination and improving outcomes for young children and their families. This needs assessment and strategic plan described the population of Iowa families with children under age 6 and identified outcome indicators aligned with the legislatively governed

Results Areas that are the focus of ECI. This assessment and plan has been updated twice since 2013, using publicly available national data (e.g., American Community Survey) and aggregate counts of characteristics and experiences from single-system state data sources (e.g., Department of Education reported counts of children enrolled in Statewide Voluntary Preschool or Department of Human Services and Public Health reported counts of home visiting slots).

While the needs assessment and strategic planning process over the last several years improved our understanding of child and family needs, stakeholders recognized it did not sufficiently inform a comprehensive birth-to-five strategic plan. Our Department of Education's most recent *Condition of Education* report suggests, for example, we are not adequately serving all birth-to-five children as evidenced by the fact that only 61% of kindergarteners meet basic early literacy benchmarks, and the range of proficiency across schools and for low-income and minority students is over 40 percentage points (42%-85%). Reports also suggested children are under enrolling in many of our programs, particularly those who face economic vulnerability. Nearly 35% of eligible children do not enroll in state-funded preschool programs, and only 22% of students in Statewide Voluntary Preschool Program (SWVPP) qualify for free/reduced lunch compared to 42% in the overall population. Eligibility for SWVPP is for students to be four-years of age by September 15 of the current school-year. Enrollment may include children who are younger or older as long as all four-year-olds requesting enrollment are served. These non-four-year-olds are not counted for state funding purposes.

In some Iowa counties, there are preschool slots available for children ages three through five whose families meet primary or secondary eligibility as indicated within Shared Visions. Primary eligibility for Shared Visions is met at 130% of the federal poverty level or below, based on family size. Secondary eligibility may account for up to 20% of children enrolled in Shared Visions and is based on a list of risk factors. Approximately 1,300 children, ages three through five, enroll in Shared Visions annually as this is a grant-based program and funding is limited. Additionally, approximately 6,500 young children attend Head Start.

As of 2018 we could not assess the unduplicated counts of children across these state-funded (SWVPP and Shared Visions) and Head Start preschool programs, identify how the same children were served in multiple settings (e.g., licensed or regulated/unregulated care), or identify the service patterns of income eligible children who received Child Care Assistance. To adequately address the comprehensive needs of our statewide population of children birth-to-five, we need to address pressing gaps in data about program enrollment, access for vulnerable populations, and whether or not our programs are making a difference for young children served (see Needs Assessment findings, section III, for more information).

Legislative authority within ECI (Iowa Code 256i) and the Head Start Act of 2007 (42 USC 9801 et seq.) have encouraged collaboration to develop an early childhood integrated data system (IDS). In Iowa, the development of an IDS has supported enhancements to ECI's capacity to address some of these previously unanswered questions. In 2013, Gold Systems Inc. of Salt Lake City, Utah, was contracted to develop a framework for an early childhood data system using funds from the Early Childhood Advisory Council Grant. Results of the Gold Systems report were used to incorporate the development of an IDS into the ECI Strategic Plan in 2015. A Board-appointed IDS Taskforce (subcommittee of the Results Accountability Component Workgroup)



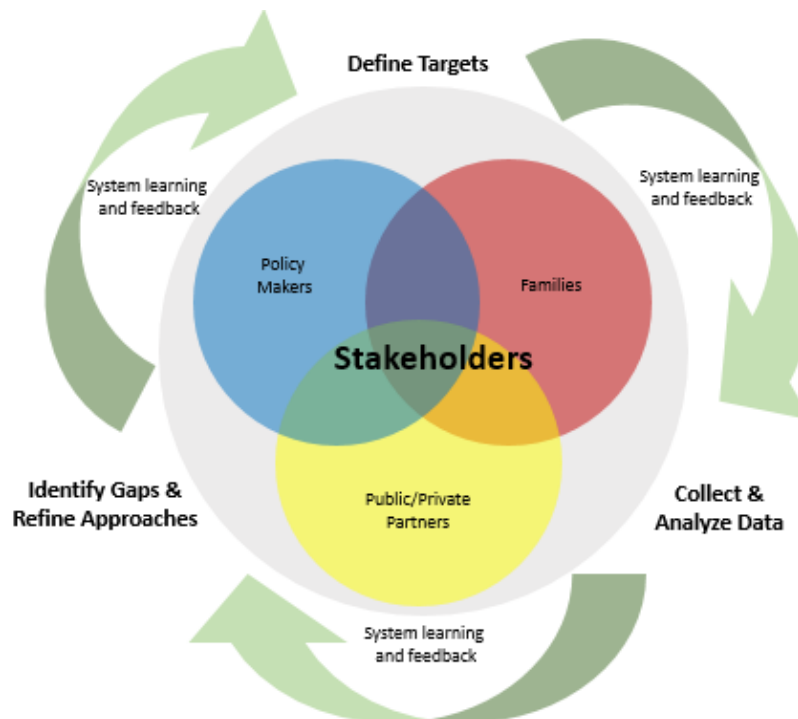
developed plans for IDS development with support from two nationally competitive training and technical assistance grants from the *Annie E. Casey Foundation* (through *Actionable Intelligence for Social Policy*; [www.aisp.upenn.edu](http://www.aisp.upenn.edu)) and *Third Sector Capital Partners*. This Taskforce met biweekly for two years to solidify Iowa's mission and vision for the IDS, update data inventories and identify priority areas, and establish a State-University Partnership governance structure to guide IDS procedures and ensure existing data are *used* to improve programming and outcomes. These partnership-building efforts across departments and with Iowa's land-grant University (Iowa State University) have accelerated ECI's capacity for collaborative data analytics to realize the intent of the 1998 ECI legislation to create an effective, efficient and coordinated birth-to-five system.

The purpose of ECI’s 2019 Needs Assessment was to address gaps in understanding Iowa children and families from birth-to-five on key issues related to early care and education (ECE) capacity, knowledge and access, supporting children with special needs, transitions, and collaborations. Our process involved strategic engagement of diverse stakeholders across the ECI system in iterative, bi-directional communications that reinforced ECI’s unique governance structure and collective approach, as embodied in the companion 2019 Strategic Plan “*We are ECI.*” The process also involved testing the value of our emerging Integrated Data System (IDS) as a sustainable infrastructure to support data-enriched governance and evidence-based policy-making adhering to ECI guiding principles of **equity, quality, privacy** and **accountability**. The following summary outlines our communications and infrastructure development processes, key definitions and terms used to guide data collection, and the primary methods used.

**Process**

Our iterative, bi-directional learning process for this Needs Assessment involved collective input from diverse stakeholders including families, community members, executive leaders, private business partners, program managers, and providers (see Figure 1). This cyclical process of system learning and feedback involved the full range of input including types of questions asked, relevant data collected, and findings gleaned from the data analyzed. It helped keep people informed of the goals of the Needs Assessment, drive data collection decisions (e.g., nature and scope of family and provider surveys and focus groups), build infrastructure tools (e.g., IDS datasets and integration protocols), and refine key results. The effort sought to gather relevant input and facilitate continued improvement in data literacy among the ECI community.

**Figure 1. Iterative bi-directional Needs Assessment process**



In addition to maximizing ECI's wide stakeholder engagement and communications networks, our Needs Assessment capitalized on recent investments in an IDS as a sustainable resource for gathering and analyzing information about Iowa children and families. ECI's IDS facilitates collaboration with executive leadership and program providers to harness and integrate siloed administrative data sources. Integrated data has the capacity to understand, for the first time, unduplicated counts of children with preschool experiences as well as document how vulnerabilities at birth are linked to child wellbeing in kindergarten. The resulting expansion of ECI's data infrastructure transforms how our system utilizes existing data to improve operations, service delivery, and decision-making as well as supports rapid dissemination of findings to our stakeholder network. Through the early testing and refinement of the IDS we have created a system that promotes ECI principles of **equity, quality, privacy, and accountability**. For example, to ensure ethical standards that value representation of all children without bias, we tested and improved data integration algorithms in the IDS. We also established data quality standards that not only supported the Needs Assessment results but also support data literacy and data improvement conversations with departments, programs, agencies, and families in the future. Throughout this process we tested and improved privacy protocols to ensure our IDS meets or exceeds national standards for secure data use. By carefully documenting IDS procedures and processes, as well as communicating our findings regularly with stakeholders, we are fostering improved accountability for data to be *used* to support ECI's mission.

Culminating from the data collection and analysis efforts was a series of inter-departmental meetings, stakeholder learning sessions, and statewide webinars to discuss results and future plans. After a first round of preliminary analyses were shared and discussed with leaders across Iowa Departments of Education, Human Services, and Public Health, two all-day learning sessions were held with invited members from the Stakeholder Alliance. At each session, data was shared and then reflected upon. A professional facilitator elicited opinions and feedback on the Needs Assessment findings to help ECI refine and understand the most pertinent issues. Learnings from these sessions were then incorporated into an all-day strategic planning session, where teams discussed how they might use the data generated to (a) refine elements of the current strategic plan and (b) develop new goals and strategies that directly relate to the Needs Assessment findings. The refined results from the learning sessions are reflected in the data presented in this report and in the content and framing of the companion strategic plan, "*We are ECI.*"

### **Key Terms and Definitions**

Informing the types of data collected through our iterative process was a set of key terms derived from state and national priorities (see Table 1). These terms were defined according to state and national indicators, and often required pooling definitions and acknowledgement that different thresholds are used across different programs (e.g., poverty thresholds that help identify eligible vulnerable families are different depending on the service system).

**Table 1. Key terms and definitions**

| Definition   | Sources <sup>a</sup>   |
|--|--|
| <b>Vulnerable children:</b> Children experiencing family poverty; homelessness; child welfare involvement; maltreatment; birth to a teen parent; parent without a high school diploma, with identified substance abuse or mental illness, or who is illiterate or incarcerated; children with disabilities   | Combined from Head Start, CCDF, Shared Visions, Early ACCESS, ECSE |
| <b>Underserved children:</b> Children who might qualify for services but are not enrolled, likely including disproportionate numbers of minority children (including immigrant or refugee families), children living in rural areas, and those with disabilities   | Early Childhood Iowa   |
| <b>Children in rural areas:</b> Iowa has 88 rural counties (out of 99), assessed as geographic units outside of urban areas (census block groups that have a population density of 1,000 people per square mile)   | US Census Bureau; Woods & Poole (2017)                             |
| <b>Quality early care and education (ECE):</b> Based on federal and state standards for program accreditation and quality ratings. These often include multiple physical, economic, and cultural dimensions  | NAEYC, NAFCC, QRIS, QPPS, FSC                                      |
| <b>Availability of ECE:</b> Based on the national estimates of child care deserts, calculated as the ratio of the number of age-eligible children divided by the number of possible slots across providers (not to exceed 3-to-1)  | Center for America Progress  |
| <b>Birth-to-five mixed delivery system:</b> comprehensive services across health, mental health, nutrition, family support, and home- and center-based environments that are inclusive of vulnerable children including those with disabilities, offered by a variety of programs and providers supported with a combination of public and private funding | Early Childhood Iowa   |

*Sources:* <sup>a</sup> Child Care Development Fund (CCDF), Early Childhood Special Education (ECSE), National Association for Education of Young Children (NAEYC), National Association for Family Child Care (NAFCC), Quality Rating Improvement System (QRIS), Quality Preschool Program Standards (QPPS), Family Support Credential (FSC).

**Data Collected**

In support of ECI’s institutional goal to improve outcomes for children, we sought the expertise and insights of families, providers, administrators, and community members iteratively and in multiple formats. While our IDS was included as one of these sources, we recognize limitations of administrative data and deliberately incorporated voices of families and providers in the Needs Assessment effort through surveys, focus groups, and community listening sessions. Whenever possible, vulnerable and underserved populations were oversampled including rural families, families with children with special needs, immigrant families, and fathers. For each type of data collected, every effort was made to produce geographically representative samples, reflecting each of ECI’s 38 local areas, and the 88 rural and 11 urban counties in Iowa. A mixed-method research design afforded a range of qualitative and quantitative feedback regarding how our state and local programming might better serve the needs young children and their families. See Table 2 (p.13) for an overview of the research methodology, sample representativeness, and type of data collected, and Appendices A-E (p.38-90) for a detailed description of these data collection efforts.

**Table 2. Needs Assessment data sources**

| <b>DATA</b>            | <b>METHOD, REPRESENTATIVENESS &amp; DESCRIPTION</b>   |
|------------------------|---|
| Document Review        | <p><i>Description:</i> Collected and summarized state documents, reports, evaluations, and existing needs assessments from all state departments with programs serving young children.</p> <p><i>Method:</i> Documents were compiled between February and March 2019 by the Early Childhood Iowa (ECI) Preschool Development Grant Core Team with feedback from the ECI Steering Committee and Results Accountability Component Groups.</p> <p><i>Representativeness:</i> Included significant reports of early childhood services and programs generated within the last ten years. A full list of the documents reviewed is provided in the References section and described throughout in Part III of this Needs Assessment.</p> |
| Integrated Data System | <p><i>Description:</i> Data reflecting child and family characteristics and program participation were analyzed to answer questions about who ECI serves and where there are gaps for vulnerable and underserved families.</p> <p><i>Method:</i> Administrative records from the Departments of Public Health, Human Services, and Education were integrated at the child level to create a cohort of 27,321 children who were born in Iowa and enrolled in kindergarten in Iowa during the 2017-2018 school year.</p> <p><i>Representativeness:</i> Included all children who were born in Iowa and were eligible to or did attend kindergarten in 2017-2018.</p>  |
| Provider Survey        | <p><i>Description:</i> These data included information on several child care attributes such as QRS level and whether the center is an active CCA provider.</p> <p><i>Method:</i> Survey data were electronically collected from 591 licensed child care centers (of 1220 targeted centers) between April and June of 2019.</p> <p><i>Representativeness:</i> The sample represents 93 of the 99 Iowa counties and provides a representative cross-section of QRS &amp; CCA participation and program type.</p>   |
| Family Survey          | <p><i>Description:</i> Respondents were asked about experiences with an array of early childhood programs, including family knowledge, use, and barriers of access to birth-to-five services.</p> <p><i>Method:</i> Survey data were electronically collected from 546 Iowa families between May and June of 2019 and include respondents from 77 of Iowa’s 99 counties. Families were recruited via email, with an anonymous survey link, from multiple ECI organizations and affiliated agencies.</p>   |

|                              |  |
|------------------------------|--|
|                              | <p><i>Representativeness:</i> Families that completed the survey had slightly higher education levels than typical Iowa families and overrepresented families that had children with disabilities.</p>   |
| Provider Focus Groups        | <p><i>Description:</i> Focus groups were asked about providers’ experiences working with families, workforce and professional development, and partnerships between programs to support transitions and collaborations.</p> <p><i>Method:</i> Data were collected from 10 service provider focus groups between May and July of 2019.</p> <p><i>Representativeness:</i> Participants were recruited by local ECI boards to reflect a range of health, education, and home and center care service providers. Participants were geographically distributed throughout the state.</p>  |
| Family Focus Groups          | <p><i>Description:</i> Focus groups were asked about families’ experiences with the Birth-to-five system, including attention to barriers and transitions.</p> <p><i>Method:</i> Data were collected from 13 family focus groups between May and July of 2019.</p> <p><i>Representativeness:</i> Participants were recruited by local ECI boards to include families with a range of health, education, and child care experiences and were geographically distributed throughout the state.</p>   |
| Community Listening Sessions | <p><i>Description:</i> Community members and local leaders reported that the top five issues to impact Iowa’s ability to thrive were child care, mental health, housing, workforce, and the farm economy. Child care responses highlighted concerns with access, affordability, quality, and support of providers, among other topics.</p> <p><i>Method:</i> Data were collected from approximately 1,200 participants across 62 statewide listening sessions held in 21 communities between June and December 2018. Early childhood themes were identified using NVivo qualitative software in May through July of 2019.</p> <p><i>Representativeness:</i> Participants were geographically distributed throughout the state, reflecting each of Iowa’s 20 Community Extension Service regions.</p> |

The comprehensive Needs Assessment conducted in 2019 included seven data collection efforts including a substantive review of existing state reports, needs assessments, and strategic plans. The **References** section (p.35-37) includes each report that comprised the substantive review as well as additional materials used to understand Iowa needs and service utilization across the birth-to-five mixed delivery system. **Appendices A through E** (p.38-90) provide full technical reports of each additional data collection effort.

The following narrative summarizes the information learned across four priority topic areas: describing Iowa's children birth-to-five, Iowa's early childhood program capacity and access, early care and education quality in Iowa, and Iowa's workforce capacity and professional development. Each topic area is summarized in three sections: (a) a review of findings from prior reports; (b) specific findings from data collected during this Needs Assessment, and (c) prioritized needs based on stakeholder feedback at the learning sessions that reviewed Needs Assessment findings and included discussion of opportunities for strategic planning.

## **1. Who are Iowa's Children?**

### **1a. Summary of Prior Reports.**

Despite having one of the top high school graduation rates in the US (over 91%), Iowa's standardized achievement results for school-aged children have recently stagnated or even begun to show declines.<sup>8</sup> Achievement gaps are growing across grades, with proficiency disparities up to 33 percentage points for Black students relative to white and Hispanic students and gaps of 22 percentage points for students qualifying for free/reduced priced lunch relative to their peers. These trends begin in early childhood, where only 61% of children meet basic literacy benchmarks at kindergarten entry, with rates for Hispanic, Black, and low-income students up to 20 percentage points lower than their peers.

The 2018 ECI Needs Assessment<sup>1</sup> provided an overview of key indicators of wellbeing for children under age 6 and their families (see Table 3). The report also highlighted three important demographic trends: First, the percentage of non-white children under age 6 continues to grow from 12% in 2000 to nearly 20% by 2018, with increases in Hispanic children outpacing other groups. Second, although unemployment rates fluctuate, the percent of young children in poverty remains steady, with nearly one-third of families reporting incomes below what households need to afford basic necessities<sup>17</sup> and over 40% of kindergarteners qualifying for free or reduced priced lunch.<sup>8</sup> Third, Iowa's population continues to move into urban areas, and decreasing proportions of young children are living in the 88 rural counties (89% of all 99 counties). As this migration occurs, rural counties are losing resources such as jobs and child care, and school consolidations increase our challenges in transportation.

**Table 3. Child and family indicators from the 2018 ECI Needs Assessment<sup>1</sup>**

| <b>Indicator</b>  | <b>Estimate</b> | <b>Trend</b> | <b>Data Source</b>                                    |
|---|-----------------|--------------|---|
| Households with children < 6 with all parents in the workforce                  | 75.0%           | Decreasing   | US Census   |
| Families with children under 6 headed by single parent                          | 25.6%           | Increasing   | US Census, American Community Survey 5-year Estimates |
| Unemployment rate   | 2.9%            | Decreasing   | 2018 Iowa Labor Force Summary (Seasonally Adjusted)   |
| Low birth weight (< 2,500 grams)  | 6.8%            | Steady       | Iowa Department of Public Health                      |
| Immunization rate of 2-year-olds  | 69.0%           | Decreasing   | Iowa Department of Public Health                      |
| Premature births  | 6.8%            | Increasing   | Iowa Department of Public Health                      |
| Infant mortality rate per 1,000 live births                                     | 6.1             | Increasing   | Iowa Department of Public Health                      |
| Percent of all births to teen mothers (<20yrs)                                  | 4.6%            | Decreasing   | Iowa Department of Public Health                      |
| Child death due to unintentional injury (rate per 100,000 children under age 5) | 10.8            | Increasing   | Iowa Department of Public Health                      |
| Incidence of child abuse per 1,000 children                                     | 18.8            | Increasing   | Iowa Department of Human Services                     |
| Domestic violence rate per 100,000  | 203.6           | Decreasing   | Iowa Department of Public Safety                      |
| Domestic violence events with children present                                  | 32.0%           | Steady       | Iowa Department of Public Safety                      |
| Kindergarteners with Dental screenings  | 76.9%           | Decreasing   | Iowa Department of Education                          |
| Children on Medicaid with at least 1 EPSDT Exam (i.e., well child visits)       | 82.0%           | Decreasing   | Iowa Department of Human Services                     |



**1b. Results from New Data Collected.** A number of data collection efforts were undertaken to supplement the existing statewide assessment summarized above. In particular, we developed and tested an integrated data system (IDS) to provide a more nuanced understanding of a cohort of children born in the state who enrolled in kindergarten in 2017-18, with a specific focus on the experiences of vulnerable and rural populations. This approach provided a comprehensive picture of children’s characteristics and risk exposure at birth, preschool enrollment, use of Child Care Assistance during the year prior to kindergarten, and a subset of kindergarten indicators including attendance rates, Individualized Education Plan (IEP) status, and suspension history. A full report with technical details about the IDS data collection, analysis, and findings can be found in Appendix A (p.39-52).

The following is a summary of major findings from the 2019 ECI-IDS cohort study:

#### Risk experiences of Iowa children

- 59% of Iowa’s children experience at least 1 risk at birth that is known to significantly influence kindergarten outcomes. Risks included poverty, low maternal education, birth to a teen mother, birth to a single mother, inadequate prenatal care, preterm/low birthweight, or smoking during pregnancy.
- Rural and minority children experience more individual *and* cumulative count of risks at birth compared to other children.

#### Child outcomes

- Vulnerable populations that are more likely to evidence poor kindergarten outcomes include: children born in low-income families; children born to unmarried, low educated, or teen mothers; children of minority racial status (i.e., Black, Hispanic, Asian, or multiple races); and children whose mothers smoked during pregnancy.
- Boys were significantly more likely than girls to have identified needs for special education (i.e., an IEP) and to be suspended from school in kindergarten.

**1c. Prioritized Needs Identified by ECI Stakeholders.** Needs Assessment findings were digested and discussed by diverse stakeholder groups in over a dozen meetings with department leaders, program managers, families, community leaders, and providers, as well as during ECI sponsored Learning Sessions. Throughout this process, several prioritized needs were identified to support ECI’s system transformation work. The following summaries, in conjunction with the above findings, were used to inform ECI’s Strategic Plan: “*We are ECI.*”

- A pervasive theme identified was the need for more effective formal and informal communications strategies to ensure that relevant information is communicated in culturally appropriate ways and to the people poised to make changes. This included explicit attention to engaging Iowa’s business community in the state’s early childhood transformation efforts.
- Stakeholders noted that families need greater outreach and engagement in order to support the regular, daily school attendance of kindergartners. Further, this outreach should be part of a system-wide education campaign to involve families as leaders in

systems change that begins as early in a child’s life as possible. This message includes that school (and ECE) attendance is strongly linked to other achievement and wellbeing outcomes, and attendance is associated with numerous risks at birth, suggesting the timing for intervention extends throughout birth-to-five.

- Persistent disparities in educational outcomes for low-income and ethnic/racial minority children are a challenge in Iowa, and stakeholders agreed that continued emphasis on supporting equity in the access of care and child developmental outcomes is needed.
- Stakeholders pressed for more discussion about identifying “leverage points” in the system to better meet the needs of vulnerable and underserved populations. In light of findings documenting how certain birth risks predict kindergarten outcomes, intervention programs could prioritize mothers without high school degrees or whose children did not have adequate prenatal care for additional or specialized services.

## **2. Early Care and Education Capacity and Access**

**2a. Summary of Prior Reports.** Iowa’s birth-to-five mixed delivery system includes comprehensive services, multiple service delivery options, and funding from local, state and federal sources. While the system prioritizes services for vulnerable and underserved children, the 2018 ECI Needs Assessment results suggest that we continue to have gaps for certain groups including ethnic minority and low-income children.<sup>1</sup>

Family Support programs are coordinated by the Iowa Department of Public Health but represent its own mixed delivery system with multiple funding sources and multiple service models. In FY2017, this blended funding structure supported nearly 135,000 home visits to over 14,000 families through the state ECI, IDPH, and DE funds (10,700 families); Department of Human Services prevention funds (1,500 families); Department of Human Rights (3,000 families); federal funds from Early Head Start (1,000 families); and federal funds from the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV; 900 families).<sup>26</sup> Together, these programs serve nearly 15,000 children, but this is only 8% of Iowa’s total population of children under age 5.

Early care and education (ECE) in Iowa includes a blend of public and private providers, universal and targeted programs, home- and center-based options, and subsidized care. Preschool (i.e., age 3-4) programs included in Iowa’s *Every Student Succeeds Act* plan require use of Iowa’s Early Learning Standards to support quality, developmentally appropriate education.

*Head Start*, a federally funded program for low-income children, has operated in Iowa since 1965, and is currently administered by 19 grantees (including one Migrant and Seasonal Head Start) serving 6,500 preschool-aged children.<sup>26</sup> Early Head Start provides services to approximately 2,000 children aged birth-3, 800 in home-based models and 1,200 in center-based models (including through child care partnerships).

Iowa was one of the first states in 1988 to implement a comprehensive, targeted state-funded (Department of Education) preschool program for low-income children, named *Shared Visions*.

This program offers care to over 1,300 children in 37% of Iowa's 99 counties. In partnership with the Iowa Department of Human Services and local licensed child care providers, nearly 70% of these children participate in wrap around care that enables them to receive 7 hours or more of care and early learning per day.

*Statewide Voluntary Preschool Program (SWVPP)*, funded by the Iowa Department of Education, began in 2007 and provides a minimum of 10 hours per week, part-day preschool in public schools (or community settings through contracts) at no charge for any 4-year-old, and serves nearly 25,000 children in 98% of school districts.<sup>26</sup> Yet, numerous indicators suggest that SWVPP does not reach large percentages of Iowa's more vulnerable children. According to parent reports collected at kindergarten enrollment, for example, 82.5% of children have attended some type of preschool program.<sup>8</sup> Children enrolled in SWVPP are also less likely than children enrolled in kindergarten through 12th grade to be of color (21.8% vs. 24.3%), to be English language learners (2% vs. 6.1%), or to qualify for free or reduced price lunch (22% vs. 41%).

*Regulated Child Care Facilities* include private sector options to complement state- and federally-funded programming. These include 2,641 registered child care homes and 1,530 licensed child care centers. Most of this care is funded by families, but Child Care Assistance is available for families under 145% of the federal poverty line (FPL) with provisions for additional support when families transition above this threshold to extend benefits up to 12 months [(paid by Child Care Development Block Grant (CCDBG), Temporary Assistance for Needy Families (TANF), and other state funds)]. The CCDBG is a federally funded program with the purpose to help subsidize childcare costs for low income families. Every state determines its reimbursement rate and Iowa utilized the 2017 Market Rate Survey to determine current payment rates. According to DHS, in FY2018 Iowa saw a historically high increase of \$19.3 million funds to the CCDBG, allowing more high quality ECE providers the ability to have the costs covered from families receiving the subsidy. Through implementation of CCDBG requirements, Iowa increased provider reimbursement rates through a tiered payment program with QRS, moved from 6 to 12 month family eligibility, and implemented a graduated phase out program. Average childcare costs for one child per year in Iowa is \$10,131, higher than in-state public tuition for postsecondary education. Infant childcare costs for a single parent in Iowa making the state's median annual income can average as much as 40% of total income. Through the raise in CCDBG funding, the idea was that families and child care providers would be positively impacted as families have more higher quality childcare options and the extra funds for the providers has potential to increase wages, and making it easier to recruit and retain high quality staff.<sup>29</sup> The effect of this implementation, however, has yet to be tested.

*Unregulated Care.* While Iowa has a robust early childhood system, we must not ignore the fact that there are other types of programming that parents may choose to utilize that are exempt from licensing or regulatory requirements. Iowa permits child care homes in which a provider is caring for no more than 5 children at any one time to operate without regulation. (Iowa Code 237A.) Given that parents are often overwhelmed or lack knowledge on the system as a whole, there is concern that parents seek unregulated care when they (a) lack access to regulated care; (b) are unsure of what to look for; or (c) operate under assumption that all programs have

regulatory oversight. Because there is a lack of oversight, we are unable to determine whether these are safe environments, let alone quality environments.

Services targeted to children who have an identified disability are provided under the Individuals with Disabilities Education Improvement Act (IDEA). In 2016 *Early ACCESS* provided early intervention services to 6,221 (2.5% of the population) children, between birth and age 3, who have an identified disability or are at risk for developmental delay, and their families.<sup>1</sup> Another 6,976 (5.6% of the population) children between ages 3 and 5 received early childhood special education services in 2016. The proportion of Iowa children receiving IDEA services is well below national averages. Across the U.S., 3.1% of children birth to 3 and 10.4% of children between 3 and 5 receive these services.

Child care deserts are defined as a “census tract with more than 50 children under age 5 that contains either no child care providers or so few options that there are more than three times as many children as licensed child care slots”.<sup>27</sup> According to the Center for American Progress, 23% of Iowa is in a child care desert. Rural and low-income families are especially affected by the low number of child care programs. Among children living in child care deserts, 35% live in rural areas and 24% are from low-income families. According to a 2018 report by Iowa Child Care Resource and Referral, there has been a 42% drop in total child care programs in the state since 2013 (including child development homes, child care centers, unregulated child care homes taking Child Care Assistance (CCA), and those unregulated child care homes that CCR&R is aware of), and a 46% drop in recent years in total programs that report accepting Child Care Assistance.<sup>28</sup>

In addressing the large drop in total number of child care programs and those that report accepting CCA, the Department of Human Services reports that a decrease in unregulated providers eligible to receive CCA with a Provider Agreement (CCA PA) is related to an increase in regulations from CCDBG. Prior to implementation of additional healthy and safety requirements, professional development requirements, and annual inspections, this population self-certified compliance with low regulations. The Department conducted an evaluation of unregulated child care homes with a CCA PA who were not serving children and closed out those providers that were inactive for a period of time. As a result, the number of providers and perceived available slots dropped quickly. Regulatory requirements and inspections were fully implemented in 2016 and since then, we have continued to see a decrease in this specific provider population.

**2b. Results from New Data Collected.** Additional data were collected and analyzed in 2019 for the current Needs Assessment to supplement our understanding from existing reports summarized above. Extensive details are provided in the Appendix of this document and include IDS data (Appendix A, p.39), Provider Survey (see Appendix B, p.53), Family Survey (see Appendix C, p.64), and Family and Provider Focus Groups (see Appendix D, p.78). Four primary questions guided the data collection and analysis for this area: (a) what are the unduplicated counts of children in preschool programs during the year before kindergarten; (b) who are underserved populations that are less likely to participate in center-based programs the year before kindergarten; (c) what is the nature and extent of waiting lists for DHS licensed centers;

and (d) what are the biggest barriers families report to accessing care (with a broader focus not just on ECE but on the range of birth-to-five care opportunities)?

The following is a summary of findings about Iowa's ECE capacity and access:

#### Unduplicated counts

- After determining duplicated counts of children across program types using our IDS, we found that 73% of children in the IDS cohort study had at least one documented, formal center-based experience (of any type) during the year before kindergarten entry.

#### Underserved and vulnerable populations

- Underserved populations who were less likely to have a formal, center-based preschool experience the year before kindergarten included Hispanic, Black and multiracial children; children born to unmarried mothers or mothers without a high school education; and children with inadequate prenatal care.
- While our Child Care Assistance program was found to reach proportionally some of our vulnerable and minority populations during the year before kindergarten (including Black, multiracial, and low-income families), disproportionate gaps were found for children born to mothers without a high school education and those with inadequate prenatal care.

#### Waiting lists

- 78% of centers serving infant/toddlers and 49% of child care centers serving preschool aged children reported waiting lists.
- Child care center waitlists were reported as comprising 77% and 40% of the total enrollment of infant/toddler and preschool classrooms, respectively (i.e., if an infant/toddler center had 100 children enrolled then they also reported a waiting list of 77 more children).
- Child care centers reporting waiting lists disproportionately reported they were also not enrolled at full capacity (57% for infant/toddler programs and 60% for preschool programs).
- Child care centers with enrollment numbers below capacity indicate that one of the primary reasons was an inability to hire staff; centers from rural areas were more likely to report this challenge compared to centers in urban areas.

#### Families reported barriers to access

- An overarching theme from provider and family surveys, focus groups, and community listening sessions was “access to care when families need it” is one of Iowa's top challenges. Families report making less-than-ideal choices for care because they feel they lack options that meet their needs at the times they need it.
- Families report the primary barriers to ECE services are waiting lists (54%) and cost of care (34%), with nearly one quarter of families also reporting that ECE programs do not meet their needs or they have barriers in transportation.

- Despite access challenges, families report high levels of knowledge about ECE services including early learning and center- and home-based child care (above 90%), with relatively less awareness of services for children with special needs (80%), home visiting and dental services (78%) and job skills support (71%).
- Families have access to technology and the internet, with 99% reporting at least one smartphone in their household.
- In times of crisis families report relying heavily on friends and family networks (95%) with very few using the internet or social media to find help (12%).

**2c. Prioritized Needs Identified by ECI Stakeholders.** Needs Assessment findings were digested and discussed by diverse groups in over a dozen meetings with department leaders, program managers, and providers. They were also discussed in Learning Sessions with broad ECI stakeholder participation where several prioritized needs were identified to support ECI’s system transformation work. The following summaries, in conjunction with the above specific findings from the Needs Assessment, were used subsequently to inform ECI’s Strategic Plan: *“We are ECI.”*

- We need to expand ECE accessibility for families, by both increasing the number of “slots” and figuring out ways to prioritize getting our most vulnerable children access to slots that are available.
- More partnerships are needed to connect our universal preschool program (SWVPP) with additional care options including wrap around care and transportation to better meet the needs of working families.
- We need to invest in stronger formal and informal communication networks. Parents need more (and better quality) information regarding available services and the level of quality of the programs from which they can choose.
- Programs need to better support families through the use of coordinated intake processes to connect children and their families with necessary services. This will better support families in accessing high-quality programs with one entry point rather than having to replicate eligibility and enrollment processes at multiple points across the system.

### **3. Early Care and Education Quality**

#### **3a. Summary of Prior Reports.**

Iowa has invested in quality improvement efforts across our ECE system including development and implementation of a statewide Quality Rating System (QRS), as well as promoting participation in national accreditation and program performance initiatives through the National Association for the Education of Young Children (NAEYC).

Iowa measures quality by examining participation in the QRS system as well as the number of center-based programs that use one of three program standards recognized by the Iowa Department of Education: NAEYC Accreditation, the federal Head Start Program Performance

Standards (HSPPS) and the state-developed Iowa Quality Preschool Program Standards. According to the 2018 ECI Annual Report,<sup>2</sup> 125 of Iowa's early learning environments were accredited by the NAEYC and fewer than 10 of regulated child development homes were accredited by the National Association of Family Child Care (NAFCC).

The Iowa QRS is a voluntary program created in 2006 by the Iowa Department of Human Services (DHS) with the intent to encourage high-quality childcare throughout the state and better inform families about what constitutes quality. The 2016 Iowa Department of Public Health (IDPH) Title V Needs Assessment Report indicated that about 50% of licensed childcare centers and 14% of registered in-home providers are rated through the QRS.<sup>15</sup> As of June 2019, there were a total of 721 licensed child care centers rated with Iowa's QRS, with 67% of those rated as a 4 or higher. Programs in rural areas are more likely to participate in the QRS and have higher ratings.<sup>16</sup> In 2018, the total number of Head Start classrooms with a QRS rating increased from 56 to 66, the highest number in the past seven years. However, this is still only 26% of all Head Start classrooms.<sup>5</sup>

As summarized in the most recent report and five-year plan from the Iowa Head Start Collaboration Office,<sup>5</sup> Iowa's QRS system could encourage participation in quality improvement by recognizing other measures of ECE quality. The Iowa Head Start Association is working with DHS to encourage higher participation in the revised QRS system when it is released (per Head Start Program Standards, 1302.53(b)(2)).<sup>20</sup> The new version will be using Head Start quality indicators as part of its assessment, and Head Start programs will receive consideration for quality measures they currently meet by being Head Start programs. Currently, many NAEYC accredited programs do not participate in QRS, because it seems to them duplicative of time and effort. Iowa's new Quality Rating and Improvement System, known as Iowa Quality For Kids (IQ4K) will address some of these concerns. In the IQ4K System, programs operating under an accreditation or other recognized professional performance standards will not be required to duplicate criteria in IQ4K that they are already practicing as part of their accreditation/performance standards. Those programs will only be required to complete IQ4K criteria that they are not already doing as part of their accreditation or performance standards.

As of 2018, regulated child development home providers and center directors report that the small financial incentives for participating in the QRS do not outweigh the additional financial costs needed in order to meet the requirements. This corroborates sentiments reflected in the 2016 Iowa ECE Workforce Study<sup>16</sup> that suggested additional types of incentives, such as access and qualification for grants or an allowance to join publicly sponsored programs, would be beneficial in making the QRS a more desired qualification to obtain and maintain.

As reflected in one of ECI's priorities and encouraged through federal legislation in the Every Student Succeeds Act and the Head Start Act, Iowa ECE providers often seek to address program access and quality through the establishment of partnerships using written agreements across programs to facilitate shared resources and provide enhanced training and collaboration opportunities. As evident in the 2018 Iowa Head Start Needs Assessment,<sup>6</sup> collaborations between Head Start and local education agencies (LEA) is one way this can be addressed. As of 2018, Head Start grantees reported having no collaboration with 47.8% of

Iowa's 330 school districts. Though Head Start programs are only operating in 130 of those districts. Head Start grantees also reported that for the 70% of districts that grantees had established communication and coordination with, it was "not at all difficult",<sup>6</sup> suggesting that opportunities for fostering similar partnerships may exist in other districts. Head Start and LEAs use variety of collaborative models, including coordinated enrollment, fully infused classrooms (Head Start and non-Head Start children in the same classroom), and 'Flip the Switch', where the same cohort of children participate in Head Start and a district classroom at different times during the same day using consistent curriculum and sometimes staff for both parts of the day. The 2018 Head Start Collaboration plan<sup>5</sup> emphasizes expanding partnerships with LEAs, and other community and state partners to improve quality, and provide working families with full-day services.

Overall, many early childhood programs across the state are highlighting the need for increased knowledge of and participation in collaborative quality improvement measures and efforts, including professional development and wage increases for the workforce. There is a need to build bridges between sectors in order to improve the quality of early childhood care for families across Iowa.

**3b. Results from New Data Collected.** Two primary questions guided data collection and analysis for this area: (a) what is the relative quality of providers who serve our most vulnerable populations; and (b) what are the biggest barriers centers report to improving the quality of care? Additional details on these data collection efforts and findings are provided in the Appendix of this document. Information was collected to add to our understanding of the quality of our ECE system from a Provider Survey (see also Appendix B, p.53), Family Survey (see also Appendix C, p.64), and Family and Provider Focus Groups (see also Appendix D, p.78).

The following is a summary of 2019 Needs Assessment findings about Iowa's ECE quality:

#### Program quality

- Of those ECE centers that participate in QRS, the QRS levels of programs that accept Child Care Assistance (CCA) are overall lower than QRS levels of all licensed centers.
- Of those ECE centers that do not participate in QRS or other accreditation programs (e.g., NAEYC), the primary reasons reported were because of staffing barriers and time constraints.
- 21% of centers that did not currently accept CCA reported that knowledge of the rate increase would change their willingness to accept children with CCA.
- More rural centers (versus urban) and those that accept CCA (versus those that do not accept CCA) reported working partnerships with Iowa's Statewide Voluntary Preschool Programs such that children participate in both programs and/or that programs share space, staff, or other financial resources.
- Three times as many rural centers (compared to urban centers) report partnerships with Head Start programs that facilitate children attending both programs.



- Families report higher levels of met need in Medicaid, home visiting, early learning (centers), dental, and services for children with special needs (i.e., over 90% report these services “met their needs”) compared to programs for job skills support (77%), housing assistance (80%), and home-based or center-based child care (83%).

Program reported barriers to improving quality

- 41% of administrators from Iowa Department of Human Services (DHS) licensed centers report concerns with their facilities that impact program quality, with over 50% of them reporting concerns with insufficient indoor gross motor space and/or concerns about the outdoor environment (size or quality).

**3c. Prioritized Needs Identified by ECI Stakeholders.** Needs Assessment findings were analyzed and discussed by diverse groups in more than twelve meetings with department leaders, program managers, and providers. Findings were also discussed in two full-day Learning Sessions with broad ECI stakeholder participation to identify prioritized needs to support ECI’s system transformation work. The following summaries, in conjunction with the above specific findings from the Needs Assessment, were used subsequently to inform ECI’s Strategic Plan: *“We are ECI.”*

- Overall, families report that quality is “moot” when they do not have access. Without tackling the access issues, improvements in program quality will not have the impact on statewide child outcomes and family wellbeing that we need.
- Systematic disconnects continue to prevent programs from improving quality that include barriers in communication between department leadership and the “boots-to-the-ground” workers who provide daily care and education for our children.
- Though we identified some relative strengths in program partnerships in our rural areas and between some Head Start grantees and their LEAs, we need to continue to build public will, vision, and incentives to cultivate these types of relationships using “effective ingredients” to improve the quality of the system as a whole.
- While some partnerships may exist among programs to facilitate transitions between programs or between ECE and kindergarten, families do not often have sufficient information about what programs to access next, what procedures have to be followed to make these transitions and how the transitions themselves can be an abrupt and confusing experience for which they have had little preparation.

**4. Early Care and Education Workforce and Professional Development**

**4a. Summary of Prior Reports.**

With funding from the W. K. Kellogg Foundation and in partnership with Iowa Association for the Education of Young Children (Iowa AEYC), Child Care Services Association (CCSA) conducted a statewide survey of the early care and education workforce in Iowa in 2016.<sup>16</sup> The study collected basic information about salaries, educational attainment, and demographics from

directors, teachers and assistant teachers in 358 licensed ECE programs. Center information included turnover rates, wages, paid benefits and nonpaid benefits.

Findings from the 2016 Workforce study identified two major challenges: (a) the majority of Iowa's ECE workforce has low educational attainment, and (b) low wages hinder the ability to recruit and retain high-quality staff. Specifically, 74% of the workforce was identified as having some college or less, with only 16% of the total workforce having an ECE degree. Program requirements for education and training varied, with nearly one fourth (23%) of programs without requirements for specific educational level/background. Although 53% of programs reported an educational requirement of a minimum of high school diploma or general equivalency diploma (GED), and only 23% of programs require teachers with an associate degree or above. ECE workforce wages in Iowa mirror national challenges, where teachers' and teacher assistants' compensation is far lower than their public school counterparts sometimes as much as one-half the average salary. In fact, the median income level for ECE educators in Iowa was below the estimated cost of living.

We also have ECE workforce needs in our programs designed to serve the most vulnerable populations. Recent Head Start needs assessment results that informed the state's Head Start Collaboration Plan<sup>5</sup> revealed a gap in connections between Head Start grantees and Iowa's institutes of higher education. While many of these grantees have partnerships with local school districts to provide braided funding opportunities and even share staffing, these reports revealed that nearly one-third of grantees in the state do not have a working relationship with four-year higher education institutions, and approximately one-fifth do not connect with community colleges, creating potential gaps in capacity to recruit college-educated ECE staff and address training needs through college education.

Iowa has invested in several workforce development programs including T.E.A.C.H. EARLY CHILDHOOD®, WAGE\$, and PAEYS<sup>23</sup> to help alleviate the identified financial and educational gaps in the ECE workforce. T.E.A.C.H. EARLY CHILDHOOD® is a comprehensive scholarship program that provides the early childhood workforce access to educational opportunities and is helping establish a well-qualified, fairly compensated and stable workforce for our children.<sup>21</sup> To further support compensation for an individual child care provider there is also a salary supplement program, known as Child Care WAGE\$ Iowa (WAGE\$). This program is based on individuals' formal education and commitment to their program.<sup>22</sup> Both T.E.A.C.H. and WAGE\$ are licensed programs of Child Care Services Association. For MIECHV funded family support professionals, the Performance and Education Yield Success (PAEYS) program provides salary supplements based on formal educational attainment and performance.<sup>23</sup> According to the Iowa 2018 Child Care WAGE\$ annual report, in FY2018 there were a total of 12 funders assisting 34 counties across Iowa.<sup>22</sup> It is recognized that there are 65 counties still in need of WAGE\$. Within counties benefiting from this program 64% of WAGE\$ recipients increased their formal education in FY2018. The 2018 T.E.A.C.H. Early Childhood Iowa annual report represented formal education outcomes for 397 early childhood educators who participated. Of these scholarship recipients, 105 participants obtained a Child Development Associate (CDA) Credential™ or higher which reflected an increase from 2017.<sup>21</sup> This includes partnerships from 33 Iowa colleges and universities as we increase the early childhood care and education and family support professionals' formal education towards degree attainment in related fields.

Iowa supports nationally licensed comprehensive scholarship programs that endorse evidence-based strategies to increase the skill and competence of the early childhood workforce. T.E.A.C.H. program participants have a 95% retention rate which increases the continuity of care and education for the young children served. Formal education, coaching supports, and retention of the early childhood workforce impacts quality. Recent attention to gaps in workforce quality for programs accepting child care assistance (CCA) included a reimbursement increase for those programs participating in the Iowa Quality Rating System (QRS). As of January 1, 2019, Iowa legislation (HF501) implemented a new tiered reimbursement increase for licensed center-based and licensed home-based programs to incentivize participation in QRS.<sup>25</sup> No evaluations of the impact of this rate increase have been done to date.

**4b. Results from New Data Collected.** Additional data were collected and analyzed in 2019 specifically for the current Needs Assessment to supplement understanding of Iowa's ECE workforce and professional development needs. Additional details on these data collection efforts and findings are provided in the Appendix of this document. Information was collected from a Provider Survey (see also Appendix B, p.53), Family Survey (see also Appendix C, p.64), and Family and Provider Focus Groups (see also Appendix D, p.78). Two primary questions guided data collection and analysis for this area: (a) what are the workforce barriers noted by ECE centers that prevent them from enhancing program quality; and (b) what are the highest priority professional development needs of ECE providers?

The following is a summary of 2019 Needs Assessment findings about Iowa's ECE workforce:

#### Insufficient ECE workforce capacity

- For the 57% of centers that report enrollment below licensed capacity, one-fourth of them report a primary reason is inability to hire staff.
- The inability to hire staff was cited twice as often in rural centers compared to urban ones (32% versus 16%); and eight times as often in centers that serve children with CCA compared to centers that do not accept CCA (37% versus 4%).
- Provider retention was highest in rural centers, with centers reporting that 89% of teachers in rural areas are retained for 12 months or more compared with only 79% of urban providers.
- Retention was lowest in centers that accept CCA, where only an average of 77% of teachers are retained for 12 months or more.
- Providers overwhelmingly report challenges in wages and benefits as barriers to improving workforce capacity and quality.
- Families report increased access challenges when their children attend centers with workforce turnover or they are forced to choose poorer quality care options because the current center is not able to find or retain staff.
- Families report challenges in their personal employment, both finding and keeping a job, when they face child care access or quality barriers.

### Providers need professional development

- Providers in rural areas and those that accept CCA report overall lower education levels than urban providers and those that do not accept CCA. That is, fewer teachers have college or graduate degrees.
- Families and providers share concerns about inadequate training of staff to address mental health and working with children with special needs.

**4c. Prioritized Needs Identified by ECI Stakeholders.** As Needs Assessment findings were analyzed and discussed by diverse groups in over a dozen meetings with department leaders, program managers, and providers. Findings were also shared in two day-long Learning Sessions with broad ECI stakeholder participation, where several prioritized needs were identified to support ECI's system transformation work. The following summaries, in conjunction with the above specific findings from the Needs Assessment, were used subsequently to inform ECI's Strategic Plan: *"We are ECI."*

- Iowa faces a significant shortage in the ECE workforce, and it is particularly acute in rural areas where it is difficult to recruit staff. This often translates into under enrollment in centers not able to staff classrooms, further contributing to the access gaps previously discussed.
- Prioritizing workforce professional development without addressing challenges in retaining staff because of low compensation and benefits will likely not improve the number of workers or their skill level.
- We need stronger communications strategies with all stakeholders regarding the importance of investment in early childhood, and what "quality" early childhood programs comprise. Such strategies could help raise awareness of the critical value of a highly trained ECE workforce capable of meeting the needs of children and families. A central partner for these communication efforts should be the business community that is well poised to support ECE workforce development and quality improvement through tax credits or on-site child care solutions.

Iowa early childhood partners collect a number of state and federal indicators related to child and family wellbeing to monitor and understand the state of the state and the impact of ECI services. For the 2019 Needs Assessment, we utilized many of these routine indicators in addition to expanding data collection efforts targeting new sources and types of information. This section discusses the range of indicators we already collect, strengths and weaknesses to using these data to inform statewide strategic planning, and opportunities to improve data collection and research capacity as informed by the current Needs Assessment.

### **Current Data and Indicators**

Early Childhood Iowa (ECI) has an approved set of statewide indicators that the State Board adopted to monitor five legislated Result Areas:

- Health Children
- Children Ready to Succeed in School
- Secure and Nurturing Families
- Safe and Supportive Communities
- Safe and Supportive Early Learning Environments

Every two years, the ECI Results Accountability Component Group reviews the adequacy of ECI's approved indicators, solicits recommendations from the stakeholders across the state about potential new indicators, and reviews new measures for possible inclusion in the ongoing data collection efforts. The Component Group then presents recommendations to the ECI Stakeholders Alliance for approval. The final step in this process is for the Component Group to seek approval from the ECI State Board. As we have encouraged the use of data-based decision-making, this is a very engaging and iterative process.

In its annual report, ECI provides trend data on each of the approved indicators (see Table 4 column 1, p.33). Formal and informal discussions are hosted at various levels within the ECI structure utilizing this information and reviewing trajectory points of the data. Two other major early childhood health programs also routinely track indicators regarding child and family wellbeing: Title V and MIECHV (see Table 4 columns 2 and 3). Many of these indicators overlap in definitions and sources, while others require different approaches to capture and report information. Taken together, these three sources of data provide a broad overview of the general context of early childhood in Iowa as well as the needs and experiences of some of our most vulnerable children.

### **Strengths and Limitations**

The intentional collection and monitoring of child and family wellbeing indicators has assisted our state in understanding the nature of child and family needs across diverse groups and contexts and over time. Strengths of this approach include (a) the breadth of indicators across multiple wellbeing domains and (b) committed state partners who support the collection and use of such information to meet needs across departments and programs (including ECI, but also for department-specific programming within health or education).

As columns 4-7 indicate in Table 4 (p.33), many of our presently monitored indicators are collected from national sources. We have also historically used state department reports of aggregate population-level information that is sometimes available with more details including breakdowns at the county or school district-level. As noted throughout our IDS development efforts over the last several years, however, the limitations of aggregate reporting are that connections cannot be made across systems, which limits our capacity for evidence-informed policy making. We need more information about subpopulations of vulnerable families in particular to more accurately and efficiently target programs and resources that ensure ECI is improving outcomes for all Iowa families. Because our state is predominantly rural and our communities often have small populations (for example, 88 of the total 99 counties in Iowa are designated as rural places with fewer than 1,000 people per square mile), aggregate population-level data collected from US Census or other national tracking systems is often suppressed at the county level because of small sample sizes. Such suppression precludes our use of relevant data elements to inform local efforts on a yearly basis, though 5-year averages can provide some of the needed context. State-level reports help alleviate this limitation in some cases, but siloed services and data systems that report on one indicator at a time also present limitations for informing comprehensive, cross-systems work.

Integrated Data System (IDS) findings from the 2019 Needs Assessment revealed the value of integrated information from state systems to identify family needs and the relations between child or family characteristics and important systems-level connections and disconnections. We demonstrated the value of this information in the current work by focusing on unduplicated counts of preschool and ECE enrollment, but will continue to build this capacity to better understand the entire birth-to-five system in the future. Missing information from important systems including home visiting, early intervention (e.g., IDEA Parts B and C), and health (e.g., immunizations, lead registry, well child visits) will need to be addressed in the next iteration of the IDS. We will also benefit from continued investment in the IDS technology and governance infrastructures so we can improve the relative speed and accuracy with which we address policy-relevant needs through data and research. We are fortunate that our investments this year included securing legal agreements to include our Head Start grantees in the data system, though the data collection across 18 different grantees was not completed in time for this needs assessment. We look forward to including these data to capture both Head Start and Early Head Start enrollment patterns in our statewide analyses moving forward.

The most recent Results Accountability Component Group review of indicators also highlighted several measures that are currently not collected but that would be of high value for tracking ECI Result Areas. Many of these are highlighted in Table 4 (p.33), column 7 (labeled “IDS Future”), as they have been incorporated into discussions about how the IDS could be expanded to address indicator gaps such as the number of ECE slots broken down by infant/toddler and preschool ages or third grade reading proficiency. These indicators are either already collected in state systems that could be added to the IDS, or they could be created by integrating disparate data system elements. Other recommended indicators do not have a population-level data system associated with them that allow for routine monitoring, such as the percent of young children who are overweight or obese. We will continue to explore opportunities to address these gaps in future data collection efforts at the system level.

## Plans for Improving Data and Research Capacity

The 2019 Needs Assessment approach and findings have supported Iowa's momentum toward building capacities for data and research. We incorporated an IDS approach that allowed us to see, for the first time, unduplicated counts of children across our preschool programs and demonstrated the capacity of integrated data to help us understand more about the needs and service utilization patterns of Iowa families with young children. It also allowed us to test the capacity of our system to collect new data through surveys and focus groups, and capitalize on ECI's networking and outreach to do so. We intend to include both approaches in the future as we enhance our IDS capacity and ensure we have family voices well represented in our strategic planning, implementation, and evaluation efforts.

IDS expansion efforts will include investments in technology, governance, and additional data systems to fully capture Iowa's birth-to-five mixed delivery system. With continued national and state emphasis on privacy and improved technology standards to address it, we will continue to evolve our IDS capacity by incorporating additional state-of-the-art protocols and applications. Investments in technology and governance processes in partnership with state leaders will ensure our data are integrated with fidelity and protected for use only for those priority projects identified to support ECI's mission.

We will also continue to incorporate new datasets and new system partners as identified through stakeholder priorities. The 2019 Needs Assessment and Strategic Planning process pointed to several systems that will be included in these expansion efforts. Such expansion will likely involve legal discussions for those not already covered in our previously secured agreements, as well as addendums to existing agreements to allow for additional data systems to be included. As indicated in Table 4, several systems have been identified for planned discussions in our next phase:

- Head Start and Early Head Start (we have secured legal agreements and are currently collecting datasets for inclusion)
- Home visiting and group-based parent education data (currently collected in one system to include ECI, DE, IDPH, and DHS; as well as separate systems for each of the Early Head Start grantees)
- IDEA Parts B and C (provided through partnerships among DE and IDPH)
- Health (e.g., immunizations, lead registry)
- Child welfare

Additional data capacities will need to incorporate routine and episodic processes for including family and provider voices into indicator monitoring. The 2019 Needs Assessment contained important perspectives that could only be collected through surveys or focus groups, as the concepts of family experiences or barriers are not readily captured in administrative data systems. Unfortunately, we acknowledge that routine surveys and focus groups are costly and time consuming, so we will want to be judicious in our planning toward this end. Identifying opportunities where families or providers are already gathered that could facilitate collecting relevant feedback, or data systems where elements of data collection could be altered or adapted will be explored. It is not our intent to continue to replicate the depth of data collected for the 2019 Needs Assessment, but we also want to ensure we have capacity for family and

provider feedback that is captured with high-quality and facilitates tracking and monitoring over time. Potential purposes and avenues we will explore for continued data collection include the following:

- *Program evaluation.* We need to routinely collect specific feedback about programs that change over time, such as the recent CCA rate increase. Including surveys or focus groups to collect additional indicators to understand program implementation, experience, and outcomes will be important.
- *Communications feedback.* With our 2019 Strategic Plan focusing on improving communications strategies, we will want to gather feedback from families, providers, and the ECI community at-large to ensure we are reaching target audiences and that messages are clear and understood.
- *Transition points.* Our 2019 Needs Assessment attempted to capture information about family experiences in transitions between programs, but families continue to struggle when they move from one program to another. We will look for opportunities to build in more routine data collection points at key points of transition (e.g., at program exits; at kindergarten entry; etc.) to understand child and family needs as well as program strengths as families move between programs. In the Statewide Voluntary Preschool Program (SWVPP) families must be involved in at least one home visit, one family night, and a minimum of two family-teacher conferences annually [Iowa Code 281-16.3(12); 256C.3(3)g]. Intentional data collection during these family engagement points, such as at the start of state-funded preschool or kindergarten (where we know a majority of the Iowa population of children will “touch” the system) could generate indicators of system improvement that we could monitor over time and use for strategic planning.

Table 4 (p.33) provides a list of current and proposed child and family wellbeing indicators. The first three columns (under the heading “Report”) identify current places where indicators are tracked and reported for program monitoring purposes. The final four columns (under the heading “Data Source”) indicate where these indicators are drawn from. The two IDS columns delineate where we have current indicators captured from administrative data, and where we have interest and discussion underway to consider inclusion in IDS future development work.



**Table 4. Child and family indicators**

|   | Report            |                                |                                    | Data Source |       |             |            |
|---|-------------------|--------------------------------|------------------------------------|-------------|-------|-------------|------------|
|   | ECI Annual Report | ECI Statewide Needs Assessment | Title V & MIECHV Needs Assessments | NATIONAL    | STATE | IDS CURRENT | IDS FUTURE |
| Percent households with children under age 6 and all parents in workforce | X                 | X                              |                                    | X           |       |             |            |
| Educational attainment of mothers   | X                 | X                              | X                                  | X           | X     | X           |            |
| Percent children under 6 in poverty                                       | X                 | X                              | X                                  | X           |       |             |            |
| Immunized children by age 2   | X                 | X                              |                                    |             | X     |             | X          |
| Dental services for Medicaid-enrolled children ages 0-5 who receive       | X                 |                                |                                    |             | X     |             |            |
| Rate of serious crime per 100k population                                 | X                 |                                | X                                  |             | X     |             |            |
| Rate of juvenile arrests per 100k population                              | X                 |                                | X                                  |             | X     |             |            |
| Child deaths due to unintentional injuries                                |                   |                                |                                    |             | X     |             | X          |
| Percent unemployment or Unemployment Rate                                 | X                 |                                | X                                  |             | X     |             | X          |
| Incidence of child abuse for children under 6                             | X                 |                                | X                                  |             | X     |             | X          |
| Births to women under age 20  | X                 | X                              |                                    |             | X     | X           |            |
| Low birth weight  | X                 | X                              | X                                  |             | X     | X           |            |
| Infant mortality rate   |                   |                                | X                                  |             | X     |             | X          |
| All people in poverty   |                   |                                | X                                  | X           |       |             |            |
| Child poverty   |                   | X                              | X                                  | X           |       |             |            |
| High school dropout rate  |                   |                                | X                                  |             | X     |             | X          |
| Binge alcohol prevalence  |                   |                                | X                                  |             | X     |             |            |
| Domestic violence rate per 100,000  | X                 |                                | X                                  |             | X     |             |            |
| 4th grade reading, percent proficient                                     |                   |                                | X                                  |             | X     |             | X          |
| Percent of children with lead screenings                                  |                   |                                |                                    |             | X     |             | X          |

|  |   |   |  |  |   |   |   |
|--|---|---|--|--|---|---|---|
| Number of children who received a developmental or behavioral health screening   |   |   |  |  | X |   | X |
| Number of pregnant women receiving home visiting services  |   | X |  |  | X |   | X |
| Distribution of preschool children’s problem-solving skills  |   |   |  |  |   |   | X |
| Early literacy skills – kindergartners meeting the fall benchmark for the early literacy universal screening measure requirements for literacy. (IA Code 279.68) | X |   |  |  |   |   | X |
| Distribution of preschool children’s social-emotional skills   |   |   |  |  |   |   | X |
| Percentage of kindergarten children suspended from school, disaggregated by vulnerable populations   |   | X |  |  |   | X |   |
| Percentage of kindergarten children with poor attendance, disaggregated by vulnerable populations  |   | X |  |  |   | X |   |
| Quality Early Learning Environments (IAEYC or NAFCC accredited, Head Start Iowa Quality Preschool Program Standards (IQPPS) Verified, QRS Level 4 and 5          | X |   |  |  |   |   |   |
| Availability of child care (measuring slots) for infants/toddlers and preschool aged children  | X |   |  |  |   |   | X |

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List of Technical Appendices

- A. Analysis from Iowa's Integrated Data System
- B. Provider Survey
- C. Family Survey
- D. Family and Provider Focus Groups
- E. Community Listening Sessions

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## Summary

The goal of Early Childhood Iowa's Integrated Data System (IDS) analyses were to support the development of Early Childhood Iowa's (ECI) 2019 Statewide Needs Assessment and Strategic Plan. Analyses focused on (1) documenting unduplicated counts of children across preschool programs, (2) describing characteristics of vulnerable and underserved children, and (3) identifying differences in characteristics, services, and outcomes for children living in Iowa's rural counties. Prior to Iowa's investment in the IDS capacity, ECI did not have the ability to answer questions about unduplicated counts of children across our programs, or what factors outside of one system may influence participation or outcomes in another. This test of Iowa's IDS investment provided fruitful results that have informed our new strategic plan, "We are ECI," and prompted avenues for future research and analytics that will continue to support our birth-to-five system coordination efforts.

## Data Sources

Administrative records from the Iowa's Departments of Public Health, Human Services, and Education were the basis for all IDS analyses (see Table A.1.). Data sharing for the purpose of this Statewide Needs Assessment followed all applicable legal and ethical standards for protecting privacy and confidentiality as established by federal and state law, and were governed by signed legal agreements among all state departments and Iowa State University.

**Table A.1. Overview of data sources included in the IDS birth-to-five cohort**

| Data source  | Description and details  |
|--|--|
| Iowa Department of Public Health Vital Statistics Birth Records (VS) | Data collected in the hospital at the time of the child's birth include date of birth, Medicaid or WIC receipt at birth, birth weight and gestational age, mother age and marital status, parent education levels, prenatal care, prenatal maternal smoking. |
| Iowa Department of Education Kindergarten Enrollment Records         | Public education enrollment records include enrollment, achievement, average daily attendance, suspensions as well as provision of district programs such as Free and Reduced Lunch and English Language Learner services.                                   |

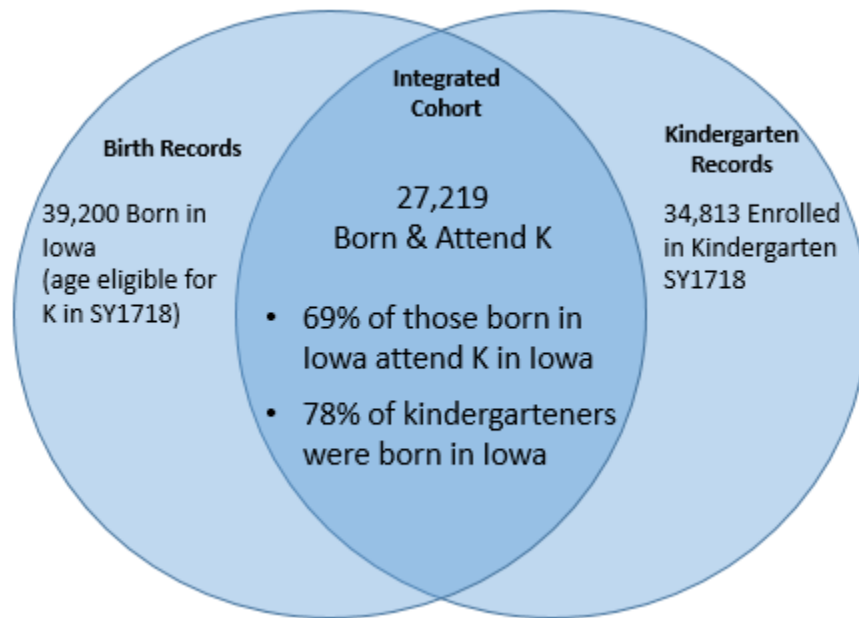
|   |   |
|---|---|
| Iowa Department of Education Funded Pre-school (DE PreK)      | Enrollment data identify children’s preschool participation in Department of Education (DE) funded programs such as Statewide Voluntary Preschool, Shared Visions, or IDEA services, including information about the school of enrollment and type of classroom. <i>Note that this data does not include Head Start programs (though these were captured in the TS GOLD dataset as all grantees participate in TS GOLD).</i>  |
| Iowa Department of Human Services Child Care Assistance (CCA) | Enrollment data include provider and child demographic information as well as child care assistance registration, capacity, attendance, and payment receipt.  |
| Teaching Strategies GOLD assessment (TS GOLD)                 | Teaching Strategies GOLD data contain program enrollment, child demographics, and developmental assessments for any child enrolled in a program who participates. The DE’s statewide license covers administrative fees for annual subscriptions for all registered Iowa programs, and public and private preschools are allowed to use the license to complete assessments for children in their programs. Per Iowa code section 279.60, prekindergarten, or four-year-old children affiliated with a local school district, must be assessed using Teaching Strategies Gold; other programs have optional participation; All Head Start grantees across the state also use TS GOLD. These records were used to capture program enrollment information for students who may have received a center-based care experience but it was NOT funded by DE or CCA, including Head Start. |

### Data Integration

Administrative records from each of the data systems were integrated using deterministic and probabilistic matching techniques for one cohort of children attending kindergarten in the 2017-2018 school year. Extensive data cleaning and verification were conducted prior to the match, following standardized data verification procedures (Long, 2009) including internal consistency and missing data reviews. Birth records and education data were joined in step one, followed by joins with CCA and TS GOLD in step two. Figure A.1. presents information on Step 1 from the data integration match, including the link between birth records and kindergarten enrollment. Results indicate that 69% of the 39,200 children who were age eligible to attend kindergarten were matched with kindergarten enrollment records from the 2017-2018 school year.



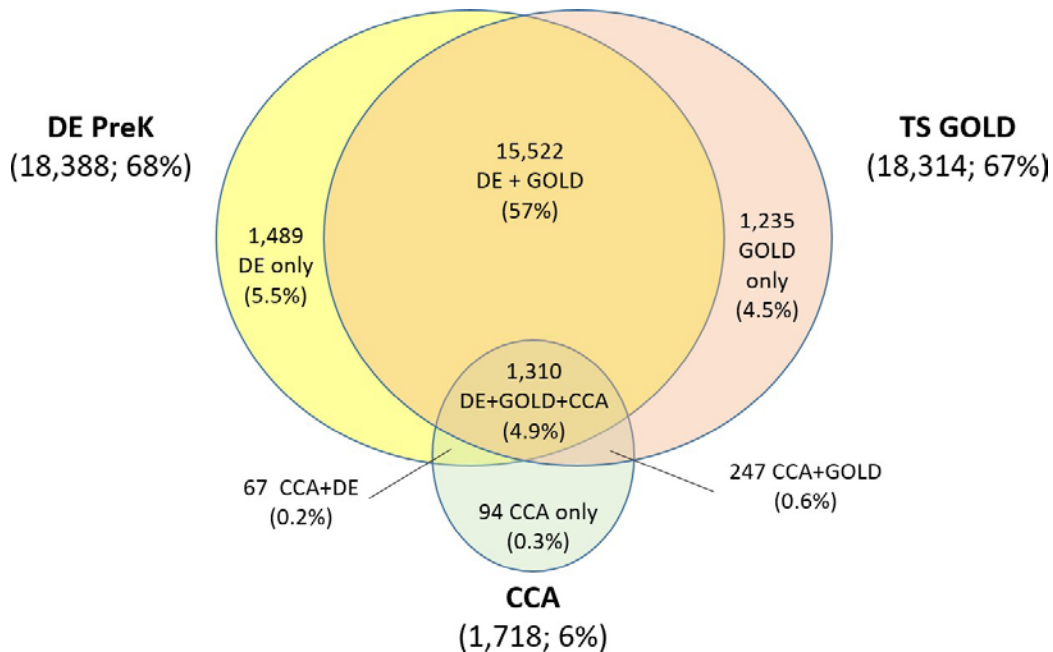
**Figure A.1. Description of the IDS birth-to-five cohort reflecting children who were born in Iowa and attended kindergarten during the 2017-2018 school year (SY1718)**



Step 2 of the data integration involved matching CCA and TS GOLD data with the birth-to-kindergarten cohort. TS GOLD data are unique in that they capture enrollment information for any child in a center that uses the Iowa license – including Head Start programs, DE funded SWVPP, and a number of private centers that are not funded by or operated by state departments.

Figure A.2. presents information on enrollment and assessment records from this match. Numbers represent the number of children with each type of experience and percents reflect the percent of the total cohort (i.e., out of the total number of 27,219 children). Findings indicated 68% of Iowa children attended a DE funded prekindergarten program, 67% had a TS GOLD assessment (i.e., were enrolled in a center-based program of any type that used the TS GOLD assessment), and 6% participated in a CCA funded center-based experience during 2016-2017. Figure A.2. visualizes the number of children who had multiple experiences, such as children who participated in a DE funded preschool and also received a CCA subsidy for an additional child care experience the year before they entered kindergarten (n=1,310+67). It also highlights the unique experience of children who were identified in one system but not others, for example those who had a TS GOLD assessment but did not attend a DE funded preschool program (n=1,235).

**Figure A.2. Preschool experiences among children in the birth-to-five cohort. Frequencies and percent of the overall cohort reported, N=27,219**



### Data Analysis

Stata 15.0 (StataCorp, 2017) statistical software was used for descriptive and multivariate analyses of children in the birth-to-five cohort with a focus on better understanding the relationship between child and family demographic characteristics, the cumulative risk factors present at birth, preschool attendance, and kindergarten outcomes. Multiple logistic regression models examined whether children’s exposure to certain risks at birth significantly predicted living in a rural area, attending preschool, or reporting a range of kindergarten experiences and outcomes. For each multivariate model, relevant child and family demographic characteristics such as child race/ethnicity and gender were included. This analytic approach was ideal for answering the key questions of whether children attended preschool or had particular kindergarten experiences because logistic regression assess dichotomous outcomes (e.g., “yes” or “no” to each question) while simultaneously addressing the influence of a range of meaningful child and family experiences and characteristics.

**Individual Birth Risk Variables.** Birth record information was used to create risk indicators based on established definitions of risk from the research literature. A proxy for poverty was assessed as whether the child’s family received Medicaid or WIC at the time of birth. Unmarried mothers were identified as women who were not married at the time of the child’s birth. Low maternal education indicated that the child’s mother completed less than 12 years of schooling. Teen motherhood identified children born to mothers younger than age 20. Preterm or low birth weight (LBW) indicated that children were born prior to 36 weeks gestation or were born weighing less than 2,500 grams. Inadequate prenatal care indicated parents did not have a prenatal visit in the first trimester of pregnancy and had fewer than four visits overall. Prenatal Smoking was noted if mothers smoked during pregnancy or the three months prior.

**Cumulative Risk Birth Variables.** As children often face multiple risks that are highly correlated and accumulate over time, a cumulative risk approach was utilized to better reflect the context of children’s lives and provider deeper insights into how agencies might address the needs of vulnerable children. To this end, a cumulative risk measure was constructed as a sum of the 7 individual birth risks including poverty, unmarried motherhood, low maternal education, teen motherhood, preterm/low birth weight, inadequate prenatal care, and prenatal smoking.

**Results**

Figure A.3. presents information on the racial/ethnic characteristics of all children in Iowa’s IDS birth-to-five cohort as well as those who live in rural places, defined as living in an area with fewer than 1,000 people per square mile (US Census Bureau; Woods & Poole; 2017). 88 of Iowa’s 99 counties and 29% of the birth-to-five cohort are considered rural using the federal definition. Among the birth-to-five cohort, 22% of all children and 18% of rural children identify as a racial or ethnic minority in 2017-2018.

**Figure A.3. Race/Ethnicity of children in the birth-to-five cohort**

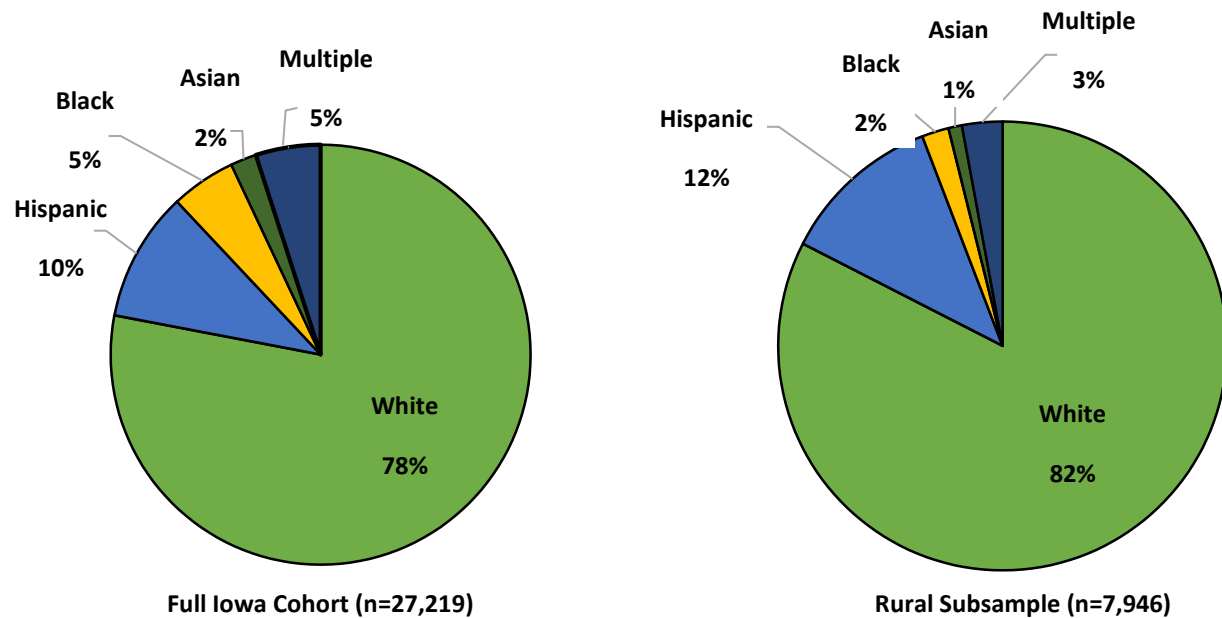


Table A.2. presents information on demographic and birth risk characteristics of children nationally, those in the IDS birth-to-five cohort, and those from the cohort who live in rural places. National estimates were assessed from publically available data sources and provided here for comparison (see table note for details). Findings indicate children who are born in Iowa and attend kindergarten are twice as likely to have a teen mother compared to national averages (4% vs. 2%). 49% of Iowa’s children qualify for Medicaid or WIC at the time of birth. Compared to all children in Iowa, rural children are more likely to qualify for Medicaid or WIC at the time of birth, be born to a teen mother, or have a mother who smoked during pregnancy.

**Table A.2. Comparison of Iowa’s birth-to-5 cohort with national and rural estimates**

|                                    | National Estimates | Iowa Estimates<br>N = 27,219 | Rural Subsample<br>N= 7,946 |
|------------------------------------|--------------------|------------------------------|-----------------------------|
| <b>Characteristics</b>             |                    |                              |                             |
| Male                               | n/a                | 51%                          | 51%                         |
| Immigrant Parent                   | n/a                | 12%                          | 11%                         |
| Average Age at PreK Entry (Months) | n/a                | 54%                          | 54%                         |
| <b>Risks at Birth</b>              |                    |                              |                             |
| Poverty (Medicaid/WIC)             | 41% <sup>b</sup>   | 49%                          | 57%                         |
| Unmarried Mother                   | 40% <sup>c</sup>   | 33%                          | 34%                         |
| Low Maternal Education             | 14% <sup>a</sup>   | 10%                          | 13%                         |
| Teen Mother                        | 2% <sup>b,c</sup>  | 4%                           | 5%                          |
| Preterm OR Low Birth Weight (LBW)  | 10% <sup>c,d</sup> | 8%                           | 5%                          |
| Inadequate Prenatal Care           | 6% <sup>e</sup>    | 1%                           | 2%                          |
| Prenatal Smoking                   | 7% <sup>f</sup>    | 23%                          | 27%                         |

Notes: National estimates used the following references: (a) U.S. Census Bureau (b) Definition includes children in families under 200% FPL); (c) Centers for Disease Control and Prevention; (d) Preterm (9.8%) or LWB (8.3%), Centers for Disease Control and Prevention, 2014; (e) National Center for Health Statistics; (f) National Center for Health Statistics, 2016 Definition includes mothers who smoked during pregnancy only.

Multiple logistic regression was used to examine whether exposure to birth risks were statistically associated with being born in a rural area (see Table A.3.). This analysis produces odds ratios, which are interpreted as the likelihood of an outcome with a given characteristic compared to the likelihood of that same outcome for a child without that characteristic. An odds ratio of 1.0, for example, indicates equal likelihood (i.e., no difference in the outcome). Odds ratios of less than 1.0 indicate a decreased likelihood of the event occurring while odds ratios greater than 1.0 indicate an increased likelihood of the event occurring. For example, children born to a teen mother are 1.5 times more likely than children without a teen mother to be born in a rural county compared to being born in an urban county. Statistically significant differences are noted with asterisks in Table A.3., and suggest that minority children (Black, Asian, or multiracial compared to white), children born preterm or with low birthweight, children born to an unmarried mother, or children whose parent is an immigrant to the United States are less likely to be born in rural areas. Children whose mothers were still teenagers, had less than 12 years of education, were in poverty, smoked during pregnancy, or had multiple children at the time of the child’s birth were more likely to live in rural areas.

Children who were identified as having at least one preschool experience prior to kindergarten entry were **more than twice as likely** to be born in rural areas compared to children who did not have a preschool experience.

**Table A.3. Odds ratios of whether a child is born in a rural place by individual birth risk**

|                                       | Odds Ratio | Standard Error |
|---------------------------------------|------------|----------------|
| Male                                  | 0.97       | (0.03)         |
| Black                                 | 0.19       | (0.02)***      |
| Hispanic                              | 0.92       | (0.05)         |
| Asian                                 | 0.49       | (0.06)***      |
| Multiple                              | 0.42       | (0.03)***      |
| Age at enrollment (DE)                | 0.99       | (0.00)***      |
| Pre-term/Low birthweight <sup>a</sup> | 0.42       | (0.03)***      |
| Teen mother <sup>b</sup>              | 1.50       | (0.11)***      |
| Low mother education <sup>c</sup>     | 1.11       | (0.06)*        |
| Unmarried mother <sup>d</sup>         | 0.89       | (0.03)**       |
| Inadequate prenatal care <sup>e</sup> | 1.10       | (0.16)         |
| Poverty (WIC/Medicaid) <sup>f</sup>   | 2.01       | (0.07)***      |
| Parent immigrant <sup>g</sup>         | 0.83       | (0.05)**       |
| Prenatal Smoking <sup>h</sup>         | 1.35       | (0.05)***      |
| Number of siblings <sup>i</sup>       | 1.06       | (0.01)***      |
| Any Preschool Experience              | 2.09       | (0.07)***      |
| Constant                              | 0.18       | (0.01)***      |
| Pseudo R-squared                      | 0.064      |                |

Notes: N=27,219; \*p<.10; \*\*p<.05; \*\*\*p<.001. Logistic regression models assessed: <sup>a</sup> Reference category is healthy weight and gestational 40 weeks. <sup>b</sup> Reference category is mother's age 20 and older. <sup>c</sup> Reference category is mother with a high school degree or more. <sup>d</sup> Reference category is mother's age married during pregnancy. <sup>e</sup> Reference category is mother with first prenatal care visit in first trimester or at least 4 prenatal care visits during pregnancy. <sup>f</sup> Reference category is mother not receiving WIC or did not use Medicaid as delivery payment. <sup>g</sup> Reference category is parent born in U.S. <sup>h</sup> Reference category is mother not smoking during pregnancy. <sup>i</sup> Reference category is 0 siblings. Age at enrollment is continuous.

Distributions of cumulative risk among children in the birth-to-five cohort are presented overall, by rurality, and by racial and ethnic grouping in Table A.4. and Figure A.4.. Results suggest rural and minority children experience more cumulative risks compared to children born in urban areas and white children. For example, 25% of rural Iowa children experience 3 or more risks (compared to 20% of all Iowa children), as well as 42% of Black children, 34% of Hispanic children, 38% of Asian/Pacific Islander (API) children, and 37% of multi-racial children.

**Table A.4. Number and percent of children in the birth-to-five cohort experiencing cumulative risks by rurality and race**

| Number of risks | Iowa<br>n = 27,219 | Rural<br>n = 7,977 | White<br>n = 21,181 | Black<br>n = 1,294 | Hispanic<br>n = 2,766 | Asian<br>n = 571 | API<br>n = 37 | Multi-race<br>n = 1,400 |
|-----------------|--------------------|--------------------|---------------------|--------------------|-----------------------|------------------|---------------|-------------------------|
| 0               | 10,949<br>(40%)    | 2509<br>(32%)      | 10,166<br>(48%)     | 73<br>(6%)         | 257<br>(9%)           | 212<br>(37%)     | 2<br>(5%)     | 239<br>(17%)            |
| 1               | 5,235<br>(19%)     | 1604<br>(20%)      | 4159<br>(20%)       | 164<br>(13%)       | 566<br>(20%)          | 107<br>(19%)     | 8<br>(22%)    | 231<br>(17%)            |
| 2               | 5,515<br>(20%)     | 1885<br>(24%)      | 3410<br>(16%)       | 516<br>(40%)       | 1003<br>(36%)         | 159<br>(28%)     | 13<br>(35%)   | 414<br>(30%)            |
| 3 or more       | 5,550<br>(20%)     | 1948<br>(25%)      | 3446<br>(16%)       | 541<br>(42%)       | 940<br>(34%)          | 93<br>(16%)      | 14<br>(38%)   | 516<br>(37%)            |

Notes: Cumulative risk is a sum of 7 individual risks (poverty, unmarried mom, low maternal education, teen mom, preterm/LBW, inadequate prenatal care, & prenatal smoking).

**Figure A4. Cumulative risk exposure among the birth-to-five cohort and by rurality**

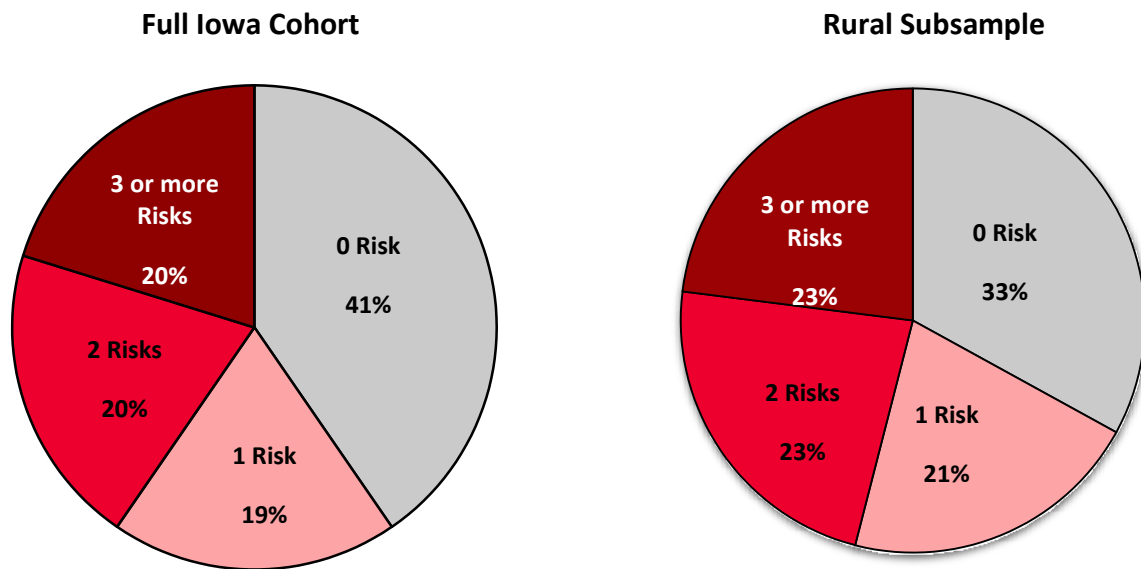


Table A.5. presents results of the multiple logistic regression analysis that examined cumulative risk characteristics related to living in a rural place. Findings confirm that children exposed to one, two, and three or more risks were more likely to be born in rural areas compared to children with zero risks identified at birth.

**Table A.5. Odds ratios of whether a child is born in a rural county by cumulative birth risk**

|                               | Odds Ratio | Standard Error |
|-------------------------------|------------|----------------|
| Male                          | 0.97       | (0.03)         |
| Black                         | 0.19       | (0.02)***      |
| Hispanic                      | 0.94       | (0.05)         |
| Asian                         | 0.48       | (0.06)***      |
| Multiple                      | 0.43       | (0.03)***      |
| Parent immigration            | 0.83       | (0.05)**       |
| Number of Siblings            | 1.08       | (0.01)***      |
| Age at enrollment (DE)        | 0.99       | (0.00)***      |
| Cumulative Risks <sup>a</sup> |            |                |
| 1 Risk                        | 1.49       | (0.06)***      |
| 2 Risks                       | 1.99       | (0.08)***      |
| 3 or More Risks               | 2.15       | (0.08)***      |
| Any Preschool Experience      | 2.09       | (0.07)***      |
| Constant                      | 0.17       | (0.01)***      |
| Pseudo R-squared              | 0.049      |                |

Notes: N=27,219; \*p<.10; \*p<.05; \*\*p<.01; \*\*\*p<.001. Logistic regression models assessed: <sup>a</sup> reference category is children exposed to zero risk factors; age at enrollment is continuous. \*p<.10; \*p<.05; \*\*p<.01; \*\*\*p<.001.

Table A.6. and Figure A.5. present results of multiple logistic regression analyses examining child demographic characteristics and individual birth risks related to several kindergarten outcomes including whether a child received free/reduced lunch (FRPL), was an English language learner (ELL), had an individualized education plan (IEP), attended school less than 90% of days in kindergarten, and was ever suspended.

Table A.6. presents odds ratios in columns organized by each kindergarten outcome. Findings indicated that minority children (Hispanic, Black, Asian, multiracial) are significantly more likely to qualify for Free/Reduced Priced Lunch and have poor attendance in kindergarten compared to white children. Children born with risks including poverty, low maternal education, unmarried mothers, teen mothers, and prenatal smoking are significantly more likely to qualify for Free/Reduced Priced Lunch in kindergarten and have poor attendance in kindergarten compared to children who do not experience these risks. Poverty is persistent over time - children who qualify for Medicaid or WIC at birth are over 10 times more likely to qualify for Free/Reduced priced lunch in kindergarten. Boys are 7.5 times more likely to be suspended in kindergarten, and 2.4 times more likely to have an IEP in kindergarten compared to girls. Poverty at birth is the only indicator that was significantly related to ALL kindergarten outcomes (FRPL, IEP, ELL, attendance, and suspensions), even when other risks and characteristics were controlled.

**Table A.6. Odds ratios of child characteristics and risks related to kindergarten outcomes. Significant results reported**

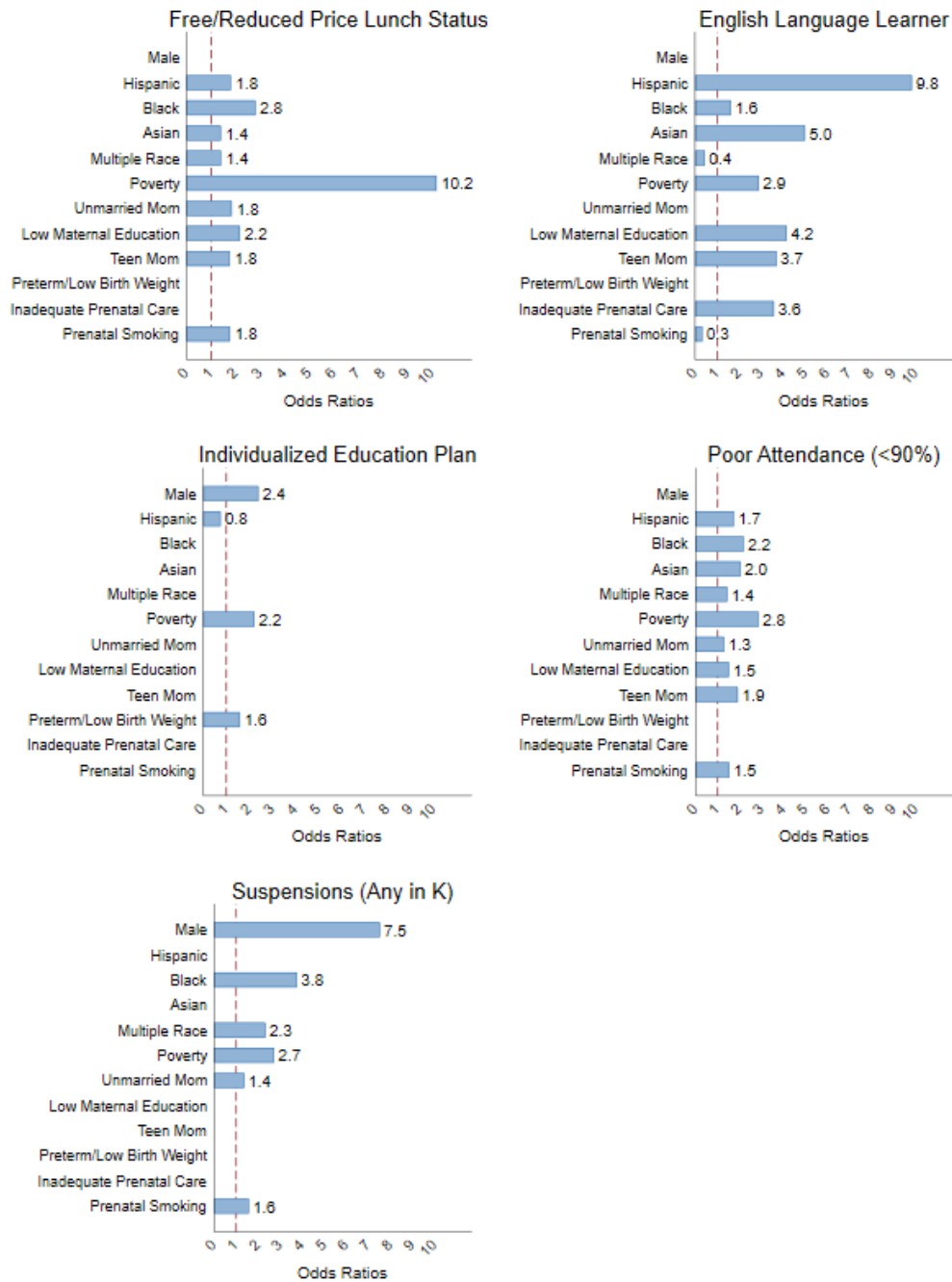
|                                     | Free or reduced lunch status<br>(n=10,655) | English Language Learner<br>(n=1,912) | Individualized education plan<br>(n=1,913) | Poor (<90% attendance)<br>(n=1,914) | Any suspension<br>(n=273) |
|-------------------------------------|--|---------------------------------------|--|-------------------------------------|---------------------------|
| <b>Characteristics <sup>a</sup></b> |  |                                       |  |                                     |                           |
| Male                                |  |                                       | 2.39                                       |                                     | 7.51                      |
| Hispanic                            | 1.8  | 9.81                                  | 0.75                                       | 1.74                                |                           |
| Black                               | 2.8  | 1.63                                  | 2.18                                       | 3.76                                |                           |
| Asian                               | 1.39                                       | 4.98                                  | 2.04                                       |                                     |                           |
| Multiple races                      | 1.4  | 0.44                                  | 1.43                                       | 2.32                                |                           |
| <b>Risks at birth <sup>b</sup></b>  |  |                                       |  |                                     |                           |
| Poverty (Medicaid/WIC)              | 10.18                                      | 2.89                                  | 2.22                                       | 2.85                                | 2.72                      |
| Unmarried mom                       | 1.84                                       | 1.3                                   | 1.36                                       |                                     |                           |
| Low maternal education              | 2.17                                       | 4.15                                  | 1.51                                       |                                     |                           |
| Teen mom                            | 1.76                                       | 3.68                                  | 1.92                                       |                                     |                           |
| Preterm or Low birth weight         | 1.59                                       |                                       |  |                                     |                           |
| Inadequate prenatal care            | 3.57                                       |                                       |  |                                     |                           |
| Prenatal smoking                    | 1.77                                       | 0.33                                  | 1.53                                       | 1.57                                |                           |

Notes: N=27,219; Logistic regression models assessed: <sup>a</sup> Reference category is white, female. <sup>b</sup> Reference category is a child with zero of the listed risks.

Figure A.5. presents the same information as Table A.6. but in a visual format. Characteristics that fall to the left of the red lines reflect significantly lower odds of experiencing the kindergarten outcome, while those to the right of the red lines indicate significantly greater odds of experiencing the outcome. Attributes with missing bars are not statistically significant.



**Figure A.5. Child characteristics and kindergarten outcomes**



SOURCE: Early Childhood Iowa Integrated Data System (ECI-IDS).

Table A.7. presents information on demographic, birth risk characteristics, and cumulative risk characteristics as a function of ECE Experience type. The indicator of “Any PreK” was coded “yes” for children that received Child Care Assistance (CCA), were in a Department of Education prekindergarten program, or that completed a GOLD assessment (i.e., were enrolled in a center-based program of any type, including Head Start, that used the GOLD assessment). The “Any Prek” indicator represents ECI’s best estimate of “unduplicated counts” of children with such a center-based experience during the year before kindergarten. Findings indicated that 73% of the full birth cohort had at least one prekindergarten experience. Further, 51% of Iowa children that had a PreK experience qualified for Medicaid or WIC at the time of birth, and 41% of these children experience 2 or more birth risks.

**Table A.7. Percent of children with characteristics and risks by type of early childhood education (ECE) experience**

|                             | Child Care Assistance<br>CCA<br>(n = 1,718) | Department of Education<br>DE PreK<br>(n =18,388) | Teaching Strategies<br>GOLD<br>(n = 18,314) | Any PreK:<br>CCA, DE<br>PreK, or<br>GOLD<br>(n = 19,944) |
|-----------------------------|---|---|---|--|
| <b>Characteristics</b>      |   |   |   |  |
| Male                        | 53%   | 51%   | 51%   | 51%  |
| White                       | 59%   | 80%   | 79%   | 78%  |
| Hispanic                    | 12%   | 10%   | 9%  | 10%  |
| Black                       | 17%   | 4%  | 4%  | 5%   |
| Asian                       | 1%  | 2%  | 2%  | 2%   |
| Multiple races              | 5%  | 5%  | 5%  | 5%   |
| <b>Risks at Birth</b>       |   |   |   |  |
| Poverty (Medicaid/WIC)      | 92%   | 49%   | 50%   | 51%  |
| Unmarried mother            | 70%   | 32%   | 33%   | 33%  |
| Low maternal education      | 12%   | 9%  | 9%  | 9%   |
| Teen mother                 | 10%   | 3%  | 4%  | 4%   |
| Preterm or low birth weight | 9%  | 8%  | 8%  | 8%   |
| Inadequate prenatal care    | 1%  | 1%  | 1%  | 1%   |
| Prenatal smoking            | 41%   | 22%   | 23%   | 23%  |
| <b>Cumulative Risks</b>     |   |   |   |  |
| No risks                    | 3%  | 40%   | 39%   | 38%  |
| 1 Risk                      | 15%   | 20%   | 20%   | 20%  |
| 2 Risks                     | 36%   | 21%   | 21%   | 21%  |
| 3 or more risks             | 45%   | 19%   | 20%   | 20%  |

Notes: N=27,219; Numbers represent percentages within each column. For example, 53% of children who receive Child Care Assistance are male.

Table A.8. and Figure A.6. present results from multiple logistic regression analyses examining the probability of participation in each of the early care education (ECE) experiences, relative to child characteristics and birth risks. In Table A.8. odds ratios are presented in columns organized by each prekindergarten experience. The same information is presented visually in Figure A.6. Minority children (i.e., Hispanic, Black, or multiracial) are significantly less likely to have any prekindergarten experience compared to white children. Children born with risks including low maternal education and inadequate prenatal care are significantly less likely to have any prekindergarten experience compared to children who do not experience these risks. Conversely, children with parents that qualify for Medicaid or WIC at the time of birth are more likely to have some form of prekindergarten experience the year before kindergarten.

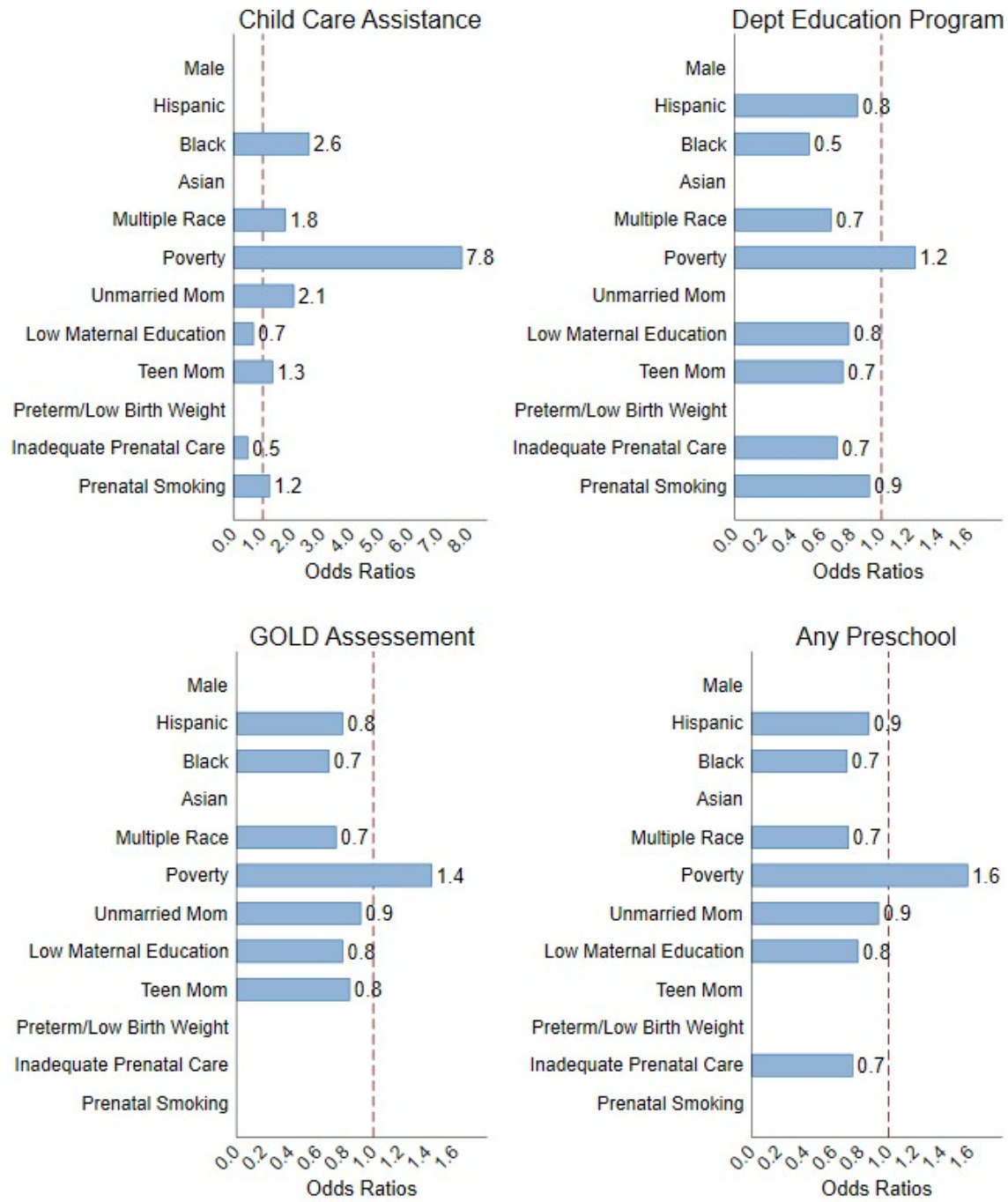
**Table A.8. Odds ratios of child characteristics and risks related to ECE participation the year before kindergarten**

|                                    | Child Care Assistance (CCA) | Department of Education (DE) | Teaching Strategies GOLD | Any PreK (CCA, DE, or GOLD) |
|------------------------------------|-----------------------------|------------------------------|--------------------------|-----------------------------|
| <b>Characteristics<sup>a</sup></b> |                             |                              |                          |                             |
| Male                               |                             |                              |                          |                             |
| Hispanic                           |                             | 0.84                         | 0.78                     | 0.86                        |
| Black                              | 2.58                        | 0.51                         | 0.68                     | 0.70                        |
| Asian                              |                             |                              |                          |                             |
| Multiple races                     | 1.78                        | 0.66                         | 0.73                     | 0.71                        |
| <b>Risks at Birth<sup>b</sup></b>  |                             |                              |                          |                             |
| Poverty (Medicaid/WIC)             | 7.76                        | 1.23                         | 1.43                     | 1.58                        |
| Unmarried mother                   | 2.06                        | 0.91                         | 0.93                     |                             |
| Low maternal education             | 0.69                        | 0.78                         | 0.78                     | 0.78                        |
| Teen mother                        | 1.34                        | 0.74                         | 0.83                     |                             |
| Preterm or low birth weight        |                             |                              |                          |                             |
| Inadequate prenatal care           | 0.50                        | 0.70                         |                          | 0.74                        |
| Prenatal smoking                   | 1.24                        | 0.92                         |                          |                             |

Notes: N = 27,219; Only significant odds ratios are presented in this table. <sup>a</sup> Reference category is white, female. <sup>b</sup> Reference category is a child with zero of the listed risks.

Figure A.6. presents the same information from Table A.8. but in visual form. Characteristics that fall to the left of the red lines have lower odds of experiencing the kindergarten outcome while those that fall to the right of the lines have higher odds of experiencing the outcome. Features with missing bars are not statistically significant.

**Figure A.6. Child characteristics and risks related to ECE participation the year before kindergarten**



**SOURCE:** Early Childhood Iowa Integrated Data System (ECI-IDS).

*Notes:* Department of Education programs refer to all DE funded preschool programs identified in Table A.1.

## **Acknowledgements**

These data were collected and analyzed by faculty and students in ISU's Department of Human Development and Family Studies (HDFS), with content expertise and distribution support from the Iowa Department of Human Services. HDFS faculty included Christine Lippard, Ji Young Choi, Carla Peterson, Cassandra Dorius, and Heather Rouse. HDFS Post-doctoral, graduate, and undergraduate student assistants supporting the work included Seulki Ku, Quentin Riser, Maya Bartel, Jessica Bruning, Allison Gress, Emma Kelley, Lexi Flake, and Kaitlyn Facile.

## **Summary**

In partnership with the Iowa Departments of Human Services (DHS) and Management (DoM), a survey of all active ECE licensed childcare centers was conducted between April and June of 2019 to gather information about center quality, capacity, and staffing to inform the 2019 Needs Assessment. This data collection effort was designed to fill gaps in the existing state administrative data files regarding providers' current (1) capacity, enrollment, and waitlists, (2) staff, (3) partnerships among programs, and (4) awareness of and response to state initiatives. Of the 1,220 licensed child care centers in Iowa, survey data was electronically collected from 591 centers between April and June of 2019. The responding providers were located in 93 of Iowa's 99 counties. The survey data was combined with existing state administrative data to produce information on child care waiting lists, Iowa Quality Rating System (QRS), partnerships and collaborations, provider capacity and facility challenges, provider staffing, distribution of Iowa Early Learning Standards – Third Edition, and providers' knowledge and perspectives on Child Care Assistance (CCA), the Child Care Development Fund subsidy program.

## **Sampling Frame**

Two sets of data were provided by the Department of Human Services to generate a complete sampling frame for this study, including a list of centers having QRS ratings and a list of all state licensed child care centers. These datasets captured information about centers' activation status, facility type, license expiration date, capacity, enrollment count, CCA effective and expiration date, financial type, age of children served (infant, twos, preschool school age), duration of operation (e.g., year round or summer only), QRS level, names of any associated school districts, Child Care Resource and Referral (CCR&R) region, and contact information (e.g., email address, physical address, phone number). The licensure and QRS data were then combined to create a master contact list of 1,568 active child care centers in Iowa as of November, 2018. Of these, programs known to serve only school age children or who only provided before and after school care were removed. The final contact list of 1,220 licensed childcare centers and preschools was used as a sampling frame for the provider survey.

## **Provider Survey Development**

Content for the provider survey was co-created with DHS and DoM personnel, members of the Preschool Development Grant (PDG) Core team, and ISU faculty with content expertise and leadership roles with ISU's ECE licensure program that trains and educates a large portion of the Iowa ECE workforce. The ISU team initially reviewed information gaps identified in the

original PDG proposal, examined existing state administrative datasets to determine what data was already available, and then generated a list of questions to include in the survey that would address the previously identified gaps. The questions generally fell into four categories: (1) capacity, enrollment, and waitlists, (2) staff, (3) partnerships among programs, and (4) awareness of and response to state initiatives. The State-University team used an iterative process to generate, evaluate, and revise survey questions over the course of two months, including feedback from additional DHS personnel. When appropriate, wording and response options of survey questions were designed to be comparable to those used in existing administrative datasets or national surveys to facilitate comparability analysis.

The survey was constructed using Qualtrics online survey software. The ISU team went through the iterative process to review, evaluate, and revise to refine question types, question order, and question routing structures. A printable 1-page worksheet was also developed to facilitate data collection and recording for more complicated questions (e.g., specific enrollment numbers, numbers of teachers with a bachelor's degree). Four centers were invited to pilot the on-line survey and worksheet to provide feedback. Three centers provided feedback that was used to revise survey wording to enhance readability and ease of completion.

### **Distribution of the Survey**

In early April 2019 the on-line survey was distributed to the 1,220 licensed child care centers in Iowa. Each center received a unique online survey link through either Qualtrics or email. Each center was asked to designate one person as the respondent for the center. Respondents were primarily center directors. Over the course of 6 weeks, research assistants followed up at regular intervals with centers who had not completed the survey. This was first done via mass emails to all non-respondents, then by individual emails, and finally by individualized emails targeting centers who were in an underrepresented category (e.g., counties with less than 1/3 response, centers offering sick child care). Once provider survey data collection was completed, the data were merged with existing administrative data. Missing responses were coded to distinguish between true missing and not applicable.

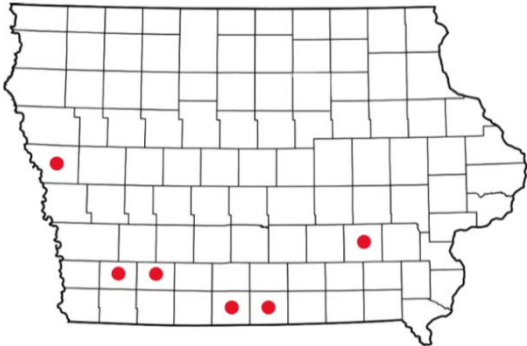
### **Response Rates & Description of Respondents**

Provider survey data were electronically collected from 591 licensed child care centers in 93 of the 99 Iowa counties between April and June of 2019. Distribution of provider type among provider survey respondents and distribution of provider QRS rating among provider survey respondents are presented in tables B.1. and B.2. (p.55), as well as Figures B.1. and B.2. (p.55-56).

| <b>Table B.1. Distribution of provider type among centers who responded to the survey</b> |                |                 |               |
|---|----------------|-----------------|---------------|
|   | Possible Sites | Responded Sites | Response Rate |
| <b>Evening Care</b>   | 7              | 3               | 43%           |
| <b>Infant providers</b>   | 522            | 255             | 49%           |
| <b>License type – child care</b>  | 859            | 392             | 46%           |
| <b>License type – preschool</b>   | 145            | 76              | 52%           |
| <b>Active Child Care Assistance (CCA) provider</b>  | 767            | 372             | 49%           |

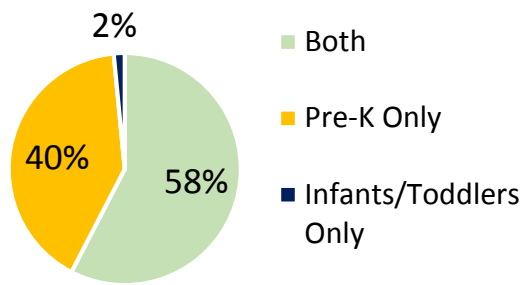
| <b>Table B.2. Distribution of provider QRS rating among centers who responded to the survey</b> |                |                 |               |
|---|----------------|-----------------|---------------|
|   | Possible Sites | Responded Sites | Response Rate |
| <b>QRS Level 1</b>  | 23             | 15              | 65%           |
| <b>QRS Level 2</b>  | 61             | 28              | 46%           |
| <b>QRS Level 3</b>  | 78             | 29              | 37%           |
| <b>QRS Level 4</b>  | 255            | 140             | 55%           |
| <b>QRS Level 5</b>  | 85             | 49              | 58%           |
| <b>Non-QRS</b>  | 718            | 330             | 46%           |

**Figure B.1. Provider response by county**



Programs responded in 93 of 99 Iowa counties (missing counties represented with red dots)

**Figure B.2. Distribution of service type by centers who responded to the survey**



Of the 526 respondents who answered the enrollment question:

- 311 (59%) report having infants and toddlers currently enrolled
- 518 (98%) report having preschoolers (ages 3-5) currently enrolled

### Findings

Findings relating to waiting lists, QRS, partnerships and collaborations, provider capacity and facility challenges, provider staffing, and distribution of Iowa early learning standards – third edition, and providers’ knowledge and perspectives on CCA were summarized below.

### Waiting Lists

Table B.3. shows information collected from the survey of Child Care Center Providers during April-May 2019. Some providers did not answer questions about enrollment or waiting lists, these notes are indicated under the table.

**Table B.3. Waiting lists**

|  | Infant/Toddler | Preschool |
|--|----------------|-----------|
| Number of programs reporting current enrollment information                  | 311            | 518       |
| Percent of programs that reported children on a waitlist <sup>a</sup>        | 78%            | 49%       |
| Waitlist as a percentage of current enrollment <sup>b</sup>                  | 77%            | 40%       |
| Centers with waitlist that are not enrolled at license capacity <sup>c</sup> | 57%            | 60%       |

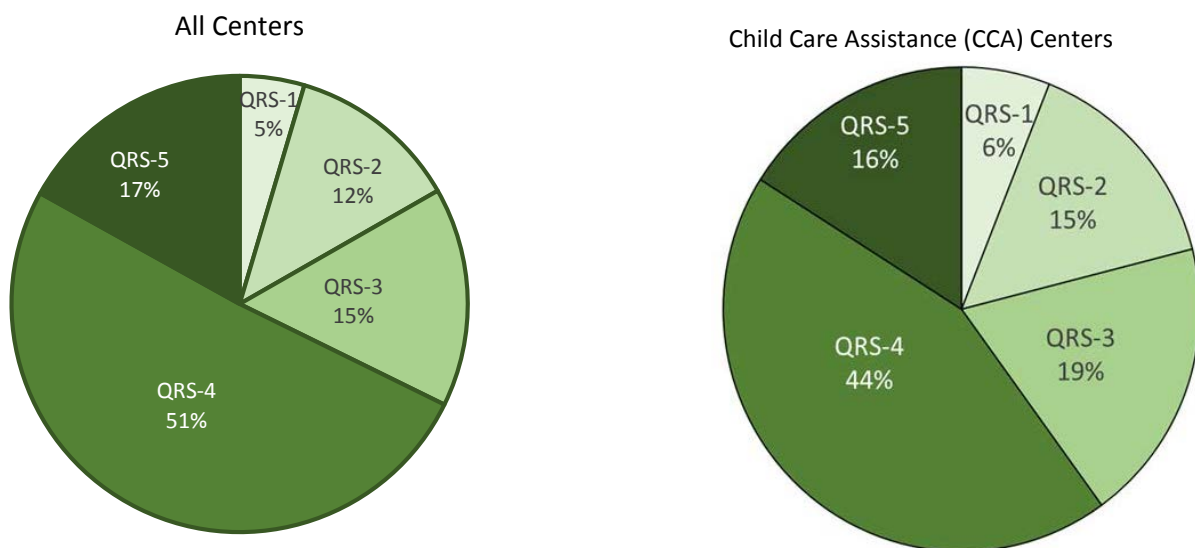
*Notes:* Waitlists were significantly longer in urban areas compared to rural areas (93% vs. 61% for Infant/Toddler providers; 48% vs. 31% for preschool-aged providers). <sup>a</sup>Number of programs reporting children on waitlist who answered question (for Infant/Toddler n=231 of 296; and Preschool n=240 of 492). <sup>b</sup>Average percentage for those centers with a waitlist for that age group. <sup>c</sup>Percentage of centers who reported children on a waitlist and reported that their current enrollment is less than their licensed capacity (for Infant/Toddler n=131/231; for Preschool n=142/238).



## Quality Rating System

Due to the nature and scope of the survey, data regarding quality was limited to asking whether centers participated in the state quality rating system (QRS), and if not, why they did not participate. Responses were combined with administrative data about the current QRS levels of centers. Where available, administrative data was chosen over self-reported data. We further explored characteristics of centers who participated in the QRS. Administrative data identifies 502 centers (41% of licensed centers) with current QRS ratings. Of respondents, 303 (57%) identified as participating in the QRS. Figure B.3. depicts the QRS scores of all participating centers and of those participating centers who accept CCA. Findings suggest that centers that accept CCA have relatively lower QRS ratings compared to the overall QRS ratings of all centers. 44% of respondents reported that they did not participate in the QRS.

**Figure B.3. QRS ratings for all centers (n=502) and for those centers that accept Child Care Assistance ([CCA], n=348)**

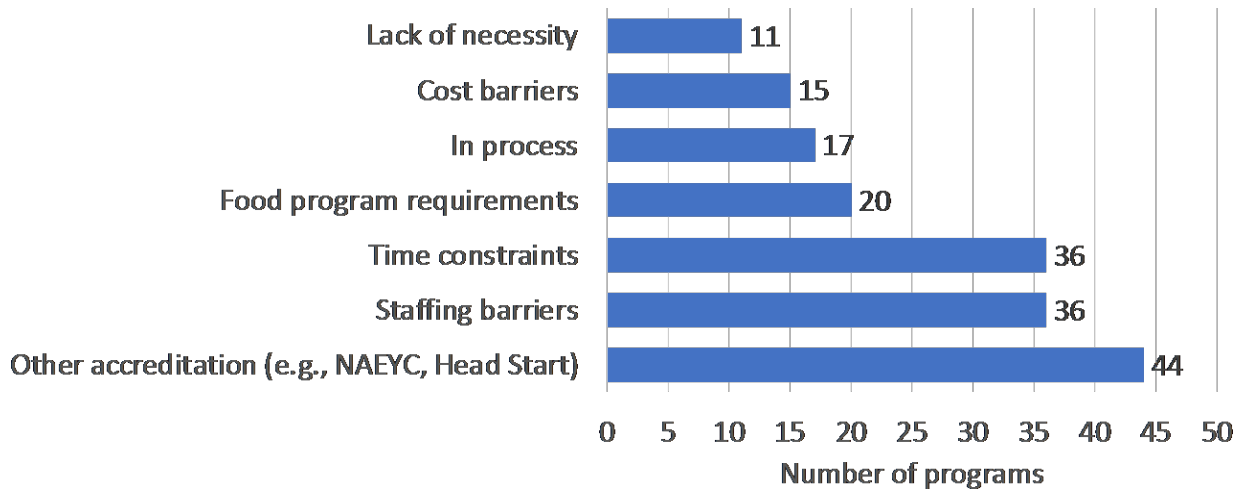


*Notes:* These QRS data were provided in DHS administrative data records of licensed center-based child care providers, not from the Provider Survey data.

The provider survey then asked providers why they do not participate in QRS. Figure B.4. shows some of the reasons respondents gave for not participating in QRS.

**Figure B.4. Reasons for not participating in QRS**

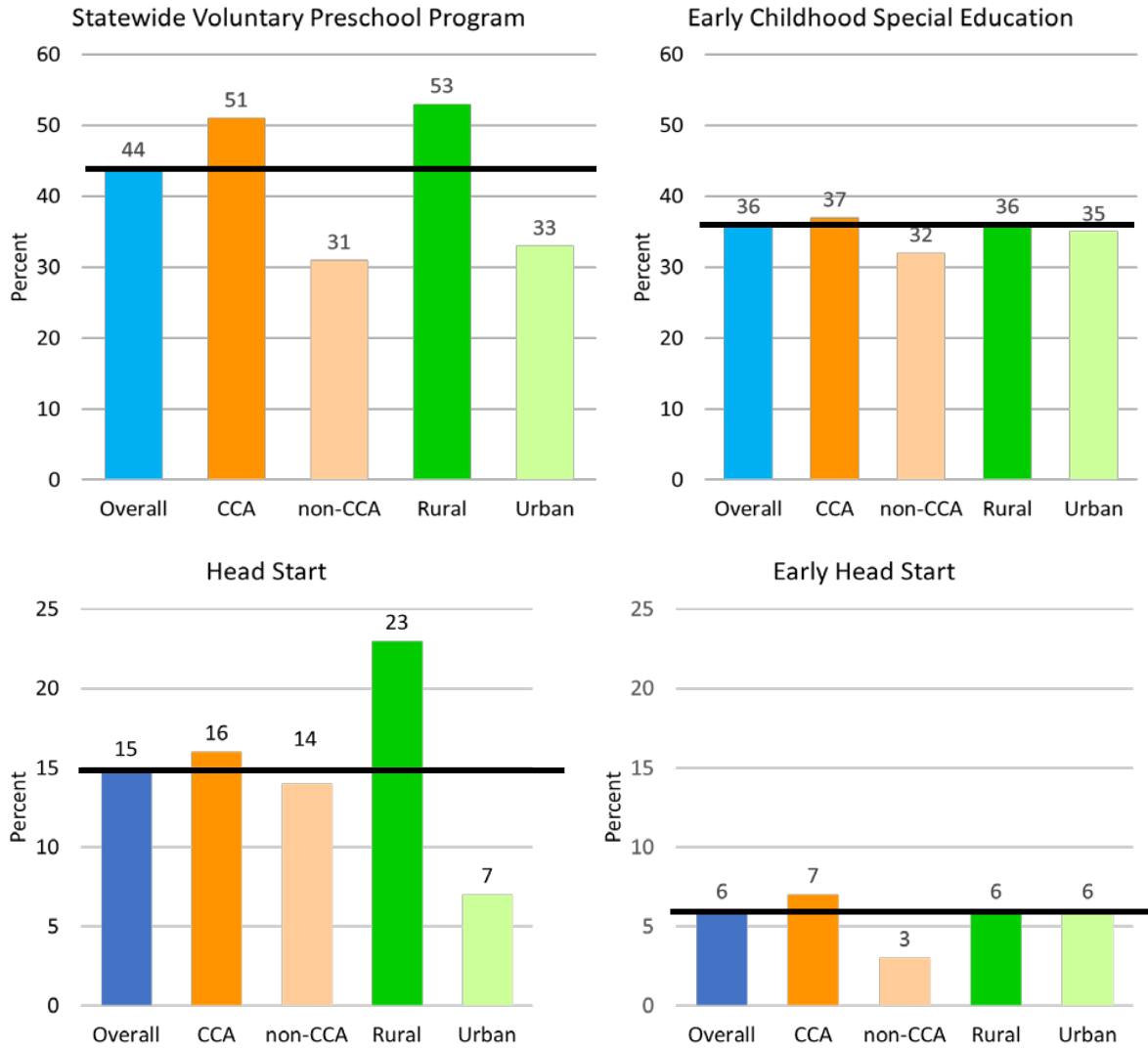
*Centers who do not participate in QRS (n=261; or 44% of respondents)*



### **Partnerships and Collaborations**

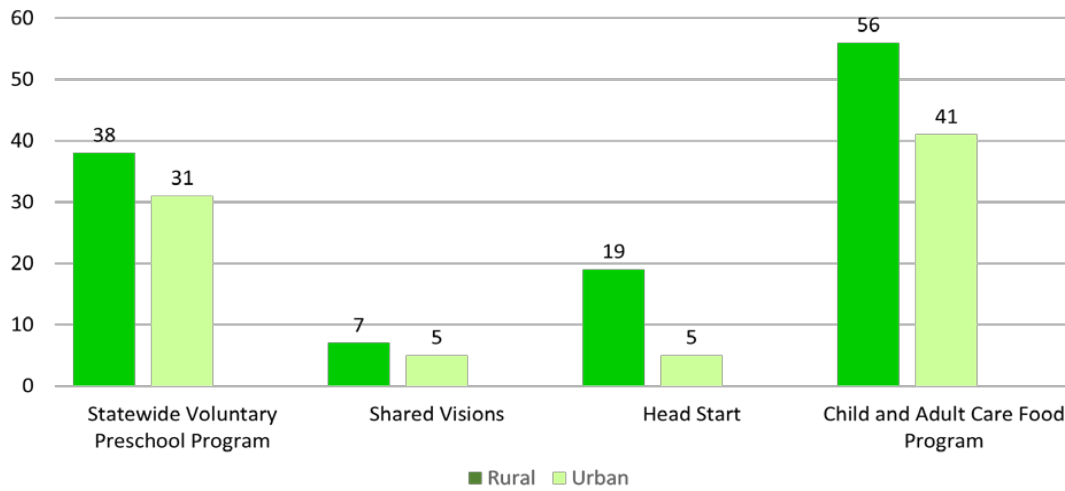
Centers reported on whether or not they served children who were also served in other programs (Figure B.5.). They also reported on what working partnerships they have (Figure B.6.). These partnerships are relationships that involve shared resources, which could include shared space or staff, or other financial relationships that contribute to program operations or participation in programs that are fully embedded within the center program (e.g., CACFP). Results in this section are also presented by centers located in rural counties versus urban counties. Iowa’s 88 rural counties were identified with rurality defined as census block groups that have a population density of 1,000 people per square mile (US Census Bureau; Woods & Poole; 2017).

**Figure B.5. Provider report of other programs in which their children participate**



Notes: Bold black lines in each figure represent the average percentage of centers across the entire sample (n=591).

**Figure B.6. Provider reported partnerships with other programs (e.g., shared space, staff)**

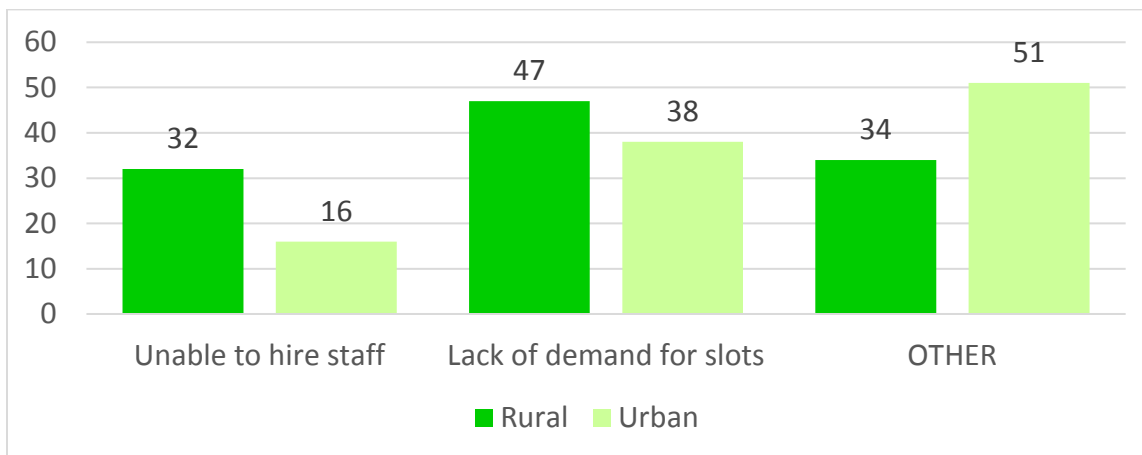


Notes: Provider Survey responses based on sample of 591 centers.

**Provider Capacity and Facility Challenges**

Provider Survey results indicated that 57% of centers report that their enrollment is lower than their full licensed capacity. Several reasons were cited, with the most frequently reported that they are unable to hire staff (24%), there is a lack of demand for additional slots (44%), or other reasons (41%; see Table B.5. for more details). Significant differences existed, however, between rural and urban centers and those that accept CCA compared with those that do not.

**Table B.4. Percentages showing frequently cited reasons for enrollment below capacity**



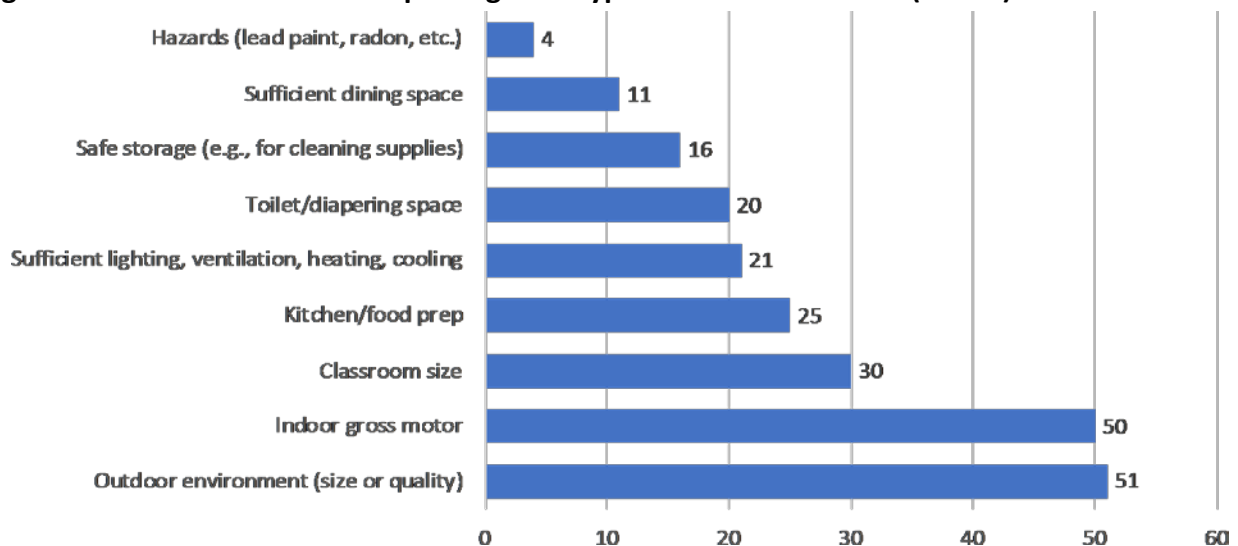
Notes: The 334 centers that indicated their enrollment was below licensed capacity then received a question about why. Percentages for rural centers were calculated based on n=172 rural centers who indicated their enrollment was below capacity, urban was based on the n=154 who indicated the same.

**Table B.5. Additional reasons for enrollment below capacity**

|  | Number of centers |
|--|-------------------|
| Quality considerations                   | 42                |
| Program/accreditation requirements       | 30                |
| Not enough demand currently              | 13                |
| Family/special population considerations | 9                 |
| Unable to hire enough staff              | 6                 |
| Space to accommodate transitions         | 5                 |
| Facility barriers                        | 5                 |
| Partnerships                             | 4                 |
| Not full day                             | 2                 |
| Funding requirements                     | 1                 |
| Lack of sufficient CCA/Scholarships      | 1                 |

Providers were also asked to identify concerns they have regarding their current facilities (see Figure B.7.). Approximately half of the survey respondents did not answer the question, which may or may not indicate that they do not have concerns related to facilities.

**Figure B.7. Percent of centers reporting each type of facilities concern (n=240)**



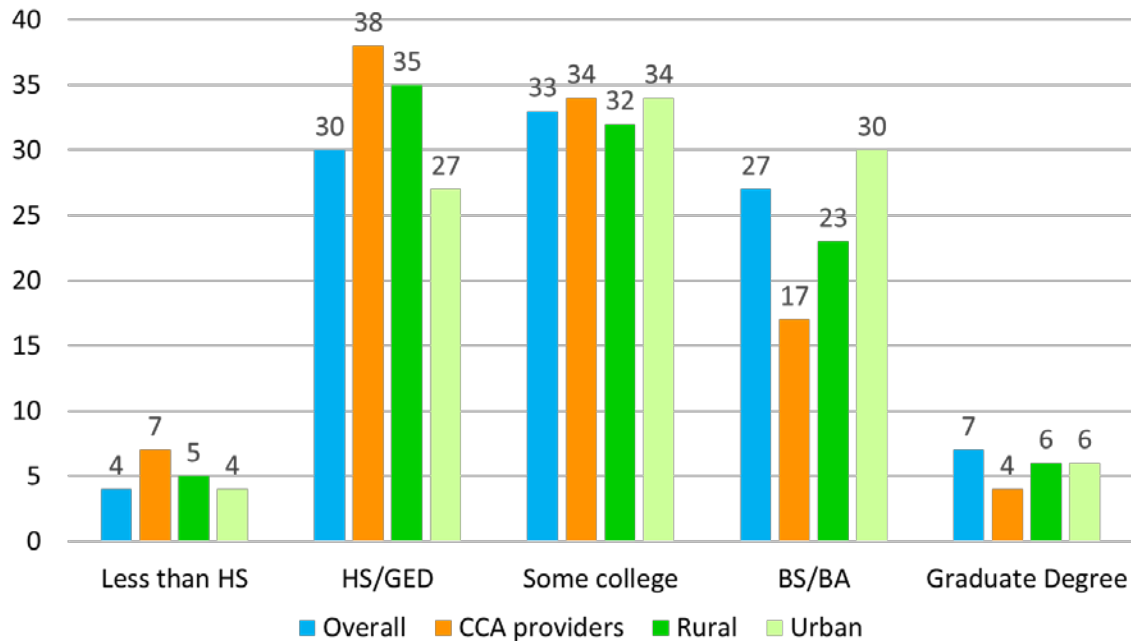
Notes: 240 of the 591 survey respondents indicated one or more concerns.

### **Provider Staffing**

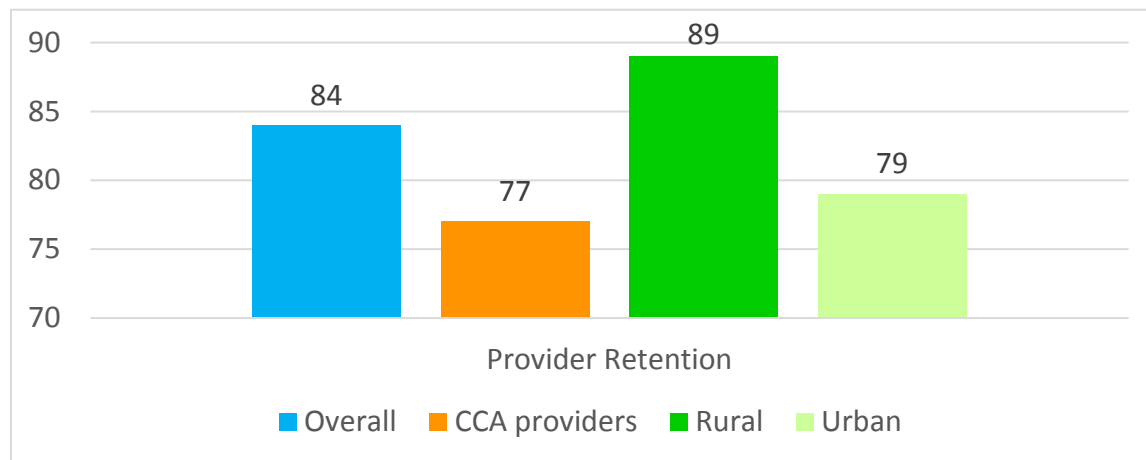
Providers were asked to report about the staff at their centers (see Figure B.8). Rural providers identified staff as primarily having a high school degree and/or some college, whereas urban providers identified the majority of their staff having at least some college and 1/3 of staff having a bachelor’s degree or more. Centers who accept CCA reported a larger proportion of

staff with no college (45%) than average. CCA providers also retained a smaller proportion of teaching staff for 12 months or more than average. In terms of 12 month retention, rural centers were able to retain a higher proportion of staff (see Figure B.9.).

**Figure B.8. Provider education levels are different across programs (n=591)**



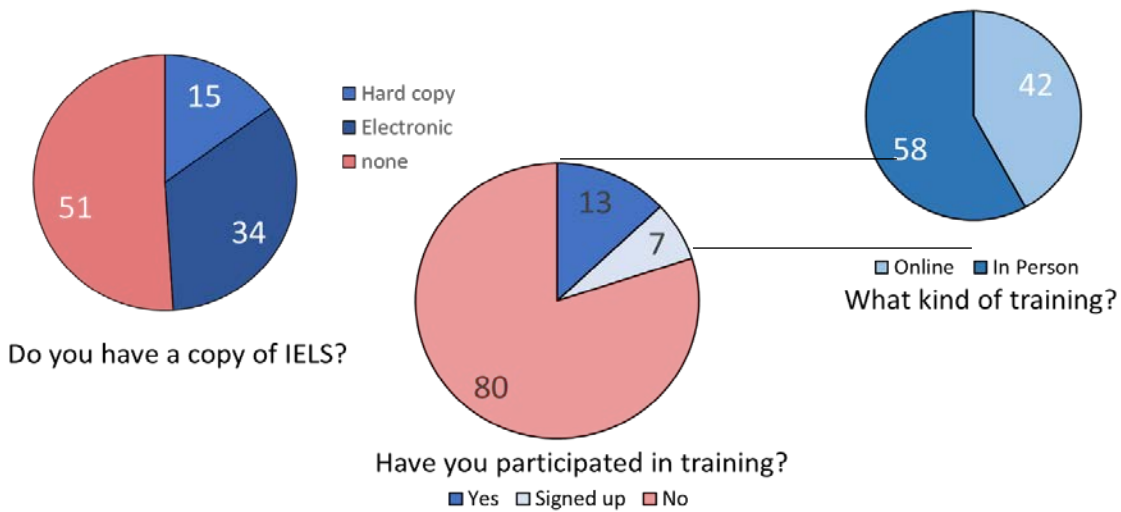
**Figure B.9. Retention: Percent of teachers retained for 12 months or more (n=591)**



***Distribution of Iowa Early Learning Standards – Third Edition***

During April – May, 2019, providers were asked to report on their interactions with the updated early learning standards. Given the emphasis during this time (and subsequent) with the sharing and training of Iowa Early Learning Standards (IELS) statewide, these numbers may have shifted since the collection of these survey data.

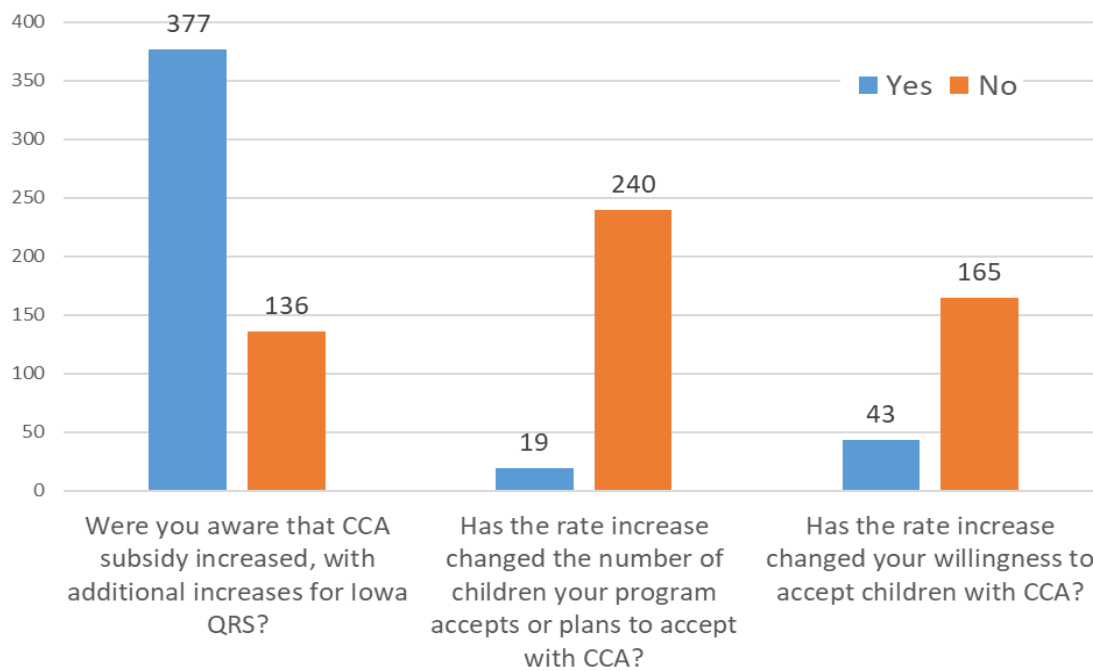
**Figure B.10. Distribution of Iowa Early Learning Standards (IELS) - Third Edition (n=591)**



### Child Care Assistance (CCA)

The survey asked if providers were aware of the recent increase in CCA subsidy rates, and 73% indicated that they were. Of those that were aware, subsequent questions asked if this knowledge changed their willingness to accept children with CCA and/or changed the number of children they were willing to accept. Results are presented in Figure B.11.

**Figure B.11. Providers' knowledge and perspectives on CCA**



*Notes:* All respondents (n=591) were asked about their awareness of CCA changes, 513 responded. Respondents were then asked if the number of children with CCA they are willing to take has changed, if already accepting CCA (n=259), or if their willingness to take children with CCA has changed, if not already accepting CCA (n=208).

### **Acknowledgements**

Content for this survey was developed by the ECI Steering Committee and PDG Core Team. Technical support for the online distribution and collection of data was provided by the ISU Extension and Outreach team. Recruitment of families was conducted through ECI networks, including local boards, Stakeholders Alliance, and the ECI website and list serve distributions. Data analysis and reporting from this survey was led by the ISU HDFS Team, including faculty Cassandra Dorius and Heather Rouse, and research assistants Quentin Riser, Maya Bartel, Jessica Bruning, Seulki Ku, and Allison Gress. Additional analysis and report support was provided from the ISU Extension and Outreach team led by Gary Taylor.

### **Summary**

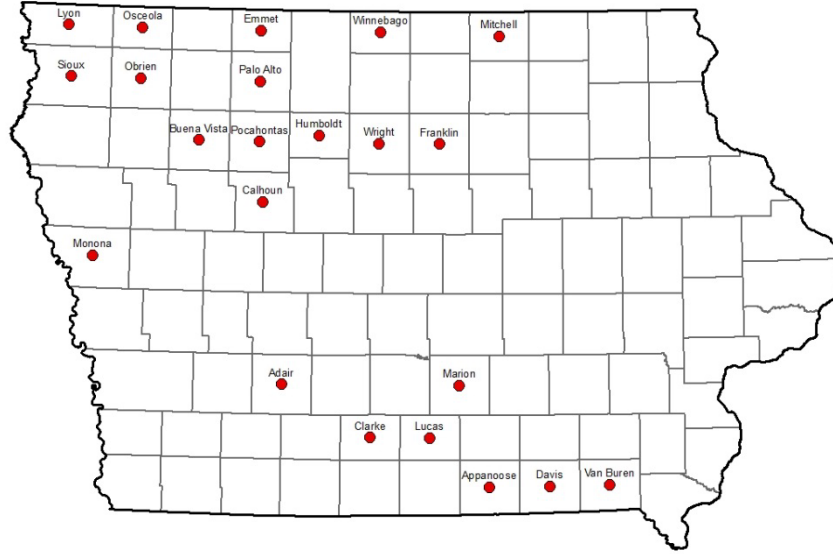
A survey to solicit family input on Iowa's birth-to-five system was designed by the ECI PDG Core Team and members of the ECI Steering Committee. This was a statewide, online survey sent to families through ECI networks and open to any Iowa family with experience with birth-to-five state programs. The purpose of the survey was to understand how families learn about birth-to-five services, experiences families have with programs, and barriers families may encounter when accessing programs and services. The survey included questions asking demographic information, experience of using services in times of crisis and early childhood education services/programs, and barriers to access and use of services. A snowball technique was utilized in the data gathering. It was distributed by ECI Area Directors via email from May through June 2019. The family survey respondents included 546 families with young children in Iowa. Participants were from 185 different cities in Iowa and represent 77 of Iowa's 99 counties (79%; see Figure C.1.).

### **Descriptions of Respondents**

Families that completed the survey were slightly more advantaged than typical Iowa families and overrepresented families that had children with disabilities. Table C.1. presents information about the sample compared to the full birth-to-kindergarten cohort used for the IDS analyses in this report. As shown in Table C.1., 95% of the respondents were female. Respondents tended to be married, non-Hispanic white mothers with young families who had at least some college and worked full- or part-time. The majority of the respondents were white (94%), 3% were Hispanic, and 2% were black. 16% of them were single parents and 3% attained education less than high school (HS). The average annual household income was \$50,000 or greater, though nearly half of respondents reported incomes of less than 200% the Federal Poverty Level (FPL) (which is approximately \$50,000 for a family of 4 in 2017). 62% of the respondents worked full-time, 15% worked part-time, 14% were stay-at-home parents, 6% were students, and 3% were unemployed. 71% of the respondents were the biological parents of the children in their household, 16% were legal guardians, 4% were adoptive parents, and 4% were grandparents or foster parents.



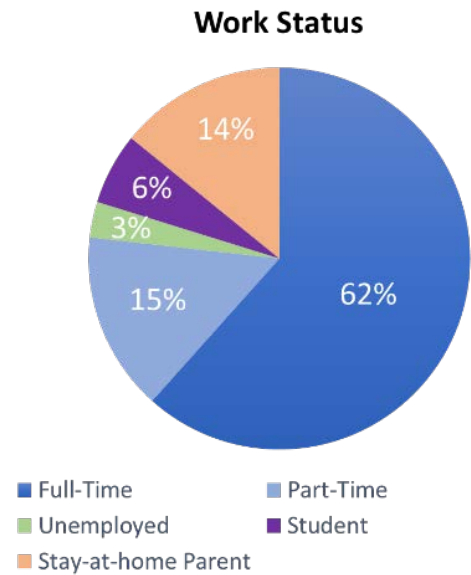
**Figure C.1. Counties not represented in the survey**



**Table C.1 Characteristics of family survey respondents**

|                            | Sample | Iowa families<br>0 - 5 |
|----------------------------|--------|------------------------|
| Female                     | 95%    | n/a                    |
| White                      | 94%    | 77%                    |
| Hispanic                   | 3%     | 10%                    |
| Black                      | 2%     | 5%                     |
| Single parent              | 16%    | 33%                    |
| < HS Education             | 3%     | 10%                    |
| < 200% FPL (i.e., < \$50k) | 45%    | 41%                    |
| Child with disabilities    | 20%    | 5-6%                   |

Notes: 2017 estimate of 200% FPL for a family of 4 is \$50,000.



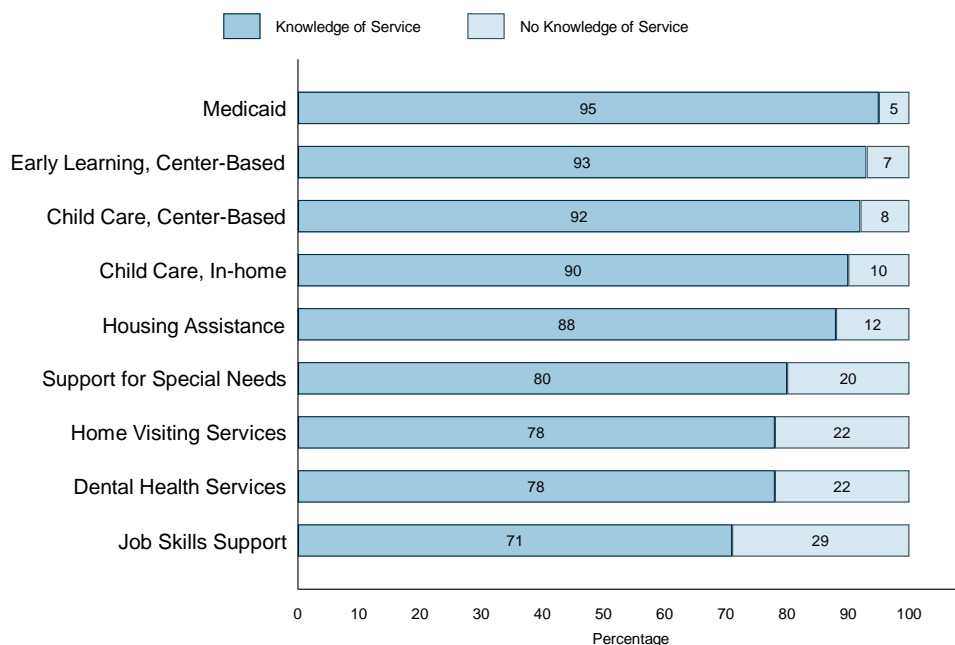
## Findings

Families provided rich information about their knowledge of services, experiences with service quality, and also barriers with service use. The following summaries provide information about overall responses across the survey respondents, as well as differences that were found for families relative to income or education, minority status, or rurality.

### Family Knowledge of and Access to Information

Figures below present families' knowledge of and access to information about services. First, the survey asked families to **“indicate whether or not you know about each of the early childhood services listed,”** and findings indicated that knowledge of early childhood services was widespread. As presented in Figure C.2., among the 9 early childhood services mentioned, Medicaid (or Hawk-i) was the most known service (95%), followed by Early Learning (93%; such as Head Start & preschool) and center-based child care (92%), in-home child care (90%).

**Figure C.2. Family knowledge of birth-to-five services**



SOURCE: ECI Family Survey, May-June 2019.

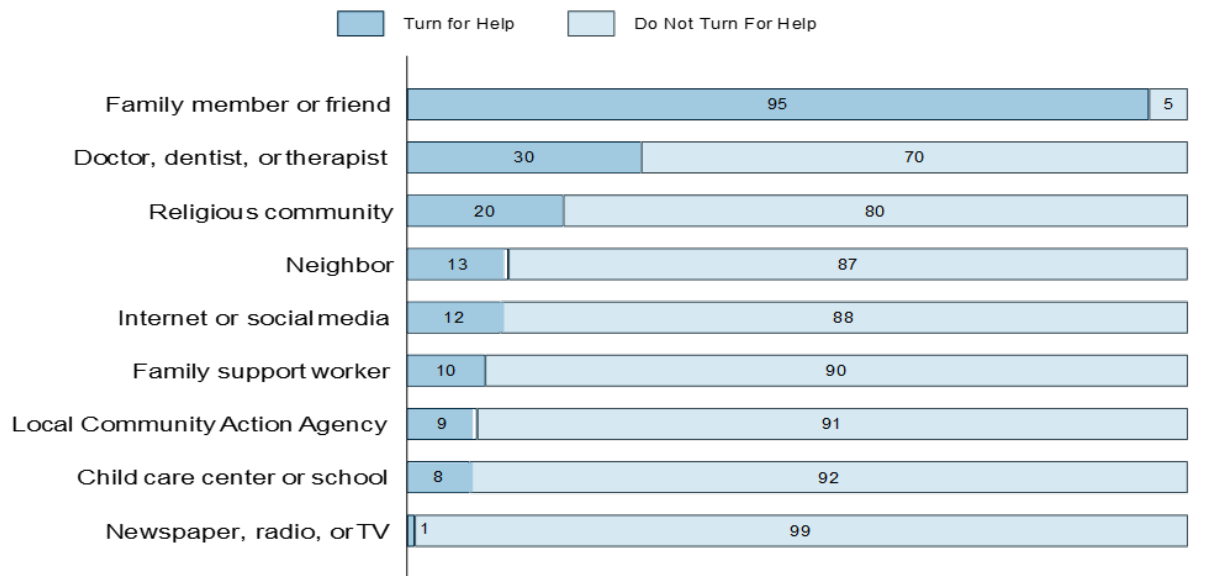
While Medicaid (or Hawk-i) and Early Learning were the two most known services regardless of rurality of the residences, economic disadvantage, education and Hispanic origin, some subgroup differences were identified.

- 59% of the respondents from rural areas knew of job skills support, while 73% of those from urban areas did.
- Low-income families reported lower percentages of knowledge across all types except job skills support (range 2-15% differences).

- Respondents with less than a high school degree reported lower percentages of knowledge across all types except job skills support (range 3-28% differences).
- Dental health services was the least known service to Hispanic/Latino families, with only 25% of Hispanic/Latino respondents knowing about this service. It was also the least known service for those who had lower education [below high school (43%)].

Figure C.3. presents the percentage of families who responded “yes” to each type of support in response to the question, “**When you or your family experience a crisis, where do you turn for help?**” Families were allowed to indicate as many responses that applied. Findings indicate that the largest percentage of families said they would turn to a family member or friend (95%). The second most frequent resource was a doctor, dentist or therapist. The least used resource in times of crisis was the newspaper, radio or TV. The trend is the same regardless of demography.

**Figure C.3. Family resources in times of crisis**



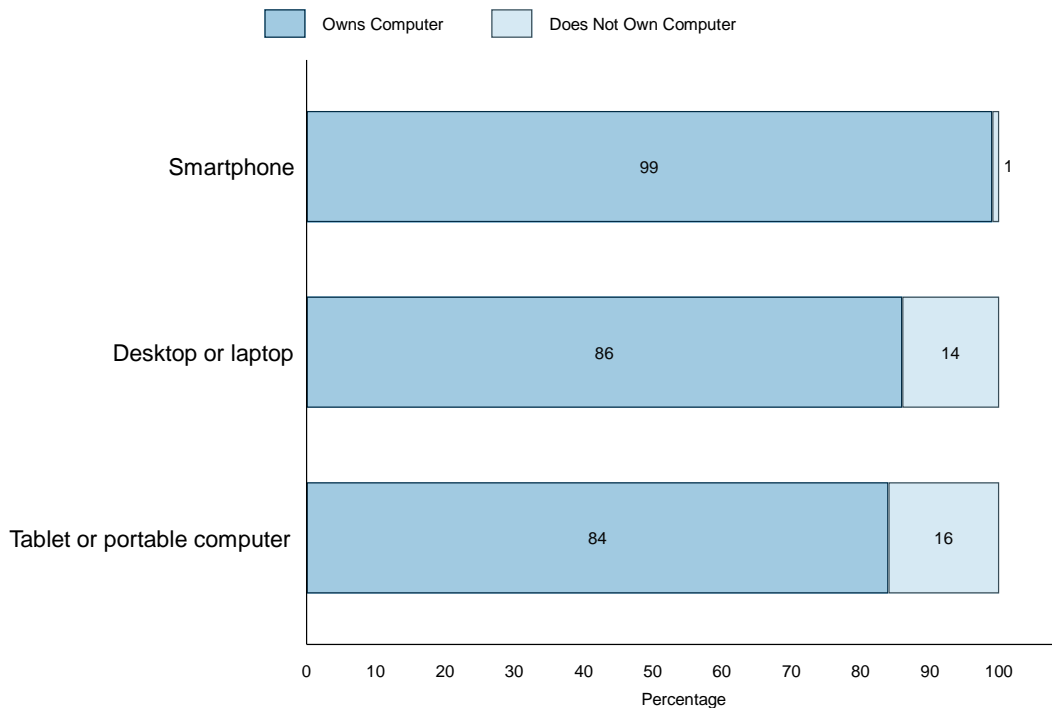
Notes: This chart reports the percent of all families that indicated each type (out of 546 families).

There were differences in subgroups related to the types of supports they turn to in crisis.

- Low-income families tended to use family support worker and local community action agency more than high-income families (range of 14-17% difference).
- Low-income families (37%) ask for help more often from doctors, dentists, or therapists, compared to higher-income families (27%).

Figure C.4. indicates responses to the question, “**do you or anyone who lives in your house own the following types of computer?**” Findings suggest that families have widespread access to computers. Smartphone was the most common type of computer (97% to 100%) with 100 % of the Hispanic/Latino or Spanish origin owning a smartphone. 95% of those with high income (\$50,000 + per year) have desktop or laptop. 84% of the total respondents have tablet or portable computer.

**Figure C.4. Family access to computers**



SOURCE: ECI Family Survey, May-June 2019.

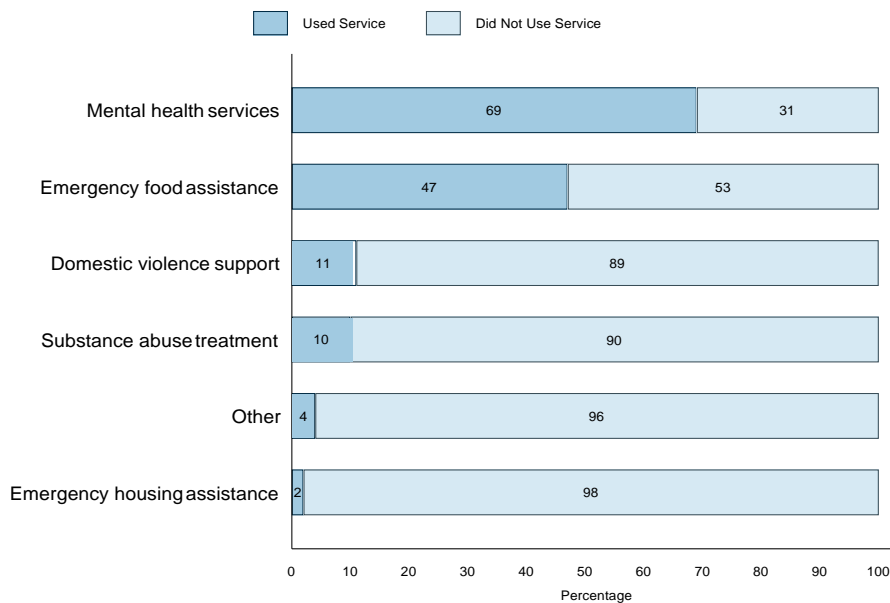
Findings indicated differences in access to computers by relevant subgroups:

- Low-income families reported lower percentages of access to all types (range in differences between 2-20%).
- Respondents with low education (i.e., less than a high school degree) reported lower percentages of access to all types than those with high education (i.e., at least a high school degree).
  - A gap for the use of smartphones was small: 97% of the respondents with low education had smartphones and similarly, 99% of those with high education did.
  - 58% of the respondents with low education had a tablet or a portable computer, whereas 88% of those with high school education did.
  - The gap was greatest for desktops/laptops: 51% of the respondents with low education had a desktop or a laptop, while 92% of those with high education did.

## Family Experiences with Programs

Families were asked, “*have you or your family ever used the following services?*” Figure C.4. includes the percent of all families that indicated each type, and suggests a range of service use across types with 69% of families reported having used mental health services, 10% used substance abuse treatment, and 9% used emergency housing assistance.

**Figure C.5. Family use of services**



SOURCE : ECI Family Survey, May-June 2019.

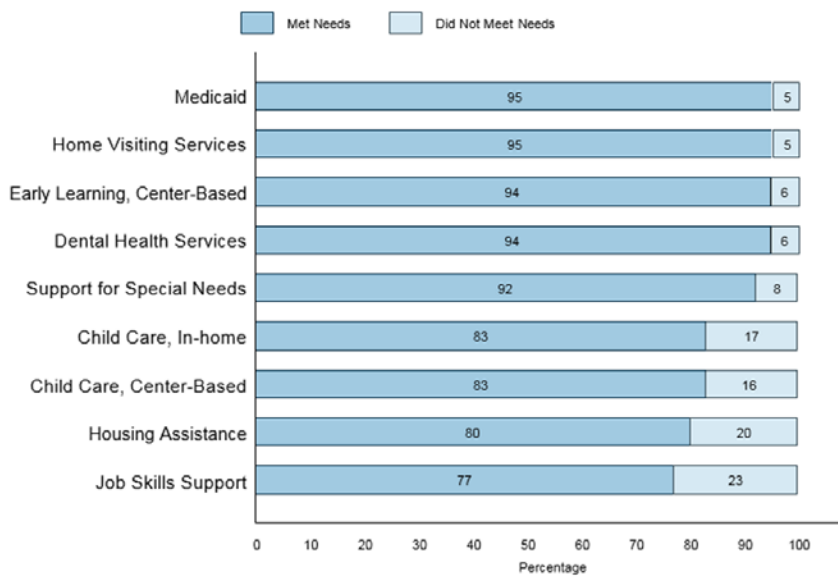
Findings by relevant subgroups revealed differences in family reports of knowledge.

- Families from rural areas showed lower percentage of using mental health services (60%), than those from urban areas (72%).
- 65% of the low-income families used mental health services, while 79% of the high-income ones did.
- Respondents with less than a high school degree (58%) used mental health services less than those with at least a high school degree (73%).
- 14% of the low-income respondents used emergency housing assistance, while 4% of the high-income ones did.
- 66% of the low-income families and 19% the high-income ones used emergency food assistance.
- Among respondents with less than a high school degree, 83% of them used emergency food assistance, and 39% of those with at least a high school degree used that service.
- Regarding emergency housing assistance, 27% of the respondents below a high school degree used that service, while 6% of those with above a high school degree did.
- Hispanic families used all types of services less than non-Hispanic families (range of 9-68% difference). In particular, 3% of the Hispanic families used emergency food

assistance, while 46% of non-Hispanic families did. Also, 1% of the Hispanic families reported using mental health services but 69% of non-Hispanics used that service.

Respondents were also asked to “*indicate whether the following services met your needs*” and responses were limited to those who had previously indicated that they utilized the service. Findings are presented in Figure C.6. indicating that most families felt that their needs were met when they utilized the early childhood services or programs. The most useful services indicated were Medicaid or Hawk-i and Home Visiting services (95% respectively). It was followed by Dental Health Service and Early Learning, Center-Based service (94% respectively), Child care center-based and in-home (83%), housing assistance (80%) and lastly, job skills support (77%).

**Figure C.6. Percent of families reporting that services met their needs, by type of service**



SOURCE: ECI Family Survey, May-June 2019.

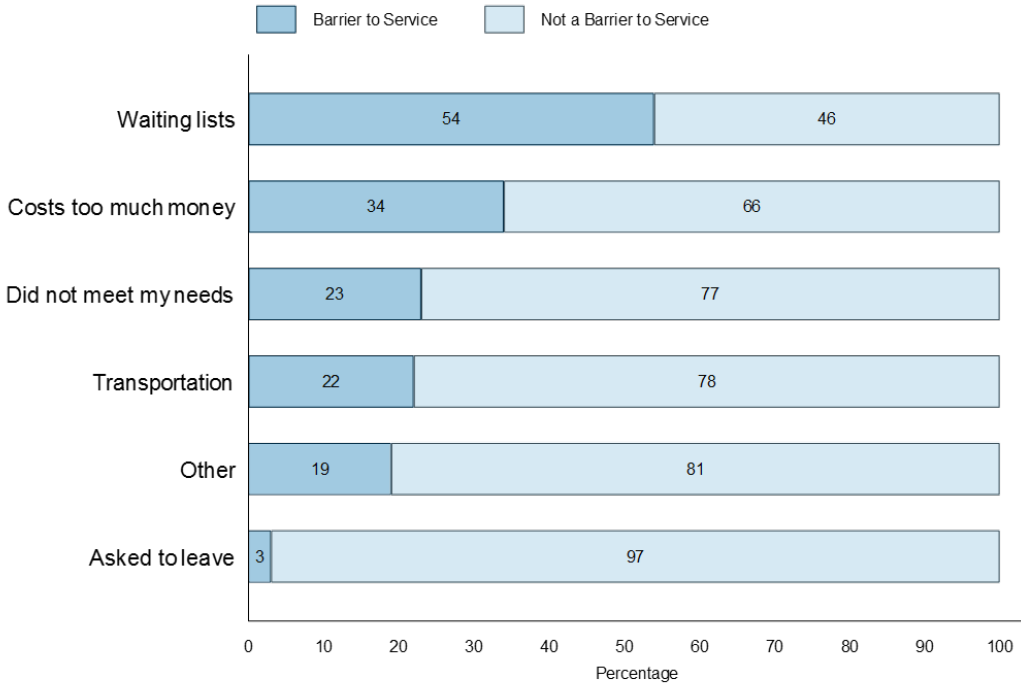
Findings indicated some subgroup differences in how families felt services met their needs.

- Rural respondents reported higher rates for housing assistance and job skills than urban respondents (range 11-13% differences).
- 83% of the rural respondents reported support for special needs met their needs, while 94% of the urban respondents indicated support for special needs met their needs.
- 78% of the low-income respondents reported housing assistance met their needs; however, all of the high-income respondents indicated housing met their needs.
- 80% of the low-income respondents reported job skills support met their needs, while 67% of the high-income respondents indicated job skills support met their needs.
- 26% of the respondents with less than a high school degree reported that job skills support met their needs but 77% of those with at least a high school degree indicated job skills met their need.

## Barriers to Service Use

Families were asked to respond to **“what has made it difficult for you to use services designed for families like yours?”** and findings are presented in Figure C.7. Families were allowed to select all answers that apply for this question and many families selected more than one. Among the respondents, 54% reported waiting list was a barrier and 34% reported that cost of services was a barrier.

**Figure C.7. Family reported barriers to service use**



SOURCE : ECI Family Survey, May-June 2019.

Findings by relevant subgroups revealed differences in family reports of barriers.

- A higher percentage of respondents from urban areas reported waiting lists and cost were significant barriers, compared to those in rural areas (range 14-21% differences).
- Transportation was a significantly greater problem for low-income families (29%) compared to higher-income families (12%).
- Transportation was also a greater problem for families with lower education levels (43%) compared to higher education levels (16%).

## Family Survey Quotes

Participants were also asked to provide open-ended feedback about their experiences with birth-to-five services with the question: ***“Please provide any further details you would like to share about finding information on services or programs, barriers to using services, and/or changes you would like to make to the service or program?”*** Several themes emerged from these responses: a) barriers to using services; b) access/waiting lists; c) cost of care; c) transportation, services used; d) children with disabilities; e) positive experiences of using the services; and f) challenging experiences of using the services. Below are sample quotes corresponding to each of these themes.

### Barriers to using services

- *“Cost is number one issue. My wife had to quit her job because we couldn't afford daycare. We supposedly don't qualify, but no one checks your debt status. With payments going out, we are barely surviving.”*
- *“Cost of child care and preschool is too prohibitive, especially for families with multiple children. Even though statewide preschool is available, there were not enough spaces and paying for wrap around child care is difficult anyway. Transportation is impossible to secure if needing preschool in a different district or trying to transport to a different child care provider.”*
- *“I can't get transportation to preschool during the day from daycare. My 4-year-old goes to a center and I want her in public preschool, but since it is only 3 hours per day I have no way to get her there and back to the center as I work full time. All day preschool doesn't cover a full work day, and I can't afford all day AND wrap around care.”*
- *“For SNAP and Medicaid, administrative barriers. Our family was going through an enormous amount of stress and having to fill out lengthy approval and re-approval forms every 6 months, by a deadline or lose benefits, added significantly to our stress.”*
- *“Difficult to find child care that meets the hours I need in this town. If I work a factory job there is not day care available for non-traditional hours.”*
- *“The people at some organizations make you feel worthless for needing the help and rude. It would be nice if Early Head Start programs actually called you back or responded to you about your application. When these programs, centers, or in home providers don't respond to you it makes it harder for moms who are on maternity leave to return back to work. They are already on limited income and when they can't return due to being unable to find a provider, it makes their postpartum depression even worse. They think that they are unable to provide for their family and how are they going to take care of their children when they can't return because they can't find provider. Also the prices of not only their child going there but also the registration fee make it even harder.”*
- *“Finding child care for an infant is impossible in my area. I had to settle for a center I was not comfortable with, but needed to return to work.”*
- *“There is not enough childcare providers for children with special needs. Not enough educated or well-rounded child care providers who deal with those children. Whether it's in home or center based. My daughter has Autism and she's 11 years old and it was impossible to find care for her while I work. Childcare for special need kids is very difficult to come by. And most daycare car tees [sic] have no skills or knowledge regarding this. It would be nice to upskill them”*
- *“I am a student and have tried to get child care assistant [sic]. And keep getting turned down. I was working as a work study and another 3 hours -2 times per week and taking 2 classes and was denied. I was not making enough to live on my own so I am living at home with my parents.”*
- *“Finding childcare is nearly impossible and outrageously priced. My family does not qualify for assistance*



*but the huge cost puts an enormous financial strain on our family and in turn makes life stressful and causes anxiety in other areas.”*

### Access/waiting lists

- *“We have been on the list for the childcare center in town for our one-year-old for a year and a half and just found out we will not get in again this next year. We contacted 10 in home daycare providers and found none with openings. For my 3-year-old son, there was only one preschool program, Montessori, that allowed us to drop him off and get to work on time. It is crazy to me how difficult the childcare scene is to navigate in such a well off community!”*
- *“Center based childcare in our county is very limited and expensive. It is only available during daytime hours and the care received is sometimes not as high quality as a parent would hope. HUD is only available now if you can go to another county. If you can’t find transportation to the appointments you can’t apply and get accepted. There are also very few housing options for families because most landlords don’t meet or can’t afford to upgrade homes to meet the HUD requirements.”*
- *“There are not enough available childcare options for before and after school care in Ames”*
- *“There is a serious shortage of early child care providers and something needs to be done.”*
- *“It is really difficult to find quality childcare in the Waterloo area. Desired centers have years-long waiting lists. Head Start/Pre-K is even more difficult unless you know someone who knows the ropes. I feel like this could be much improved.”*
- *“The waiting lists for GOOD childcare in mason city [sic] are horrendous. I have been on a waiting list for 8 months to get my 2 children in the west town Charlie Brown center as my in home provider can no longer meet my needs as the school bus will not take them to her home because it is out of my school district. Child care is impossible to find here.”*
- *“The options for licensed daycare centers is extremely limited. We moved about 9 months ago, and the most stressful part was finding new childcare for my son. The options for licensed daycare centers is extremely limited.”*
- *"More family-friendly hours. Many services are only available during the day, which makes it difficult for working families to access. I dropped out of Nurse Family Partnership because my home visitor would not schedule visits outside of my work hours. Also, my kids are covered by Medicaid but they have frequently been dropped for various reasons (including computer glitches). It takes a lot of work to re-apply and that creates a gap in services. My employer does not offer health insurance. My husband's does, but we cannot afford to pay the premiums."*
- *“Finding child care was a huge problem. We moved to Ames with a 1 and 3-year-old, and were not able to find a quality provider with open slots. We were on waiting lists for multiple years, had to hire our own private nanny as “back up” because we had no other options (that met minimal quality standards -which the only ones open did not, in my opinion), and basically had to “wait it out”; until our kids were old enough to enter preschool & kindergarten. We are a dual professional family, with significant expertise in the early childhood field in particular, and were not able to access the care we needed (In Ames, of all places, this was very surprising).”*
- *“When we first moved to the area, we were faced with no childcare available in Iowa Falls that was financially feasible, the childcare center was open at that time but for both children it would have cost \$1200 a month for full time care. We had to drive 18 miles for childcare each way until a new provider opened up in Iowa Falls. And this provider is now full as well, so I worry about new families and new childcare needs as there are no current providers with openings that are in town.”*
- *“Looking for child care is hard to find even if you are willing to travel to a larger community for care.”*

## Cost of care

- *“Cost is number one issue. My wife had to quit her job because we couldn't afford daycare. We supposedly don't qualify, but no one checks your debt status. With payments going out, we are barely surviving.”*
- *“Finding childcare is nearly impossible and outrageously priced. My family does not qualify for assistance but the huge cost puts an enormous financial strain on our family and in turn makes life stressful and causes anxiety in other areas.”*
- *“Cost of child care and preschool is too prohibitive, especially for families with multiple children. Even though statewide preschool is available, there were not enough spaces and paying for wrap around child care is difficult anyway. Transportation is impossible to secure if needing preschool in a different district or trying to transport to a different child care provider.”*
- *“I would like the early access program to open the child care centers for children from 6 weeks to school age. Most of families who their children receive a child care assistance from the state, they are having trouble to find the child care centers when needed. Because all the child care centers in our state are private and most of them don't accept the state pay. I'm a single mom and student, and have part-time job to help me pay my bills. I receive child care assistance from my state but I haven't used it yet because I couldn't find a child care centers that accept the state pay. If the early access program open the child care centers in Iowa City, and Coralville that will be helpful for the families and whole communities. Thanks!”*
- *“Diapers are a problem. There are some non-profits that can provide diapers when they have them available, but there are no reliable formal sources for kids who go to daycare. Daycares don't want kids who come without diapers, but we could not always afford them. Also, we could not choose a quality program we were comfortable with because of cost. The programs we wanted did not accept CCA block grant.”*
- *“I am a Student and have tried to get child care assistant [sic]. And keep getting turned down. I was working as a work study and another 3 hours - 2 Times per week and taking 2 Classes and was denied. I was not making enough to live on my own so I am living at Home with my Parents Thank You”*

## Transportation

- *“Transportation is impossible to secure if needing preschool in a different district or trying to transport to a different child care provider.”*
- *“We had to drive 18 miles for childcare each way until a new provider opened up, and this provider is now full as well, so I worry about new families and new childcare needs as there are no current providers with openings that are in town.”*
- *“We live in [x] but for logistics reasons we do child care and preschool in [y]. My struggle is finding child care and then getting transportation to and from preschool/school. It's been very frustrating and I get why a lot of moms stay at home. Getting transportation is awful.”*
- *“Transportation is a huge barrier. Buses run every hour (too spaced out) and only go until 6pm. The buses also don't run on Sundays.”*
- *“I can't get transportation to preschool during the day from daycare. My 4-year-old goes to a center and I want her in public preschool, but since it is only 3 hours per day I have no way to get her there and back to the center as I work full time. All day preschool doesn't cover a full work day, and I can't afford all day AND wrap around care.”*
- *“Transportation is a major barrier to care.”*
- *“more opportunities for transportation from daycare to school would be great”*

- *“Being in a rural town, but 15 minutes from a very large town, I always have to drive 30 minutes to a place. I would like to see more expansion of pre-k -- The programs get full, and don’t work for parents who work. It’s nice to have programs for young kids, but it’s only helpful for the parents that don’t have a commitment during the day. I had to travel farther than preferred for consistent childcare; my rural town has very little in terms of in-home child care (no licensed- just folks babysitting) and it’s why I have to drive somewhere else for care. I don’t know what I will do for pre-k when I work, as universal pre-k is NOT offered at the state license daycare center my child goes to. Transportation with River Bend or by another person is not an option. Why can’t there be options for wraparound child care with pre-k or full day programs working parents could sign up for? I see great fun activities around the quad cities, but don’t forget things can occur on Saturday and Sunday too!!!”*
- *“Any services available for transportation help? Financial help? I’ve gotten one call and no questions answered”*

### Services used

- *“My family participates in a free home visitation program through the health department. I was hesitant to sign up for the program because I felt “over qualified” for the program. We do not struggle financially, my husband and I both have advanced degrees, and we can manage our stress well. I felt that by participating in the program I would be taking away a resource for a family who may need it more than I do. I wish there would be a way to eliminate the stigma of participating in these types of programs because no matter your income level, or no matter what your degree is in, being a first time mom is really hard. Like many other moms, I didn’t realize how much I was neglecting my own needs until this program.”*
- *“I have used Child Care Resource and Referral to find child care placements for my kids for over a decade. It is very helpful!”*
- *“My home visitor helps me a lot with my child. And with other family stuff”*

### Children with disabilities

- *“There is not enough childcare providers for children with special needs. Not enough educated or well-rounded child care providers who deal with those children. Whether it’s in home or center based. My daughter has Autism and she’s 11 years old and it was impossible to find care for her while I work.”*
- *“There is a lack of understanding of autism in many programs, which has made it harder for my family to work with many programs. They are not equipped to handle some of the behavior and sensory problems that come with it. The services that are specifically for autism often have really long wait list or appointments are not available during times that are most convenient for our family so I have to basically re-arrange our whole life to accommodate them; this can often cause a lot of conflict between all family members.”*
- *“We have had an amazing experience with the Early Access program. All of the different specialists/therapists we have seen have been both personable and excellent in their professional skills and abilities.”*
- *“Like stated previously, it would be beneficial to my family and families like mine who would consider the unique situation of the family in terms of income. My daughter has disabilities and I am unable to work full time/ if at all. My husband “makes too much” because his income before taxes and child support is too high- yet that number is not what we have to provide for our family- we don't see even 3 quarters of his pay due to taxes and child support- how can I provide medical or food for my family with money we don't actually have? Also- the resource allotment is not realistic. My husband needs his car for work- and I need mine for appointments therefore we NEED 2. We cannot- not have two vehicles but we are punished because we have too many ‘resources’. FINALLY, I want to add that the system needs revamping- my sister who has 4 kids by 3 guys, no job, gets money from her rich mom and step-dad to pay what HUD doesn't cover (24 dollars of her \$450 rent) food stamps, and Medicaid for all of them-her included- she lives her life*

*mooching smokes, drugs (she has a record for meth), alcohol off of everyone else yet our taxes pay for her house food and medical- sounds fair right?"*

- *"I would like to know about more services to help with fixing up my house and vehicle. Something to help with finding activities for kids. And more help for people with disabilities"*
- *"Childcare for special needs kids is very difficult to come by. And most daycare car tess [sic] have no skills or knowledge regarding this. It would be nice to upskill them."*
- *"Attempted to contact Early ACCESS several times, no call back"*
- *"The daycare center we were at refused to utilize services to assist in our child's problem behaviors."*
- *"Some services do not want to take Title 19 clients."*
- *"It would be beneficial to my family and families like mine who would consider the unique situation of the family in terms of income. My daughter has disabilities and I am unable to work full time/ if at all.. "*

### Positive family responses about service use

- *"I used the Parents As Teachers (PAT) program and loved it. My child did age out."*
- *"The only program my family has used is the PAT program. I knew about this program because I used to be a PAT educator and my family entered the program as a client when I became pregnant. The program provides useful information, discussion, and activities; there isn't really anything I would like to change about it."*
- *"I have used Child Care Resource and Referral to find child care placements for my kids for over a decade. It is very helpful!"*
- *"I am thankful for the information provided by Child Care Resource and Referral in helping me find a daycare for my daughter. In being new to the area, I was unfamiliar with the daycare centers in my area. The list they provided with centers that had availability made it very easy for me to narrow my focus and I eventually enrolled in one of the centers on that list."*
- *"We have had an amazing experience with the Early Access program. All of the different specialists/therapists we have seen have been both personable and excellent in their professional skills and abilities."*
- *"Early Access has been wonderful and my son has made great progress."*
- *"We used AEA out of [x] and there staff was wonderful."*
- *"Love that FAMILY, Inc. has bilingual staff. Wish more programs did."*
- *"I wish Head Start was available to all children. The teachers and teacher aids are compassionate and always making the children feel important."*

### Challenging responses from families about service use

- *"The daycare center refused to utilize services to assist in our child's problem behaviors."*
- *"Child Care Assistance telling you, you have to work 28 hours in order to get childcare. But telling you, you make too much money working 28 hours. Head Start having not enough room for infants and toddlers. Section 8 having a closed waiting list for 6 months."*
- *"Most of families who their children receive a child care assistance from the state, they are having trouble to find the child care centers when needed. Because all the child care centers in our state are private and most of them don't accept the state pay. I'm a single mom and student, and have part-time job to help me pay my bills. I receive child care assistance from my state but I haven't used it yet because I couldn't find a child care centers that accept the state pay."*

- *“It would be nice if Early Head Start programs actually called you back or responded to you about your application. When [they] don't respond to you it makes it harder for moms who are on maternity leave to return back to work. They are already on limited income and when they can't return due to being unable to find a provider, it makes their postpartum depression even worse.”*

### Childcare availability impacts workforce

- *“Need childcare but no openings, so difficult to start a job when I can't get my child into childcare that is licensed.”*
- *“The licensed childcare centers in [X] make it difficult to afford having more than 2 children enrolled. I quit my job to take care of 2 small children because the cost of daycare for them both left little money left after my paychecks at a job I made 19/hr and 9 years. I would have loved to stay working but I didn't want to work to pay for daycare only.”*
- *“Cost is number one issue. My wife had to quit her job because we couldn't afford daycare. We supposedly don't qualify, but no one checks your debt status. With payments going out, we are barely surviving.”*
- *“When these programs, centers, or in-home providers don't respond to you it makes it harder for moms who are on maternity leave to return back to work. They are already on limited income and when they can't return due to being unable to find a provider, it makes their postpartum depression even worse. They think that they are unable to provide for their family and how are they going to take care of their children when they can't return because they can't find a provider.”*
- *“I run an in-home daycare first and second shift for parents working in the medical field. It's not easy [for me] to take time away from without people losing work hours.”*
- *“My struggle is finding child care and then getting transportation to and from preschool/school. It's been very frustrating and I get why a lot of moms stay at home. Getting transportation is awful.”*

### Acknowledgements

The ECI PDG Core Team and ISU Data and Analysis Team led the development of the focus group strategy, key questions, and facilitator guidelines.

Iowa State University Extension and Outreach (ISUEO) Community and Economic Development (CED) staff members developed the focus group process, scripts and other documents, and facilitated the groups. Jane Nolan Goeken, ISUEO community development specialist, and Gary Taylor, ISUEO CED director, led development of the focus group process and scripts. Focus groups were facilitated by Lynn Adams, Steve Adams, Eric Christianson, Jane Goeken, Himar Hernandez, Shelley Oltmans, Scott Timm and Ross Wilburn.

### Summary

To supplement learning from the ECI 2019 Needs Assessment surveys and IDS analytics, the PDG Core team requested family and provider feedback through focus groups across the state. From May to July, 2019, 12 family focus groups and 10 service provider focus groups were facilitated by ISUEO Community and Economic Development staff members. This report outlines key takeaways, themes, and processes from the 22 focus groups based on a review of focus group transcripts and facilitators' notes, as well as analysis of transcripts using NVivo software.

#### Primary themes from the family focus groups included:

1. Word of mouth is the main source of information about child care options and openings. DHS and social media were also listed.
2. Information about other kinds of services for children commonly comes from providers of services. Other parents are a secondary source of information.
3. Unmet needs identified by parents include mental health services, behavioral specialists, housing, transportation, and local healthcare specialists.
4. Concern was expressed about the availability of support services for low-income, working families who are just above the income cut-off lines for programs.

#### Primary themes identified from the provider focus groups included:

1. Need was identified for more access to early intervention mental health services for children and their families.
2. Service providers collaborate on referrals and professional development training when possible, but universal applications, forms and waivers are needed to reduce paperwork and make it easier and quicker for multiple agencies to serve children with multiple programs/services.
3. Budget issues have reduced services, programs and staffing levels, and have taken a toll on the morale of service providers.

Within themes, subcategories emerged related to strengths (i.e., collaboration, people, services, and safety), barriers (i.e., funding, training, time, and access), and suggestions for improvement (i.e., communication, processes, and funding).

### **Sampling**

ECI Area Directors organized the focus groups and recruited participants under the direction of the Department of Management. To ensure widespread and diverse input, focus groups were scheduled in all geographical regions of the state and reflected a diversity of program experience. Nine general family focus groups were facilitated, in addition to four groups comprised of traditionally under-represented groups: 1) parents of children with special needs; 2) Latino immigrant parents; 3) non-Latino immigrant parents; and 4) fathers. Most focus group participants were mothers, but foster parents and grandparents also participated. Participants in the service provider focus groups included home child care providers, child care center employees and directors, a former home child care provider, Head Start staff, county public health staff, Area Education Agency staff, and representatives of other programs that serve young children in Iowa.

Approximately 56 individuals participated in the focus groups; though the number varies based on whether attendance was taken at the beginning or end of the session as several parents came late or left early, and several immigrant parents declined to participate after learning that sessions were audio recorded. While quality input was received through the focus group assessments, the number of family focus group participants was smaller than desired. A few focus group organizers indicated it was difficult to contact parents and get commitments to attend focus groups in the summer (versus during the school year). Some parents indicated they would participate in a focus group, but did not follow through; for example, 9 parents of children with special needs indicated they would participate in a focus group via video conference, but only three actually joined the session. However, input from those three parents was excellent in that it addressed topics and services that were not mentioned during the other 11 family focus groups. A focus group scheduled in Atlantic was cancelled after no parents indicated they would attend.

Because of the number of participants, care should be taken to avoid making conclusions about all parents of young children in Iowa. However, the input provided during the family focus groups richly illuminated barriers and resources associated with early childhood services.

### **Analysis Method**

Each theme was analyzed from a statewide perspective using NVivo qualitative analysis software and includes a short analysis description with examples of quotes from the discussions. Following the statewide analysis, a location-specific analysis was conducted on each participating areas, illustrated by prominent quotes reflecting strengths, barriers, and suggestions. The subcategory in which the quote was organized is included with the quote.

## Findings

### **Access to Child Care Was the Most Significant Concern for Parents and Providers**

Access to child care services was the most significant problem cited by almost all parents and service providers. Some parents stated that issues with child care forced them to leave or lose jobs; and several said they were unable to take higher-paying jobs because child care during nontraditional hours is not available in their communities. Due to limited child care options, the issue of quality is often moot; many parents simply do not have or are unaware of alternatives from which to choose.

While parents and providers noted that child care is too expensive for many families (especially for families with more than one child), they also empathized with child care providers, acknowledging that one reason child care is scarce is that child care providers tend to leave the field due to poor compensation. This has played a role in the closure of child care centers in recent years. It also plays a role in child care providers' willingness and ability to become certified and participate in professional development opportunities; all home child care providers and many employees of child care centers are participating in training on their own time, unpaid. Several representatives of child care centers said expansion was needed but unlikely to happen because they could not hire additional staff at the wages that made childcare affordable for local families.

- *"We've lost registered providers by about 42 percent."* – Northwest Iowa provider
- *"Usually the smaller the kid, the longer the wait list is."* – Southeast Iowa parent
- *"We just don't have the providers. Like, last week I had almost every provider around here in \_\_\_\_\_ County got called from three different parents with two different kids each and six kids that had nowhere to go. It just is – yeah, there's no spots."* – Southwest Iowa provider
- *"I think for an infant there right now, I think it's like five or six month [wait list] they're saying now."* – Central Iowa parent
- *"If people don't want a child care home provider, to find a child care center, there's not that many here and then they're full. You know, it's hard to get in."* – Central Iowa parent
- *"We have a number of in-home daycare providers, but a lot of them don't take low-income, so that's an issue for a lot of people."* – Southwest Iowa parent
- *"If we don't have any open spots, they say, where can you recommend? We try and tell them. They say, we've already called there. They don't have any spots. They don't have any spots. And so we've encountered a lot of families that are just frustrated because they can't find a place for their child to be."* – Central Iowa provider
- *"My daughter used to work, like, night shift .... You know, she worked for an agency where it wasn't a consistent place, she would just do fill-ins, and she – she got to the point where we couldn't watch her [child] because my husband and I both work, and my kids were – you know, my kids have to go to school, so she ended up having to quit that because she couldn't find anybody to watch, you know, her [child] ...."* – Northwest Iowa grandparent
- *"So I mean it wasn't that it was just horrible, but there were just some things that were just not what we approved of, you know, as a family or as parents, but there was – there's not options in small towns."* – Northwest Iowa parent
- *"And the rating system then doesn't really apply. I mean, if that's the only place that's available."* – Southwest Iowa parent



- *"It's pricey, especially if you have more than, like, two kids, it's a lot."* – Central Iowa parent
- *"Outrageous. I think it's very expensive."* – Southwest Iowa parent
- *"I paid double the rate because he had a disability, so I was paying about, per week, what I pay for two kids here, so if children do have special needs, they have a different rate."* – Southeast Iowa parent
- *"Yeah, it's expensive ... It makes me not want to think about, you know, a third [child] just because having three in a day care center full-time."* – Central Iowa parent
- *"That's why I chose to let my mom live with me, you know, and support her rather than pay for daycare. I save more money having her live with me and supporting her than I would, you know, putting them in daycare."* – Southwest Iowa parent
- *"A lot of our parents, both parents work, and – but one of the incomes goes totally to child care. That doesn't mean these [child care provider] ladies are getting rich. It certainly does not."* – Northwest Iowa provider
- *"I think starting pay is like \$8.25. I've known teachers that have worked there for 10-plus years and don't make over \$9 an hour."* – Central Iowa parent
- *"And, like, legit, I'm here because child care is my passion. It really is, but I left because I could make \$5 more an hour with a Monday through Friday, eight to five job [at HyVee]."* – Northwest Iowa former child care provider
- *"Benefits many times is what takes them [former child care providers] elsewhere."* – Southwest Iowa provider

### **Family Focus Groups: 4 Key Takeaways**

**Theme 1:** Word of mouth is the main source of information about child care options and openings. In addition, Department of Human Services and other agencies provide lists of licensed and registered providers (although openings are not necessarily available). Facebook is also used to find openings listed by child care providers.

- *"I would probably say word of mouth ..."* – Central Iowa parent
- *"I kind of used Google at first because coming from the city, I guess I was used to Googling and kind of doing more online research. However, I kind of found out, kind of more like she said, the word of mouth."* – Southwest Iowa parent
- *"My sister-in-law already had a daughter at our day care, and that's kind of where we just went."* – Central Iowa parent
- *"We [get information about childcare] from DHS."* – Northwest Iowa Parent
- *"I'm not from here, but his mom has been born and raised here, so, yeah, she really took care of that."* – Northeast Iowa parent
- *"It's hard. You always just have to find out for yourself with stuff like that."* – Central Iowa parent
- *"When I moved back to Iowa, I was a single mom, low income, so I went to DHS to get some guidance for services like WIC, and child care assistance was something that was brought up. Then they mentioned the QRS rating system and gave me a pamphlet on what that was ... Then they had a list of providers there, so that's where I went to get my provider."* – Southwest Iowa parent
- *"I've noticed a lot of people post it on Facebook on their group, like a garage sale group or something."* – Northwest Iowa parent

**Theme 2:** Information about other kinds of services for children commonly comes from providers of services. Children and families working with one service provider are often

referred by that provider to other providers for additional services. Other parents are a secondary source of information.

- *"I know the Salvation Army does. I've gotten that list before, and it gives me a lot of information about food stamps like FIP and everything else."* – Central Iowa parent
- *"I've gotten a lot of information from Headstart, also ..."* – Southwest Iowa parent
- *"My daughter, my daughter the [Headstart] school recommended that she start counseling because of her – like, her behavior with her whole dad situation."* – Northwest Iowa parent
- *"I would probably include, like, a doctor. Like, pediatrician provides information."* – Central Iowa parent
- *"Ours is the DHS. DHS gives – gave us a lot of that information, and they continue to do it, yeah."* – Northeast Iowa parent
- *"I think the teachers called and said that they had concerns."* – Northwest Iowa parent
- *"... I think the AEA is, like, a very helpful agency."* – Southwest Iowa parent
- *"She [kindergarten teacher] noticed the delay, and I talked to his pediatrician, and he talked about it with her, and she said, 'Let's see about getting the OT in here,' and I mean, she just took it away, and I was okay with that. Because I don't – that was not my expertise, and she was just absolutely wonderful with those things."* – Southeast Iowa parent
- *"I think it was you that mentioned HIPP (Health Insurance Premium Payment Program). We also accessed that program, but we didn't find that – we found out about that through a friend whose child also receives services, and that's an amazing program, and it's kind of like, 'Why didn't somebody else tell us about that?'"* – Parent of child with special needs

**Theme 3:** Unmet needs identified by parents include mental health services, behavioral specialists, housing, transportation, and local healthcare specialists.

- *"I know I just recently looked into counseling for me and the boys. I found that a lot of places have a waiting list, and it takes a while to get it, which is, you know, unfortunate if you have that immediate need."* – Southwest Iowa parent
- *"Like, I feel, like, people are afraid of that word and that topic, and like, you don't have to be in your 20s to have a mental health disease."* – Central Iowa parent
- *"I had talked to my psychiatrist about getting involved in a support group, but I would have to drive to Des Moines."* – Southwest Iowa parent
- *"So going back there's not a lot of options in behavioral services."* – Southeast Iowa parent
- *"My son's autistic, so I would – honestly I probably would be nervous about taking him to a day care center."* – Central Iowa parent
- *"And because there is such a shortage [of rental housing], people will pay an arm and a leg to get it because they need – they need something."* – Northwest Iowa parent
- *"I heard a comment just earlier today about someone looking for a place, but they charged 7 or \$800 a month in rent. By the time you spend that on your rent payment – and that's just rent. It's not, you know, a house that you're putting money in for yourself, so it's difficult."* – Southwest Iowa parent
- *"They don't care if it's dirty. They don't care if they have bed bugs. They don't care if the landlord can be the worst landlord in the world ..."* – Northwest Iowa parent
- *"We're back at a center now because we don't – my in home didn't provide transportation for preschool."* – Southwest Iowa parent
- *They should have something that we can call and the kids can get picked up and then dropped off. And according to the incomes, you know, get paid or not, you know."* – Central Iowa parent
- *"A taxi service for little people, little humans."* – Northwest Iowa parent

- *“I have had a hard time in our community find(ing) things for my son. I just actually drove back from Ames from his occupational therapy. I have to go twice a week for therapy to Ames.”* – Northwest Iowa parent
- *“If we’re dreaming, I would love if the hospital would have some of the resources to – for some of these specialists to come down here and do their work instead of always have to go to big cities for these things.”* – Southwest Iowa parent
- *“But for, like, mental health or anything like that, it seems that they’re coming from Johnson County, Linn, so that’s a struggle because they’re only here, you know, certain days or hours. I see a lot of families struggling with that.”* – Southeast Iowa parent

**Theme 4:** Concern was expressed about the availability of support services for low-income, working families who are just above the income cut-off lines for programs.

- *“Yeah, you’re a little bit over, but – so you don’t qualify, but it’s still tough to pay for things.”* – Northwest Iowa parent
- *“They need to just put it [income limit] down a little bit so they can – we can go work more hours and over what we need. Because if you work enough hours, and you make – you and your husband or you wife, you make that – you above that amount.”* – Central Iowa parent
- *“Most child care centers are income based, so if you make so much money, you can’t be involved.”* – Central Iowa parent
- *“It just depends on, you know, everybody’s income and if they do qualify for assistance, but that working pool that’s out there, sometimes they fall in-between the cracks. It’s difficult.”* – Southwest Iowa parent
- *“The thing I’ve always wanted to say is, like, they need to be, like – have some kind of income guideline for the working families, like, so we have some limit.”* – Central Iowa parent

### **Provider Focus Groups: 3 Key Takeaways**

**Theme 1:** Need was identified for more access to early intervention mental health services for children and their families.

- *“I just had a kiddo that we had to essentially kick out of our program because of violent behaviors, but his mom was trying to get him an IEP and they would not. They said, we’ll do it at the beginning of the school year.”* – Southwest Iowa provider
- *“Speaking as an in-home child care provider, in-home child care providers do not have enough support to deal with children who have a mental health issue and those kinds of things.”* – Southeast Iowa provider
- *“I think to piggy back on your comment about Title 19 for mental health, especially for children, there’s not a lot of places they can get assistance if they need it.”* – Central Iowa provider
- *“Here, I feel like we have a nice starting point of services, but I think our wait list and our workload is tremendous, and, I mean, I just think we need more staffing to service the needs.”* – Northwest Iowa provider
- *“I think it’s a challenge for the preschool age. I think there’s a bit more once they get to kindergarten, some other programs that come in as far as like K-12, but for preschool and early childhood, it’s a definite challenge.”* – Central Iowa provider
- *“I would have to say home providers that are highly skilled in mental health to work with primarily the families. I mean, you have children with mental health behavioral issues, but supporting parents to be able to support the child is huge, I think.”* – Southwest Iowa provider (when asked for suggestions)

**Theme 2:** Service providers collaborate on referrals and professional development training when possible, but universal applications, forms and waivers are needed to reduce paperwork

and make it easier and quicker for multiple agencies to serve children with multiple programs/services.

- *“... when we think about all of us working together, we always kind of come back to the whole consent, HIPAA, all of those things, so I don’t know how you can figure out how to do it, but if there’s a way that we can all communicate easily with one type of release, like the magical golden release form, like, that would be great.”* – Southeast Iowa provider
- *“Make sure the dots are connected. So what I mean by that, there could be high level collaboration between the head of the Department of Public Health, the head of the Iowa Department of Education, the head of the Iowa Department of Human Services, but it may not trickle down to the boots-to-the-ground folks here that this is a policy change, and this is how it’s going to be.”* – Southwest Iowa provider
- *“That’s a challenge as they’re going between school and daycare because of privacy.”* – Southeast Iowa provider
- *“... I go back to what you said about having six care coordinators trying to do the same thing, but I think our hands are tied because those are expectations of our agencies. So, like, even if you knew that I would take care of it, you still have to somehow document on it and so you still have to figure it out.”* – Central Iowa provider
- *“Some of it has to be kind of limited because of privacy, confidentiality issues, and I think we walk a fine line. There are times I’d like to say more and feel it would be beneficial to say more, but I’m kind of bound by a few things.”* – Northwest Iowa provider
- *“I think insurance for kids and families accessing insurance, applying for insurance. It’s confusing. It’s not in a language that they understand or we understand with educations.”* – Southeast Iowa provider (identifying barriers)

**Theme 3:** Budget issues have reduced services, programs and staffing levels, and have taken a toll on the morale of service providers.

- *“It costs money too obviously, and everybody knows that, but it costs a fair amount of money to employ a person, and with all the training that’s required, which I understand for quality care – in a short amount of time ... it’s quite an investment, yep, and – yeah, it often goes out the door.”* – Northeast Iowa provider
- *“We used to have a lot more money, but it’s dried up over the years.”* – Northwest Iowa provider
- *“Well, if we could get some money ...”* – Central Iowa provider
- *“If we’re overwhelmed, we know parents are.”* – Southwest Iowa provider
- *“And then there’s more rules and they expect more, but they expect you to take care of it.”* – Northwest Iowa provider
- *“I feel like I never in my entire life thought I would know as much about insurance as I do. Never. I didn’t sign up for that.”* – Southeast Iowa provider
- *“The [MCO] program didn’t work the way it was supposed to work, so that has impacted a great deal of the services and the programs that we used to provide for the children and knew what we were doing with them.”* – Southeast Iowa provider
- *“Well, we need to fund early childhood like we do K through 12, that’s the bottom line, and until lawmakers put that as their priority, we’re going to be struggling with the same story ...”* – Southwest Iowa provider

## Summary

The most pervasive finding across the family focus group participants and locations was that child care **affordability** and **access** are critical concerns among Iowa families, especially when they impact a parent's ability to get and stay employed. Parents across groups mentioned affordability affecting their decisions on *whether* to work, while availability impacted *when* parents could work, where they should live, and the transportation they required. A review of how local employment, housing and transportation options map on to child care services was identified as a crucial next step in understanding how services might be improved and targeted to meet parent's needs.

Funding for providers was also a serious concern for parents of young children, as parents acknowledge a mismatch between the high quality of care they want their children to receive and the **low wages** given to providers. Parents would also like additional state funding to support and expand child care centers so that waitlist times can be reduced. Participants shared that the early care system needs to seriously consider how to create better wages for child care workers in order to address staff turnover and promote new people joining the child care field.

The fact that government services and programs were mostly viewed in a positive light among parents was a final theme in the data, as many parents noted that they **trusted and relied** on these organizations to help them in their daily lives. It would also appear that these services and programs are doing well to advertise themselves and educate parents about what it is that they do, though some parents would like to see more of a one-stop-shop online for this type of information.

Provider focus groups corroborated sentiments related to **affordability, access, and low wages**, as well as the reoccurring idea that **mental health** services were lacking in terms of availability, funding, and awareness. For both groups, **word of mouth and social media** were reported as the two most common (and useful) forms of community outreach and education.

A final theme that emerged among providers was the need for **coordinated intake** to support referrals and transitions. Shared agencies were often referred to positively, however the referral process overall was often discussed as ununiformed and incomplete.

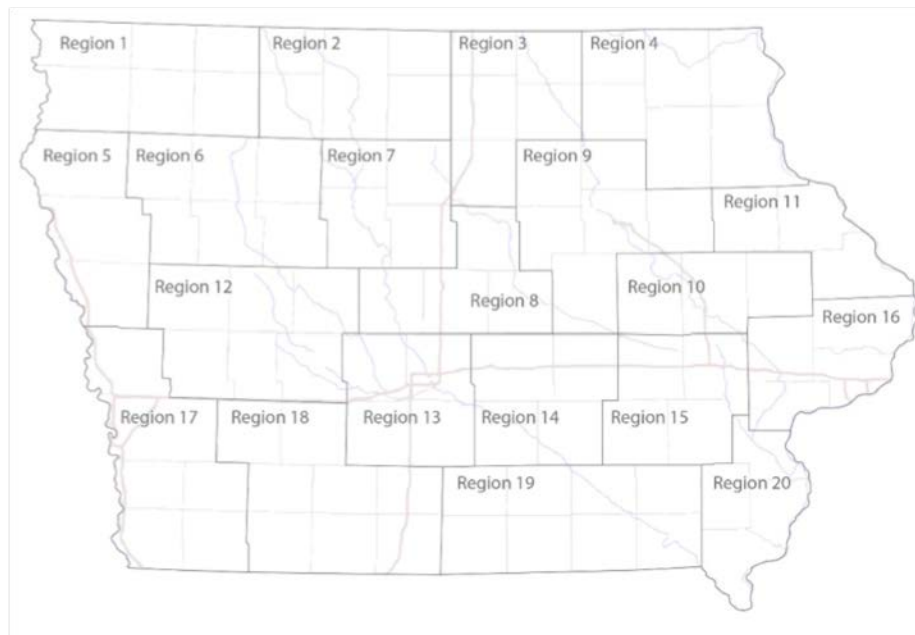
**Acknowledgements**

These data were collected and analyzed by an ISU Extension and Outreach team led by Director Gary Taylor.

**Summary**

During the fall of 2018, John Lawrence, Vice President for Extension and Outreach (VPEO), conducted listening sessions in all of ISU Extension and Outreach’s (ISUEO) 20 regions throughout Iowa (see Figure E.1.). These listening sessions were conducted in order to understand what specific issues are impacting Iowa’s, and each region’s, ability to thrive over the next five years. The VPEO conducted 62 listening sessions in total. Each region had three listening sessions: one with a group of the region’s stakeholders, one with Extension staff who work in the region, and one with the County Extension Councils of that region. The VPEO also conducted two listening sessions with Extension staff from the Iowa State campus.

**Figure E.1. Map of ISUEO regions for community listening sessions**



While these listening sessions were not originally conducted in connection with the ECI 2019 Needs Assessment, state of Iowa partners believed that the information gathered from these sessions could reveal valuable supplemental information useful to the Needs Assessment because it was clear during the listening sessions that the issues of childcare and early childhood education were of critical concern to all participants. In fact, the issue of “childcare” was identified as one of the “Top Five” issues critical to the future success of Iowa. Of particular interest to ISUEO was the identified need for childcare providers to have easier access to gaining professional certifications, as well as help with expanding their businesses. Multiple regions mentioned that ISUEO should be communicating with these providers in

response to a question about reaching all lowans and the underserved. Such communications could provide additional context around affordability and availability concerns.

It was obvious from the original analysis that the volume of references to childcare and early childhood education indicated a statewide lack of access to childcare - or restraints on accessing affordable and quality childcare. While the format of the notes from the listening sessions did not provide a great amount of detail on specific topics for the ECI 2019 Needs Assessment - such as clear references to underserved children - the fact that there was a total of 110 coded references to childcare and early childhood education from the 20 regions' listening sessions demonstrates that these services need attention throughout the state.

The purpose of the current work was to reanalyze these data to support the ECI 2019 Needs Assessment. The ECI PDG Core Team specifically requested that the Community & Economic Development (CED) unit of ISUEO conduct a re-analysis of the feedback—gathered through note-taking by an Extension staff member present at each listening session— with specific attention to comments related to childcare, early childhood education, and related topics.

## **Methods**

Using NVivo software for qualitative analysis, notes from each region's listening sessions were coded for references to childcare and early childhood education. Some aspect of childcare was identified as an issue in every region. When a very general statement was included in the notes from the listening sessions, the statement was coded under "Childcare Access." If the speaker provided sufficient additional context, then the statement was coded appropriately under affordability, quality, impacts on quality of life, etc. A statement was also coded under two or more categories if it was clearly intended to reference multiple issues.

## **Findings**

Childcare Access (61 references). This category was the largest, with a total of 61 references in NVivo, coded across 19 of 20 regions. The one region it was not coded in mentioned more specific issues with childcare and so that region's statements were coded appropriately. Some of the statements regarding childcare access are very specific and some are more generalized.

- The overwhelming number of references to childcare as a "top five" issue in each region simply includes statements such as "Daycare," or "Availability of childcare" as a problem. Some of the 61 references make further connections between employment and access to childcare.
- The number of references to a lack of childcare demonstrates that this unavailability of care options is affecting employment opportunities—one statement from Region 1 stakeholders indicated the snowball effect this has, saying "Childcare problems - can't find a job to afford daycare & then leads to housing problems."
  - Staff in Region 1 also noted that childcare issues go hand in hand with the issue of a living wage: "Daycare issues & living wage (13)" (The 13 at the end denotes how much support this comment received from others in attendance at the listening session.)

- This sentiment was echoed by staff in Region 16, who also noted the “ripple effect” between child care and employment.
- Region 1 had many comments regarding child care access, including pinpointing Osceola County as an area that is in need of daycare facilities.
- Council members in Region 12 mentioned childcare access as an issue, going so far as to bring up possible innovative solutions: “Is there enough daycare available in the community? That was another recent thing in one of the nursing homes in Audubon. They used their second floor as a daycare.”
- Region 6 specifically mentions a lack of childcare during evening hours—both Extension staff and the region’s Council brought up this point.
- Region 8 stakeholders asked that Extension focus on business development in order to address a lack of childcare.
  - They also noted that not all children could get a spot in childcare: “Pre-school and early childhood – need more – not everyone gets in; available and quality for all.”

Affordability of Childcare (12 references). The affordability of childcare was indicated to be a “top five” issue by stakeholders in a number of regions.

- The affordability of childcare was indicated to be a “top five” issue by stakeholders in Region 10, and they specifically highlighted that childcare is not affordable in urban areas.
- Region 13 stakeholders also identified the affordability of childcare as a “top five” issue, with the direct statement saying it was “effecting employees.”
- Regions 17’s Council members identified childcare quality and affordability as a “top five” issue, with stakeholders stating childcare access was a problem more generally.
- Stakeholders in Region 18 and staff in Region 20 made “Lack of affordable/available childcare” a “top five” issue.
- In Region 4, a total of 8 stakeholders stated that “lack of affordable providers, keeping it affordable for families” is a problem regarding childcare.
- Region 7 and Region 9 stakeholders each identified affordability as a problem.
- Region 16’s Council members specifically asked how ISU Extension could help parents who are struggling with childcare expenses: “People are working 2 jobs, have child care expense – how can we help?”

Quality of Childcare (12 references). Comments on the quality of childcare were made in multiple regions.

- In most regions, the notes referencing childcare quality were very simple (“quality of childcare”) Quality was specifically mentioned by both stakeholders and staff in multiple regions.



- Six regions mentioned quality as a particular issue, with many stakeholders “voting” for a lack of quality childcare as one of their region’s “top five” issues.
- Region 8 went into slightly more detail, with stakeholders stating that “Pre-school and early childhood – need more – not everyone gets in; available and quality for all.”

Childcare and Quality of Life (10 references). Multiple nuanced references were made to how childcare issues impact other aspects of communities.

- In Region 12, stakeholders tied childcare to impacting what could be called “quality of life” in their communities. In response to a question about “What issues should we be working on?” a response was: “Keeping our residents in our communities--access to housing, childcare, jobs, education.”
- Region 14’s Council members had this to say about childcare and quality of life: “Childcare deserts – workforce is effected- safe place for child – Business Development - Cooperative Childcare in some communities – parents want childcare with preschool.”
- Region 16’s staff highlighted what they called the “ripple effect” of a lack of access to childcare: “Shortage of early child care providers--causes ripple effect can’t work without child care.” This sentiment was echoed by Extension staff in Region 2.

Childcare Providers (7 references). The need to better support childcare providers was raised as an issue in four regions.

- Region 14 stakeholders brought up the question of helping with childcare certifications: “Childcare providers – Support for certification – What is the business template?”
- Region 18 stakeholders asked that Extension work with childcare providers to “find what is stopping them from growing their business/center.”
- The issue of certifications and continuing education was also brought up in Region 20 by the Extension Council.
- In Region 19, childcare providers were identified as individuals who needed to be reached out to in order to engage “all lowans and underserved.” This statement was echoed in Region 20 as well.

Early Childhood Education (4 references). Comments about Early Childhood Education were less clearly articulated than other topics. From the context of discussing regional issues during the listening sessions, it is reasonable to assume that none of these notes about early childhood education were stated as positives.

- Region 1 included the following in their end comments from stakeholders: “Literacy-early childhood; Head start - consult needs assessments”
- In Region 11, in response to a question about who Extension should be speaking with to identify needs, stakeholders identified early education providers.

- Stakeholders in Region 14 mentioned afterschool programs—specifically literacy—as an issue in their region. However, staff in Region 14 mentioned their programming for early childhood as a strength.
- Region 15 mentioned an issue in their region being a lack of funding for early childhood education, stating: “Education funding-K-12, disparity, early childhood.”

Refugee and Trauma-Informed Childcare (2 references).

- Region 13 stakeholders, in response to a question about how to reach all lowans, brought up refugee populations and said that: “Refugee community is tough to meet between 8 and 5 and transportation, dinner & childcare are issues – refugee community needs to build trust?”
- And while Trauma-Informed childcare and early education may be outside the scope of this Needs Assessment, Region 11 stakeholders did bring up the importance of trauma-informed programming. Their comment in full reads: “Trauma-informed care is huge in communities right now. ACES – Adverse Childhood Experiences. (Title 1 kids). At risk childhood experiences. Enrichment activities for kids who do not normally get those experiences. Continue with programming for sharing with kids in the community.”

Childcare for Non-English Speakers (1 reference).

- Region 9’s stakeholders identified a need for more childcare opportunities for non-English speakers. However, such a sentiment was not echoed during other region’s listening sessions.