Preparing for the Future:
Indiana's Preschool Development Grant

Indiana's Birth to Age Five Mixed Delivery System Needs Assessment

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EXECUTIVE SUMMARY

Over the past decade, the state of Indiana has substantially increased its investment in early childhood care and education (ECCE). In addition to federal funding and programs such as Head Start and Child Care and Development Fund (CCDF) vouchers, Indiana has also invested state funds and time in expanding access to high quality preschool for young children from low income backgrounds through the On My Way Preschool program and enhancing the quality of ECCE programs through the Paths to Quality (PTQ) rating system. These efforts have made substantial improvements in the overall quality and access to ECCE services in many counties; however, there is still a need to further support this system as there are a number of gaps in data and services. In response to this need, and to actively support the state's continued progress in service for young children and their families, Indiana recently applied for and was awarded a federal Preschool Development Grant (PDG). As a central step in this process, Purdue University was hired to conduct an Indiana ECCE Needs Assessment.

As is detailed in the body of this needs assessment, there are over half a million children birth to age five who live in Indiana (6.3% of the state's population), but only around one in four of these children are enrolled in some form of child care. Moreover, this enrollment varies substantially across counties (4% to 63%). Although there are nearly 5,000 ECCE programs in the state, the percentages of total ECCE slots by population is 34%, which also varies substantially by county (4% to 57%). Among these providers, although approximately 60% participate in PTQ, only 47% of all children in ECCE programs are in programs rated as "high quality" (Level 3 or 4 on PTQ). It is clear that Indiana has made a number of important steps in improving the landscape of ECCE across the state; however, as can be observed in this document, there are a number of critical gaps and specific needs that should be addressed to ensure that the ECCE system in Indiana is optimally supportive of all children. Below, we highlight a few of these areas, but note that more details and a broader set of gaps and recommendations can be found in the body of the document.

Critical Gaps

Program Quality and Access

- Despite substantial increases in PTQ participation in the last several years, a significant portion of ECCE providers are still not participating in PTQ or are only at Level 1 or 2.
- In some counties, families have no access to high quality programs.
- Approximately half of children receiving CCDF vouchers are not in high quality programs.
- There is no information regarding why there are such low rates of subsidized care for infants, and data on parental preferences may help elucidate this potential issue.

Data Quality and Information

- There are no reliable data on the number of unduplicated children being served by ECCE so it is not possible to identify how many individual children are receiving various services.
- There is only very limited data on children who are awaiting services which prevents us from identifying specific demands for the various programs across counties.
- Comprehensive data on family income, demographic information, and other vulnerabilities are not collected from all families in the ECCE system in a systematic fashion. Thus, the state does not have a complete picture of participation rates in the system for vulnerable populations.

Key Recommendations

Program Quality and Access - There is a need for enhancing access to high quality programs through efforts such as:

- Encouraging providers who are not participating in PTQ to participate and facilitating advancement in PTQ for those who are participating but are at lower levels.
- Refining and better assessing the quality of programs beyond current PTQ ratings because being a PTQ Level 3 or 4 provider is not consistently related to better classroom practices or greater gains in child outcomes. Further, additional observational data could be collected during PTQ visits that help build comprehensive supports for providers for quality improvements.
- Systematically evaluating parent choice to identify why they do or do not enroll their children in certain types of programs or at different times in their development. This will enable the state to identify if presented gaps are real gaps or a function of parental selection.

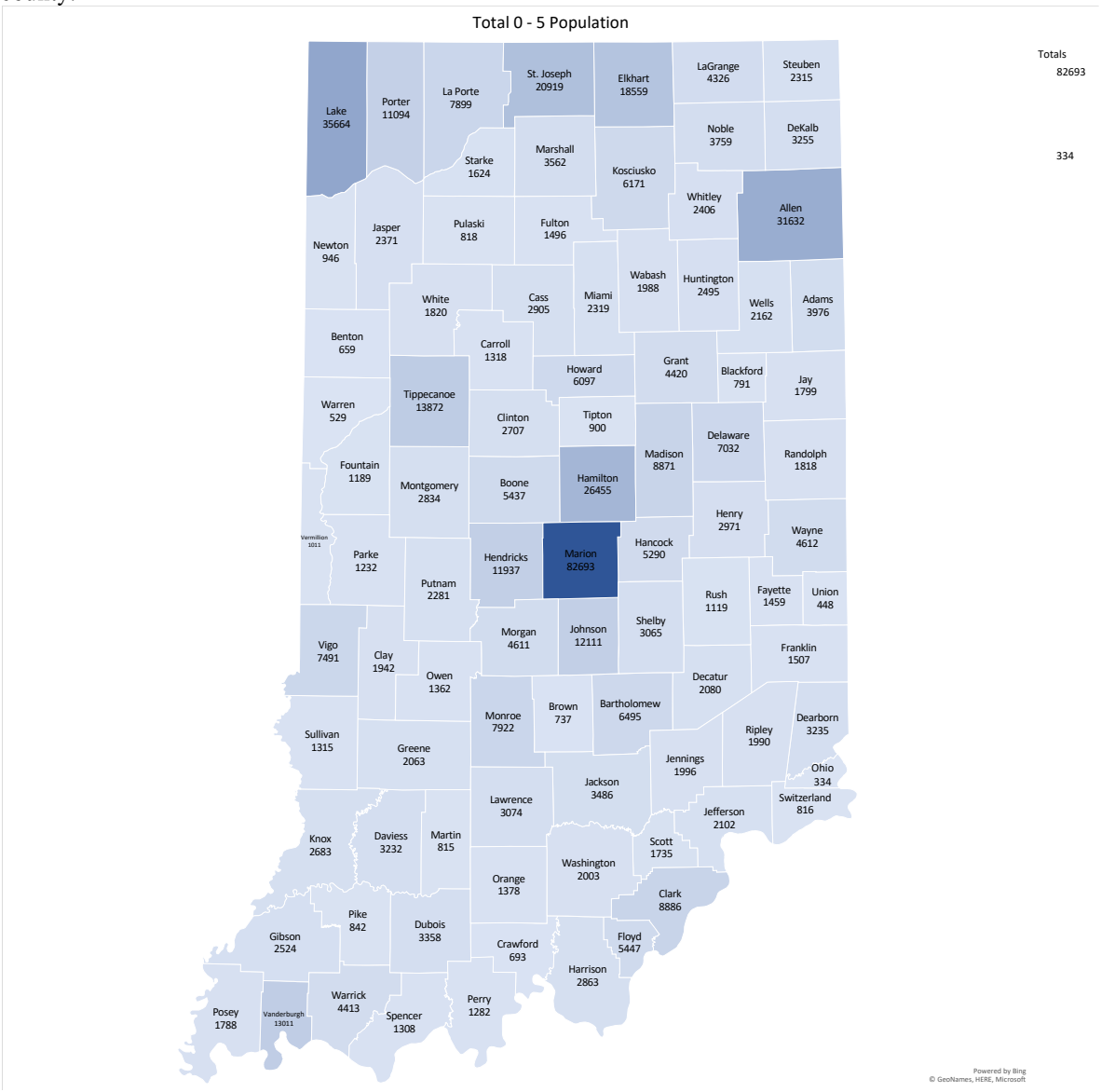
Data Quality and Information - There is a need for a more consistent, systematic, and comprehensive reporting system that is capable of integrating across agencies/systems, including:

- A comprehensive data management system that links child and program level data so that the state can reliably assess access, quality, and vulnerable populations receiving services. This system should include unique identifiers for children that are linked to their identifier in the K-12 system so that the unduplicated number of children being served in existing programs could be accurately captured in enrollment counts.
- A universal measure of kindergarten readiness that cuts across the ECCE system and the Indiana Department of Education is needed because more coordination of kindergarten transition efforts between ECCE providers and kindergarten teachers would likely allow for a smoother transition, more individualized instruction, and stronger school readiness for young children.

Overall, the results of the needs assessment indicate that efforts should be focused on enhancing the quality of existing programs, supporting the development of new programs to fill gaps in the system, and building a more comprehensive data management system that provides Indiana with a process for continual evaluation of progress and needs. In the full document, data describing availability, access, and quality are presented at both the state and county level (when possible) and by age and demographic variables (when possible). Each section of the document also includes weaknesses or gaps and specific recommendations on how to support the improvement of ECCE services throughout the state.

OVERVIEW OF THE BIRTH TO AGE 5 POPULATION

In Indiana, nearly 70% of children have all available parents (both parents in a two-parent household or the custodial parent in a one-parent household) in the labor force.[1] Indiana is home to 506,257 children from birth to 5 years of age which is approximately 6.3% of the total state population.[2] This map shows the number of children ages 0-5 per county.[2]

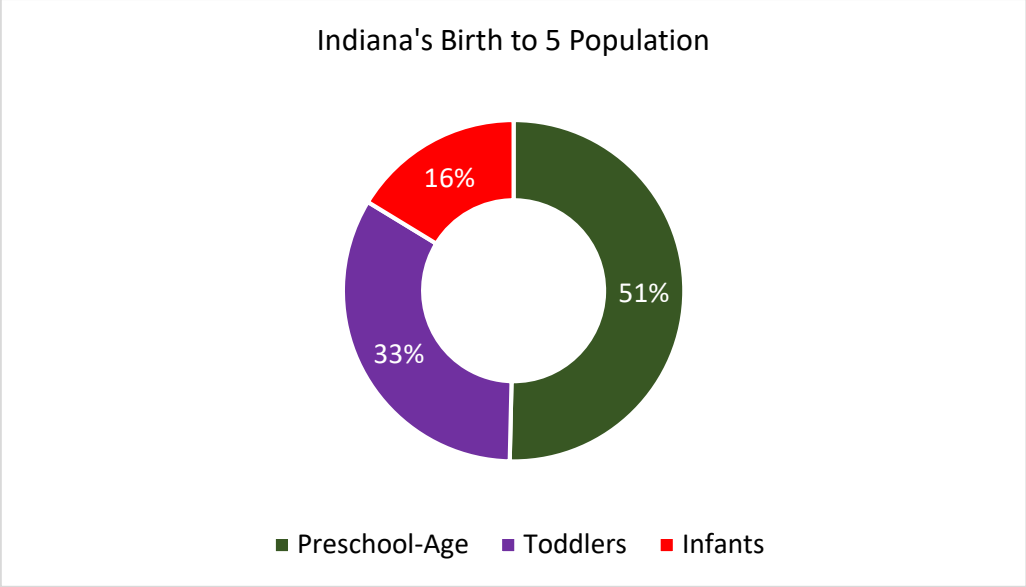


[1] https://datacenter.kidscount.org/data/tables/5057-children-under-age-6-with-all-available-parents-in-the-labor-force#detailed/1/any/false/871,870,573,869,36,868,867,133,38,35/any/11472,11473

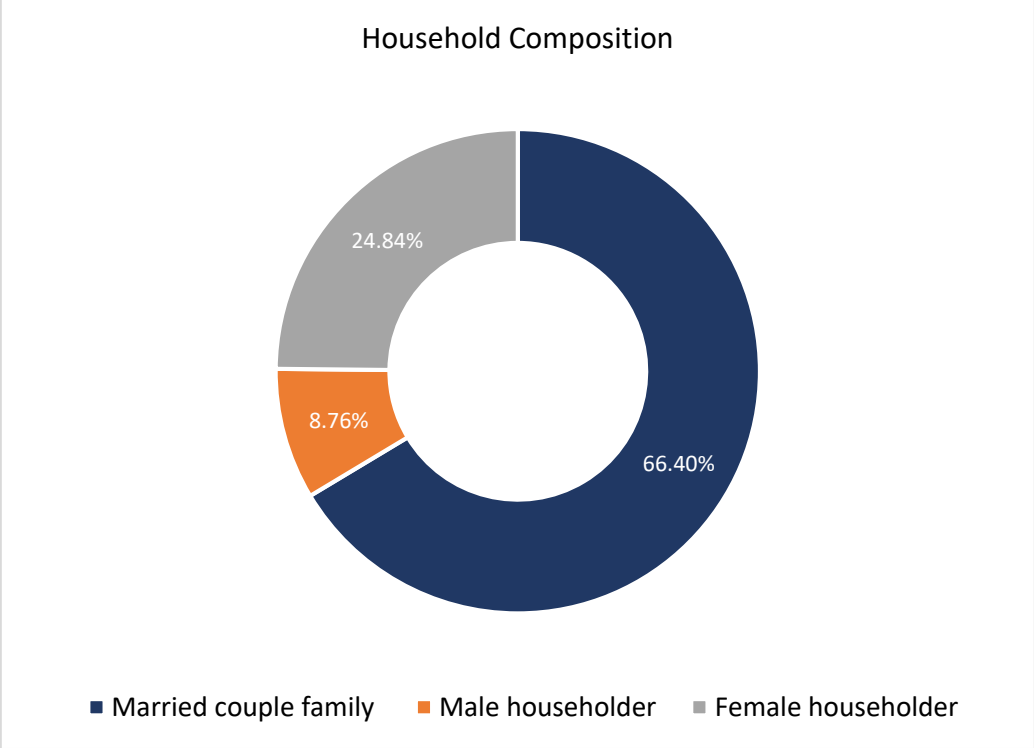
[2] Office of Juvenile Justice and Delinquent Populations: Easy Access to Juvenile Populations. https://www.ojjdp.gov/ojstatbb/ezapop/

Demographics

Of the 506,257 children ages birth-5 in Indiana, 82,498 are infants (0-12 months), 168,798 are toddlers (13 months-36 months), and 254,961 are preschoolers (37-60 months).[3]



The majority of Indiana's children ages 0-5 live in two-parent households (married couple).[4]

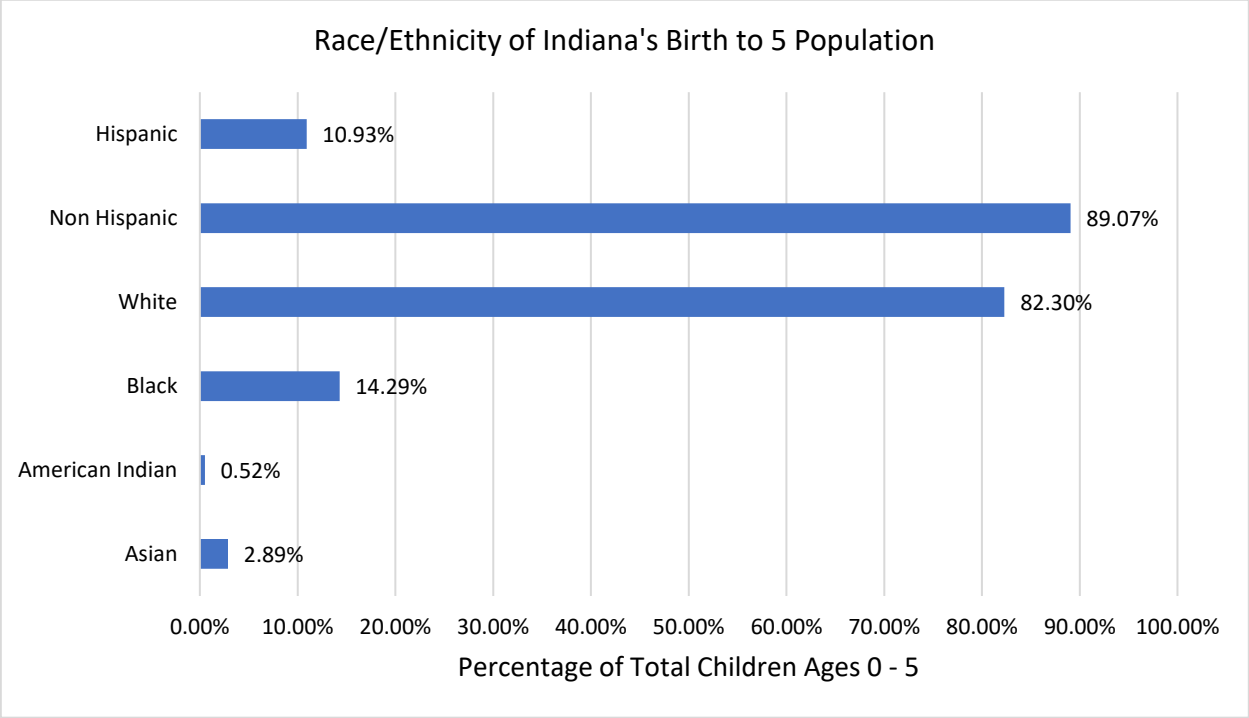


The majority of Indiana's children ages 0-5 are classified as Non-Hispanic (89%) and White.[5]

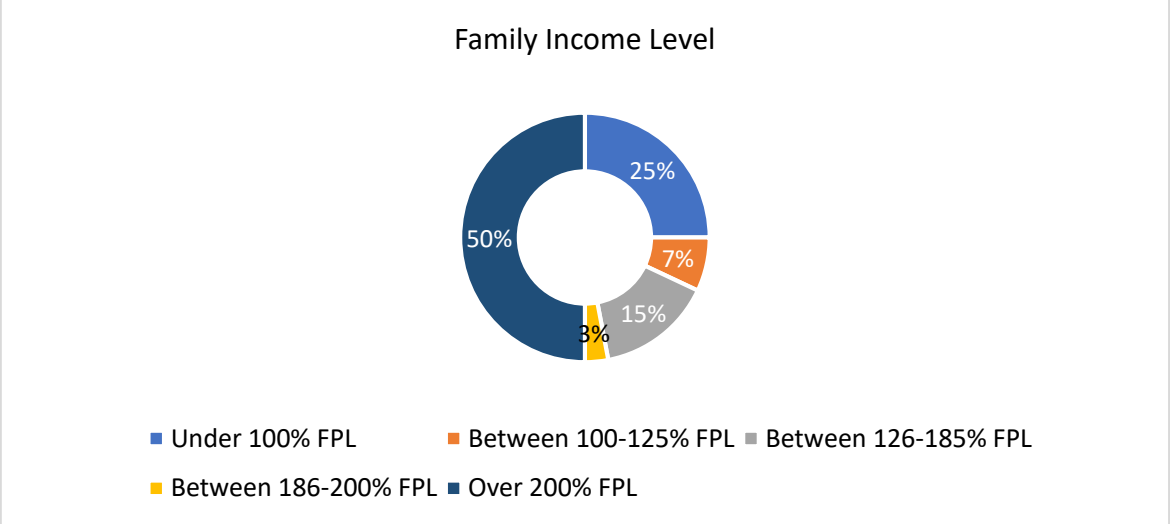
[3] Data source: Office of Juvenile Justice and Delinquent Populations: Easy Access to Juvenile Populations. https://www.ojjdp.gov/ojstatbb/ezapop/

[4] Data source: American Community Survey 5-Year Estimates

[5] Office of Juvenile Justice and Delinquent Populations: Easy Access to Juvenile Populations. https://www.ojjdp.gov/ojstatbb/ezapop/



Approximately 25% of children ages 0-5 live in poverty (i.e., below 100% of the Federal Poverty Line [FPL]).[6]



[6] US Census Bureau, 2012-2016; American Community Survey 5-Year Estimates retrieved from ELAC data dashboard: http://www.elacindiana.org/data/elac-annual-report-interactive-dashboard/

DEFINITIONS OF TERMS

Quality early childhood care and education: A Level 3 or Level 4 on PTQ.

Early childhood care and education (ECCE) availability: Number of providers serving children birth to age 5. Child care deserts refer to communities with limited to no access to quality services or programs that include a census tract with at least 50 children under the age of 5, with no child care provider, or family support programs.

ECCE slots: Desired capacity of providers.

ECCE participation: Number of children enrolled in ECCE system settings.

Awaiting service: Number of children/families who are actively pursuing ECCE programming but are currently not enrolled.

Age breakdowns:

- **Infant:** 0 – 12 months
- **Toddler:** 13 – 36 months
- **Preschooler:** 37 – 60 months

Types of Care:

- **Child care center**: The program is operating a child care center within a non-residential structure.
- **Family child care home**: The program is either licensed or unlicensed and operating out of a residential structure.
- **Preschool program:** The program is a preschool program caring for children for less than four (4) hours a day and/or exempt by the Office of Early Childhood and Out of School Learning's (OECOSL) definitions.
- **Head Start program**: The program is a Head Start, licensed or exempt.
- **Ministry**: The program is a ministry operated by a church or religious ministry that is a religious organization exempt from federal income taxation under Section 501 of the Internal Revenue Code.

Vulnerable or underserved children: Vulnerable or underserved populations include children and families who are low-income, experience health disparities, or have had certain risk factors that may limit their full participation in the ECCE system. Some of these risk factors, along with the most recent Kids Count and agency data include:

GROUP OF CHILDREN	DESCRIPTION
Children in families with low-income at or below 250% Federal Poverty Line (FPL). *Note. This definition varies depending on the data set used in the needs assessment. For example, in some cases, data on children from families with low incomes represent families at or below 127% or 100% FPL.*	53% of children under 17 live in households with incomes less than 250% of FPL (Kids Count, 2016).
Children/families who indicate a language other than English as primary language	10% of children ages 5-17 speak another language at home (Kids Count, 2016).
Children who are foreign-born or reside with at least one foreign-born parent	6% of children under the age of 17 are either foreign-born or who have at least one foreign-born parent in which neither resident parent has been in the country more than five years (Kids Count, 2016).
Children born pre-term	Indiana State Department of Health (ISDH) data shows that 9.6% of children are born preterm, with African American mothers having the highest rate at 12.8% and Hispanic mothers at 9.3%.
Children born with low birth-weight	ISDH data indicates 8% of children born are at low birthweight. African American mothers have the highest rate at 12.4%, compared to 7.4% for white mothers and 7.1% for Hispanic mothers.
Children born substance exposed	Data from the Indiana

	Perinatal Improvement Collaborative and its Perinatal Substance Use Task Force shows about 5,800 children were born with prenatal exposure to drugs or alcohol in 2017.
Children at-risk for developmental delays	24% of children 10 months to 5 years have received a standardized developmental screening. Additionally, 28% of Indiana parents who have a child under the age of 5 have concerns about their child's development (Child Trends, 2017).
Children diagnosed with a disability	First Steps received 27,952 referrals in 2017 – an 8% increase from the previous year and a 23% increase since 2012. The total number of children served in 2017 with an individualized family service plan, or IFSP, was 20,775.
Children who are homeless or housing unstable	According to 2016 data from the McKinney Vento Act, 15,919 in Indiana children meet the homeless or housing unstable definition.
Children in foster care	Children less than 1 year of age account for 7% of children in foster care and children ages 1 through 5 account for 38% of children in foster care (Kids Count, 2016).
Children who experienced abuse/neglect	20.6% of children under the age of 17 had a substantiated case of abuse or neglect in 2017. This indicator has been increasing each year and has almost doubled since 2008, when 12.6% of children had a substantiated case of abuse or neglect (Kids Count 2016).
Children of incarcerated parents	According to data from the National Survey of Children's Health (NSCH), 9.6% of children under the age of five in Indiana live with a parent who has been incarcerated in their lifetime.
Children who live in counties that are medically underserved	32 of Indiana's 92 counties are medically underserved. These include the federal Health Professional Shortage Areas as well as a formula developed by researchers at Purdue University that measures healthcare accessibility.
Children living in rural communities	A rural area is defined as (1) a town with a population of less than 2,500 and (2) areas with a population between 2,500 - 49,999. Indiana has 49 of its 92 counties classified as rural (Economic Research Service, U.S. Department of Agriculture).

Early childhood care and education (ECCE) system: Indiana's B-5 mixed delivery system consists of early care and education, health, early intervention, and family support programs and services. Indiana's mixed delivery system is designed to allow families to choose from various programming options offered in diverse community-based settings, public, private, or charter schools. This definition of the ECCE system was developed specifically for the PDG and has not been used in the past.

Challenges with Definitions

The state has not been required to define these variables in the past, and thus, the definitions have not differed in key ways from previous definitions. There have been a few notable challenges with these definitions that have been identified during the needs assessment. First, as noted above, different data sources break down family income in different ways, and thus, although the data available fall within the "family income at or below 250% FPL" category, in most cases, data represent families at or below either 127% FPL or 100% FPL. Second, there is no consistent definition across data sources with regard to "children at risk for developmental delays."

FOCAL POPULATIONS OF THE GRANT

******This domain is in progress as the KSMC team is still waiting for data from FSSA.**

NUMBER OF CHILDREN BEING SERVED AND AWAITING SERVICE

In this section, a report and data are provided on the number of children receiving and awaiting child care services. Information on other programs within the ECCE system is provided in the section titled "Availability of and Participation in Early Childhood Care and Education (ECCE) Programming for Vulnerable Populations."

Data describing the unduplicated number of children being served in existing programs: There are existing data on children being served in regulated ECCE programs and, in some cases, unregulated care across the state. For example, the Office of Early Childhood and Out of School Learning (OECOSL) collects data regularly on enrollment numbers in licensed child care centers, licensed family child care homes, and registered ministries. Moreover, Early Learning Indiana (ELI) collects enrollment data on some exempt providers. However, there are no reliable data on the *unduplicated* number of children being served in existing programs.

Biggest data gaps/challenges regarding data describing the unduplicated number of children being served in existing programs:

- Although data regarding children being served in the ECCE system exist from multiple sources (e.g., ELI, Early Learning Advisory Committee, OECOSL, Indiana Department of Education), there is no way to know from the data whether the final enrollment counts represent the *unduplicated* number of children being served. It is possible that children are receiving services from multiple providers who are including them in their enrollment counts, in which case, these children could be duplicated.
- There are no available data on the availability of or participation in *all* of the exempt/unregulated ECCE providers across the state. The primary data set (from ELI) used to describe availability and participation in child care does include some information on these providers, but this was likely an underrepresentation of what is currently available.
- There are no reliable data on total available ECCE slots broken down by age in Indiana.
- For some providers in some counties, there are no recent data (i.e., within the last two years) on availability or participation in ECCE programming.
- There is a gap in data regarding accurate counts for the frequency of services children are receiving (e.g., participating in a full time ECCE program, participating in a half-day program three days per week).
- Available data on child care deserts suggest that over half of Indiana families with young children may not have easy access to child care. However, there several important gaps in these data, which include:
    - The data used to assess the issue of child care deserts only included licensed child care centers, licensed family child care homes, and registered ministries. It is reasonable to assume that some families may have access to unlicensed or exempt child care providers in census tracts/counties considered to be child care deserts; however, there are no available data on unregulated care options.
    - The data also are only broken down by census tract, not by county specifically. In some cases, census tracts cover one county in full so inferences can be made about particular counties and plans could be put in place to address barriers to child care in those counties. In other cases, there is more than one census tract that covers a particular county and the child care capacity category is not the same across the tracts, making the development of a plan forward for addressing potential capacity issues by county challenging.
- Although several data sources exist on the ECCE system in Indiana, several inconsistencies were noted across these sources in terms of variables collected and variables used when calculating availability and/or participation, making comparisons across data sets difficult. For example, some agencies collect and report on information regarding licensed capacity and use this to calculate available slots, and others report on desired capacity and use this to report on desired slots. Or, in some cases, data sources have information only at the provider-level, whereas in other cases, they have data at the child-level. Finally, data dictionaries were rarely available when the Purdue team requested them from program staff across agencies.
- There are no data across the state with regard to parental choice in terms of selecting to utilize ECCE programming, potential reasons parents choose particular types of care, or potential reasons parents may choose to utilize ECCE programming during certain developmental stages and not others. Parental choice may play a significant role in the level of participation in ECCE programming in some counties. For instance, in some counties where there are few infants enrolled in ECCE programs, it may be that parents

are *choosing* to stay home with their infants, and thus, any identified problems with infant capacity or enrollment may be overestimated. Further, in other counties with few child care centers for example, it may be that parents are choosing family child care homes or other arrangements, and thus, there is not a market or need for center-based care. Again, this may be identified as a problem that may not actually require attention.

- Further, there are no easily accessible or consistently collected data on parent engagement or involvement in ECCE programming. Although some programs (e.g., On My Way Pre-K) require a family engagement component, there are no data collected from all programs reflecting existing strategies or initiatives for engaging or involving families.

Data describing the unduplicated number of children being served in existing programs: With the exception of children awaiting Child Care Development Fund (CCDF) vouchers, there are no data available on the number of children in the general population awaiting ECCE services. This represents the most significant gap in this area.

Strengths and weaknesses of the available data on children being served

Strengths: A strength of the data collected regarding children being served is that in many cases, the data are gathered at the county level. Thus, inferences can be made regarding availability and enrollment in programming at a more community-based level, which can inform resource allocation. Further, with regard to enrollment numbers, data are also broken down by age, so the state can get a snapshot of age groups that may be underserved across counties. Finally, innovative research has been conducted recently examining the issue of child care deserts in Indiana.

Weaknesses: There are several key weaknesses of the data regarding children being served in the ECCE system. For example, the data that the state collects describing the number of children being served likely includes duplicate numbers of children. There are no unique identifiers used across systems/agencies/providers, so documenting the unduplicated number of children being served is impossible. There are also no unique identifiers used across agencies for providers that could then be linked to child-level data. Another key weakness is a lack of consistency in reporting across providers and datasets, which calls the reliability of the data into question. Finally, there are relatively few data sources that have demographic information included, which makes documenting participation in the ECCE system for vulnerable and underserved populations challenging.

There are currently initiatives under way within Indiana's PDG to improve these data. For instance, the data road mapping project is intended to shed light on this issue. The state is also engaging partners in other projects related to identifying ways to document unduplicated children receiving services in the birth to age 5 system.

Recommendations: There is a need for 1) a more consistent, systematic, and comprehensive reporting system for all providers, regardless of regulation status with data broken down by age, including breakdown of prekindergarten eligible children, and by county (or other localized areas); 2) a unified data system that is consistent across agencies/systems that includes data dictionaries; 3) children to be assigned unique identifiers when entering the ECCE system so that the unduplicated number of children being served in existing programs could be accurately captured in enrollment counts; 4) providers in the ECCE system to be assigned a unique identifier that could then be linked to child-level data; and 5) data and research on parental choice and engagement with ECCE programming broken down by age and by county.

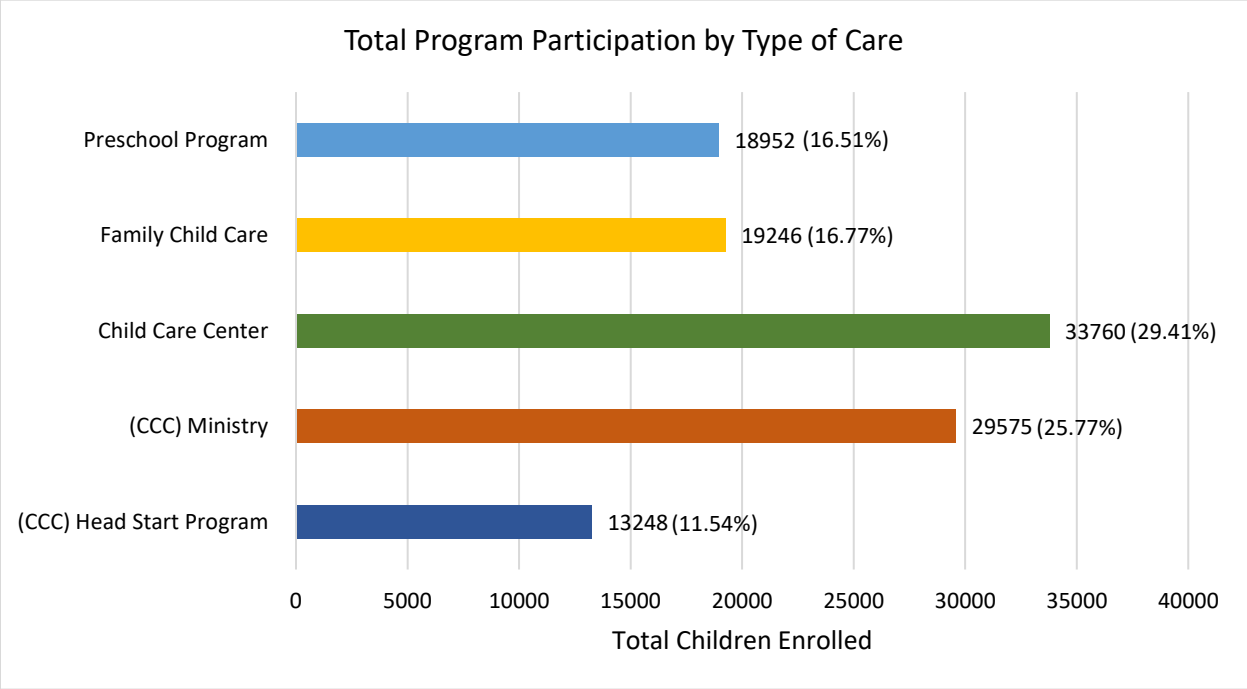
Participation in ECCE Programming

Total Participation in ECCE Programming in Indiana

The population of children between the ages of 0 and 5 in Indiana is 506,257.[7] Of these children, 114,781 (23%) are enrolled in some type of child care.[8]

Total Participation by Type of Care in ECCE Programming in Indiana

Nearly 30% of Indiana's young children who are enrolled in child care are attending child care centers. Fewer than 12% are enrolled in Head Start.[8]

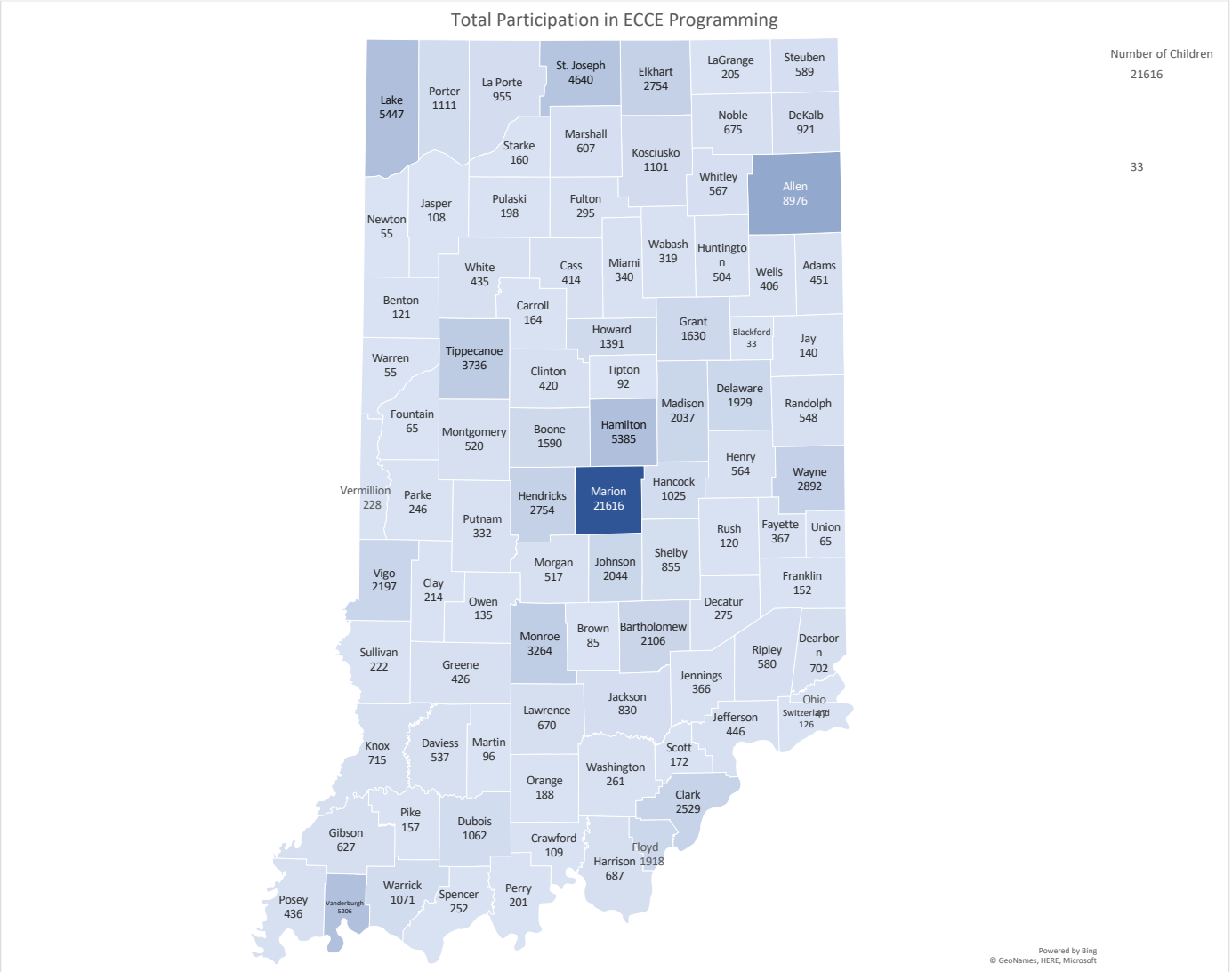


[7] Office of Juvenile Justice and Delinquent Populations: Easy Access to Juvenile Populations. https://www.ojjdp.gov/ojstatbb/ezapop/

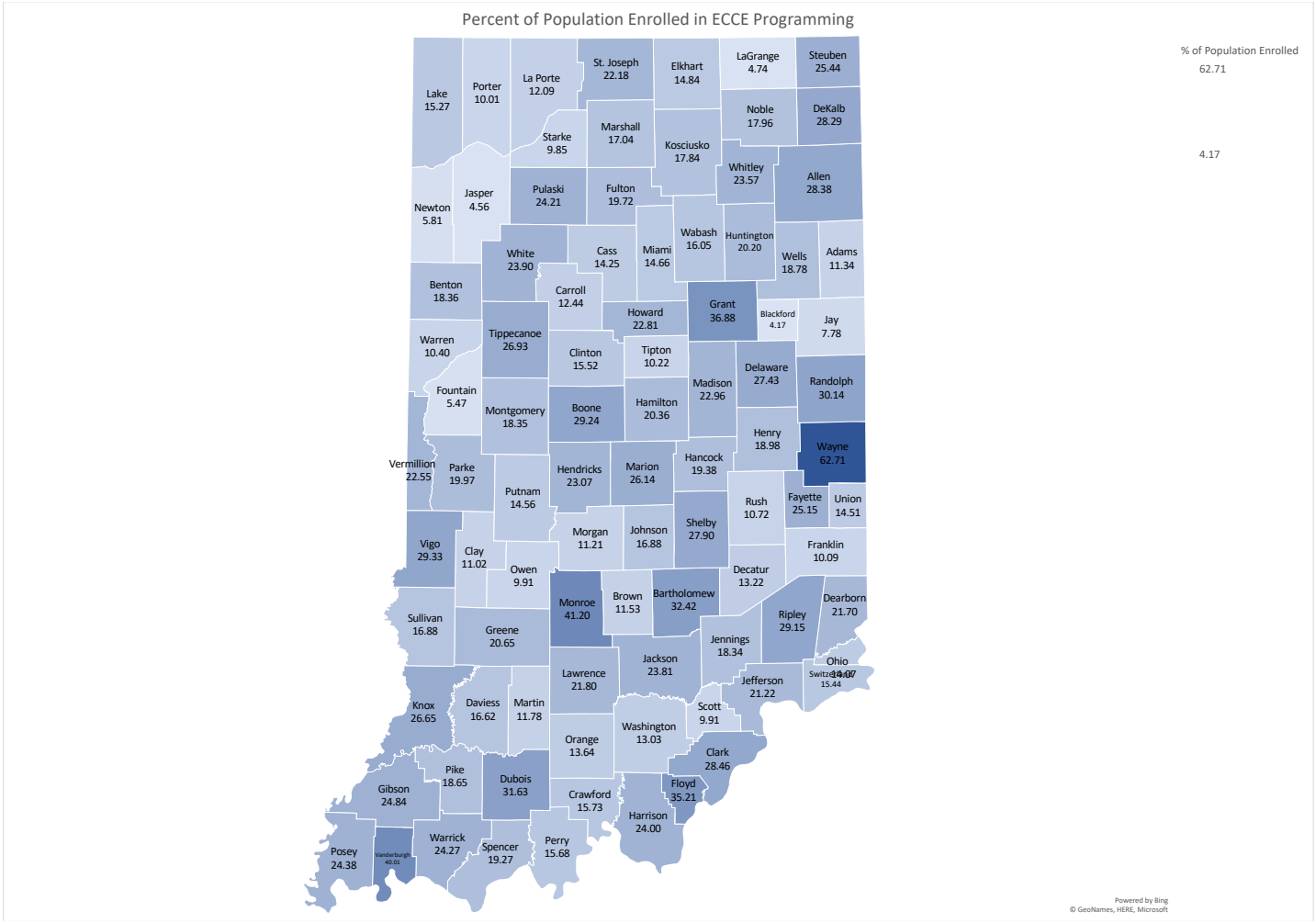
[8] Data source: Early Learning Indiana, received 4/19/19

Total Participation in ECCE Programming in Each County[9]

Marion and Allen counties have the most children enrolled in ECCE programming in the state, whereas Blackford and Ohio have the fewest. However, when taking county population into account, Wayne and Monroe counties have the highest percentage of children enrolled (62.71% and 41.20%, respectively), and Jasper and Blackford counties have the lowest percentage of children enrolled (4.17% and 4.56%, respectively).



[9] Data source: Early Learning Indiana, received 4/19/19


Percent of Population Enrolled in ECCE Programming
% of Population Enrolled
62.71
4.17
Lake 15.27
Porter 10.01
La Porte 12.09
St. Joseph 22.18
Elkhart 14.84
LaGrange 4.74
Steuben 25.44
Noble 17.96
DeKalb 28.29
Starke 9.85
Marshall 17.04
Kosciusko 17.84
Whitley 23.57
Allen 28.38
Newton 5.81
Jasper 4.56
Pulaski 24.21
Fulton 19.72
Wabash 16.05
Huntington 20.20
Wells 18.78
Adams 11.34
White 23.90
Cass 14.25
Miami 14.66
Benton 18.36
Carroll 12.44
Howard 22.81
Grant 36.88
Blackford 4.17
Jay 7.78
Warren 10.40
Tippecanoe 26.93
Clinton 15.52
Tipton 10.22
Madison 22.96
Delaware 27.43
Randolph 30.14
Fountain 5.47
Montgomery 18.35
Boone 29.24
Hamilton 20.36
Henry 18.98
Wayne 62.71
Vermillion 22.55
Parke 19.97
Putnam 14.56
Hendricks 23.07
Marion 26.14
Hancock 19.38
Rush 10.72
Fayette 25.15
Union 14.51
Vigo 29.33
Clay 11.02
Owen 9.91
Morgan 11.21
Johnson 16.88
Shelby 27.90
Franklin 10.09
Decatur 13.22
Monroe 41.20
Brown 11.53
Bartholomew 32.42
Dearborn 21.70
Ripley 29.15
Sullivan 16.88
Greene 20.65
Jennings 18.34
Jackson 23.81
Ohio 14.07
Switzerland 15.44
Lawrence 21.80
Jefferson 21.22
Knox 26.65
Daviess 16.62
Martin 11.78
Scott 9.91
Washington 13.03
Orange 13.64
Clark 28.46
Pike 18.65
Dubois 31.63
Floyd 35.21
Gibson 24.84
Crawford 15.73
Harrison 24.00
Warrick 24.27
Spencer 19.27
Perry 15.68
Posey 24.38
Vanderburgh 40.01
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Total Participation by Type of Care in ECCE programming in Each County
This table provides raw numbers of children enrolled in each type of care by county in alphabetical order.[10]

Total ECCE Participation by Program Type					
County	**(CCC) Head Start Program**	**(CCC) Ministry**	**Child Care Center**	**Family Child Care**	**Preschool Program**
Adams	95	306	50	0	0
Allen	599	1,884	2,174	1,326	2,993
Bartholomew	40	1,054	412	234	366
Benton	40	0	0	39	42
Blackford	16	0	0	17	0
Boone	28	680	593	227	62
Brown	0	0	0	85	0
Carroll	35	54	0	39	36
Cass	52	227	82	53	0
Clark	862	557	645	157	308
Clay	53	85	10	26	40
Clinton	52	102	0	50	216
Crawford	55	0	0	14	40
Daviess	78	222	0	224	13
DeKalb	157	258	58	32	416
Dearborn	96	107	256	30	213
Decatur	20	72	98	62	23
Delaware	264	768	519	333	45
Dubois	40	255	249	386	132
Elkhart	272	822	858	190	612
Fayette	173	129	18	47	0
Floyd	227	440	488	459	304
Fountain	48	0	8	9	0
Franklin	16	0	0	136	0
Fulton	34	101	0	80	80
Gibson	68	122	166	120	151
Grant	202	346	0	95	987
Greene	108	47	0	201	70
Hamilton	100	767	3,602	425	491
Hancock	117	512	63	233	100
Harrison	69	152	92	150	224
Hendricks	62	663	1,464	362	203
Henry	116	46	108	152	142
Howard	328	358	451	101	153
Huntington	80	163	73	20	168
Jackson	36	333	27	285	149
Jasper	57	13	0	38	0
Jay	20	32	0	88	0
Jefferson	50	84	33	187	92
Jennings	48	20	39	259	0
Johnson	32	768	902	275	67
Knox	258	99	164	194	0
Kosciusko	260	159	192	103	387
La Grange	16	51	0	30	108
La Porte	289	18	216	410	22
Lake	1,041	1,586	1,575	830	415
Lawrence	110	217	50	145	148

[10] Data source: Early Learning Indiana, received 4/19/19

Madison	339	347	349	562	440
Marion	2,470	6,442	8,062	2,795	1,847
Marshall	75	156	135	241	0
Martin	0	24	50	16	6
Miami	88	96	0	11	145
Monroe	262	465	1,207	530	800
Montgomery	56	247	0	58	159
Morgan	90	245	108	74	0
Newton	55	0	0	0	0
Noble	64	62	216	60	273
Ohio	18	0	0	0	29
Orange	34	0	0	154	0
Owen	72	0	0	63	0
Parke	32	102	0	112	0
Perry	58	0	66	23	54
Pike	33	36	0	88	0
Porter	50	321	599	141	0
Posey	51	52	127	20	186
Pulaski	51	82	0	65	0
Putnam	58	82	43	64	85
Randolph	80	45	184	6	233
Ripley	32	0	236	186	126
Rush	51	16	0	53	0
Scott	28	68	0	76	0
Shelby	8	102	46	99	600
Spencer	54	50	56	46	46
St. Joseph	115	1,041	1,933	1,016	535
Starke	85	18	0	17	40
Steuben	62	320	76	101	30
Sullivan	18	125	0	79	0
Switzerland	40	49	0	37	0
Tippecanoe	252	912	1,428	541	603
Tipton	0	80	0	12	0
Union	65	0	0	0	0
Vanderburgh	347	690	2,091	767	1,311
Vermillion	28	17	40	45	98
Vigo	218	126	312	1,066	475
Wabash	17	54	42	44	162
Warren	0	0	55	0	0
Warrick	125	101	146	447	252
Washington	68	30	0	163	0
Wayne	706	1,765	163	221	37
Wells	20	163	41	10	172
White	0	176	39	100	120
Whitley	54	189	175	79	70
TOTAL	13248	29575	33760	19246	18952

Total Participation by Age in ECCE programming in Indiana[11]

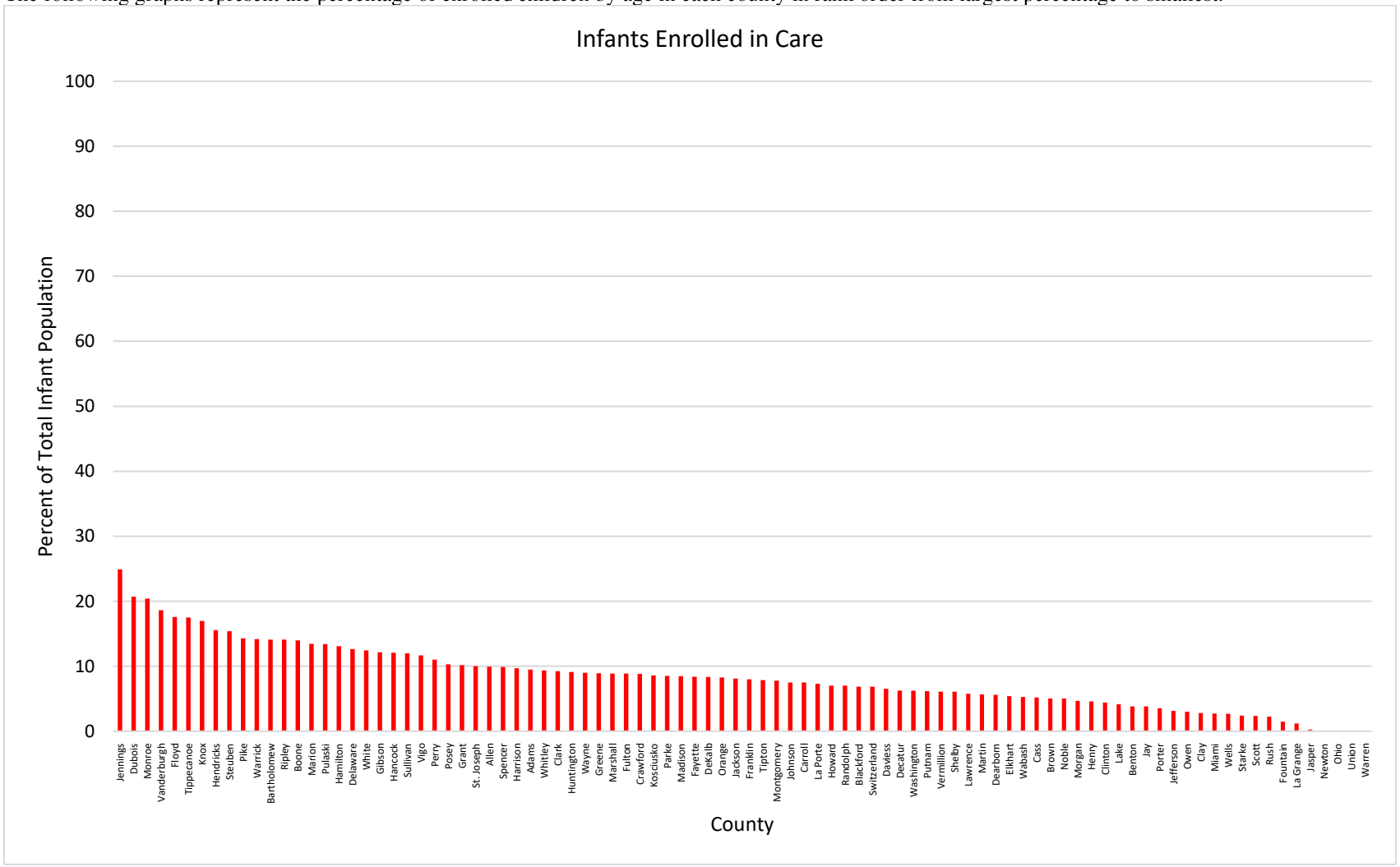
This table provides raw numbers and percent of children enrolled in ECCE programming across the state by age.

Total ECCE Participation by Age			
	Total Enrolled	**Total Population**	**Percent Enrolled**
Infants	8,416	82,498	10.20%
Toddlers	30,520	168,798	18.08%
Preschool-Age	75,845	254,961	29.75%

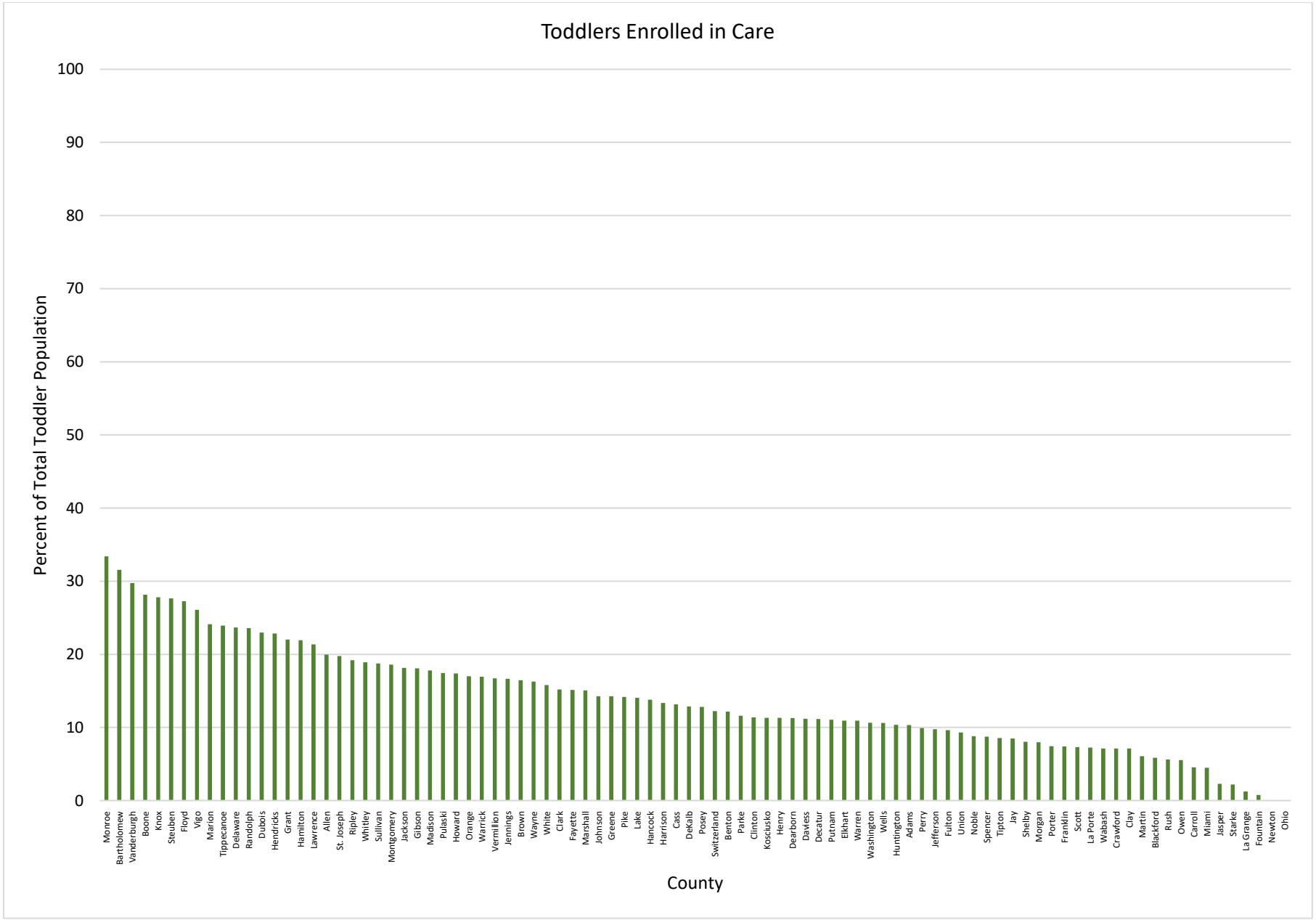
[11] Data source: Early Learning Indiana, received 4/19/19

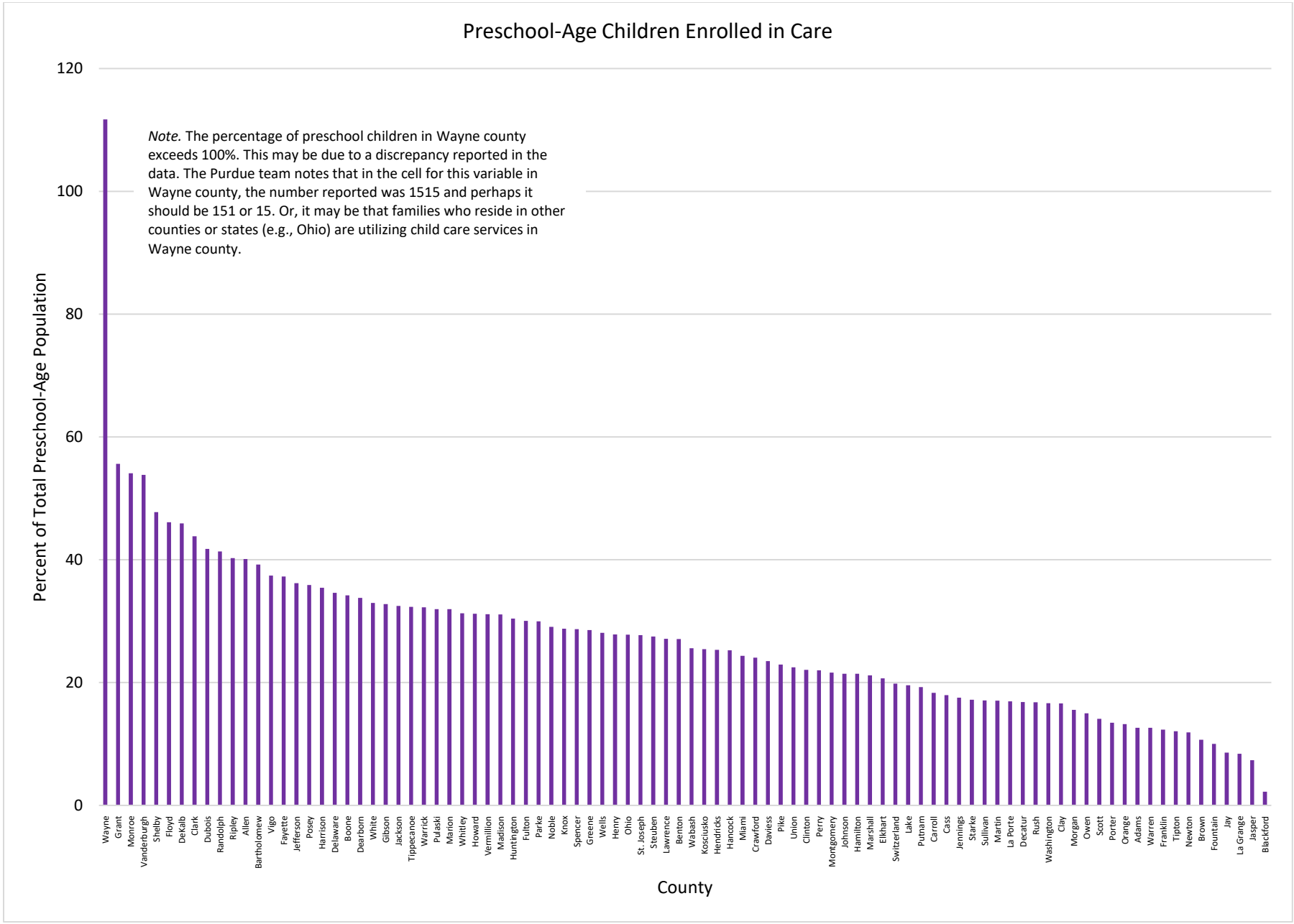
Total Participation by Age in ECCE Programming in Each County[12]

The following graphs represent the percentage of enrolled children by age in each county in rank order from largest percentage to smallest.

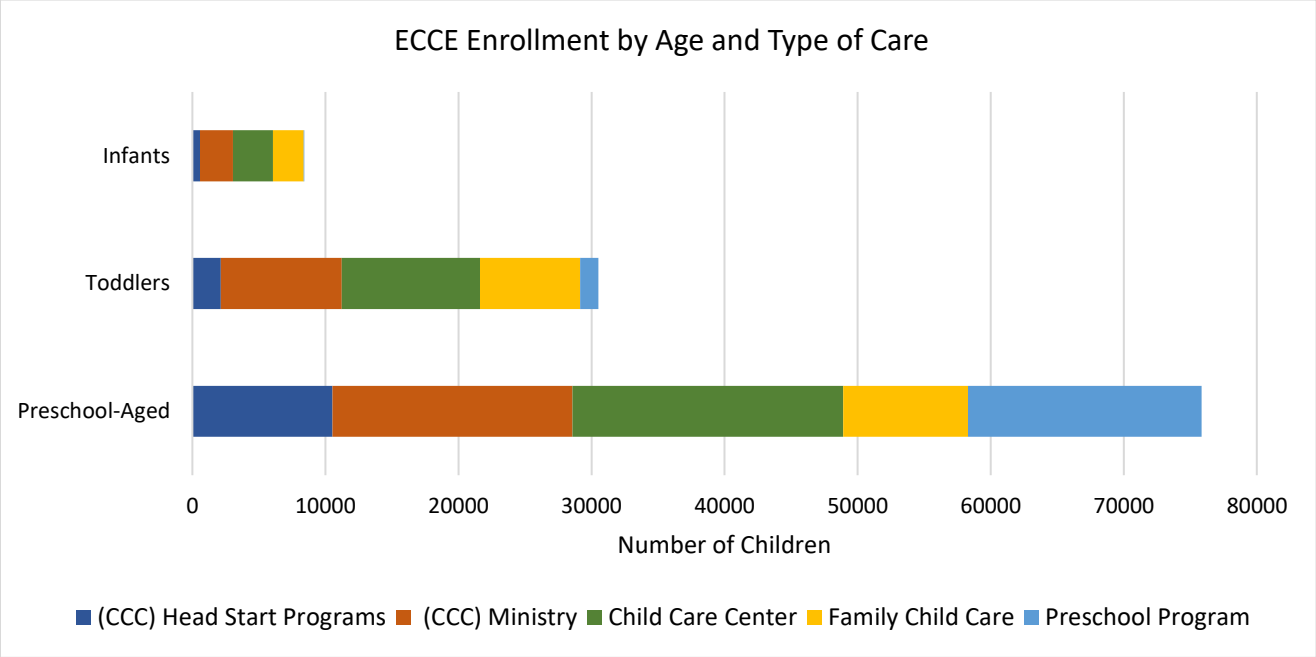


[12] Data source: Early Learning Indiana, received 4/19/19


Toddlers Enrolled in Care
Percent of Total Toddler Population
100
90
80
70
60
50
40
30
20
10
0
Monroe
Bartholomew
Vanderburgh
Boone
Knox
Steuben
Floyd
Vigo
Marion
Tippecanoe
Delaware
Randolph
Dubois
Hendricks
Grant
Hamilton
Lawrence
Allen
St. Joseph
Ripley
Whitley
Sullivan
Montgomery
Jackson
Gibson
Madison
Pulaski
Howard
Orange
Warrick
Vermillion
Jennings
Brown
Wayne
White
Clark
Fayette
Marshall
Johnson
Greene
Pike
Lake
Hancock
Harrison
Cass
DeKalb
Posey
Switzerland
Benton
Parke
Clinton
Kosciusko
Henry
Dearborn
Daviess
Decatur
Putnam
Elkhart
Warren
Washington
Wells
Huntington
Adams
Perry
Jefferson
Fulton
Union
Noble
Spencer
Tipton
Jay
Shelby
Morgan
Porter
Franklin
Scott
La Porte
Wabash
Crawford
Clay
Martin
Blackford
Rush
Owen
Carroll
Miami
Jasper
Starke
La Grange
Fountain
Newton
Ohio
County

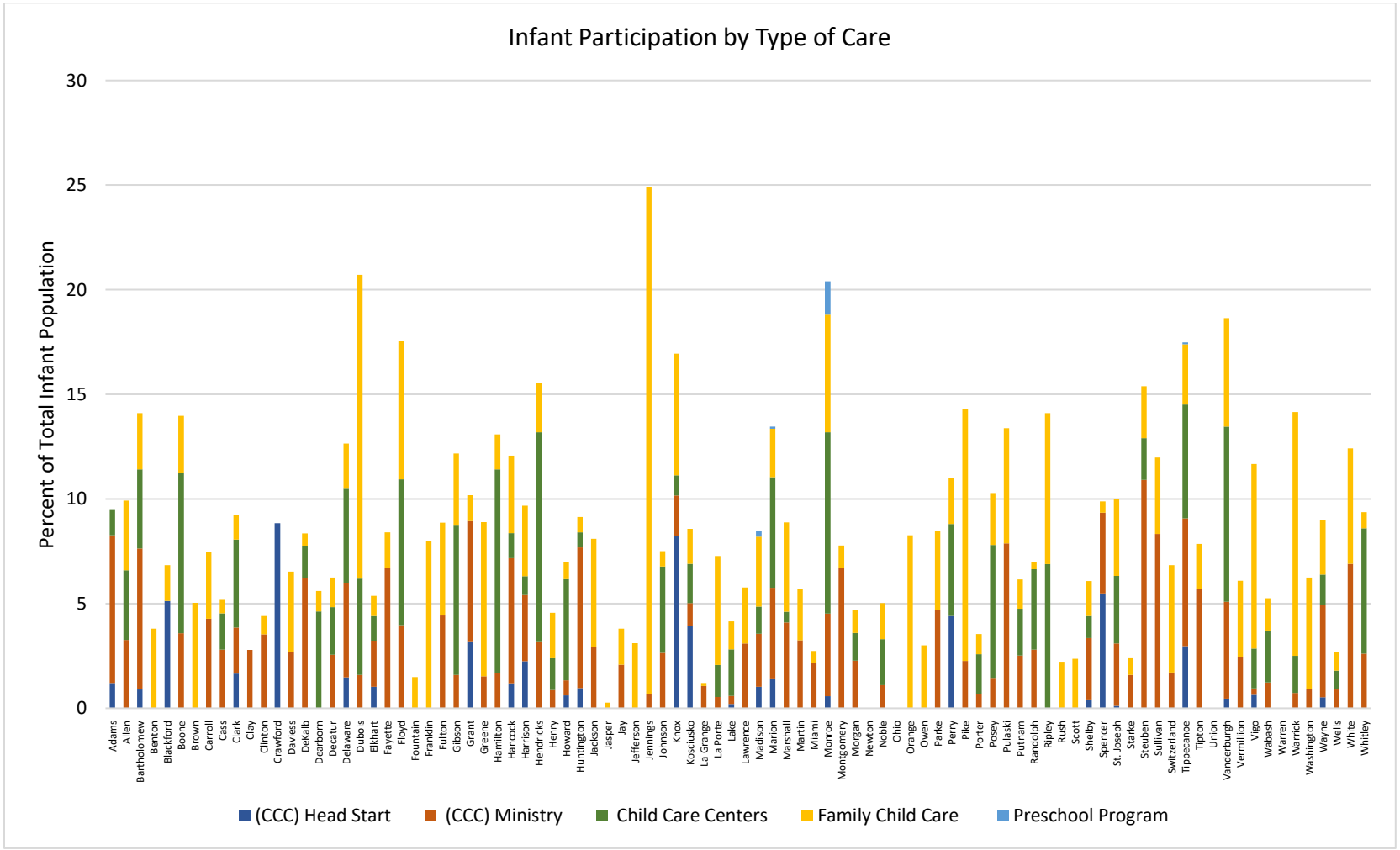

Preschool-Age Children Enrolled in Care
120
100
80
60
40
20
0
Percent of Total Preschool-Age Population
Note. The percentage of preschool children in Wayne county exceeds 100%. This may be due to a discrepancy reported in the data. The Purdue team notes that in the cell for this variable in Wayne county, the number reported was 1515 and perhaps it should be 151 or 15. Or, it may be that families who reside in other counties or states (e.g., Ohio) are utilizing child care services in Wayne county.
Wayne
Grant
Monroe
Vanderburgh
Shelby
Floyd
DeKalb
Clark
Dubois
Randolph
Ripley
Allen
Bartholomew
Vigo
Fayette
Jefferson
Posey
Harrison
Delaware
Boone
Dearborn
White
Gibson
Jackson
Tippecanoe
Warrick
Pulaski
Marion
Whitley
Howard
Vermillion
Madison
Huntington
Fulton
Parke
Noble
Knox
Spencer
Greene
Wells
Henry
Ohio
St. Joseph
Steuben
Lawrence
Benton
Wabash
Kosciusko
Hendricks
Hancock
Miami
Crawford
Daviess
Pike
Union
Clinton
Perry
Montgomery
Johnson
Hamilton
Marshall
Elkhart
Switzerland
Lake
Putnam
Carroll
Cass
Jennings
Starke
Sullivan
Martin
La Porte
Decatur
Rush
Washington
Clay
Morgan
Owen
Scott
Porter
Orange
Adams
Warren
Franklin
Tipton
Newton
Brown
Fountain
Jay
La Grange
Jasper
Blackford
County

Total Participation by Age and Type of Care in ECCE Programming in Indiana

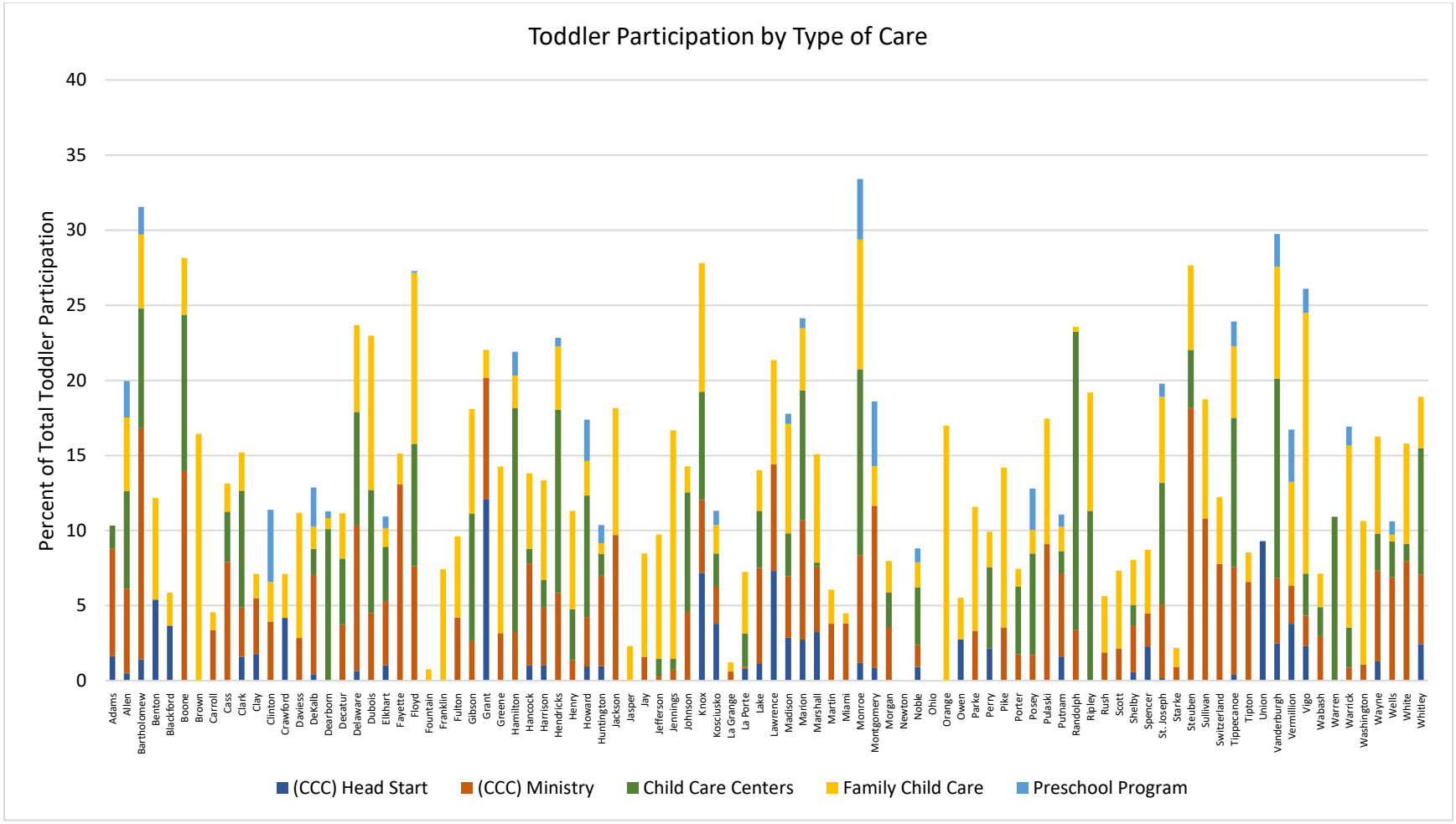


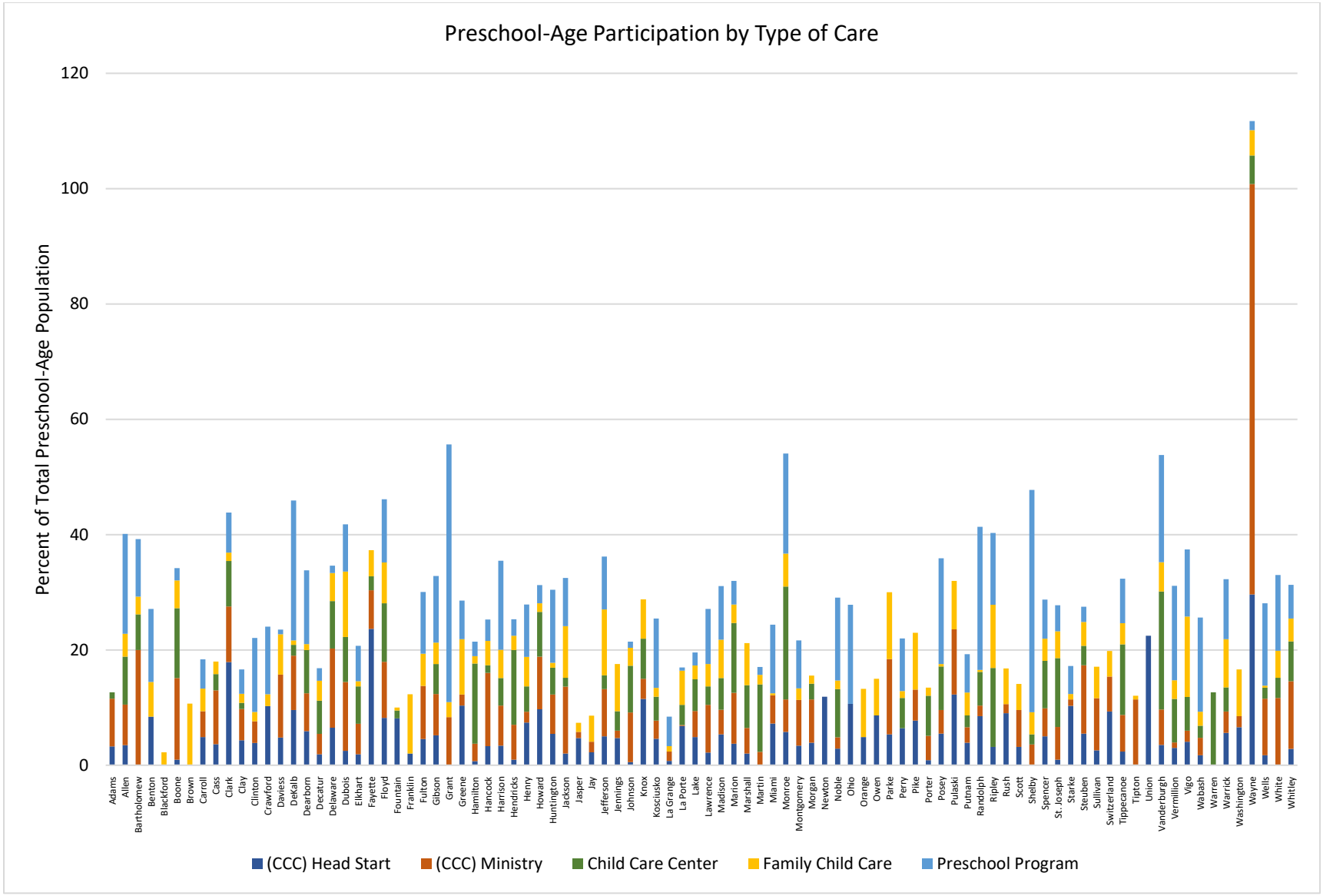
Total Participation by Age and Type of Care in ECCE Programming in Each County[13]

The following graphs represent the percent of children enrolled in each type of program by age in each county in alphabetical order.



[13] Data source: Early Learning Indiana, received 4/19/19

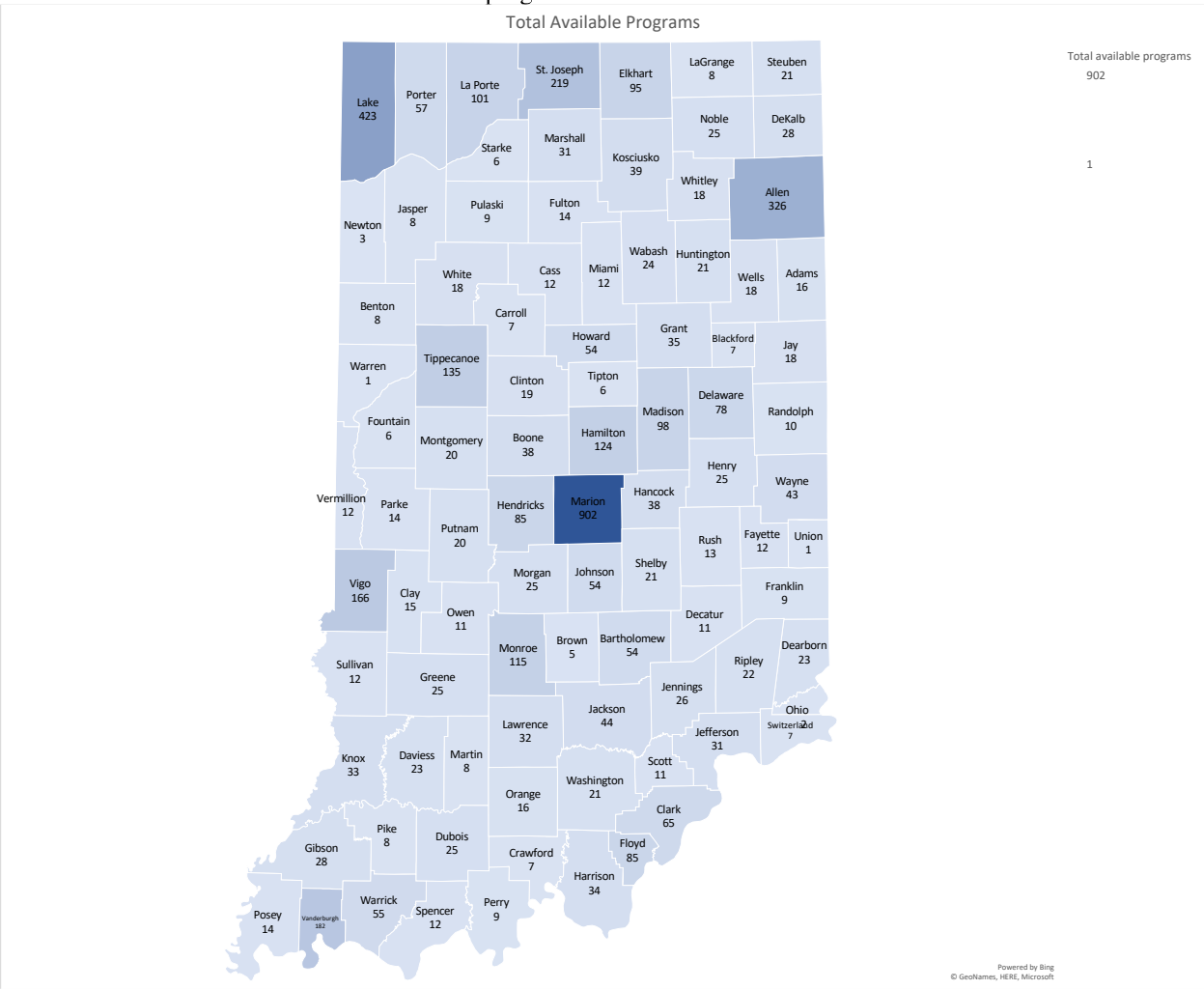

Toddler Participation by Type of Care
Percent of Total Toddler Participation
40
35
30
25
20
15
10
5
0
Adams
Allen
Bartholomew
Benton
Blackford
Boone
Brown
Carroll
Cass
Clark
Clay
Clinton
Crawford
Daviess
Dekalb
Dearborn
Decatur
Delaware
Dubois
Elkhart
Fayette
Floyd
Fountain
Franklin
Fulton
Gibson
Grant
Greene
Hamilton
Hancock
Harrison
Hendricks
Henry
Howard
Huntington
Jackson
Jasper
Jay
Jefferson
Jennings
Johnson
Knox
Kosciusko
La Grange
La Porte
Lake
Lawrence
Madison
Marion
Marshall
Martin
Miami
Monroe
Montgomery
Morgan
Newton
Noble
Ohio
Orange
Owen
Parke
Perry
Pike
Porter
Posey
Pulaski
Putnam
Randolph
Ripley
Rush
Scott
Shelby
Spencer
St. Joseph
Starke
Steuben
Sullivan
Switzerland
Tippecanoe
Tipton
Union
Vanderburgh
Vermillion
Vigo
Wabash
Warren
Warrick
Washington
Wayne
Wells
White
Whitley
(CCC) Head Start
(CCC) Ministry
Child Care Centers
Family Child Care
Preschool Program


Preschool-Age Participation by Type of Care
Percent of Total Preschool-Age Population
120
100
80
60
40
20
0
Adams
Allen
Bartholomew
Benton
Blackford
Boone
Brown
Carroll
Cass
Clark
Clay
Clinton
Crawford
Daviess
DeKalb
Dearborn
Decatur
Delaware
Dubois
Elkhart
Fayette
Floyd
Fountain
Franklin
Fulton
Gibson
Grant
Greene
Hamilton
Hancock
Harrison
Hendricks
Henry
Howard
Huntington
Jackson
Jasper
Jay
Jefferson
Jennings
Johnson
Knox
Kosciusko
La Grange
La Porte
Lake
Lawrence
Madison
Marion
Marshall
Martin
Miami
Monroe
Montgomery
Morgan
Newton
Noble
Ohio
Orange
Owen
Parke
Perry
Pike
Porter
Posey
Pulaski
Putnam
Randolph
Ripley
Rush
Scott
Shelby
Spencer
St. Joseph
Starke
Steuben
Sullivan
Switzerland
Tippecanoe
Tipton
Union
Vanderburgh
Vermillion
Vigo
Wabash
Warren
Warrick
Washington
Wayne
Wells
White
Whitley
(CCC) Head Start
(CCC) Ministry
Child Care Center
Family Child Care
Preschool Program

AVAILABILITY OF EARLY CHILDHOOD CARE AND EDUCATION PROGRAMMING

Total availability of ECCE programming in Indiana[14]
In total, Indiana has 4,730 available ECCE programs. The percentage of total ECCE slots by population is 34%, and this varies substantially by county (4% to 57%)

Total Availability of ECCE Programming in Each County[14]
As seen in the map and table below, Marion and Lake counties have the most ECCE programs available and Union and Warren counties have the fewest available programs.



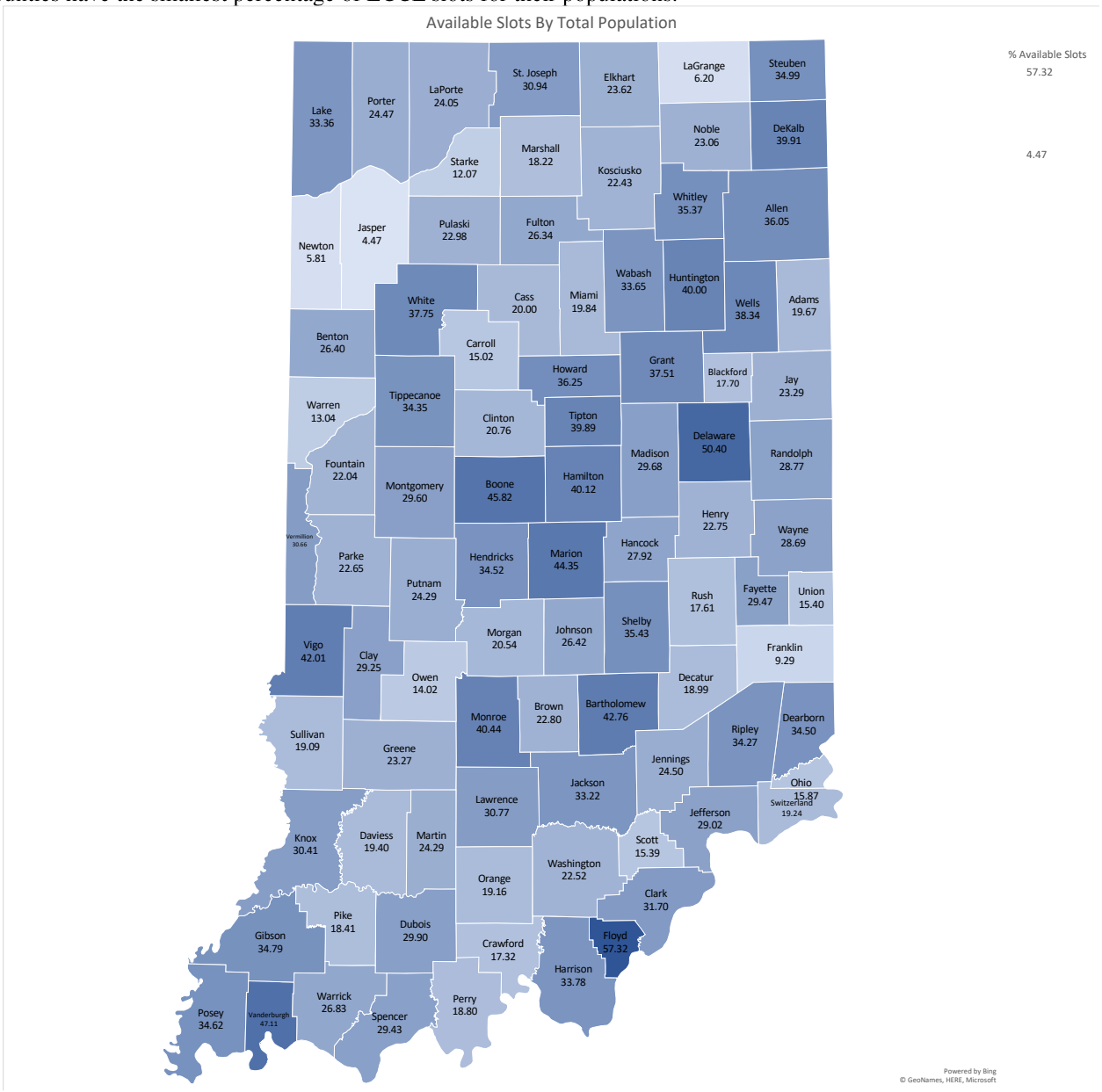
[14] Data source: Early Learning Indiana, received 4/19/19

Total Availability of ECCE Programming[15]		
10 Highest Counties		
County	**Total 0 – 5 Population**	**# of Programs**
Marion	82,693	902
Lake	35,664	423
Allen	31,632	326
St. Joseph	20,919	219
Vanderburgh	13,011	182
Vigo	7,491	166
Tippecanoe	13,872	135
Hamilton	26,455	124
Monroe	7,922	115
La Porte	7,899	101
10 Lowest Counties		
County	**Total 0 – 5 Population**	**# of Programs**
Carroll	1,318	7
Blackford	791	7
Tipton	900	6
Starke	1,624	6
Fountain	1,189	6
Brown	737	5
Newton	946	3
Ohio	334	2
Warren	529	1
Union	448	1

[15] Data source: Early Learning Indiana, received 4/19/19

Percentage of Available Slots for the County Population of Children Birth to 5[16]

Floyd and Delaware counties have the largest percentage of ECCE slots for their populations. Jasper and Newton counties have the smallest percentage of ECCE slots for their populations.



[16] Data source: Early Learning Indiana, received 4/19/19

Child Care Deserts

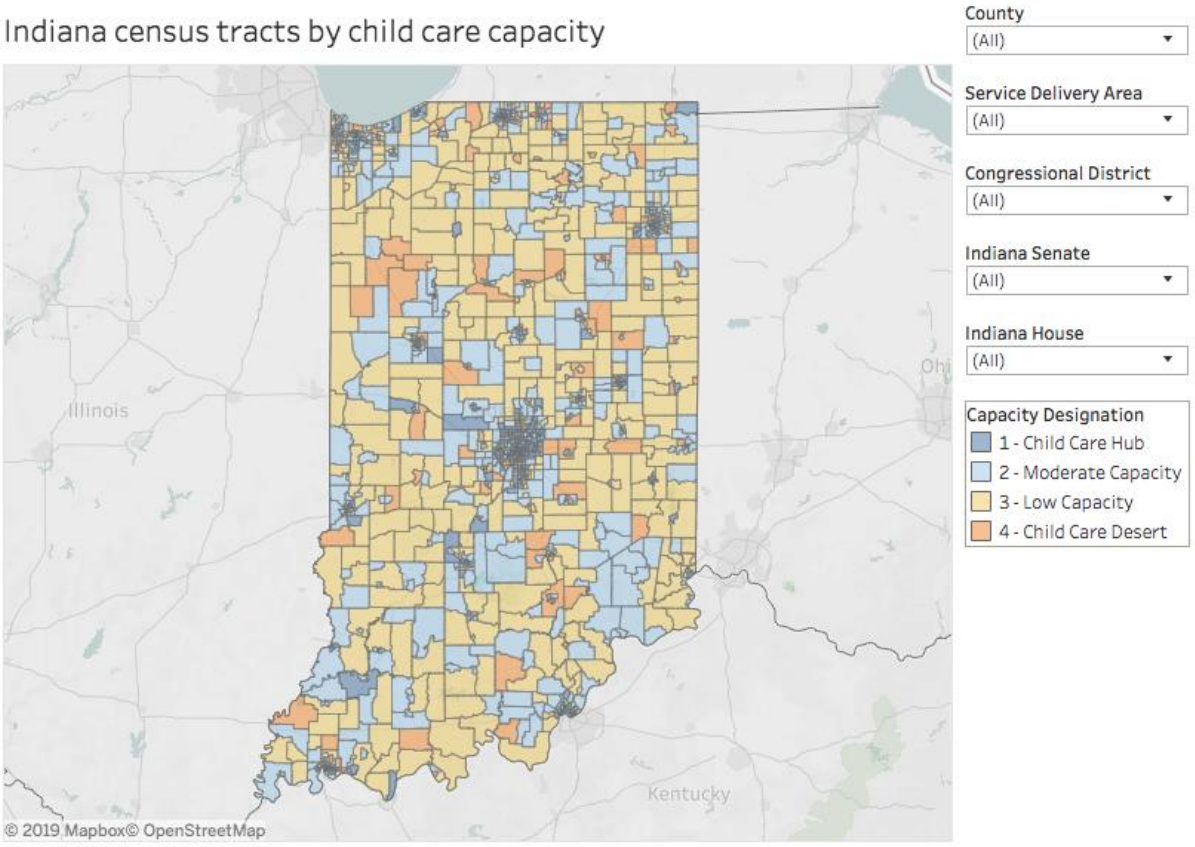
In Indiana, nearly 70% of children have all available parents (both parents in a two-parent household or the custodial parent in a one-parent household) in the labor force.[17] However, according to a recent report by the Center for American Progress,[18] 55% of families in Indiana reside in child care deserts. This number is slightly higher than the national average of 51%. A child care desert is defined as any 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. Thus, over half of Hoosier families with children younger than age 5 have little to no access to a licensed child care provider. Certain populations in Indiana are at higher risk of low child care supply. For example, whereas 72% of families in rural communities have little to no access to a licensed child care provider, 46-48% of families in suburban or urban communities face this undersupply. Although undersupply is an important issue across these geographic regions, strategies for addressing the problem may have to be tailored to the unique needs of the communities. Child care access is also more problematic for Non-Hispanic, white children and Hispanic/Latino children (57% of children from these groups live in child care deserts) relative to Non-Hispanic, black/African American children (40% of children from these groups live in child care deserts).

Child Care Deserts by County/Census Tract

Child care deserts are more pronounced in certain counties/census tracts in Indiana. In a recent study using geocoding techniques, ELI and the Indiana Business Research Center sorted census tracts in the state into four categories: child care hub (areas with at least 1.5 licensed child care slots per child), moderate capacity (areas with a ratio of licensed child care slots to children between .33 and 1.49), low capacity (areas with more than 3 children for every licensed child care slot but a small number of jobs and a relatively low population of children, and child care desert (areas where there are more than 3 children per licensed slot and a large number of jobs and a high population of children). As indicated in the map below (click link for an interactive map by county: http://www.incontext.indiana.edu/2019/jan-feb/article2.asp), most of the state's census tracts had a capacity designation of moderate to low. Rural counties (e.g., Jasper county) were at particularly high risk for being designated as a child care desert.

[17] https://datacenter.kidscount.org/data/tables/5057-children-under-age-6-with-all-available-parents-in-the-labor-force#detailed/1/any/false/871,870,573,869,36,868,867,133,38,35/any/11472,11473

18 https://childcaredeserts.org/index.html



Note. Data used for this map only included licensed child care facilities.

Child Care Deserts for Infants and Toddlers

Each year, over 80,000 babies are born in Indiana[19] indicating a potential high demand for child care for infants and toddlers. Despite this potential need, there appears to be an undersupply of child care slots for this age range. In a recent report by the Center for American Progress on understanding infant and toddler child care deserts specifically,[20] data indicated that of the total infant-toddler population of 245,461 in Indiana, there were just 29,482 slots available in licensed facilities, which translates to approximately 8 children per available slot. Of the nine states included in this report, Indiana was the lowest in terms of total capacity for infants and toddlers in licensed facilities (i.e., 12% of the infant-toddler population has capacity available).

Consequences of Child Care Deserts

An undersupply of child care has potential consequences for Indiana families. If working parents do not have access to child care, they may not be able to participate in the labor force, which could have implications for Indiana's growing economy. Further, when working families do not have access to licensed care in particular, they may have to rely on unregulated care, which could have implications for their children's health and well-being.

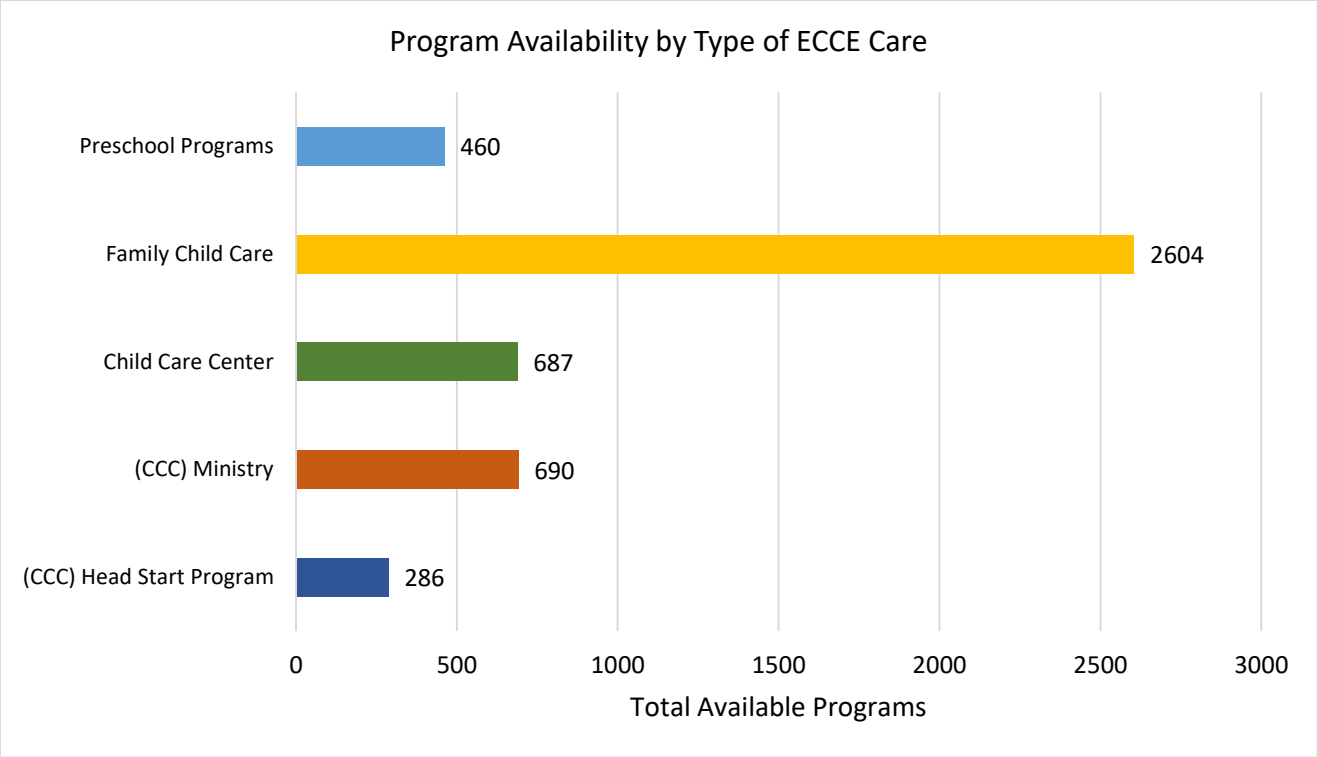
Note. Data reported in the above section on child care deserts reflect licensed care options only. Some families may have access to unlicensed or exempt child care providers.

[19] Data source: Indiana Department of Health. https://www.in.gov/isdh/27472.htm

20 https://www.americanprogress.org/issues/early-childhood/reports/2018/10/31/460128/understanding-infant-toddler-child-care-deserts/

Total Availability by Type of Care in ECCE Programming in Indiana[21]

Licensed, family child care homes represent the largest portion of ECCE programming in the state of Indiana, followed by registered ministries and licensed child care centers.[22]



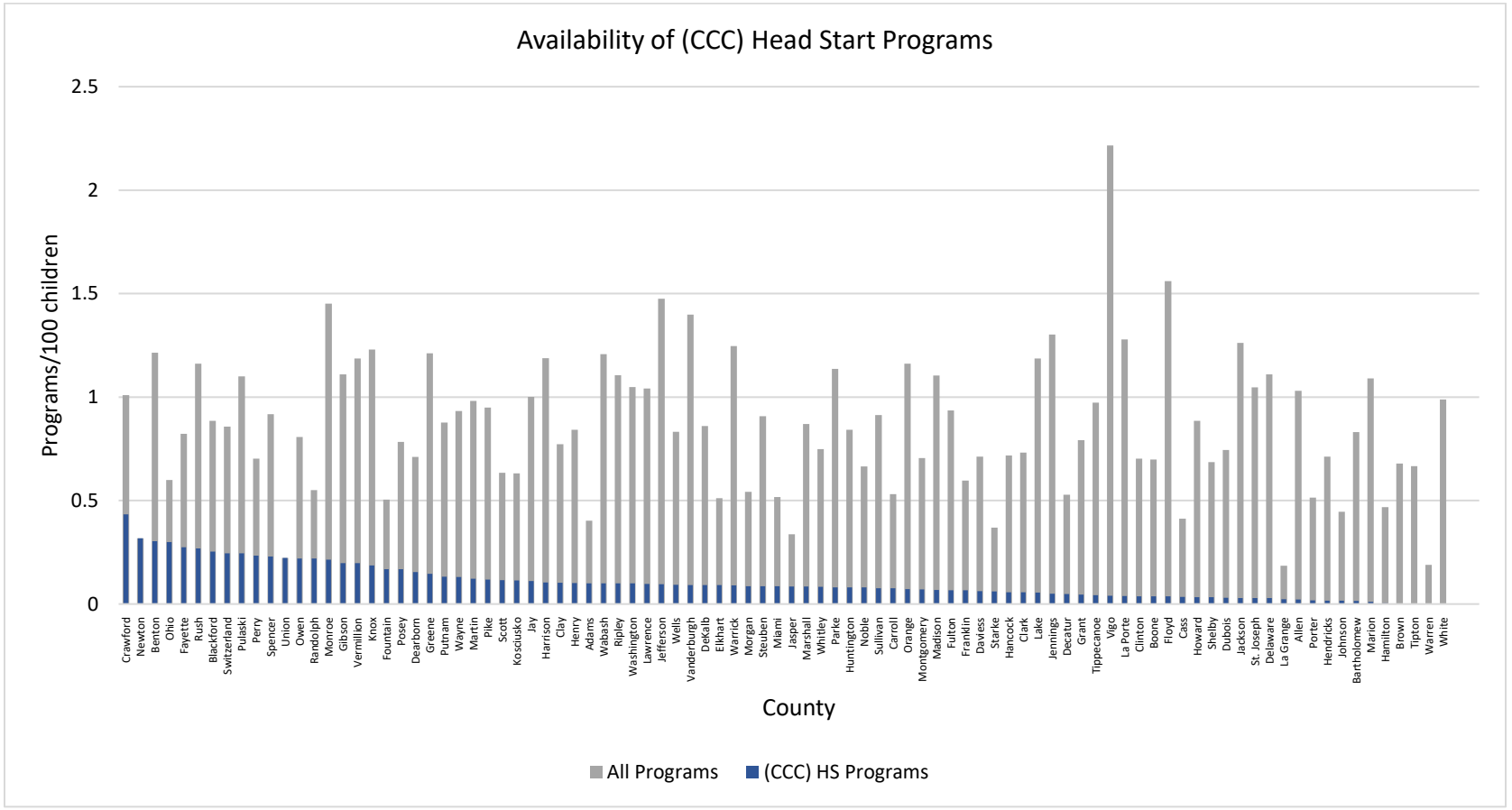
[21] Data source: Early Learning Indiana, received 4/19/19

[22] In the Early Learning Indiana data set, 690 child care centers are listed, however, most of the data were missing for 3 sites. Thus, we report 687 centers here.

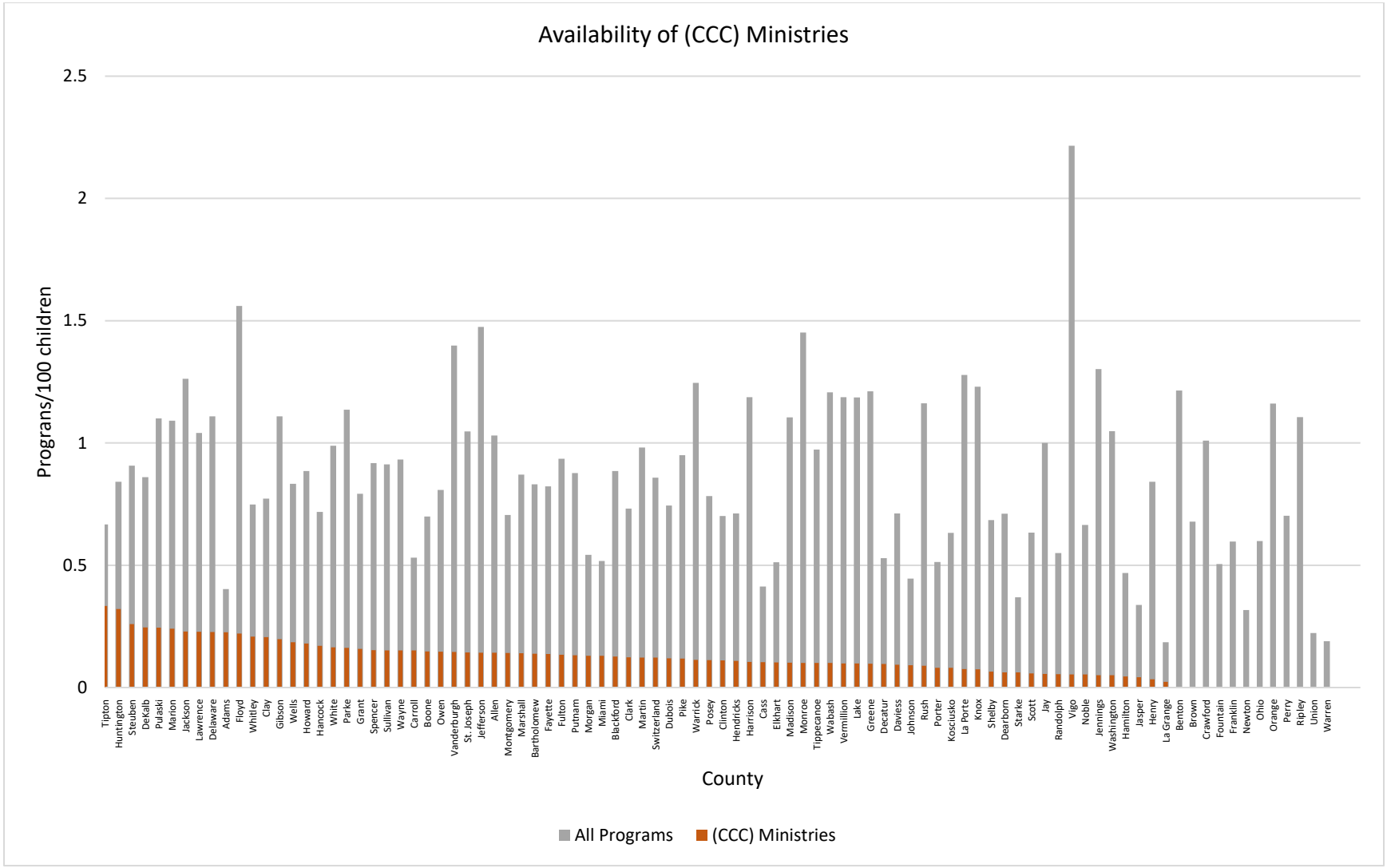
Total Availability by Type of Care in ECCE Programming in Each County[23]

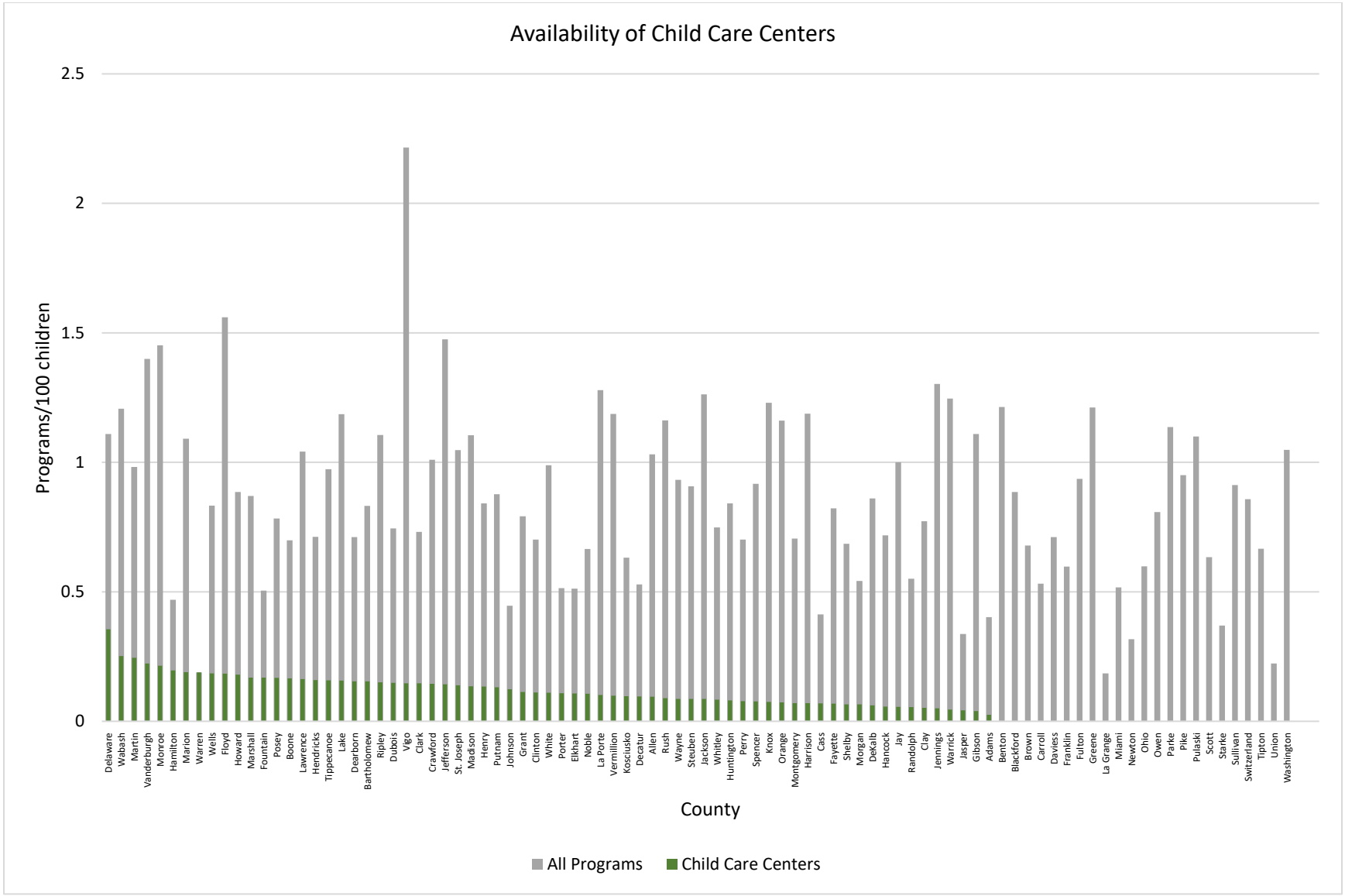
The following graphs represent the number of each type of program per 100 children in each county in rank order from largest number available to smallest. In some counties, there are no Head Start programs (e.g., Tipton, Warren), indicating that there may not be enough support for children from low income backgrounds. In other counties, there are no licensed child care centers (e.g., Tipton, Union) or family child care homes (e.g., Union, Warren).

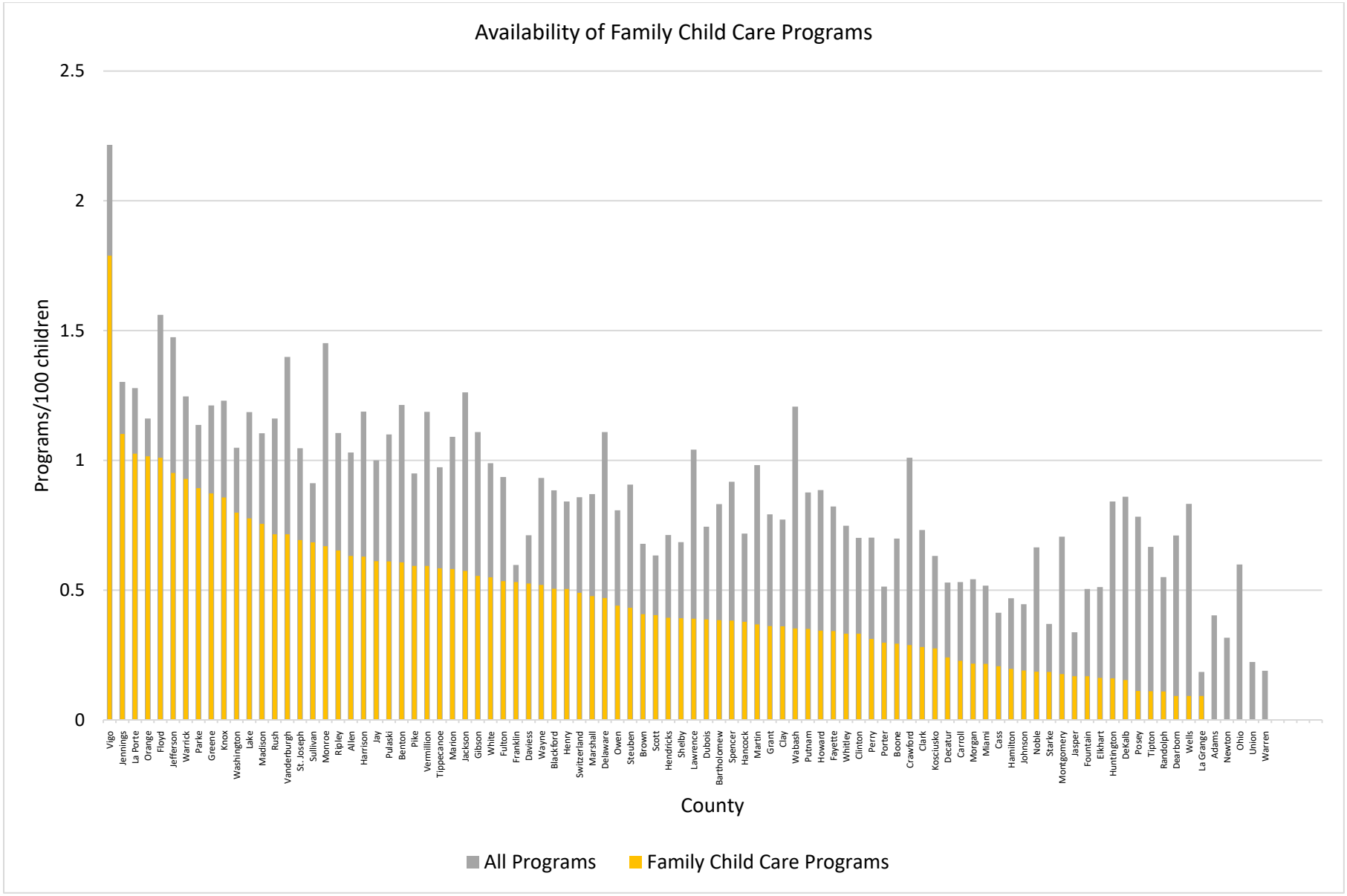
Note. Gray bars represent total available ECCE programs in each county.

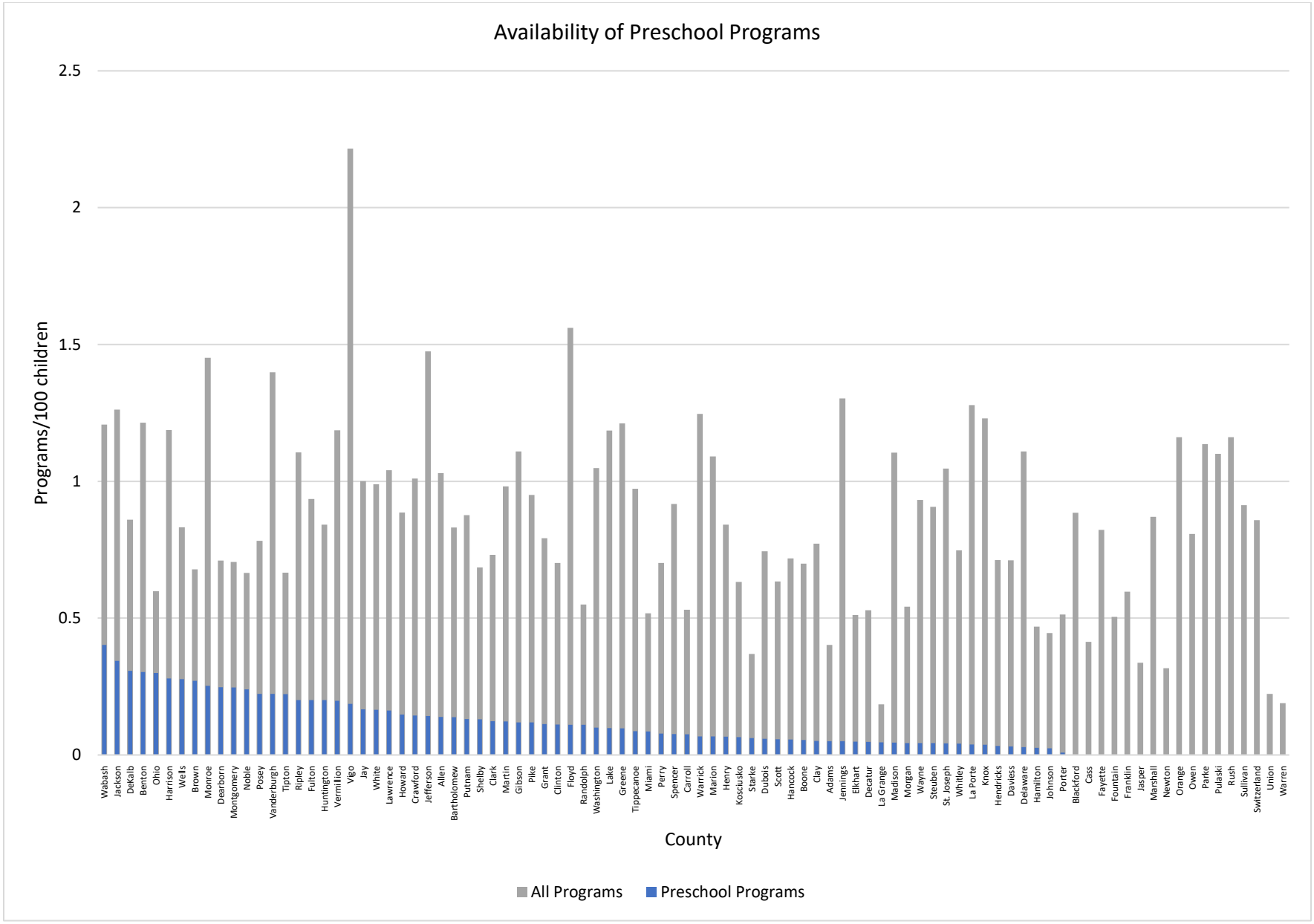


[23] Data source: Early Learning Indiana, received 4/19/19


Availability of (CCC) Ministries
Prograns/100 children
2.5
2
1.5
1
0.5
0
Tipton
Huntington
Steuben
DeKalb
Pulaski
Marion
Jackson
Lawrence
Delaware
Adams
Floyd
Whitley
Clay
Gibson
Wells
Howard
Hancock
White
Parke
Grant
Spencer
Sullivan
Wayne
Carroll
Boone
Owen
Vanderburgh
St. Joseph
Jefferson
Allen
Montgomery
Marshall
Bartholomew
Fayette
Fulton
Putnam
Morgan
Miami
Blackford
Clark
Martin
Switzerland
Dubois
Pike
Warrick
Posey
Clinton
Hendricks
Harrison
Cass
Elkhart
Madison
Monroe
Tippecanoe
Wabash
Vermillion
Lake
Greene
Decatur
Daviess
Johnson
Rush
Porter
Kosciusko
La Porte
Knox
Shelby
Dearborn
Starke
Scott
Jay
Randolph
Vigo
Noble
Jennings
Washington
Hamilton
Jasper
Henry
La Grange
Benton
Brown
Crawford
Fountain
Franklin
Newton
Ohio
Orange
Perry
Ripley
Union
Warren
County
All Programs
(CCC) Ministries


Availability of Child Care Centers
Programs/100 children
2.5
2
1.5
1
0.5
0
Delaware
Wabash
Martin
Vanderburgh
Monroe
Hamilton
Marion
Warren
Wells
Floyd
Howard
Marshall
Fountain
Posey
Boone
Lawrence
Hendricks
Tippecanoe
Lake
Dearborn
Bartholomew
Ripley
Dubois
Vigo
Clark
Crawford
Jefferson
St. Joseph
Madison
Henry
Putnam
Johnson
Grant
Clinton
White
Porter
Elkhart
Noble
La Porte
Vermillion
Kosciusko
Decatur
Allen
Rush
Wayne
Steuben
Jackson
Whitley
Huntington
Perry
Spencer
Knox
Orange
Montgomery
Harrison
Cass
Fayette
Shelby
Morgan
DeKalb
Hancock
Jay
Randolph
Clay
Jennings
Warrick
Jasper
Gibson
Adams
Benton
Blackford
Brown
Carroll
Daviess
Franklin
Fulton
Greene
La Grange
Miami
Newton
Ohio
Owen
Parke
Pike
Pulaski
Scott
Starke
Sullivan
Switzerland
Tipton
Union
Washington
County
All Programs
Child Care Centers


Availability of Family Child Care Programs
Programs/100 children
2.5
2
1.5
1
0.5
0
Vigo
Jennings
La Porte
Orange
Floyd
Jefferson
Warrick
Parke
Greene
Knox
Washington
Lake
Madison
Rush
Vanderburgh
St. Joseph
Sullivan
Monroe
Ripley
Allen
Harrison
Jay
Pulaski
Benton
Pike
Vermillion
Tippecanoe
Marion
Jackson
Gibson
White
Fulton
Franklin
Daviess
Wayne
Blackford
Henry
Switzerland
Marshall
Delaware
Owen
Steuben
Brown
Scott
Hendricks
Shelby
Lawrence
Dubois
Bartholomew
Spencer
Hancock
Martin
Grant
Clay
Wabash
Putnam
Howard
Fayette
Whitley
Clinton
Perry
Porter
Boone
Crawford
Clark
Kosciusko
Decatur
Carroll
Morgan
Miami
Cass
Hamilton
Johnson
Noble
Starke
Montgomery
Jasper
Fountain
Elkhart
Huntington
DeKalb
Posey
Tipton
Randolph
Dearborn
Wells
La Grange
Adams
Newton
Ohio
Union
Warren
County
All Programs
Family Child Care Programs


Availability of Preschool Programs
Programs/100 children
2.5
2
1.5
1
0.5
0
Wabash
Jackson
DeKalb
Benton
Ohio
Harrison
Wells
Brown
Monroe
Dearborn
Montgomery
Noble
Posey
Vanderburgh
Tipton
Ripley
Fulton
Huntington
Vermillion
Vigo
Jay
White
Lawrence
Howard
Crawford
Jefferson
Allen
Bartholomew
Putnam
Shelby
Clark
Martin
Gibson
Pike
Grant
Clinton
Floyd
Randolph
Washington
Lake
Greene
Tippecanoe
Miami
Perry
Spencer
Carroll
Warrick
Marion
Henry
Kosciusko
Starke
Dubois
Scott
Hancock
Boone
Clay
Adams
Jennings
Elkhart
Decatur
La Grange
Madison
Morgan
Wayne
Steuben
St. Joseph
Whitley
La Porte
Knox
Hendricks
Daviess
Delaware
Hamilton
Johnson
Porter
Blackford
Cass
Fayette
Fountain
Franklin
Jasper
Marshall
Newton
Orange
Owen
Parke
Pulaski
Rush
Sullivan
Switzerland
Union
Warren
County
All Programs
Preschool Programs

Total Availability by Age in ECCE Programming in Indiana

Unfortunately, there are no reliable data available on the availability of ECCE programming broken down by age. Although the primary dataset used for this report on availability and participation in ECCE programming (from ELI) does provide age breakdowns, there are inconsistencies in the way providers report availability which makes it impossible to aggregate these data in a reliable manner.

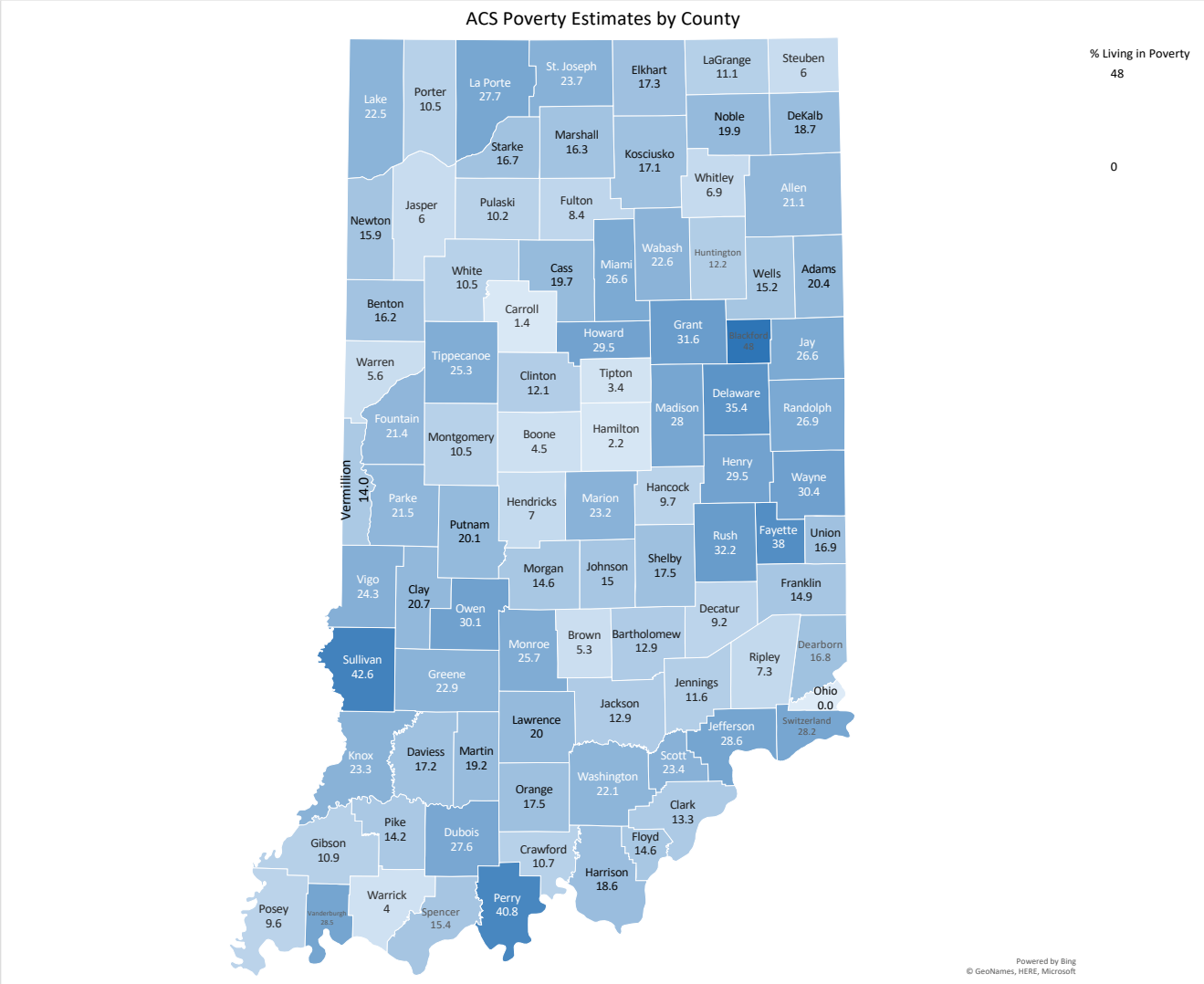
Availability of and Participation in Early Childhood Care and Education Programming for Vulnerable Populations

Unfortunately, comprehensive data on family income, demographic information, and other vulnerabilities are not collected from all families in the ECCE system in a systematic fashion. Thus, a complete picture of participation rates in the system cannot be provided. However, several agencies within the mixed delivery system collect some information regarding vulnerable populations. Thus, we report on available data regarding child care participation and quality of care for children from low income backgrounds,[24] participation in disability and special education services, and participation in other programs designed to support vulnerable populations. When possible, we provide the demographic characteristics of children and families participating in these programs as a means of describing service use of vulnerable populations in the state. We also provide maps that identify potential high risk counties.

[24] Data and information for On My Way Pre-K is provided in the "Quality (including quality and availability of programs and supports)" section.

Children from Low-Income Backgrounds

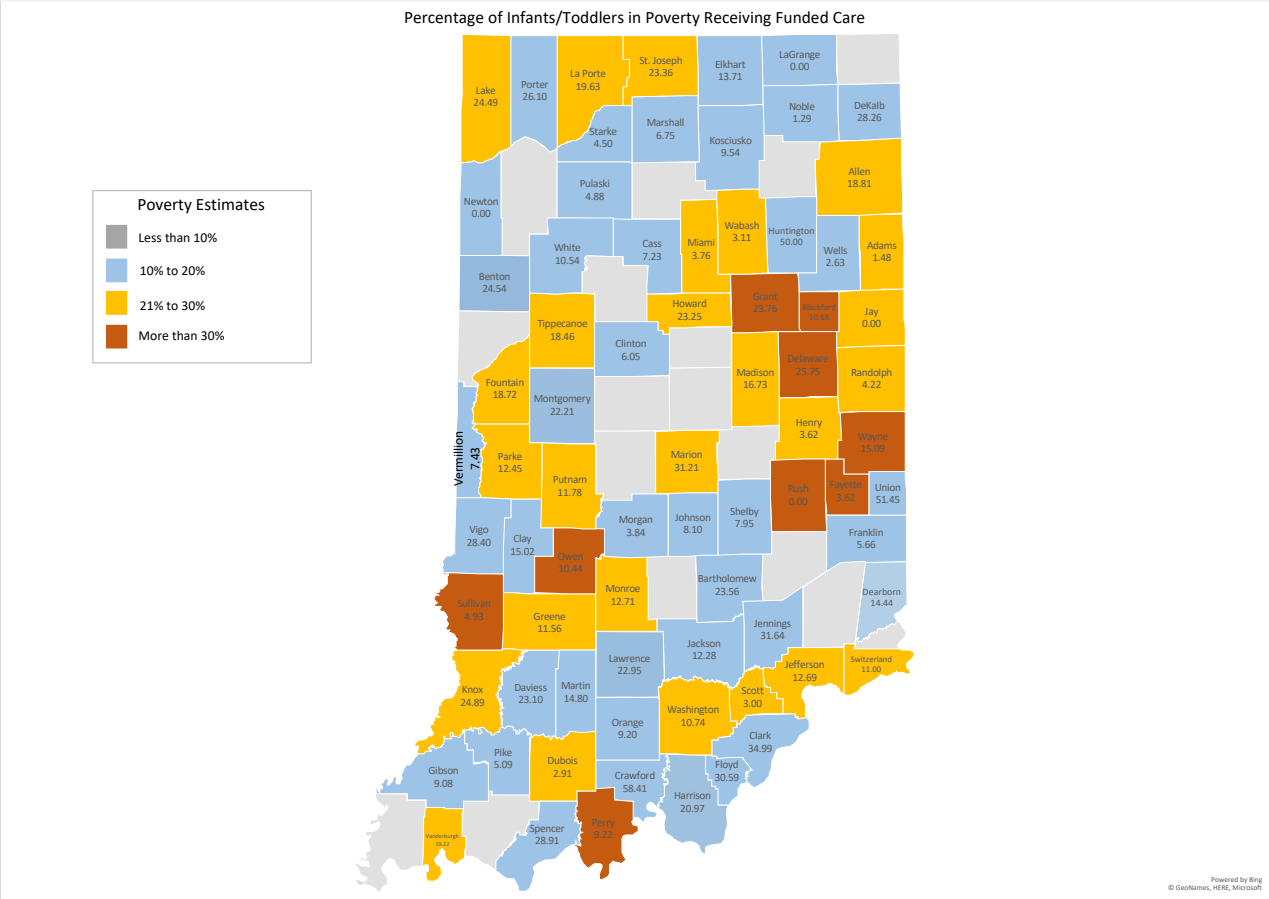
According to the U.S. Census Bureau, approximately 25% of children in Indiana ages 0-5 live in poverty (i.e., below 100% of the Federal Poverty Line [FPL]).[25] Below is a map of Indiana with poverty estimates by county.[26] In this report, we use children below 100% of the FPL as our reference group (e.g., when presenting percentages of children from low-income backgrounds receiving care) because these data were most accessible for children 0-5 at the county level and because this category of income was most in line with eligibility requirements for state and federal child care subsidies.



[25] US Census Bureau, 2012-2016; American Community Survey 5-Year Estimates retrieved from ELAC data dashboard: http://www.elacindiana.org/data/elac-annual-report-interactive-dashboard/

[26] Percentages reported from 2013-2017 American Community Survey (ACS) 5-Year Estimates for "all families of households of low-income with related children of the householder under 5 years only". ACS does not report on other income brackets.

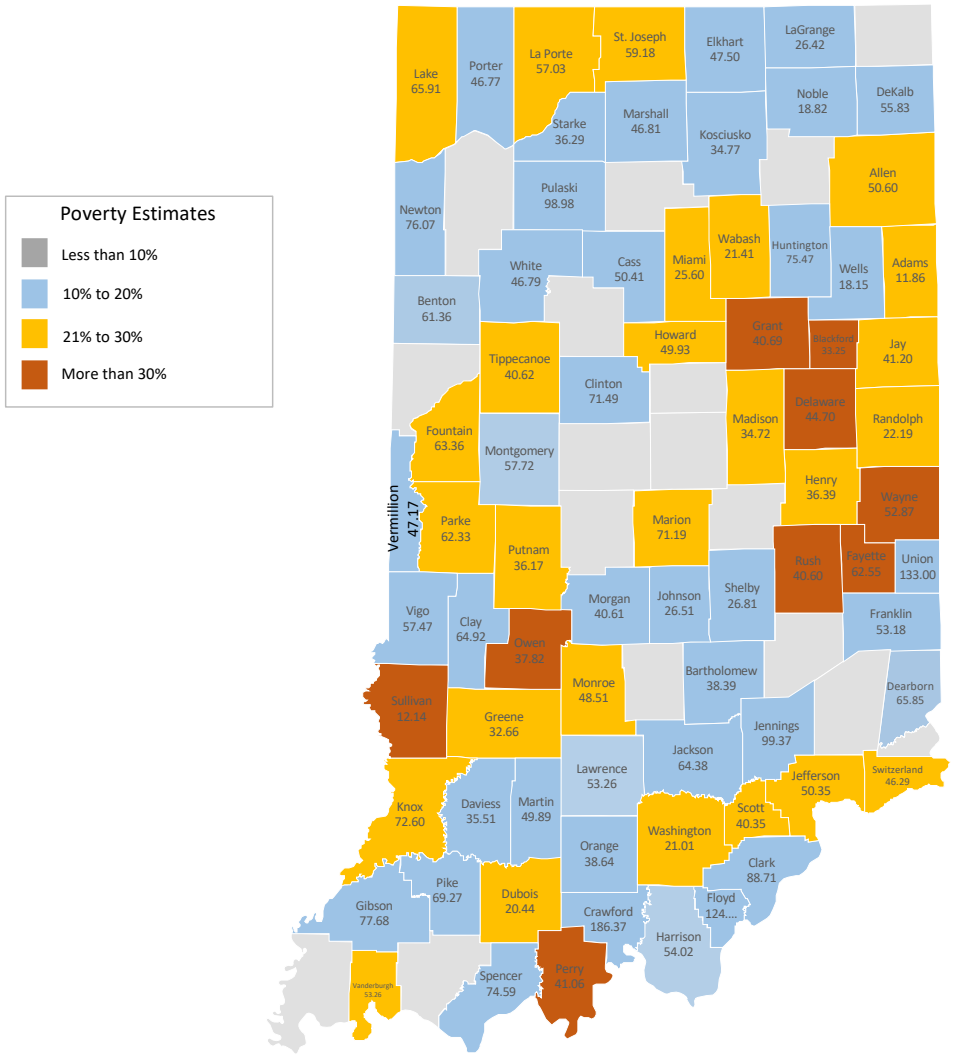
Supports for Indiana families with low incomes who are seeking child care are provided through the following mechanisms: Head Start, Child Care Development Funds (CCDF), and On My Way Pre-K (OMW). Below, maps are provided that represent the percentage of infants/toddlers and preschoolers who are living in poverty (below 100% of the FPL) who are receiving support through these mechanisms.[27,28] The counties with less than 10% of children living in poverty are colored in gray and are not included in the report. Counties that have high poverty rates and few infants/toddlers receiving funded care include Rush, Fayette, Sullivan, and Perry. Although more preschoolers in poverty are receiving funded care, there are some counties that have high poverty rates that have less than 40% of these children in funded care (e.g., Rush, Sullivan, Blackford). The majority of counties that have high poverty and low percentages of children in poverty receiving funded care are rural.



[27] Data sources: FSSA; Office of Head Start; 2013-2017 American Community Survey (ACS) 5-Year Estimates; Easy Access to Juvenile Populations (EZAPOP: 1990-2017), National Center for Juvenile Justice

[28] Formula for calculating % of infants/toddlers in poverty receiving funded care = Total Number of Infants/Toddlers receiving funded care (CCDF + Early Head Start) / [% ACS poverty rate*Total Infant/Toddler Population]; Formula for calculating % of preschool-age children in poverty receiving funded care = Total Number of Preschool-Age children receiving funded care (CCDF + Head Start + OMW) / [% ACS poverty rate*Total Preschool-Age Population]; Children receiving CCDF vouchers may be receiving care from a program in a different county. Enrollment percentages depicted here are based on the child's reported home county.

Percentage of Preschool-Age Children in Poverty Receiving Funded Care



Availability of and Participation in Head Start[29]

Federal regulations require that the majority of Head Start slots be occupied by children from low-income backgrounds. In total, Indiana has 67 Head Start providers (30 Early Head Start, 37 Head Start). There are no Migrant and Seasonal Head Start or American Indian and Alaska Native Head Start providers in Indiana.[30] The total funded enrollment in Head Start is 14,219. Approximately 71% of children enrolled come from families with incomes below 100% of the FPL, 8% are in foster care placements, and 6% are considered homeless. Further, the large majority of children in Head Start speak English as their primary language.

The capacity of Head Start programming varies by county. Below are two tables of the counties with the highest Early Head Start and Head Start capacities and the lowest capacities.[31]

Early Head Start Capacities		
10 Highest Counties		
County	**Total Infant/Toddler Population**	**Early Head Start Capacity**
Lake	17,438	230
Marion	42,109	200
Delaware	3,455	138
Grant	2,211	114
St. Joseph	10,367	112
Elkhart	9,360	96
Howard	2,974	86
Tippecanoe	7,089	86
DeKalb	1,665	82
Madison	4,397	80
10 Lowest Counties		
Clay	997	12
Owen	668	12
Parke	635	12
Putnam	1,098	12
Washington	969	11
Greene	1,020	9
Orange	683	9
Hamilton	12,468	8
Miami	1,100	6
Martin	387	4

Head Start Capacities		
10 Highest Counties		
County	**Total Preschool-Age Population**	**Head Start Capacity**
Marion	40,584	1319
Lake	18,226	1115
St. Joseph	10,552	560
Allen	15,810	504
Elkhart	9,199	460
Vanderburgh	6,549	321
Wayne	2,302	306
La Porte	3,944	306
Floyd	2,760	276
Monroe	3,850	267

[29] Data source: Office of Head Start – Program Information Report (PIR) data, 2018

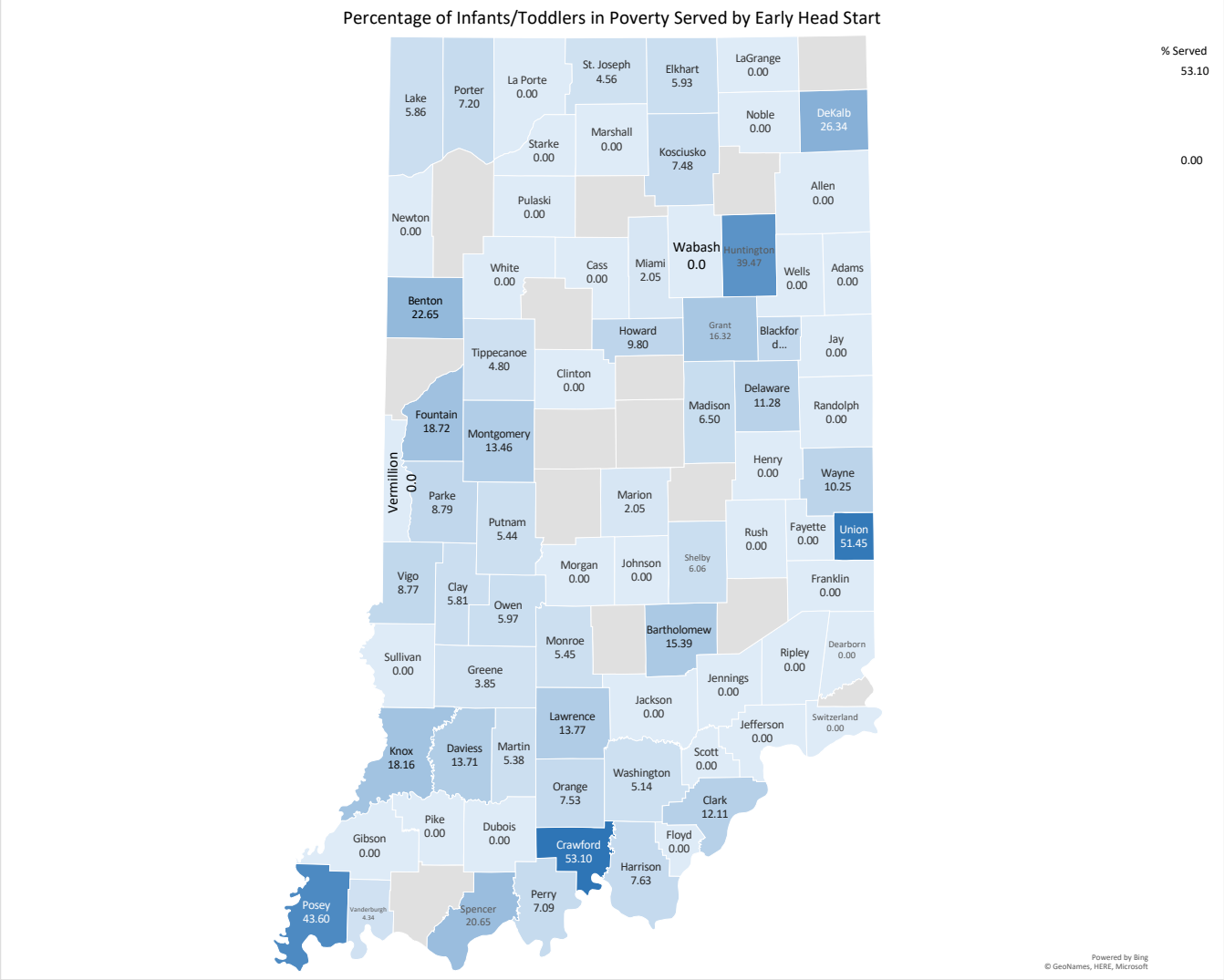
[30] Although there are no Migrant and Seasonal Head Start or American Indian and Alaska Native Head Start grantees in Indiana, there are children being served in Indiana through these programs. For example, in Tippecanoe county, there is a Migrant Head Start program that is funded through a grantee in Texas.

[31] Capacity = number of slots available. In the table, the 10 counties with the lowest capacities are included that have at least 1 slot available. Two counties have 0 Early Head Start slots available.

10 Lowest Counties		
Fulton	749	20
Wells	1,160	20
White	916	19
Carroll	714	18
Decatur	1,064	18
Ohio	169	18
Sullivan	696	18
Washington	1,034	17
Brown	393	16
Vermillion	530	16

Participation rates in Head Start programming also vary by county. Below are maps of the percentages of children ages 0-5 living in poverty (income below 100% FPL)[32] being served in Early Head Start and Head Start.[33] The counties with less than 10% of children living in poverty are colored in gray and are not included in the report.

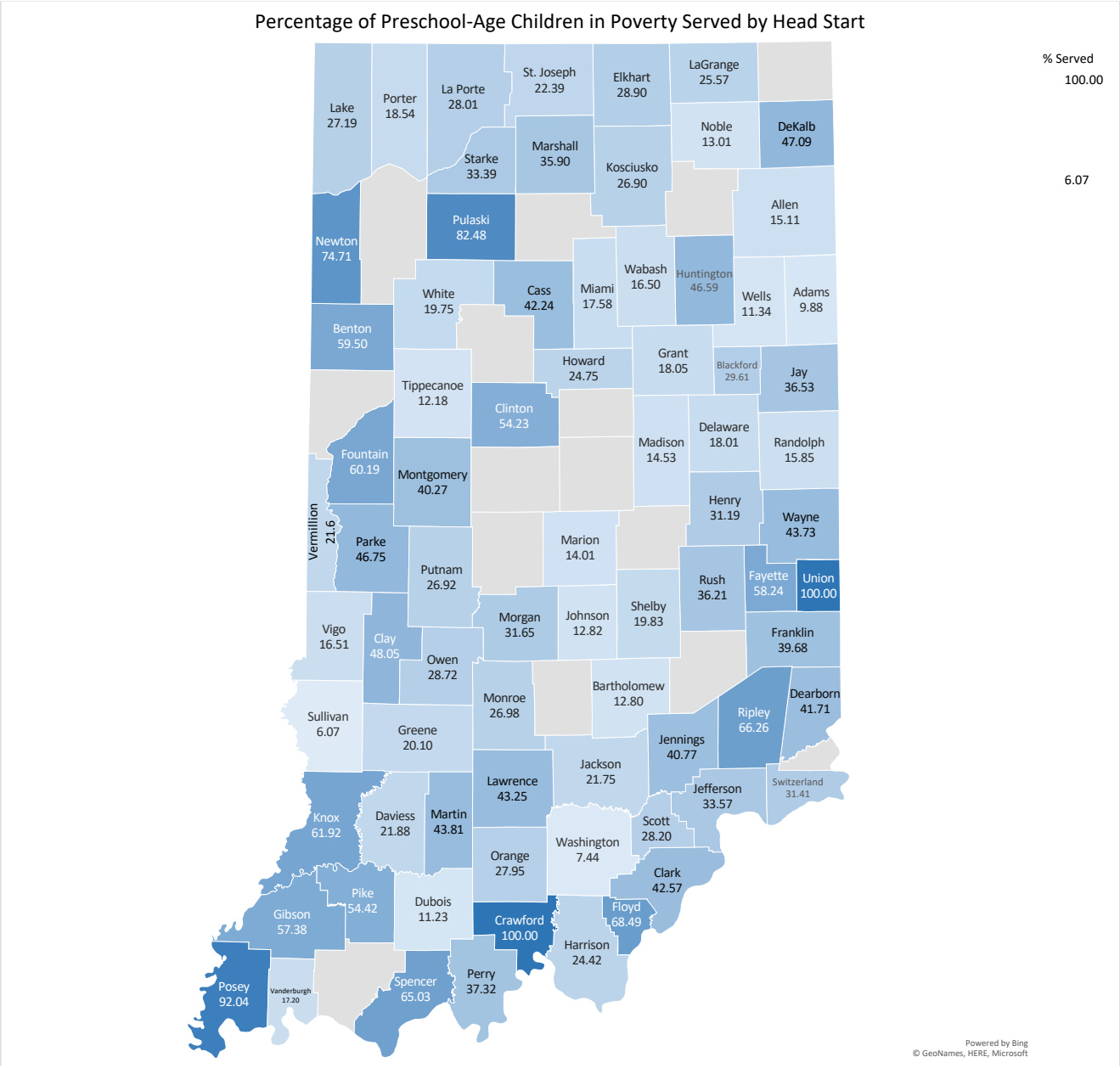
Union and Crawford counties serve the highest proportion of infants and toddlers in poverty in Early Head Start. In several counties, no infants and toddlers are being served.



[32] Data source: Poverty percentages used in the calculation come from the 2013-2017 American Community Survey 5-Year Estimates for "all families of households of low-income with related children of the householder under 5 years only." Data for number of children being served by Early Head Start and Head Start come from the Office of Head Start. % of Infants/Toddlers in Poverty Served by Early Head Start = (Total Early Head Start Capacity) / (% of Children in Poverty * Total Number of Infants/Toddlers).

[33] Counties have been adjusted to 100% if they were serving more than the estimated number of children in poverty.

Union and Crawford counties serve the highest proportion of preschoolers in poverty in Head Start. Sullivan and Washington serve the fewest.



Below is a table of Early Head Start capacity, enrollment, and demographic information broken down by county.[34]

Early Head Start Enrollment and Demographics					
	EHS Capacity	**EHS Enrollment**	**Children in EHS in foster care (%)**	**Children in EHS who are homeless (%)**	**English Language Learners Served by EHS (%)**
Adams	0	0	0 (0)	0 (0)	0 (0)
Allen	0	72	2 (2.78)	11 (15.28)	34 (47.72)
Bartholomew	64	80	17 (21.25)	21 (26.25)	2 (2.50)
Benton	12	0	0 (0)	0 (0)	0 (0)
Blackford	16	0	0 (0)	0 (0)	0 (0)
Boone	12	0	0 (0)	0 (0)	0 (0)
Brown	0	0	0 (0)	0 (0)	0 (0)
Carroll	0	0	0 (0)	0 (0)	0 (0)
Cass	0	0	0 (0)	0 (0)	0 (0)
Clark	72	72	4 (5.56)	8 (11.11)	30 (41.67)
Clay	12	0	0 (0)	0 (0)	0 (0)
Clinton	0	0	0 (0)	0 (0)	0 (0)
Crawford	20	0	0 (0)	0 (0)	0 (0)
Daviess	38	0	0 (0)	0 (0)	0 (0)
Dearborn	0	0	0 (0)	0 (0)	0 (0)
Decatur	0	0	0 (0)	0 (0)	0 (0)
DeKalb	82	60	7 (11.67)	29 (48.33)	0 (0)
Delaware	138	0	0 (0)	0 (0)	0 (0)
Dubois	0	0	0 (0)	0 (0)	0 (0)
Elkhart	96	0	0 (0)	0 (0)	0 (0)
Fayette	0	0	0 (0)	0 (0)	0 (0)
Floyd	0	0	0 (0)	0 (0)	0 (0)
Fountain	24	80	6 (7.50)	26 (32.50)	1 (1.25)
Franklin	0	0	0 (0)	0 (0)	0 (0)
Fulton	0	0	0 (0)	0 (0)	0 (0)
Gibson	0	0	0 (0)	0 (0)	0 (0)
Grant	114	130	24 (18.46)	6 (4.62)	6 (4.62)
Greene	9	0	0 (0)	0 (0)	0 (0)
Hamilton	8	0	0 (0)	0 (0)	0 (0)
Hancock	0	0	0 (0)	0 (0)	0 (0)
Harrison	20	0	0 (0)	0 (0)	0 (0)
Hendricks	0	0	0 (0)	0 (0)	0 (0)
Henry	0	0	0 (0)	0 (0)	0 (0)
Howard	86	114	16 (14.04)	41 (35.96)	0 (0)
Huntington	60	60	19 (31.67)	25 (41.67)	3 (5.00)
Jackson	0	0	0 (0)	0 (0)	0 (0)
Jasper	0	0	0 (0)	0 (0)	0 (0)
Jay	0	0	0 (0)	0 (0)	0 (0)
Jefferson	0	0	0 (0)	0 (0)	0 (0)
Jennings	0	0	0 (0)	0 (0)	0 (0)

[34] Capacity = number of slots available. Enrollment = ACF Funded Enrollment + non-ACF Funded Enrollment. Percentages are based on enrollment totals rather than capacity totals. English Language Learners are comprised of children who speak non-English languages at home (i.e., Spanish, Central/South American and Mexican, Caribbean, Middle Eastern/South Asian, East Asian, Native North American/Alaska Native, Pacific Island, European and Slavic, African, 'Other', 'Unspecified')

Johnson	0	0	0 (0)	0 (0)	0 (0)
Knox	54	101	17 (16.83)	0 (0)	4 (3.96)
Kosciusko	40	40	5 (12.50)	11 (27.50)	24 (60.00)
La Grange	0	0	0 (0)	0 (0)	0 (0)
La Porte	0	0	0 (0)	0 (0)	0 (0)
Lake	230	336	31 (9.23)	17 (5.06)	27 (8.04)
Lawrence	42	66	25 (27.88)	9 (13.64)	0 (0)
Madison	80	218	57 (26.15)	41 (18.81)	16 (7.34)
Marion	200	208	47 (22.60)	9 (4.33)	34 (16.35)
Marshall	0	40	3 (7.50)	2 (5.00)	15 (37.50)
Martin	4	0	0 (0)	0 (0)	0 (0)
Miami	6	0	0 (0)	0 (0)	0 (0)
Monroe	57	57	11 (19.30)	4 (7.02)	10 (17.54)
Montgomery	20	0	0 (0)	0 (0)	0 (0)
Morgan	0	0	0 (0)	0 (0)	0 (0)
Newton	0	0	0 (0)	0 (0)	0 (0)
Noble	0	0	0 (0)	0 (0)	0 (0)
Ohio	0	0	0 (0)	0 (0)	0 (0)
Orange	9	0	0 (0)	0 (0)	0 (0)
Owen	12	0	0 (0)	0 (0)	0 (0)
Parke	12	0	0 (0)	0 (0)	0 (0)
Perry	20	80	17 (21.25)	1 (1.25)	17 (21.25)
Pike	0	0	0 (0)	0 (0)	0 (0)
Porter	40	0	0 (0)	0 (0)	0 (0)
Posey	36	0	0 (0)	0 (0)	0 (0)
Pulaski	0	0	0 (0)	0 (0)	0 (0)
Putnam	12	36	10 (27.78)	0 (0)	3 (8.33)
Randolph	0	0	0 (0)	0 (0)	0 (0)
Ripley	0	0	0 (0)	0 (0)	0 (0)
Rush	0	0	0 (0)	0 (0)	0 (0)
Scott	0	0	0 (0)	0 (0)	0 (0)
Shelby	16	0	0 (0)	0 (0)	0 (0)
Spencer	20	0	0 (0)	0 (0)	0 (0)
St. Joseph	112	208	10 (4.81)	3 (1.44)	47 (22.60)
Starke	0	0	0 (0)	0 (0)	0 (0)
Steuben	0	0	0 (0)	0 (0)	0 (0)
Sullivan	0	0	0 (0)	0 (0)	0 (0)
Switzerland	0	0	0 (0)	0 (0)	0 (0)
Tippecanoe	86	78	13 (16.67)	42 (53.85)	27 (34.62)
Tipton	0	0	0 (0)	0 (0)	0 (0)
Union	20	20	1 (5.00)	4 (20.00)	0 (0)
Vanderburgh	80	116	6 (5.17)	9 (7.76)	27 (23.28)
Vermillion	0	0	0 (0)	0 (0)	0 (0)
Vigo	80	80	32 (40.00)	7 (8.75)	1 (1.25)
Wabash	0	0	0 (0)	0 (0)	0 (0)
Warren	0	0	0 (0)	0 (0)	0 (0)
Warrick	0	0	0 (0)	0 (0)	0 (0)
Washington	11	0	0 (0)	0 (0)	0 (0)
Wayne	72	72	3 (4.17)	0 (0)	6 (8.33)
Wells	0	0	0 (0)	0 (0)	0 (0)
White	0	0	0 (0)	0 (0)	0 (0)
Whitley	0	0	0 (0)	0 (0)	0 (0)

Below is a table of Head Start capacity, enrollment, and demographic information broken down by county.[35]

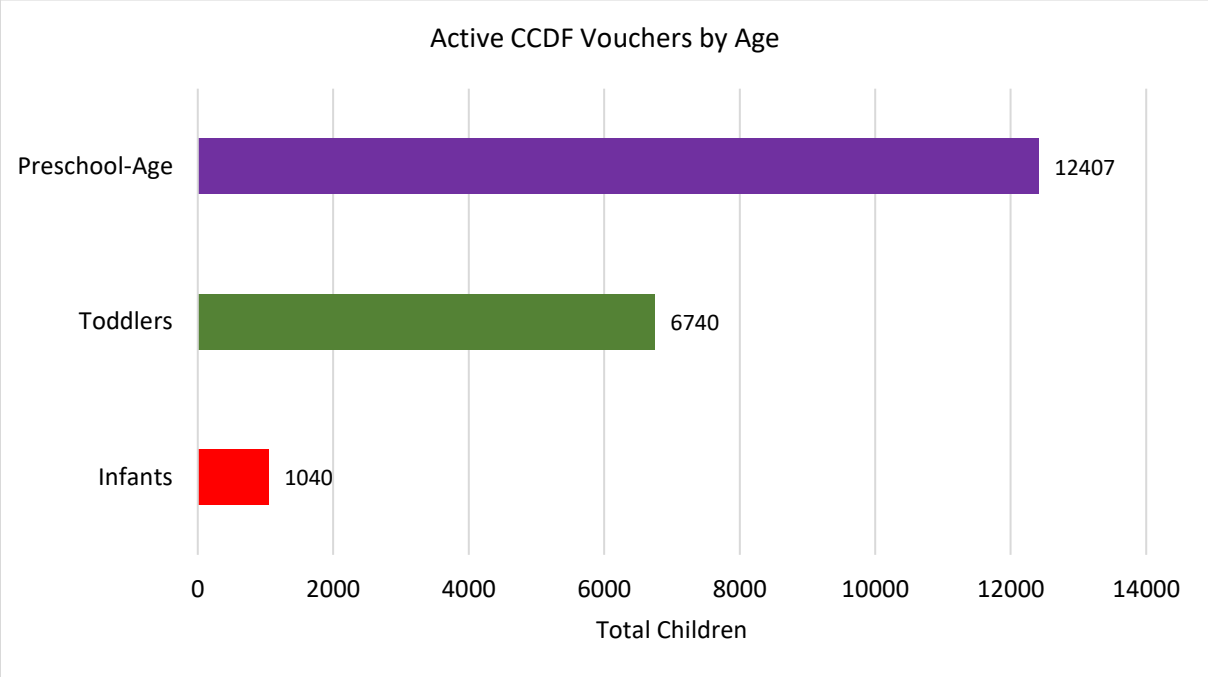
Head Start Enrollment and Demographics					
	HS Slots	HS Enrollment	Children in HS in foster care (%)	Children in HS who are homeless (%)	English Language Learners Served by HS (%)
Adams	40	0	0 (0.00)	0 (0.00)	0 (0.00)
Allen	504	585	53 (9.06)	41 (7.01)	131 (22.39)
Bartholomew	54	311	57 (18.33)	34 (10.93)	51 (16.40)
Benton	32	0	0 (0.00)	0 (0.00)	0 (0.00)
Blackford	57	0	0 (0.00)	0 (0.00)	0 (0.00)
Boone	44	0	0 (0.00)	0 (0.00)	0 (0.00)
Brown	16	0	0 (0.00)	0 (0.00)	0 (0.00)
Carroll	18	0	0 (0.00)	0 (0.00)	0 (0.00)
Cass	119	176	14 (7.95)	9 (5.11)	50 (28.41)
Clark	250	250	27 (10.80)	5 (2.00)	53 (21.20)
Clay	94	0	0 (0.00)	0 (0.00)	0 (0.00)
Clinton	88	0	0 (0.00)	0 (0.00)	0 (0.00)
Crawford	67	0	0 (0.00)	0 (0.00)	0 (0.00)
Daviess	61	0	0 (0.00)	0 (0.00)	0 (0.00)
Dearborn	114	266	25 (9.40)	39 (14.66)	5 (1.88)
Decatur	18	0	0 (0.00)	0 (0.00)	0 (0.00)
DeKalb	140	140	13 (9.29)	46 (32.86)	0 (0.00)
Delaware	228	0	0 (0.00)	0 (0.00)	0 (0.00)
Dubois	50	193	17 (8.81)	0 (0.00)	24 (12.44)
Elkhart	460	0	0 (0.00)	0 (0.00)	0 (0.00)
Fayette	162	203	11 (5.42)	0 (0.00)	5 (2.46)
Floyd	276	276	18 (6.52)	2 (0.72)	13 (4.71)
Fountain	76	288	25 (8.68)	54 (18.75)	16 (5.56)
Franklin	47	0	0 (0.00)	0 (0.00)	0 (0.00)
Fulton	20	0	0 (0.00)	0 (0.00)	0 (0.00)
Gibson	82	0	0 (0.00)	0 (0.00)	0 (0.00)
Grant	126	126	5 (3.97)	1 (0.79)	6 (4.76)
Greene	48	0	0 (0.00)	0 (0.00)	0 (0.00)
Hamilton	120	0	0 (0.00)	0 (0.00)	0 (0.00)
Hancock	40	0	0 (0.00)	0 (0.00)	0 (0.00)
Harrison	66	0	0 (0.00)	0 (0.00)	0 (0.00)
Hendricks	91	0	0 (0.00)	0 (0.00)	0 (0.00)
Henry	144	250	24 (9.60)	10 (4.00)	10 (4.00)
Howard	228	285	17 (5.96)	86 (30.18)	10 (3.51)
Huntington	71	0	0 (0.00)	0 (0.00)	0 (0.00)
Jackson	50	0	0 (0.00)	0 (0.00)	0 (0.00)
Jasper	58	0	0 (0.00)	0 (0.00)	0 (0.00)
Jay	86	314	28 (8.92)	62 (19.75)	19 (6.05)
Jefferson	96	202	49 (24.26)	1 (0.50)	14 (6.93)
Jennings	48	0	0 (0.00)	0 (0.00)	0 (0.00)
Johnson	119	0	0 (0.00)	0 (0.00)	0 (0.00)
Knox	203	330	25 (7.58)	0 (0.00)	24 (7.27)

[35] Capacity = number of slots available. Enrollment = ACF Funded Enrollment + non-ACF Funded Enrollment. Percentages are based on enrollment totals rather than capacity totals. English Language Learners are comprised of children who speak non-English languages at home (i.e., Spanish, Central/South American and Mexican, Caribbean, Middle Eastern/South Asian, East Asian, Native North American/Alaska Native, Pacific Island, European and Slavic, African, 'Other', 'Unspecified')

Kosciusko	140	135	13 (9.63)	21 (15.56)	30 (22.22)
La Grange	60	0	0 (0.00)	0 (0.00)	0 (0.00)
La Porte	306	308	20 (6.49)	15 (4.87)	19 (6.17)
Lake	1115	1,228	97 (7.90)	71 (5.78)	119 (9.69)
Lawrence	134	221	31 (14.03)	26 (11.76)	1 (0.45)
Madison	182	410	66 (16.10)	34 (8.29)	34 (8.29)
Marion	1319	1,439	126 (8.76)	52 (3.61)	361 (25.09)
Marshall	102	148	20 (13.51)	0 (0.00)	12 (8.11)
Martin	36	0	0 (0.00)	0 (0.00)	0 (0.00)
Miami	57	0	0 (0.00)	0 (0.00)	0 (0.00)
Monroe	267	267	26 (9.74)	31 (11.61)	34 (12.73)
Montgomery	60	0	0 (0.00)	0 (0.00)	0 (0.00)
Morgan	106	0	0 (0.00)	0 (0.00)	0 (0.00)
Newton	55	0	0 (0.00)	0 (0.00)	0 (0.00)
Noble	47	0	0 (0.00)	0 (0.00)	0 (0.00)
Ohio	18	0	0 (0.00)	0 (0.00)	0 (0.00)
Orange	34	0	0 (0.00)	0 (0.00)	0 (0.00)
Owen	60	0	0 (0.00)	0 (0.00)	0 (0.00)
Parke	60	0	0 (0.00)	0 (0.00)	0 (0.00)
Perry	90	291	26 (8.93)	4 (1.37)	25 (8.59)
Pike	33	0	0 (0.00)	0 (0.00)	0 (0.00)
Porter	113	0	0 (0.00)	0 (0.00)	0 (0.00)
Posey	82	0	0 (0.00)	0 (0.00)	0 (0.00)
Pulaski	35	0	0 (0.00)	0 (0.00)	0 (0.00)
Putnam	64	415	58 (13.98)	16 (3.86)	34 (8.19)
Randolph	40	0	0 (0.00)	0 (0.00)	0 (0.00)
Ripley	49	0	0 (0.00)	0 (0.00)	0 (0.00)
Rush	66	0	0 (0.00)	0 (0.00)	0 (0.00)
Scott	58	0	0 (0.00)	0 (0.00)	0 (0.00)
Shelby	54	0	0 (0.00)	0 (0.00)	0 (0.00)
Spencer	68	0	0 (0.00)	0 (0.00)	0 (0.00)
St. Joseph	560	1,020	34 (3.33)	15 (1.47)	234 (22.94)
Starke	46	0	0 (0.00)	0 (0.00)	0 (0.00)
Steuben	127	187	13 (6.95)	8 (4.28)	20 (10.70)
Sullivan	18	0	0 (0.00)	0 (0.00)	0 (0.00)
Switzerland	38	0	0 (0.00)	0 (0.00)	0 (0.00)
Tippecanoe	209	334	27 (8.08)	76 (22.75)	82 (24.55)
Tipton	0	0	0 (0.00)	0 (0.00)	0 (0.00)
Union	49	49	1 (2.04)	9 (18.37)	0 (0.00)
Vanderburgh	321	544	36 (6.62)	12 (2.21)	41 (7.54)
Vermillion	16	0	0 (0.00)	0 (0.00)	0 (0.00)
Vigo	150	150	23 (15.33)	5 (3.33)	2 (1.33)
Wabash	37	0	0 (0.00)	0 (0.00)	0 (0.00)
Warren	0	0	0 (0.00)	0 (0.00)	0 (0.00)
Warrick	110	0	0 (0.00)	0 (0.00)	0 (0.00)
Washington	17	0	0 (0.00)	0 (0.00)	0 (0.00)
Wayne	306	306	8 (2.61)	4 (1.31)	26 (8.50)
Wells	20	0	0 (0.00)	0 (0.00)	0 (0.00)
White	19	148	19 (12.84)	4 (2.70)	14 (9.46)
Whitley	34	0	0 (0)	0 (0)	0 (0)

Child Care Development Funds (CCDF)[36]

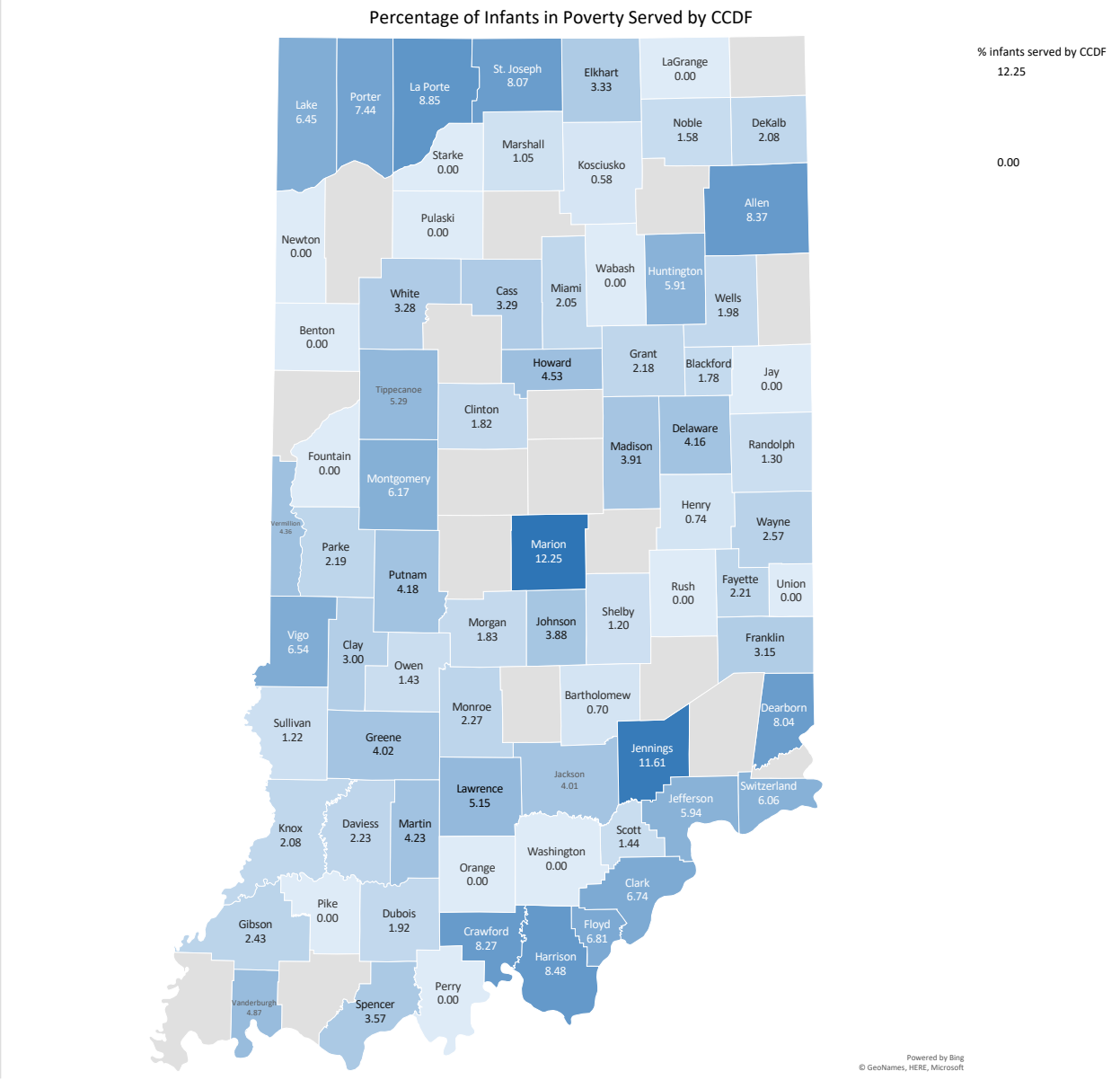
There are 4,476 providers in Indiana that accept CCDF vouchers, and there are 20,187 children ages 0-5 with active CCDF vouchers. The figure below breaks down this total by age.[37] As can be seen below, preschoolers represent the age range with the most active CCDF vouchers, and infants represent the age range with the fewest.



[36] Data source: Family and Social Services Administration, received 2/25/19.

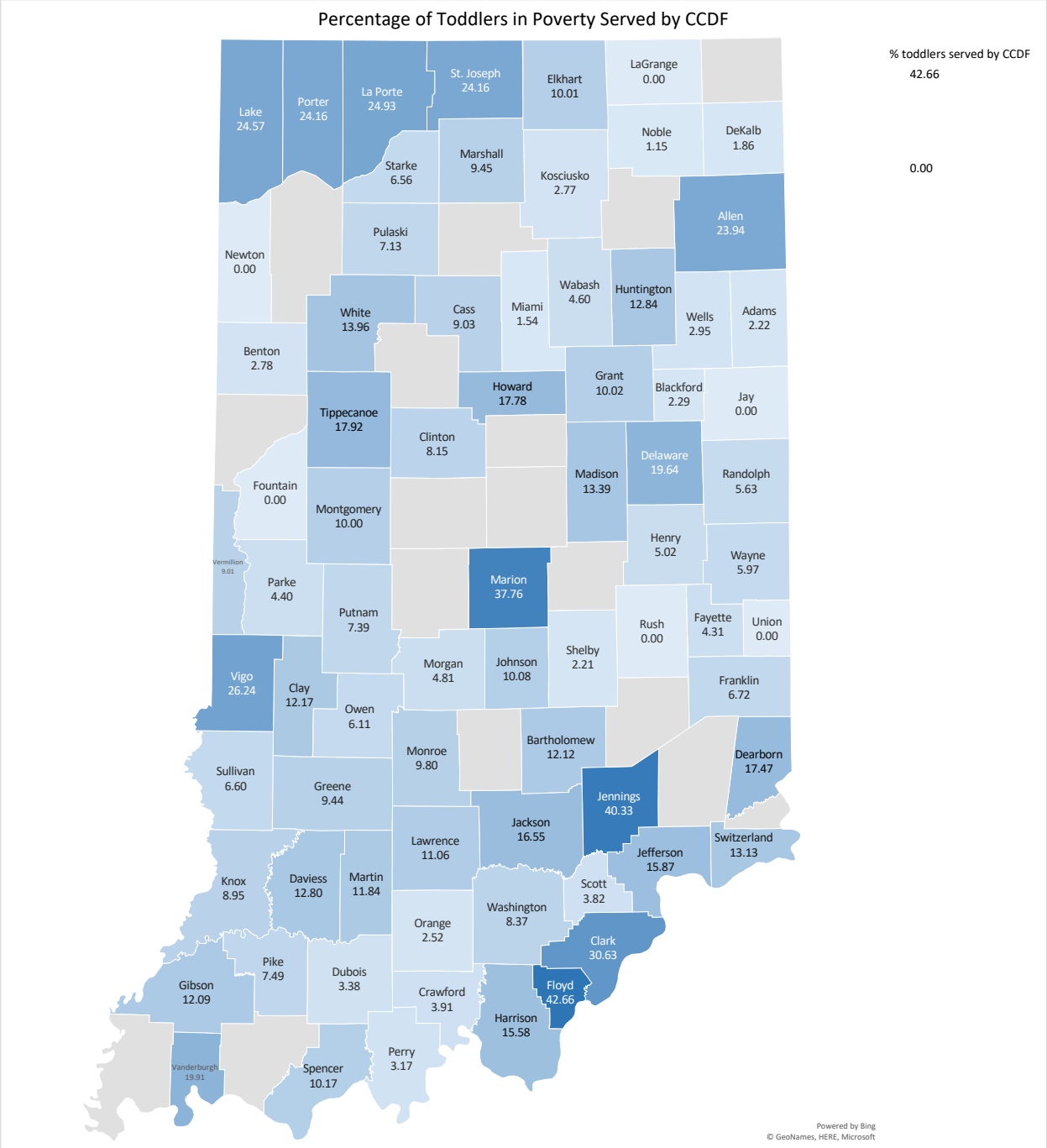
[37] We only include those children with active vouchers. In order to best represent the unduplicated number of children utilizing both CCDF and OMW, we do not include children noted as using CCDF wrap-around services.

Below is a map of the percentages of infants living in poverty (below 100% of the FPL) with active CCDF vouchers.[38] The counties with less than 10% of children living in poverty are colored in gray and are not included in the report. Marion and Jennings counties have the most infants with active CCDF vouchers. In many counties, no infants who are from low-income backgrounds have active CCDF vouchers.



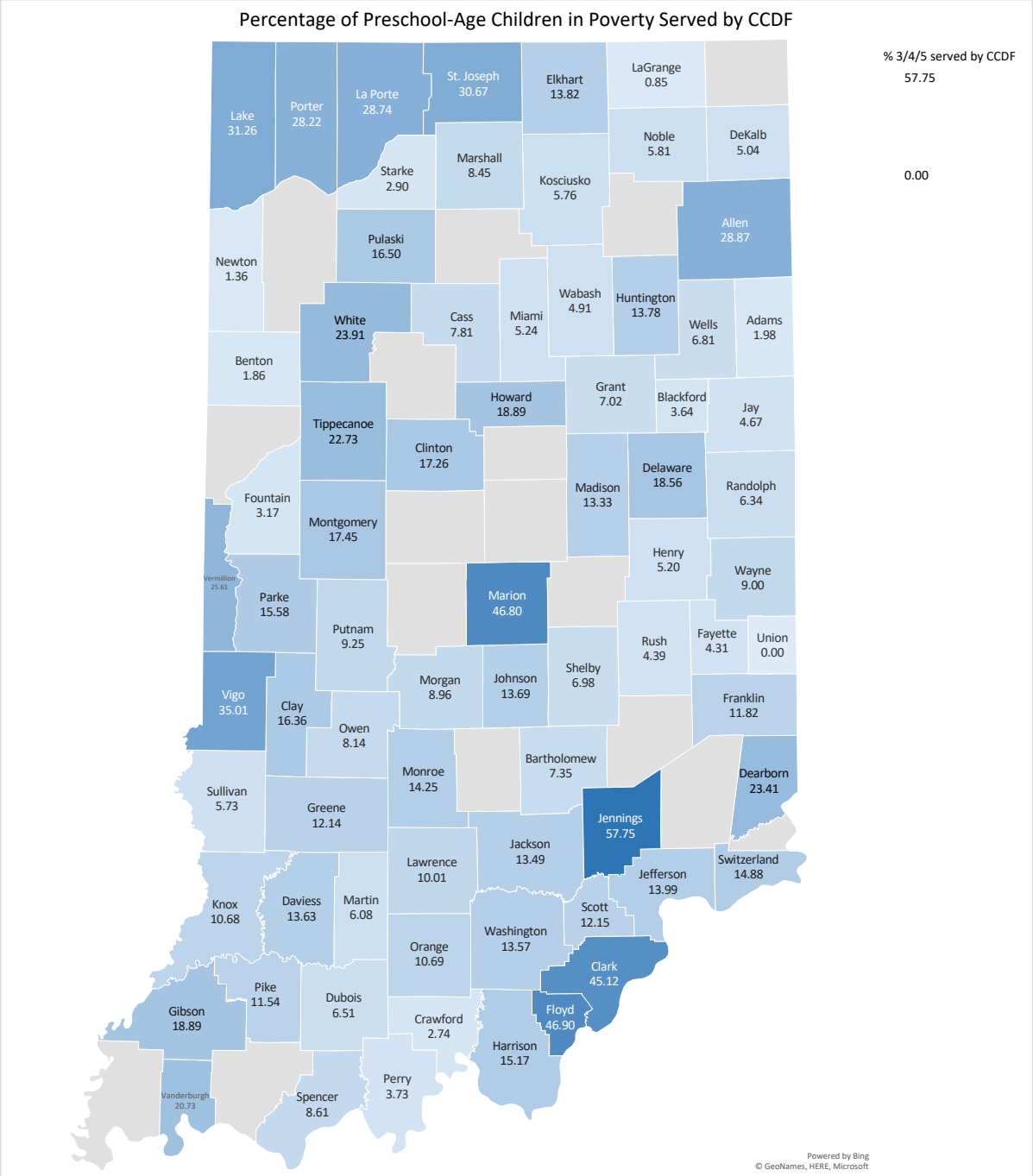
[38] Infants receiving CCDF vouchers may be receiving care from a program in a different county. Enrollment percentages depicted here are based on the child's reported home county.

Below is a map of the percentages of toddlers living in poverty (below 100% of the FPL) with active CCDF vouchers.[39] The counties with less than 10% of children living in poverty are colored in gray and are not included in the report. Floyd and Jennings counties have the most toddlers with active CCDF vouchers. In several counties, no toddlers who are from low-income backgrounds have active CCDF vouchers.



[39] Toddlers receiving CCDF vouchers may be receiving care from a program in a different county. Enrollment percentages depicted here are based on the child's reported home county.

Below is a map of the percentages of preschoolers living in poverty (below 100% of the FPL) with active CCDF vouchers.[40] The counties with less than 10% of children living in poverty are colored in gray and are not included in the report. Floyd and Jennings counties have the most preschoolers with active CCDF vouchers. Union and La Grange counties have no preschoolers from low-income families with active CCDF vouchers.



[40] Preschoolers receiving CCDF vouchers may be receiving care from a program in a different county. Enrollment percentages depicted here are based on the child's reported home county.

Children with Disabilities

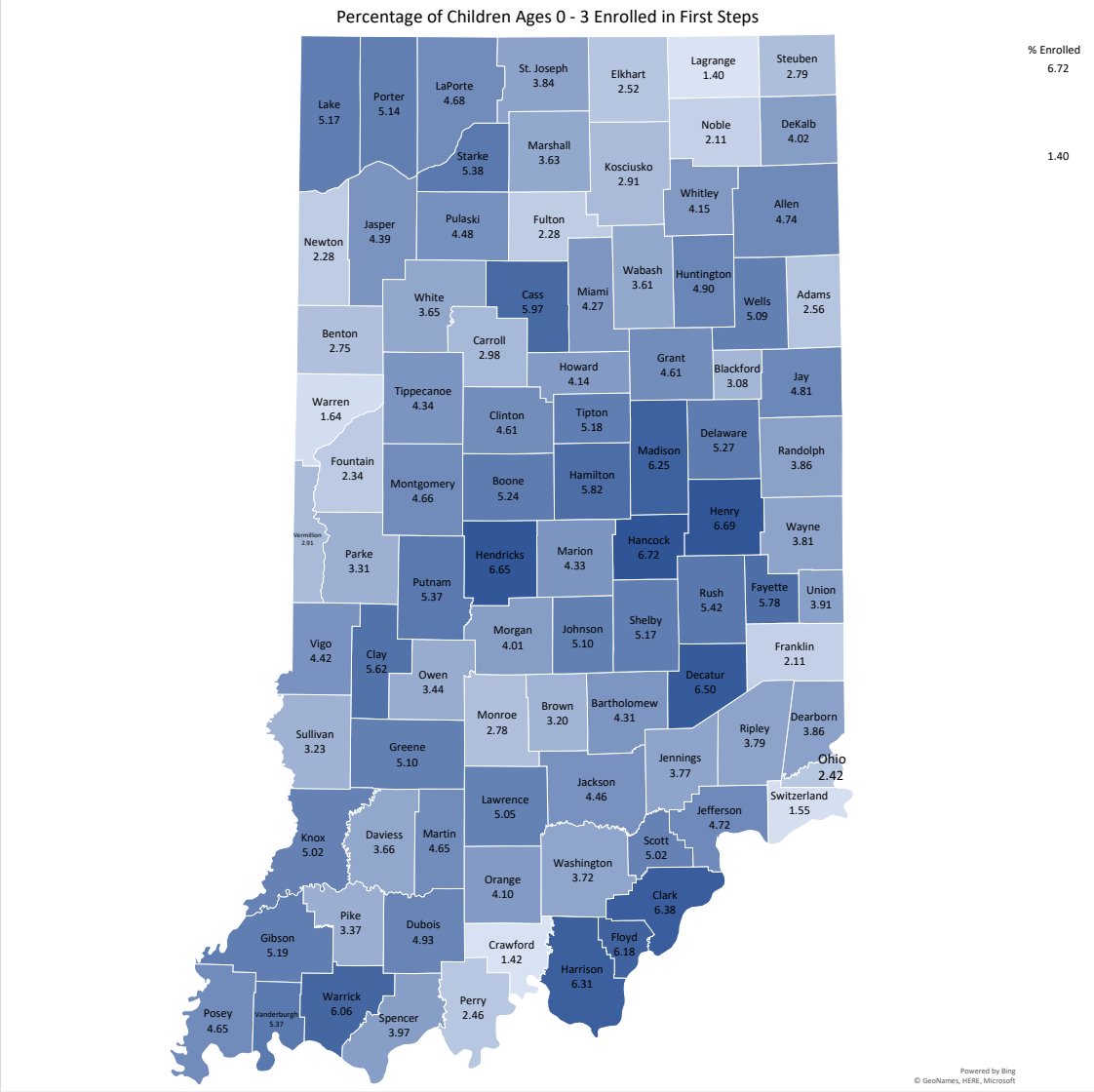
Data on children with disabilities were obtained from two primary sources: First Steps and the Indiana Department of Education (IDOE). Indiana's First Steps program (Part C of the Individuals with Disabilities Act [IDEA]) serves children ages birth to 3 who have developmental delays and disabilities. There are First Steps providers in all 92 counties in the state, serving 4.6% of children ages birth to 3.

The data presented below represent a snapshot of enrollment in First Steps in one month.[41] These data indicate that on 12/18/18, First Steps was serving approximately 11,500 children. The majority of these children in First Steps were two- to three-year-olds (n = 6633; 58%), followed by one- to two-year-olds (n = 3396; 30%), and then birth- to one-year-olds (n = 1026; 9%). Most children in First Steps are White (n = 8090; 70%), followed by Black or African American (n = 1096; 10%), two or more races (n = 856; 7%), Hispanic/Latino (n = 828; 7%), and other (2%). Nearly all the families report English as the child's spoken language (96%).

In terms of family income, the largest group of families receiving First Steps are below the poverty line (n = 4731; 41%), followed by families with incomes between 128%-250% of the poverty line (n = 2647, 23%), then families with incomes between 251%-350% (n 1194; 10%), with all other income groups representing less than 7% of the families being served.

[41] Data source: First Steps, received on 5/15/19.

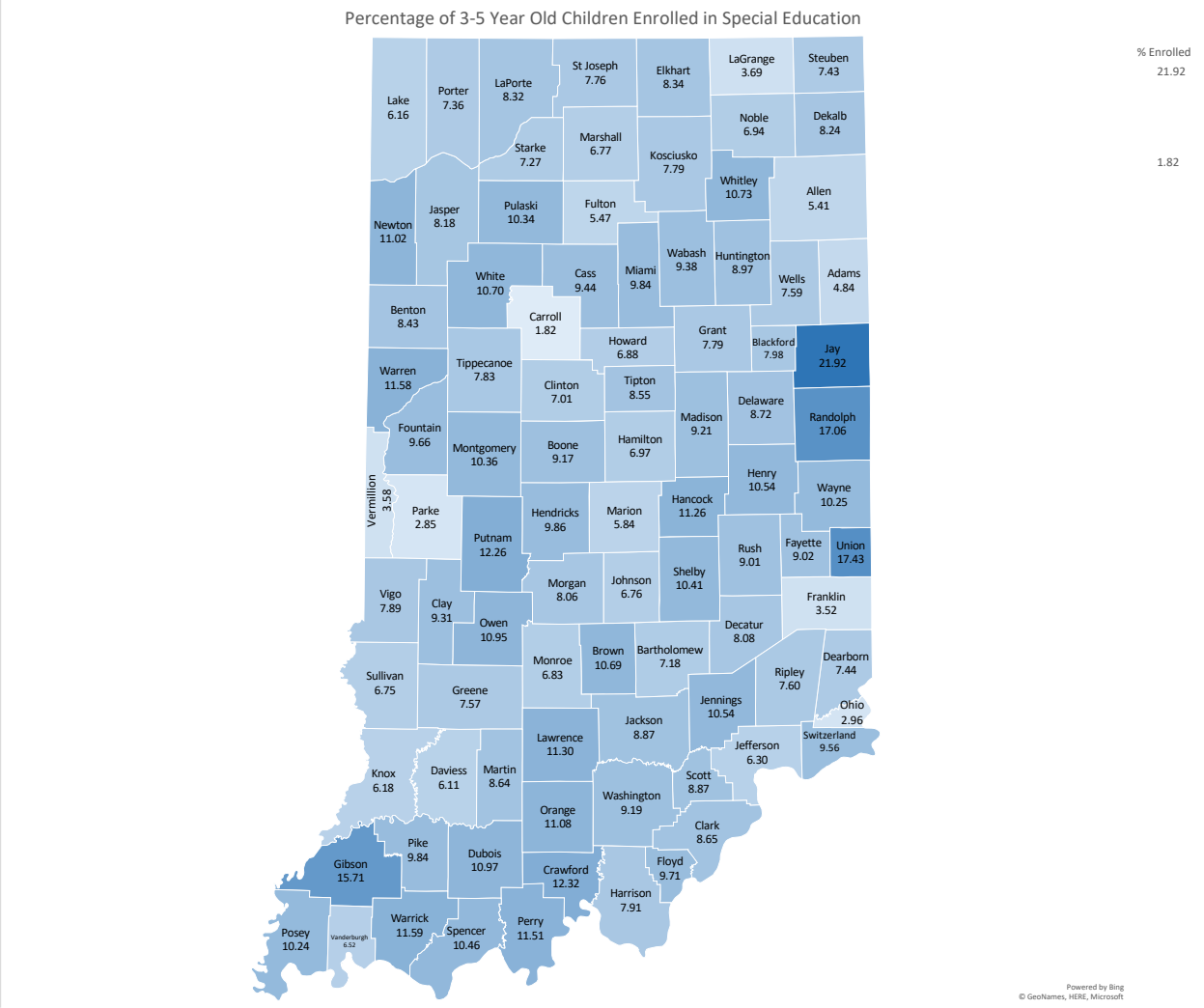
The map shown below indicates the percentages of children enrolled in First Steps by county.[42] The county with the highest percentage of children served by First Steps is Hancock (6.7%) and the ones with the lowest percentages are Crawford (1.4%) and La Grange (1.4%).



[42] Data source: First Steps, received on 5/15/19.

IDOE provides preschool and special education services to children ages 3-5 who have developmental delays and disabilities (Part B of the IDEA; Developmental Preschool). All 92 counties in Indiana have children in Developmental Preschool or Special Education. Jay County serves the highest percentage of these children at 21.9% and Carroll County serves the lowest percentage at 1.8%.[43]

IDOE currently serves 19,350 children with developmental delays or disabilities in total. Five-year-olds represent the most children in Developmental Preschool or Special Education (n = 8076; 42%), followed by four-year-olds (n = 6395; 33%), and then three-year-olds (n = 4879; 25%). Most children are White (n = 14,154; 73%), followed by Hispanic/Latino (n = 2,057; 11%), Black or African American (n = 1,782; 9%), and two or more races (n = 1,001; 5%), with all other groups making up less than 2%. Of the children in Developmental Preschool or Special Education, 6,540 (34%) are in Title I programs. Nearly all the families report English as the child's spoken language (92%), and 169 (1%) are homeless.



[43] Data source: Indiana Department of Education, received 6/7/19

Programs Designed to Support Vulnerable or Underserved Children and Families

Nurse Family Partnerships[44]

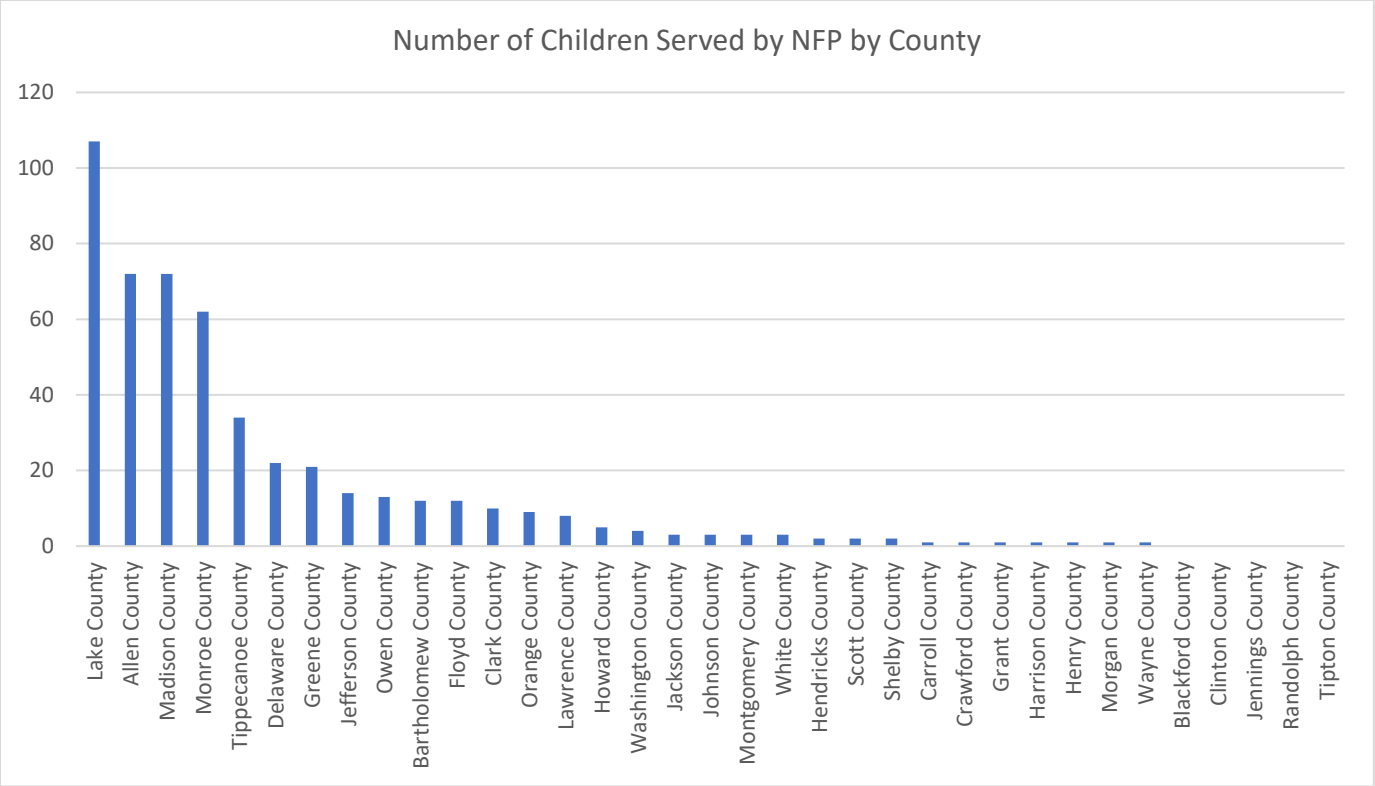
Nurse Family Partnerships (NFP) is a community health program designed to support vulnerable mothers pregnant with their first child and continues until the child turns two. This program is currently active in 36 counties in Indiana and is administered by three agencies.[45] The Healthier Moms and Babies NFP serves Allen County. The IU-Health NFP serves Green, Lawrence, Monroe, Orange, and Owen counties. The remaining 30 counties are served by the Goodwill NFP. A map of the counties served can be seen below.[46]

At present, 891 children are being served by NFP with the majority (55.7%) being served in Marion County (n = 389; 43.7%) and Lake County (n = 107; 12.0%). Of the 36 counties served, five currently do not have any families participating in NFP services (Blackford, Clinton, Jennings, Randolph, and Tipton). Another seven counties only have one family each participating (Carroll, Crawford, Grant, Harrison, Henry, Morgan, and Wayne). A graph of the children served per county can be found in the figure below. Note that Marion County is not included in the figure for ease of presentation.

[44] Data source: Healthier Moms and Babies NFP and IU-Health NFP. Goodwill NFP data comes from Disease Management Coordination Network and is from 2018.

45 https://www.nursefamilypartnership.org/wp-content/uploads/2019/04/IN_2019-State-Profile.pdf

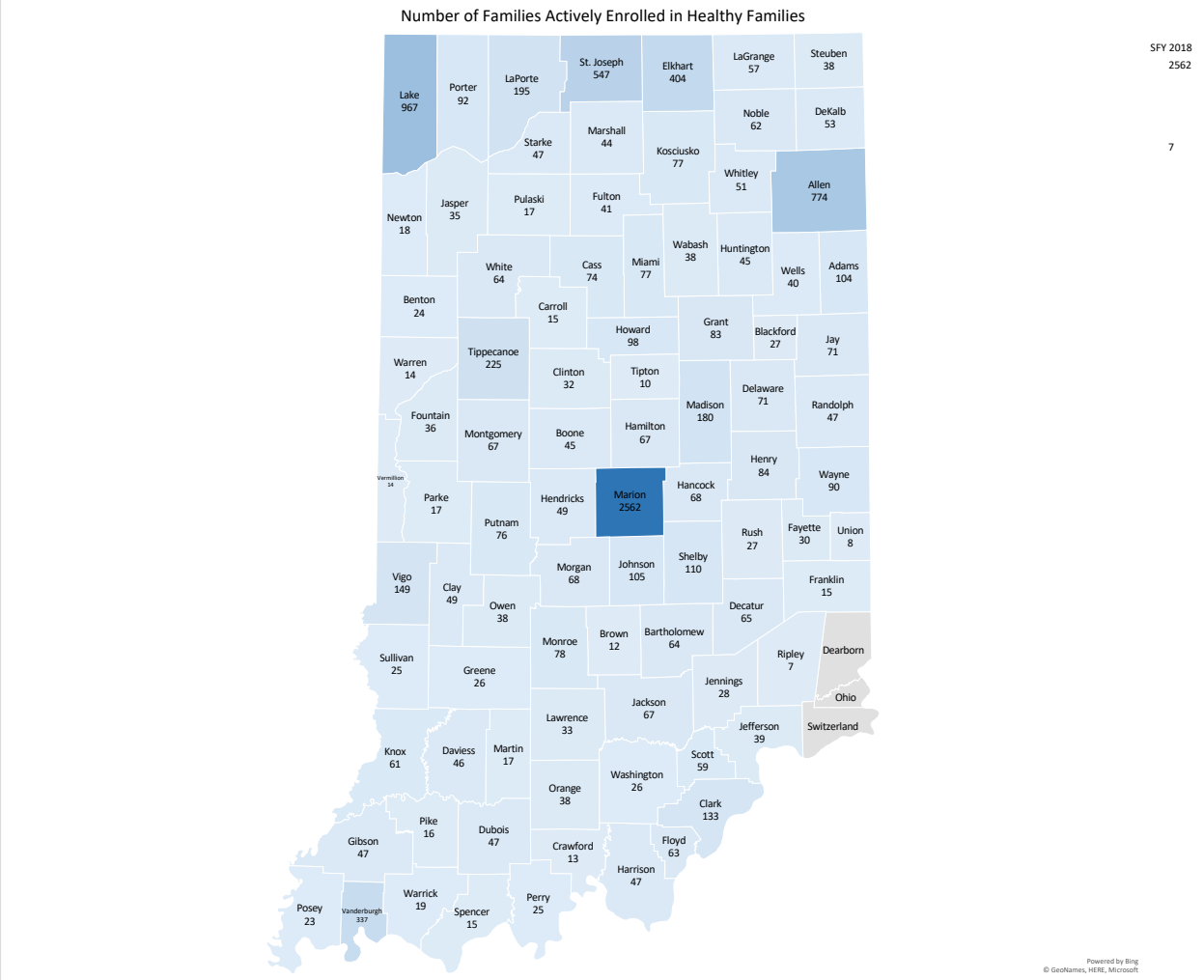
46 https://www.nursefamilypartnership.org/wp-content/uploads/2019/04/IN_2019-State-Profile.pdf



Among the children who are served by NFP, 56.3% are from families equal to or less than the FPL, 18.5% were between 101-200% of the FPL, and 1.5% were from families above 200% of the FPL (23.7% of families were not reported or unknown). The families served are from diverse backgrounds (36.9% African American, 32.7% White, 11.0% more than one race, 1.0% American Indian, 1.9% Asian, 0.4% Native Hawaiian/Pacific Islander, and 16.1% declined to respond or unknown). Of these children, 18.3% were reported as Hispanic. A substantial number of the children were reported as having other risk factors: low birthweight (10.4%), pre-term births (9.4%), homeless (1.6%), and a parent who smoked during pregnancy (1.3%), reduced smoking during pregnancy (3.7%), or quit smoking during pregnancy (6.7%).

Healthy Families Indiana[47]

Healthy Families Indiana is a home visiting program funded through the Indiana Department of Child Services (DCS) that is designed to promote family well-being and healthy child development for vulnerable families and prevent abuse and/or neglect. Families begin services prenatally or shortly after birth and receive services until the child turns three. Approximately 10,000 families participated in Healthy Families Indiana in 2018. Below is a map of the number of families who participated in each county. Counties colored in gray had fewer than five families participating.



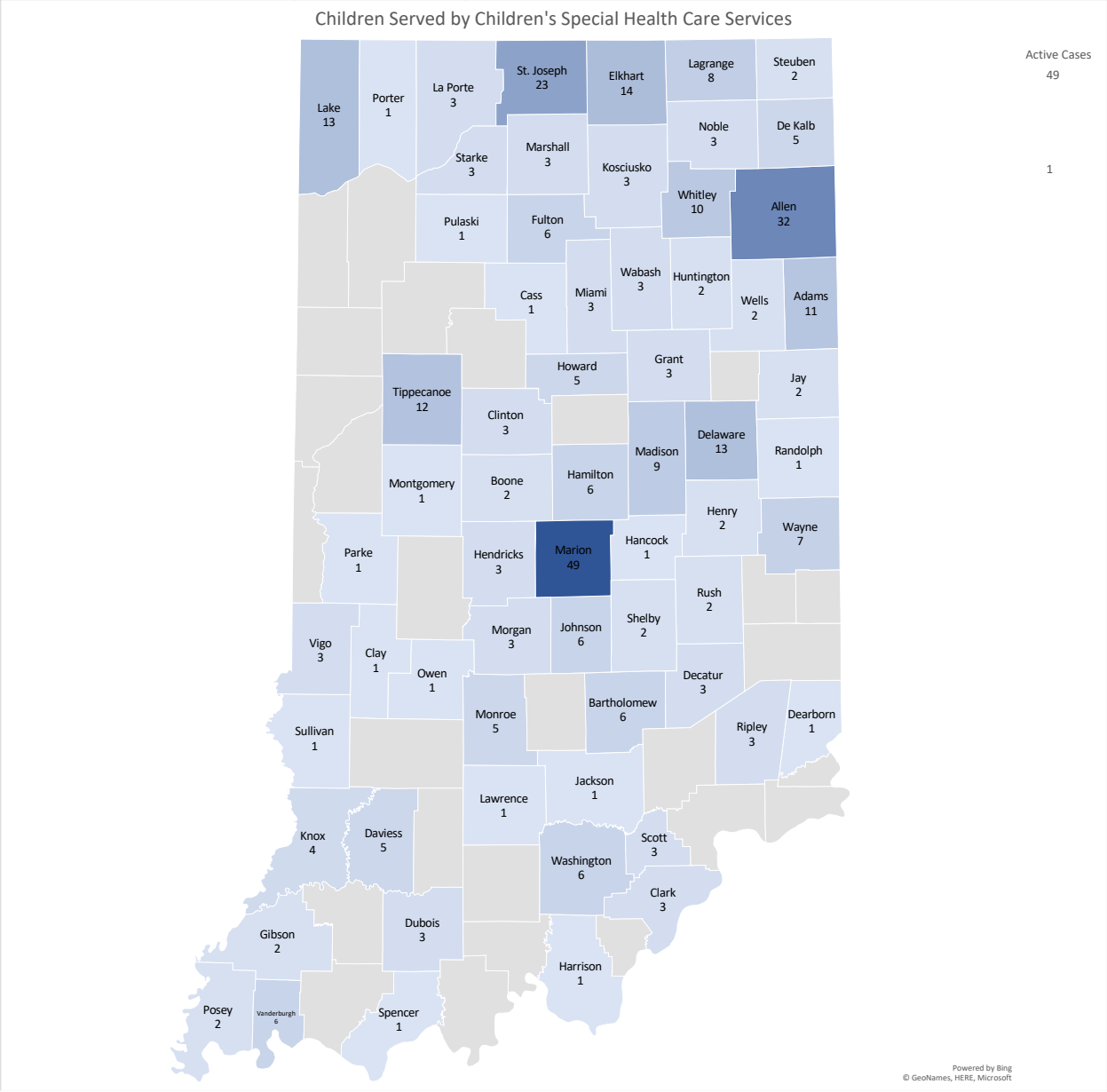
The families being served reported experiencing several risks. For example, in 2017, over 60% of parents receiving services reported a history of being physically abused as a child, and over 50% reported history of substance abuse, mental illness, or criminality. Further, nearly 60% reported having no social support.

In terms of the demographics of families participating in the program in 2017, 52% were Anglo/American, 29% were African American, 12% were Latino, 5% were Multi-Ethnic, and 2% were other. Over half of the sample (56%) were single parents, 23% were married, 16% were living with a partner, 4% were separated or divorced, and 1% did not report. The majority of families were English speakers (93%).

[47] Data source: Healthy Families Indiana, received 6/27/19

Children's Special Health Care Services (CSHCS)[48]

CSHCS provides supplemental medical coverage for children ages 0-21 who have serious or chronic medical conditions and whose families meet eligibility criteria. Currently, there 351 active cases of children birth to age 5 in CSHCS. Below is a county map of children being served.



The majority (84%) of these families speak English as their first language. Seventy three percent of children birth to age 5 receiving services are White, non-Hispanic, 11% are Hispanic, 8% are Black, non-Hispanic, 2% are Asian or Pacific Islander, 2% are Multi-racial, and 4% are unknown. In terms of family income, 40% are below 150% FPL, 8% are between 150-175% FPL, 15% are between 175-200% FPL, and 37% are between 200-251% FPL.

[48] Data source: Children's Special Health Care Services, received 7/18/19

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)[49]
WIC provides services to pregnant, postpartum, and breastfeeding women from low-income backgrounds and infants and children (through age 5) who are at elevated risk for health or nutrition difficulties. In 2015, 154,485 Indiana residents received WIC benefits, and approximately half were children. No other data on WIC is publicly available.

Title 1 Preschools[50]
Across the state of Indiana, a total of 37,207 children are served through General Education Title 1 funds. This includes 559 3-year-olds (in 31 counties), 4,220 4-year-olds (in 64 counties), and 32,428 5-year-olds (in all 92 counties). A breakdown of numbers by county and age can be found in the table below.

COUNTY	3-year- olds	4-year olds	5-year olds
Adams	3	28	145
Allen	0	460	1603
Bartholomew	0	1	133
Benton	0	0	30
Blackford	0	1	78
Boone	0	0	64
Brown	0	56	94
Carroll	0	18	94
Cass	0	1	303
Clark	1	149	689
Clay	1	26	53
Clinton	5	10	205
Crawford	4	8	50
Daviess	0	71	147
Dearborn	0	0	19
Decatur	0	0	176
Dekalb	0	26	177
Delaware	0	65	509
Dubois	14	37	111
Elkhart	0	209	1491
Fayette	1	0	128
Floyd	0	1	297
Fountain	17	57	89
Franklin	0	27	47
Fulton	0	0	102
Gibson	0	0	93
Grant	0	15	312
Greene	0	2	183
Hamilton	0	7	167
Hancock	0	0	72

[49] Data source: Indiana WIC Annual Report, 2016
[50] Data source: Indiana Department of Education, received 6/7/19

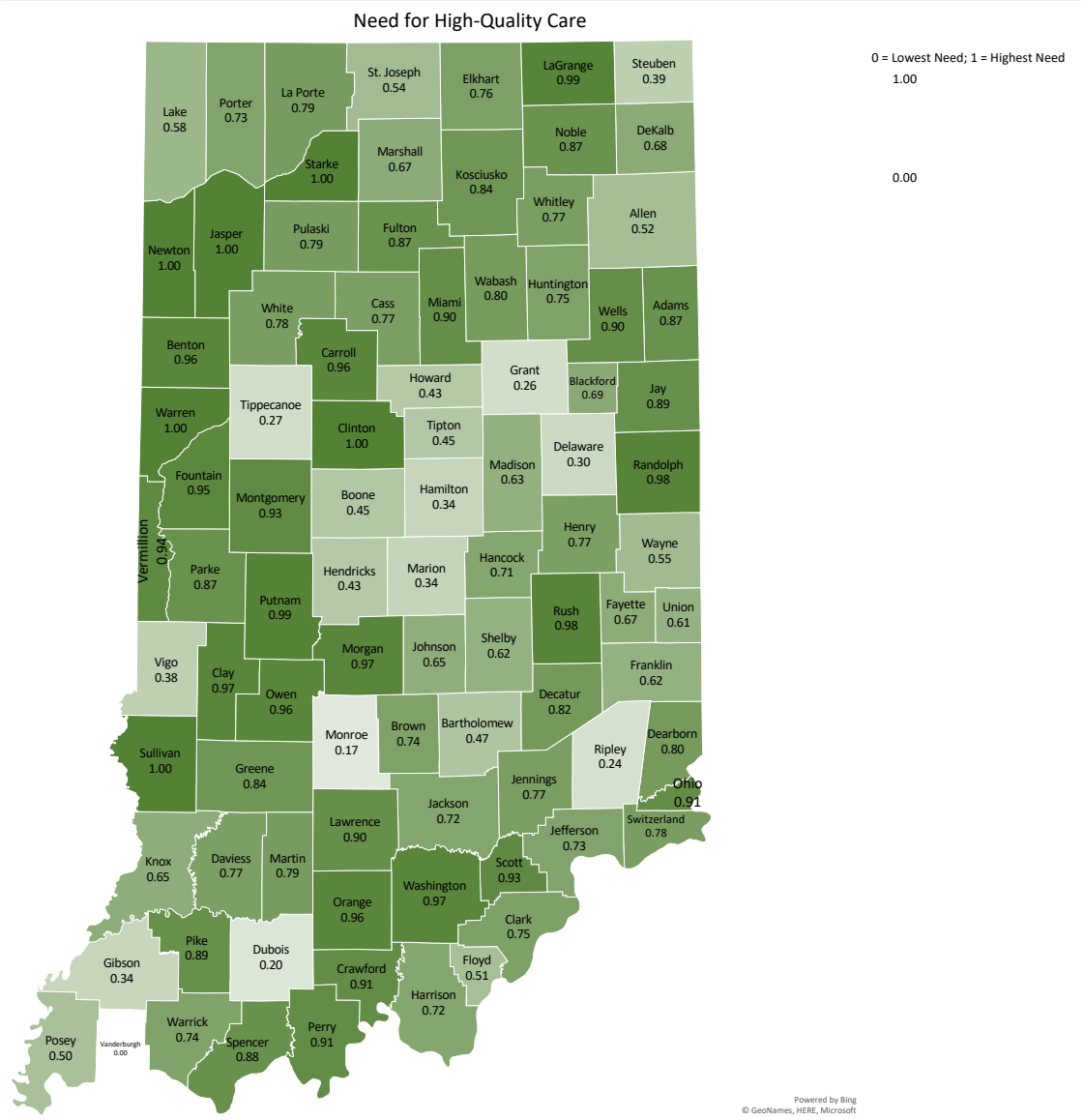
Harrison	0	0	145
Hendricks	0	4	237
Henry	3	22	261
Howard	73	179	560
Huntington	0	0	159
Jackson	0	0	257
Jasper	0	1	134
Jay	0	0	84
Jefferson	0	2	165
Jennings	0	0	144
Johnson	1	20	423
Knox	1	0	223
Kosciusko	0	4	245
LaGrange	0	0	140
LaPorte	5	133	717
Lake	195	652	2817
Lawrence	0	1	204
Madison	8	252	701
Marion	99	470	8375
Marshall	5	36	273
Martin	4	11	62
Miami	0	2	266
Monroe	3	87	350
Montgomery	3	61	250
Morgan	0	145	354
Newton	0	0	28
Noble	0	0	237
Ohio	0	0	28
Orange	0	35	117
Owen	0	33	99
Parke	4	34	94
Perry	16	12	99
Pike	12	3	41
Porter	0	1	679
Posey	6	19	100
Pulaski	0	0	48
Putnam	0	0	49
Randolph	0	0	79
Ripley	0	16	164
Rush	0	8	99
Scott	0	89	225

Shelby	17	98	283
Spencer	0	1	95
St Joseph	22	59	849
Starke	0	13	106
Steuben	0	0	49
Sullivan	8	14	161
Switzerland	0	0	76
Tippecanoe	1	1	917
Tipton	0	17	47
Union	0	0	18
Vanderburgh	8	42	376
Vermillion	0	45	111
Vigo	1	229	564
Wabash	0	9	198
Warren	0	0	23
Warrick	0	0	65
Washington	0	41	209
Wayne	18	22	486
Wells	0	0	136
White	0	0	111
Whitley	0	22	155

Maps Identifying High Risk Counties

Map of Access to High Quality Child Care[51]

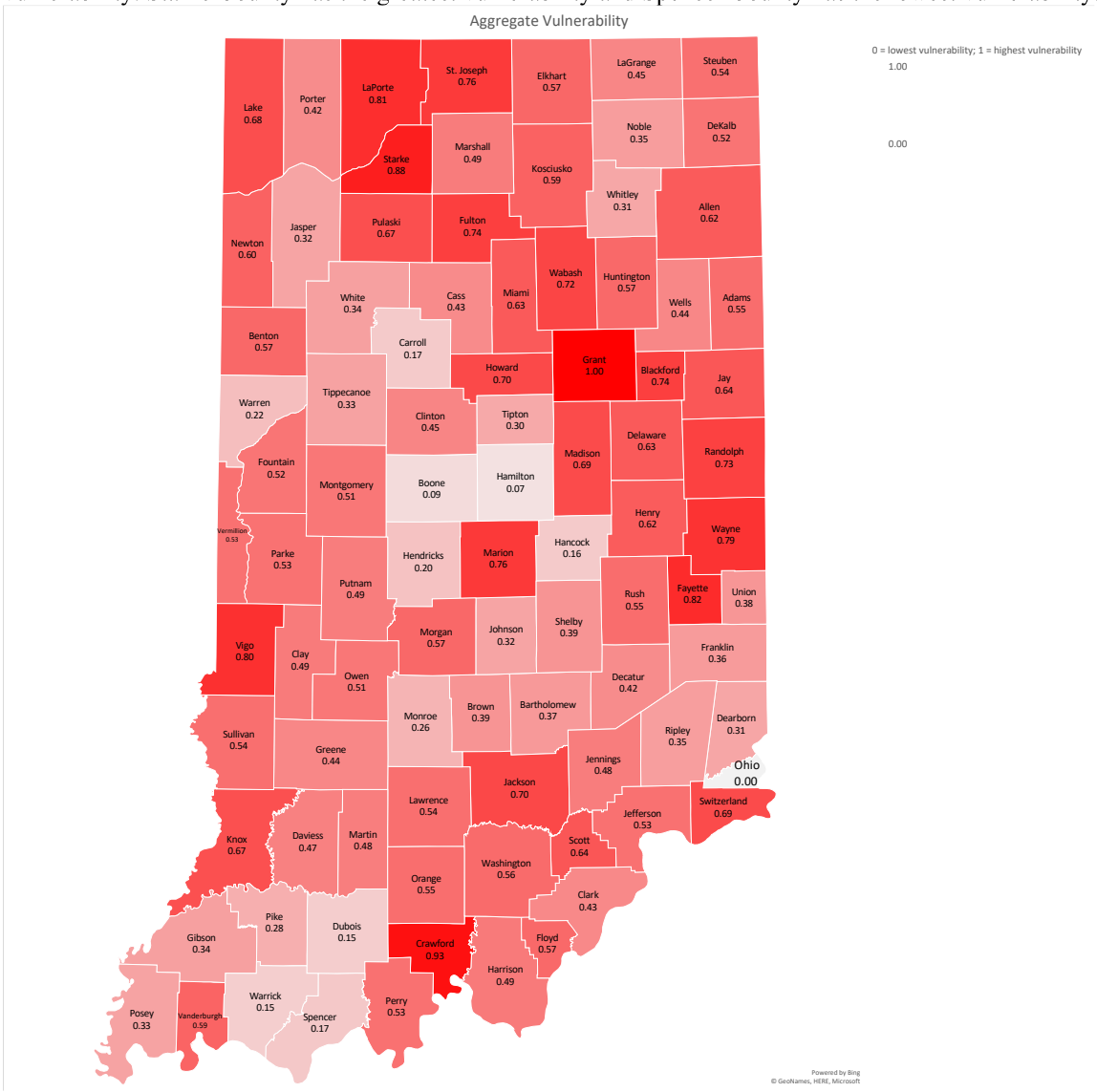
Below is a map of Indiana that indicates counties with a need for high quality child care. The need for high quality programs is based on county-level rates of infant, toddler, and preschool children enrollment in programs rated as 3 or 4 on the Paths to Quality (PTQ) scale. Ratings are scaled from 0 to 1, with 1 reflecting the lowest rates of enrollment and 0 reflecting the highest rates of enrollment in high quality programs. Clinton, Jasper, Newton, Starke, Sullivan, and Warren counties had a score of 1, which indicates these counties have no children birth to age 5 who are enrolled in high quality programs. Vanderburgh county has a score of 0, which indicates that this county has the highest rates of enrollment in high quality programs.



[51] Data source: Early Learning Indiana, received 4/19/19

Map of Vulnerabilities[52]

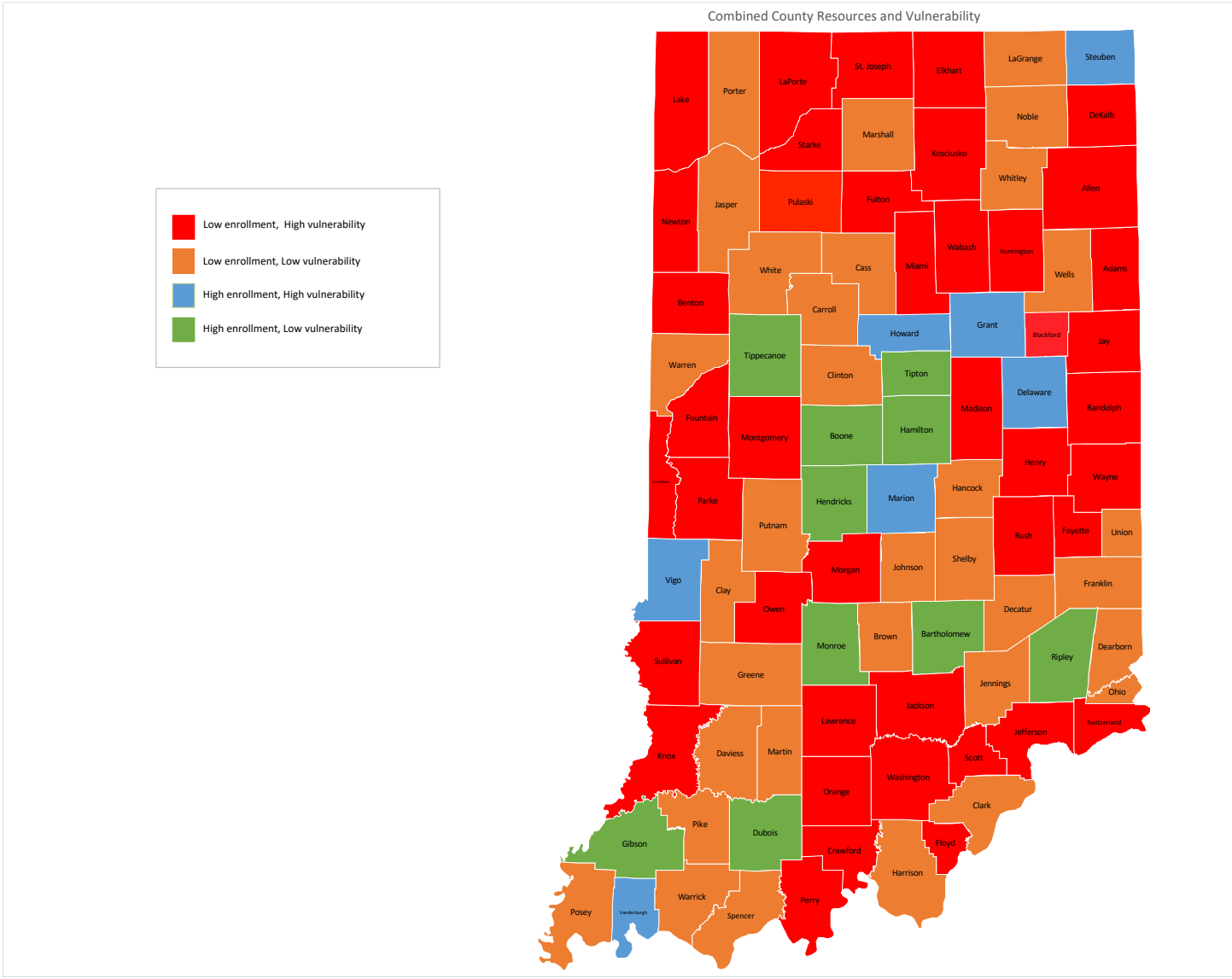
Below is a map of Indiana that indicates counties with high vulnerability. The rating represents each county's vulnerability on eight indicators pulled from the Indiana State Department of Health. The vulnerability indicators are 1) the percent of families on Medicaid, 2) child (ages 19-35 months) immunization rates (reverse coded; i.e., higher scores representing lower rates of immunization), 3) maternal smoking during pregnancy, 4) low birthweight infants, 5) prenatal care in the first trimester (reverse coded; i.e., higher scores represent less prenatal care in first trimester), 6) deaths from drug poisoning involving opioids, 7) number of substantiated abuse/neglect cases, and 8) percent of children living in poverty. Each indicator is weighted equally by creating standardized scores that are then combined. Ratings are scaled from 0 to 1, with 1 reflecting the greatest vulnerability and 0 representing the lowest vulnerability. Starke County has the greatest vulnerability and Spencer County has the lowest vulnerability.



[52] Data sources: Indiana State Department of Health; Department of Child Services; American Community Survey2013-2017 5-Year Estimates

Combined Map of Access to High Quality Child Care and Vulnerabilities[53]

Below is a map that combines data from the previous two maps on access to high quality child care and vulnerabilities. Average rate of enrollment in child high quality child care is color coded (e.g., red represents lowest enrollment rates).[54] The same vulnerability data are presented within each county (0 = lowest vulnerability, 1 = highest vulnerability).



53 Data sources: Early Learning Indiana, received 4/19/19; Indiana State Department of Health; Department of Child Services; American Community Survey 2013-2017 5-Year Estimates

54 Color coding is based on each county's average rates for enrollment per 100 children in high quality programs. Cutoffs were established by quartiles – and the ranges are as follows: 0 – 2.18 = Low enrollment; 2.19 – 4.49 = Medium-low enrollment; 4.50 – 9.54 = Medium-high enrollment; 9.55 – 19.40 = High enrollment.

Summary and Recommendations

Strengths: There are some data collected on 1) child care availability and quality for children from low income backgrounds; 2) the utilization of services targeting children who have developmental delays or disabilities; 3) and participation in programs serving vulnerable families.

Weaknesses: The following weaknesses in available data were identified:

- Comprehensive data on family income, demographic information, and other vulnerabilities are not collected from all families in the ECCE system in a systematic fashion. Thus, the state does not have a complete picture of participation rates in the system for vulnerable populations.
- Data on vulnerable populations are not aligned or integrated across state agencies so child care participation rates in this report likely represent duplicated numbers of children. For example, there are likely children who are enrolled in Head Start programs and are utilizing CCDFS vouchers, and thus, these children would be duplicated across data sets from Head Start and FSSA. Similarly, this tends to be a highly mobile population, so enrollment numbers even within one organization (e.g., Head Start) likely represent duplicated children (e.g., children who move from one Head Start program to another).
- With the exception of statewide data on Healthy Families Indiana participation, there are no publicly available data on participation in any Department of Child Services (DCS) programs or involvement in child welfare services for children birth to age 5, and we were unable to obtain nonpublic data from DCS. There are some statewide data on participation rates for children 0-18, but these data are not broken down by age. Furthermore, none of the available data are broken down by county.
- Data from some organizations and agencies are not stored in a systematic or easily accessible way. For example, some demographic First Steps data are collected and stored in paper form in children's files, and therefore, are not easily accessible.

Recommendations:

- ***There is a need for systematic and comprehensive data on vulnerable populations who engage in the ECCE system broken down by age and by county (or other localized areas). Further, there is a need for a data system that is consistent across agencies/systems that includes data dictionaries. Finally, there is a need for children to be assigned unique identifiers when entering the ECCE system so that the unduplicated number of vulnerable children being served in existing programs could be accurately captured in enrollment counts.***
- ***There is a need for data regarding parental choice in ECCE programming. We do not know why there are such low rates of subsidized care for infants, and data on parental preferences may help elucidate this potential issue.***
- ***Approximately half of children receiving CCDF vouchers are not in high quality programs. Thus, there is a need to increase the quality of these programs. However, it is important to note that increasing PTQ level does not necessarily guarantee better outcomes. In recent PTQ evaluation work,[55] outcomes for preschoolers were not generally improved when they were in PTQ 3 or 4 care vs. PTQ 0-2 care. There is some evidence for improved outcomes for toddlers in higher PTQ-rated quality care.[52]***
- ***There is a need to expand certain programs so that children and families across the state have access. For example, Nurse Family Partnership programs are only available in 36 of the 92 counties in Indiana. There may also be a need for additional funding for Early Head Start and Head Start slots, particularly in underserved counties.***
- ***It may be useful to develop target rates of enrollment in programs for vulnerable children so there is a sense of what the state is working towards.***

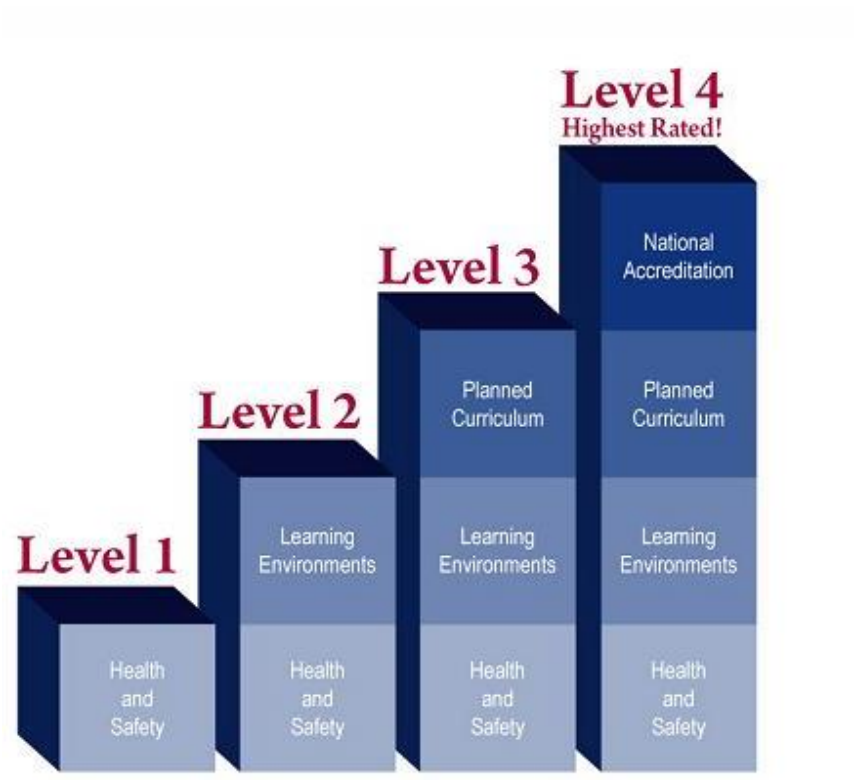
[55] Paths to QUALITY evaluation research conducted by Purdue University, 2008-2018, PI: Elicker

QUALITY (INCLUDING QUALITY AND AVAILABILITY OF PROGRAMS AND SUPPORTS)

The Office of Early Childhood and Out of School Learning (OECOSL) invests substantially in quality initiatives designed to support young children and their families. These initiatives vary in terms of format (e.g., coaching, Quality Rating and Improvement System [QRIS]), but are all designed to increase the quality of children's ECCE experiences which in turn, should lead to better child outcomes. In this report, we focus on one quality initiative currently under way in Indiana: Paths to QUALITY (PTQ), Indiana's QRIS. We also provide data on quality of care for vulnerable populations and discuss On My Way Pre-K (OMW), a state-funded prekindergarten program, designed to increase access to high quality care for vulnerable populations. Data regarding programs that identify children who are developmentally delayed and connect them to services can be found in the section titled, "Availability of and Participation in Early Childhood Care and Education (ECCE) Programming for Vulnerable Populations."

Paths to Quality

In January 2008 the Bureau of Child Care (now OECOSL) of the Indiana Family and Social Services Administration launched the statewide QRIS, PTQ, which is a voluntary system that consists of four levels:



The three primary goals of PTQ are:

1. Helping Indiana child care providers improve the quality of early education and care they offer to children and families;
2. Providing higher quality child care that supports and improves children's development, learning, and readiness for school; and
3. Helping parents become aware of PTQ and the information this system provides, so that they trust and use PTQ information to choose high quality providers when making their child care decisions.

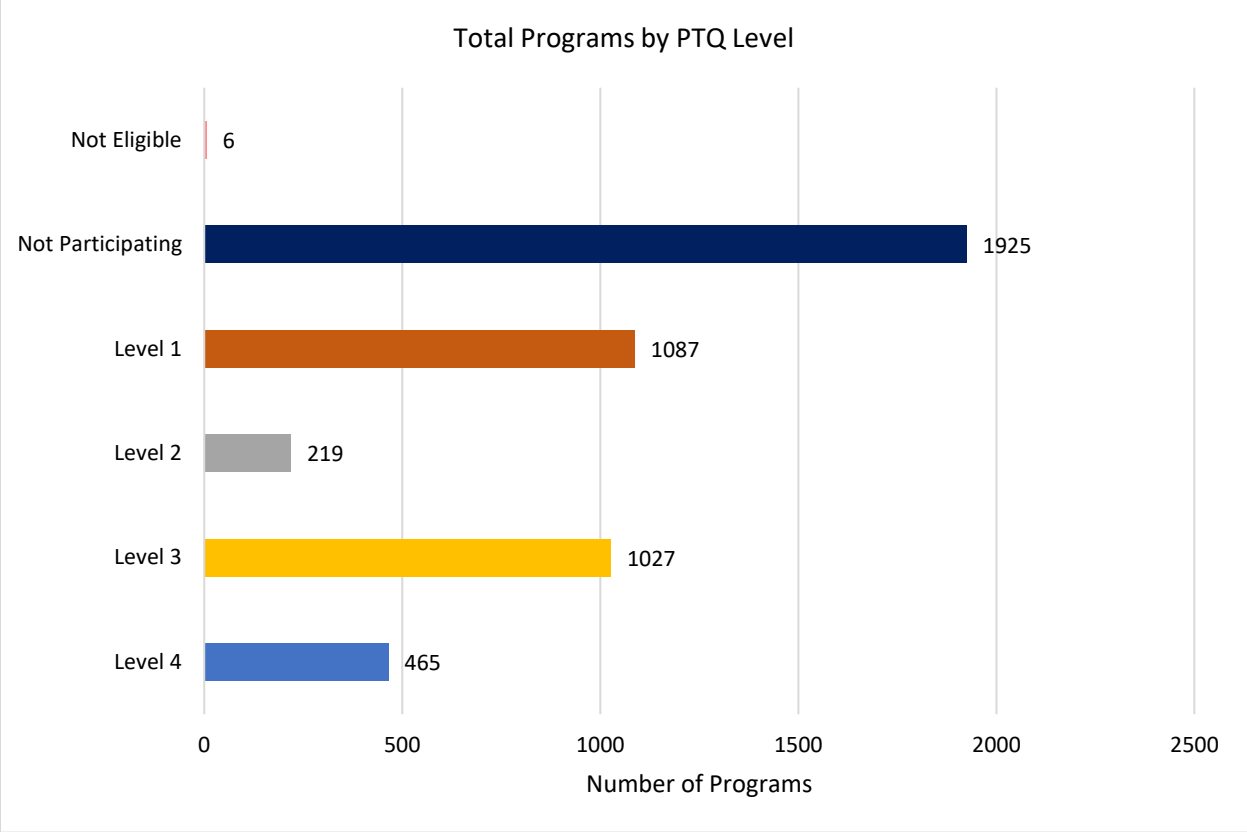
Data on all providers (urban and rural) enrolled in PTQ are collected primarily through state Training and Technical Assistance (TA) coaches. Data on all PTQ providers are collected via annual onsite visits where coaches document rating levels and ensure that providers are maintaining requirements of their PTQ Level. In some cases, additional data are collected through coaches during onsite visits that occur because a provider has requested TA for quality advancement or a provider has been identified as needing supports by OECOSL. During these visits, coaches provide summary reports in a data system that document what occurred during the visit (e.g., going through the provider to do a checklist or a PTQ readiness checklist). However, these data primarily come from a monitoring and compliance perspective, rather than from an outcomes perspective. For instance, data are not collected on things the coaches may be observing during the visits (e.g., teacher-child interactions) that may be related to improvements in child outcomes. Thus, the data do not provide an understanding of whether moving up a PTQ Level, for example, is related to improved classroom practices. Moreover, the coaches are solely responsible for entering the data, and the data entered are not always comprehensive, consistently reported, or accurate.

Recommendation: There is a need for additional, observational data to be collected during PTQ onsite visits that can be used to build comprehensive supports for providers for quality improvements. Further, there is a need for a consistent reporting system to be used by PTQ coaches so that aggregate data on quality advancement supports can be accurately documented.

PTQ Providers

According to research conducted at Purdue University,[56] participation rates and quality advancement in PTQ have steadily increased over the last several years. Currently, there are 4,729 programs in Indiana, and approximately 60% participate in PTQ.[57] Indiana has high participation rates in PTQ relative to other states according to a recent report published by the Center for American Progress.[58] Family child care programs and child care centers in Indiana rank in the top 10 in the United States for participation in PTQ.[58]

Below is a figure with number of programs participating in PTQ at each Level.[57] There are currently more Level 3 and Level 4 rated programs (n = 1492) than Level 1 or Level 2 rated programs (n = 1306). However, as can be seen from the figure below, although programs advance to higher levels, many do not progress beyond Level 3.

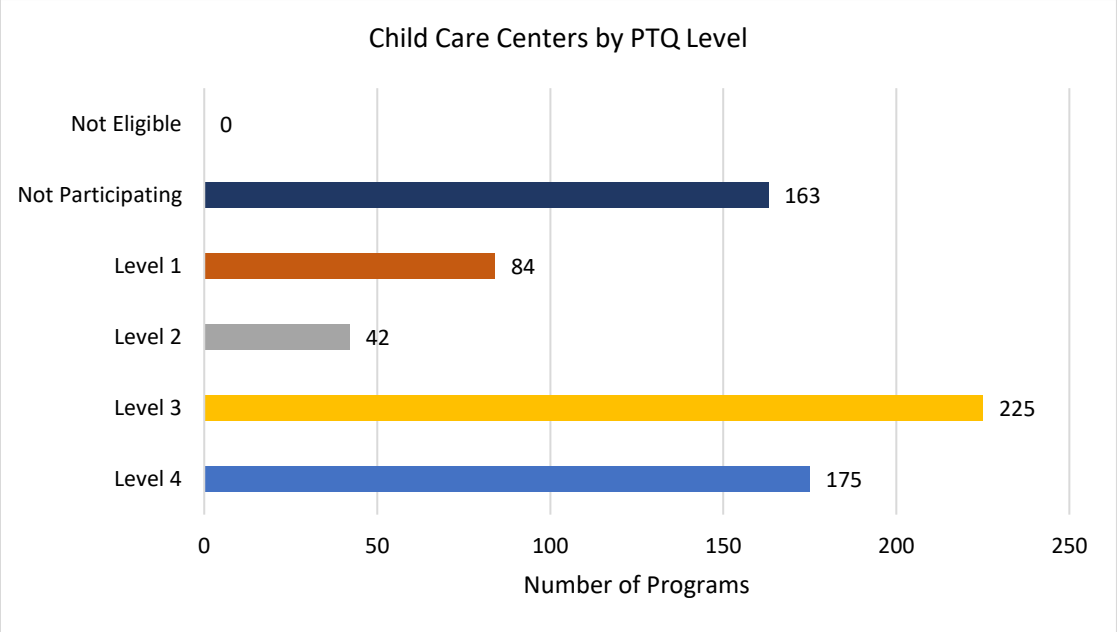


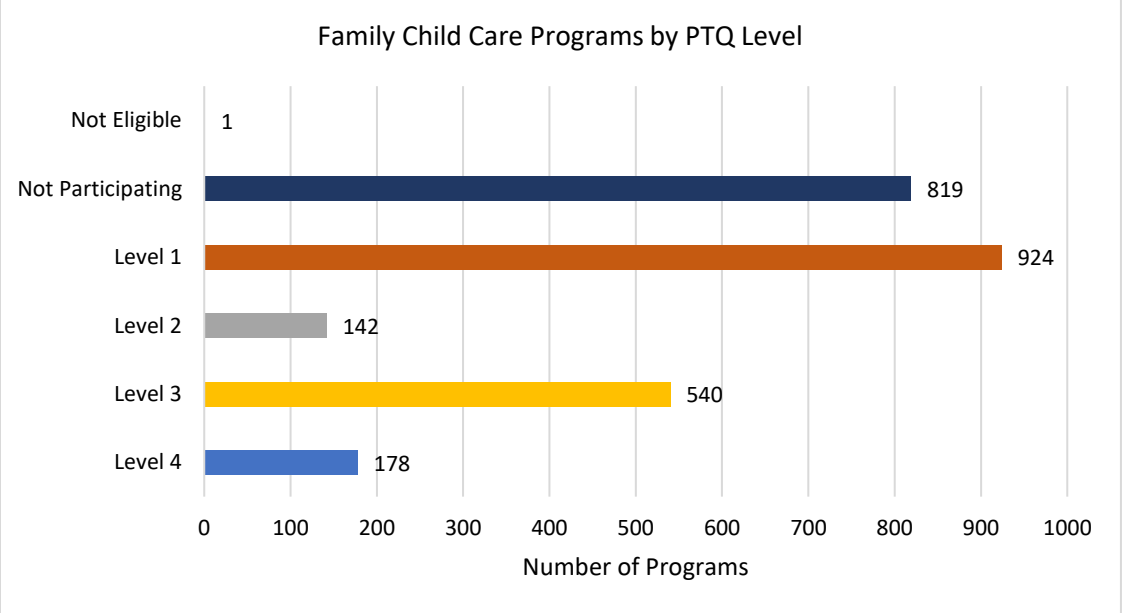
[56] Elicker, J., Lane, S., Gold, Z. S., Mishra, A., & Christ, S. (2018). Final Report: Paths to QUALITY Evaluation. https://docs.lib.purdue.edu/cffpub/70

[57] Data source: Early Learning Indiana, received 4/19/19

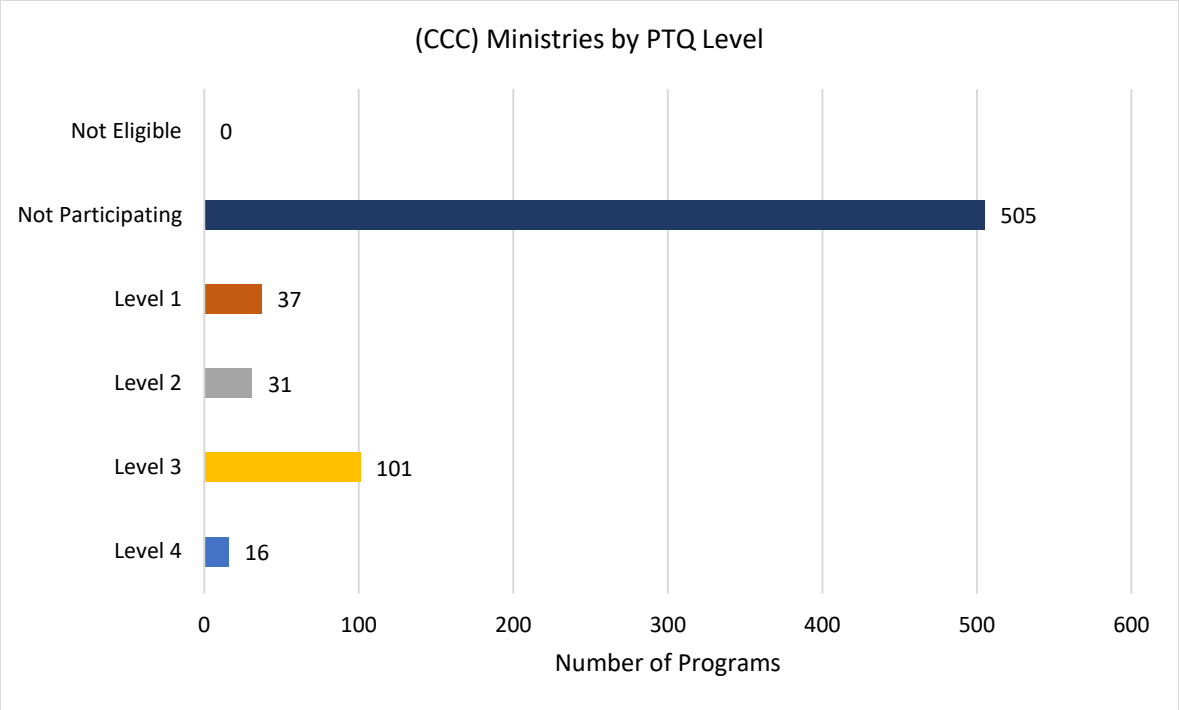
[58] Workman, S. (2017) QRIS 101: Fact Sheet. https://www.americanprogress.org/issues/early-childhood/reports/2017/05/11/432149/qris-101-fact-sheet/

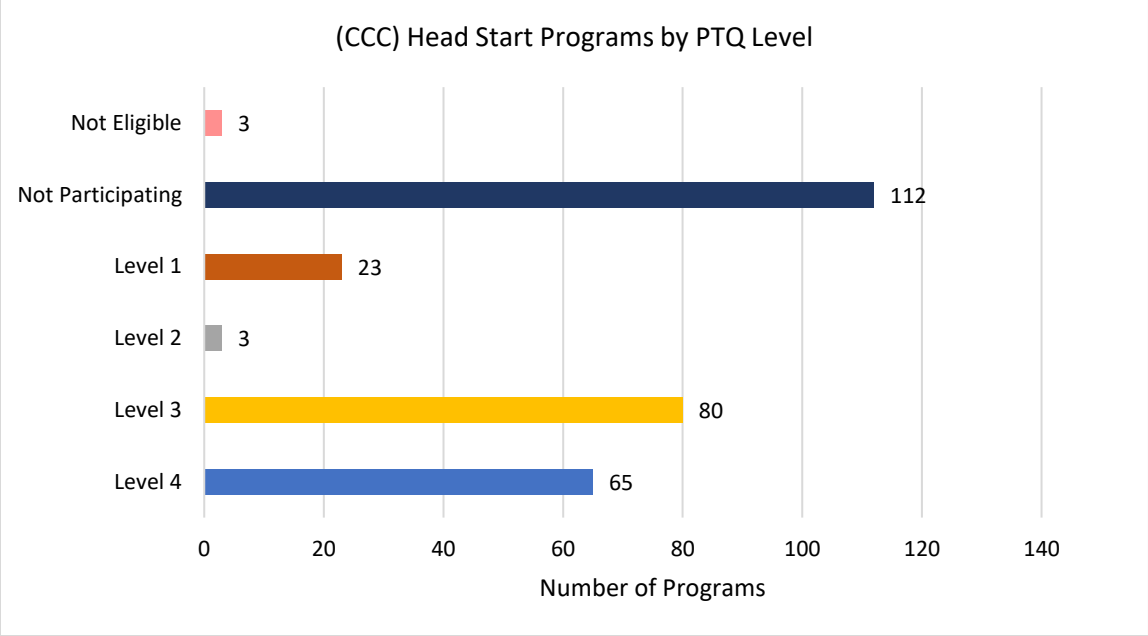
Below are figures with the number of programs participating in PTQ by program type.[59] There are more child care centers and Head Start programs that are rated at Levels 3 and 4 than are rated at Levels 1 or 2. However, there are fewer family child care homes, ministries, and preschool programs rated at Levels 3 and 4.

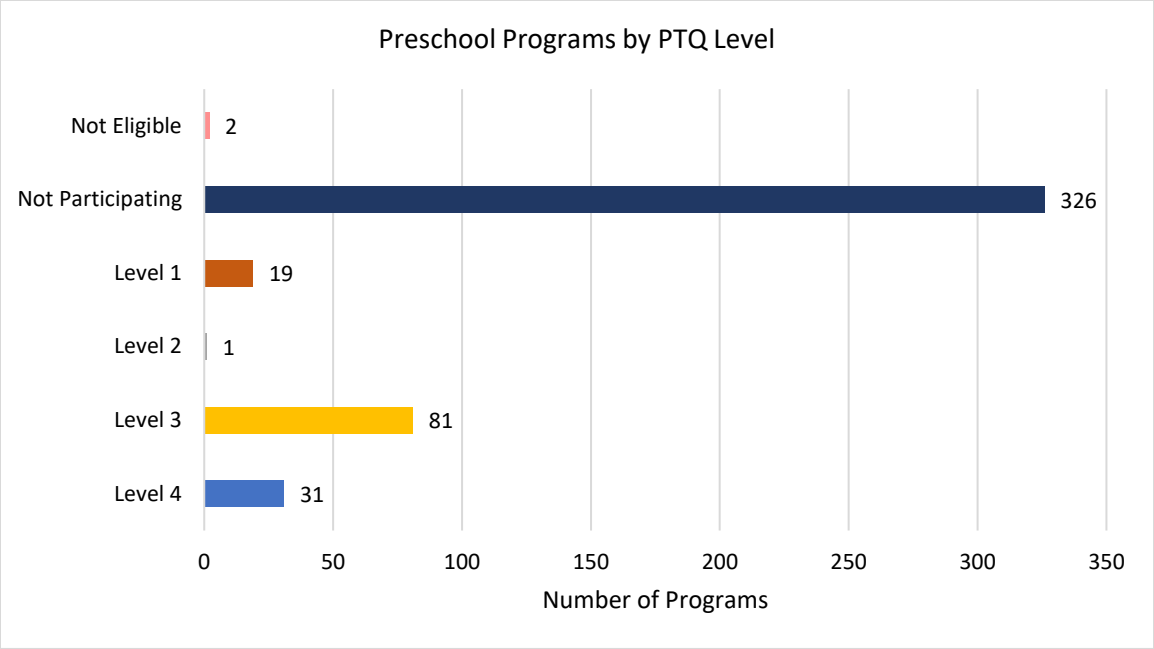




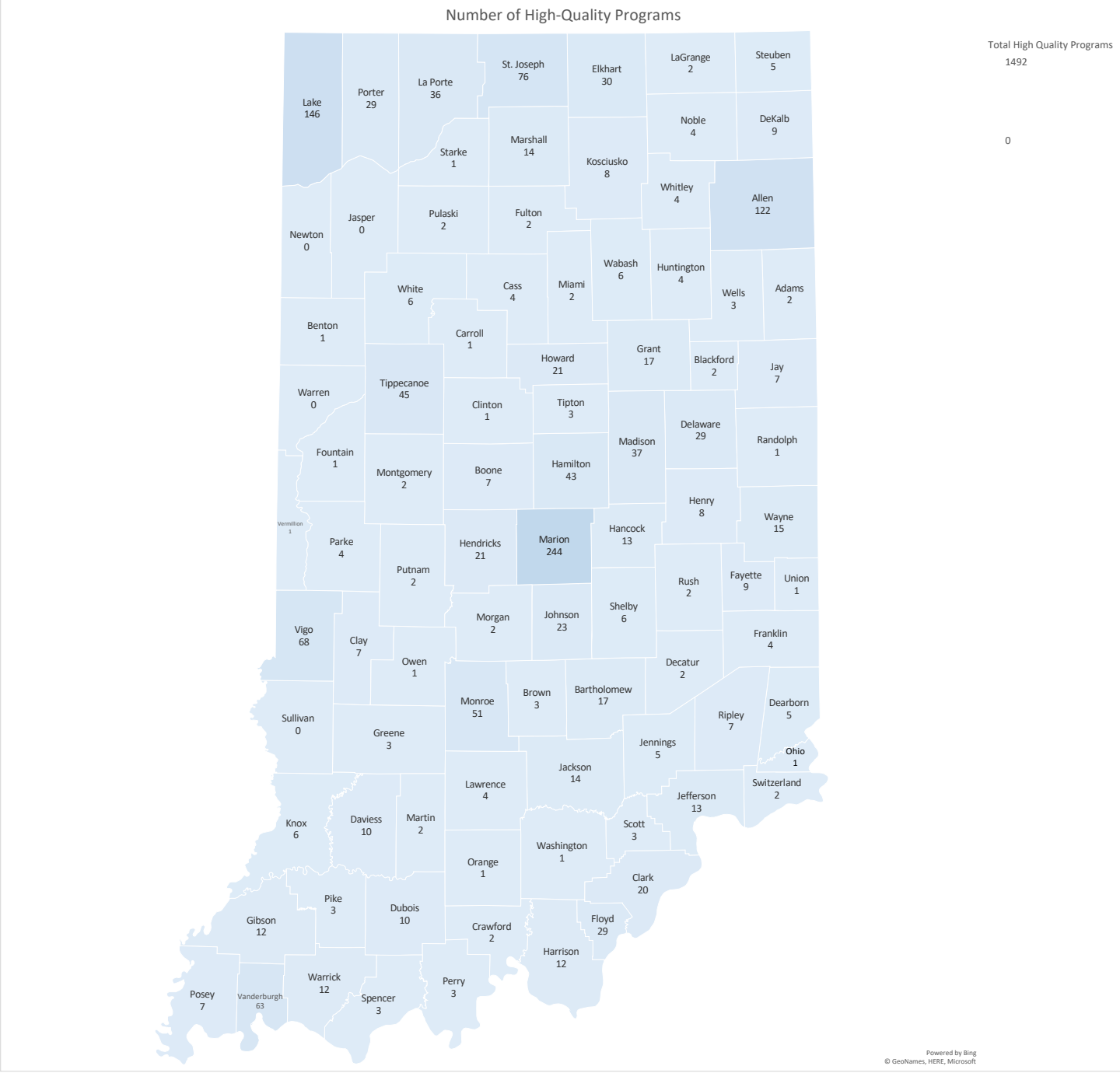
[59] Data source: Early Learning Indiana, received 4/19/19


(CCC) Ministries by PTQ Level
Not Eligible
Not Participating
Level 1
Level 2
Level 3
Level 4
0
505
37
31
101
16
0
100
200
300
400
500
600
Number of Programs


(CCC) Head Start Programs by PTQ Level
Not Eligible
Not Participating
Level 1
Level 2
Level 3
Level 4
3
112
23
3
80
65
0
20
40
60
80
100
120
140
Number of Programs

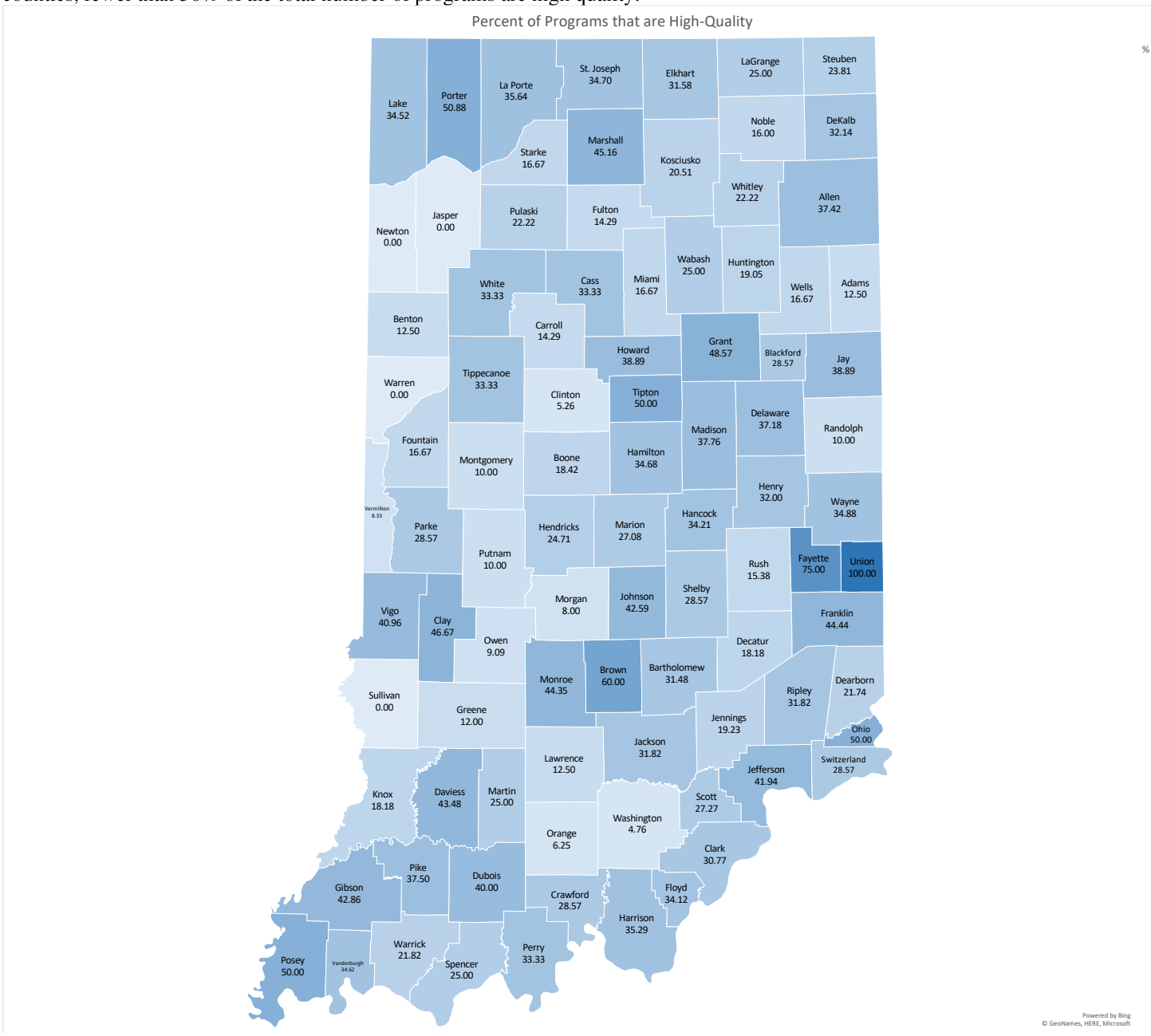

Preschool Programs by PTQ Level
Not Eligible
2
Not Participating
326
Level 1
19
Level 2
1
Level 3
81
Level 4
31
0
50
100
150
200
250
300
350
Number of Programs

Every county in Indiana, including urban and rural counties and those that have high rates of poverty, has programs that participate in PTQ.[60] However, not all counties have programs that are considered high quality (Level 3 or 4). For example, Newton, Jasper, Warren, and Sullivan counties have no high quality child care programs available to children and families.



[60] Data source: Early Learning Indiana, received 4/19/19

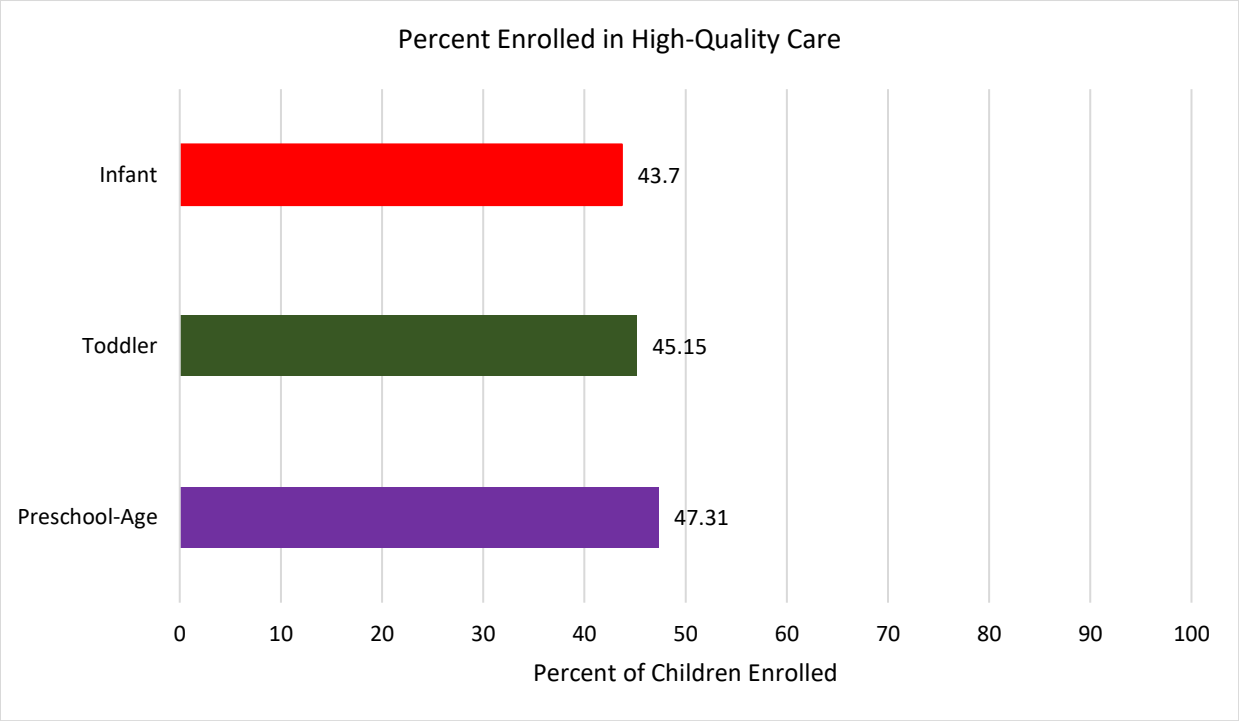
Further, below is a map of the percentage of programs in each county that are considered high quality.[61] In nearly all counties, fewer than 50% of the total number of programs are high quality.



[61] Data source: Early Learning Indiana, received 4/19/19

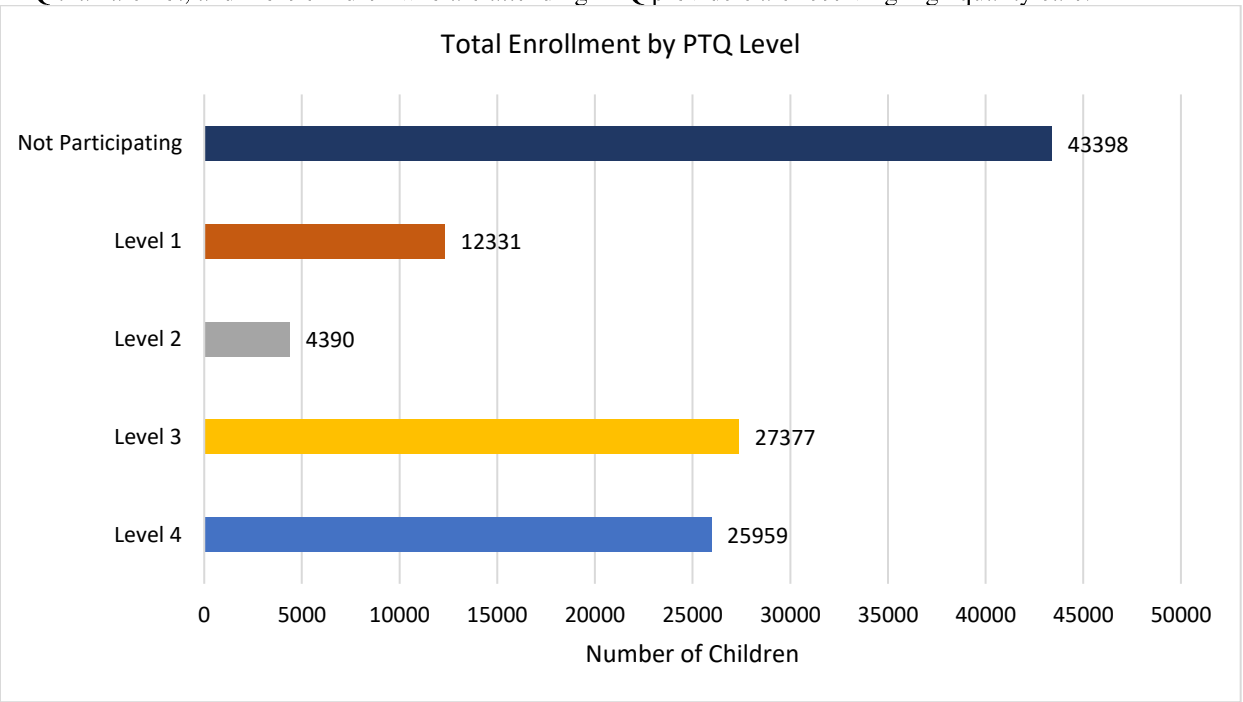
Enrollment in High Quality Care

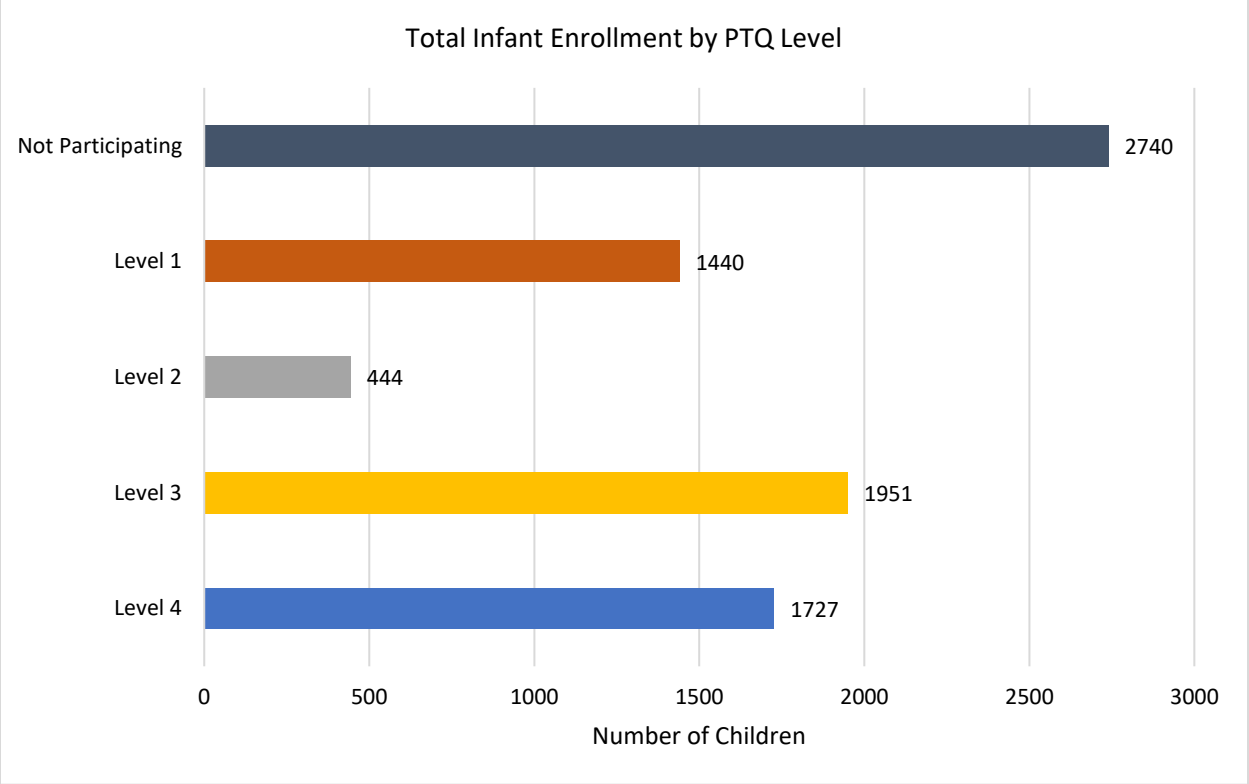
In Indiana, approximately 46% of children ages 0-5 (53,336) are enrolled in high quality care.[62] However, the numbers of children enrolled in high quality care vary slightly by age, with more preschoolers enrolled in high quality care than infants and toddlers.



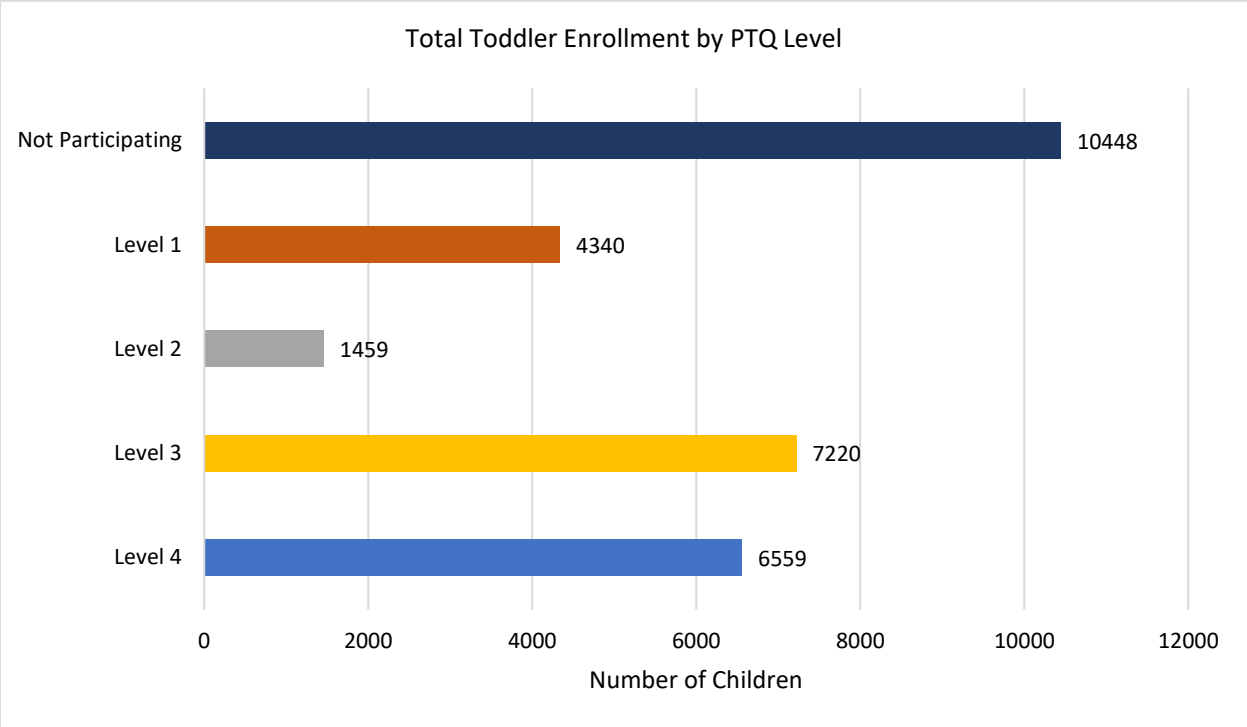
[62] Data source: Early Learning Indiana, received 4/19/19

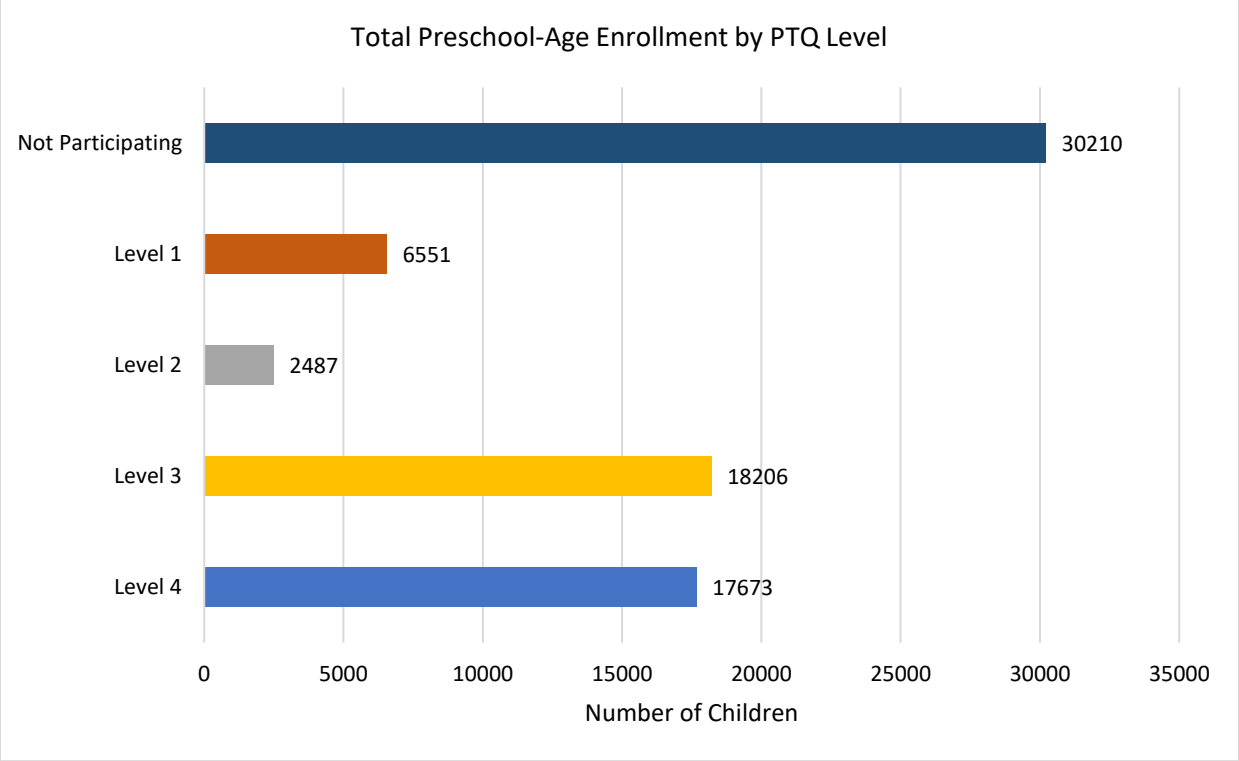
Below are figures that represent total numbers of children ages 0-5 in programs across each PTQ level across the state, which are then broken down by age.[63] Consistent across ages, more children are attending programs that are in PTQ than are not, and more children who are attending PTQ providers are receiving high quality care.



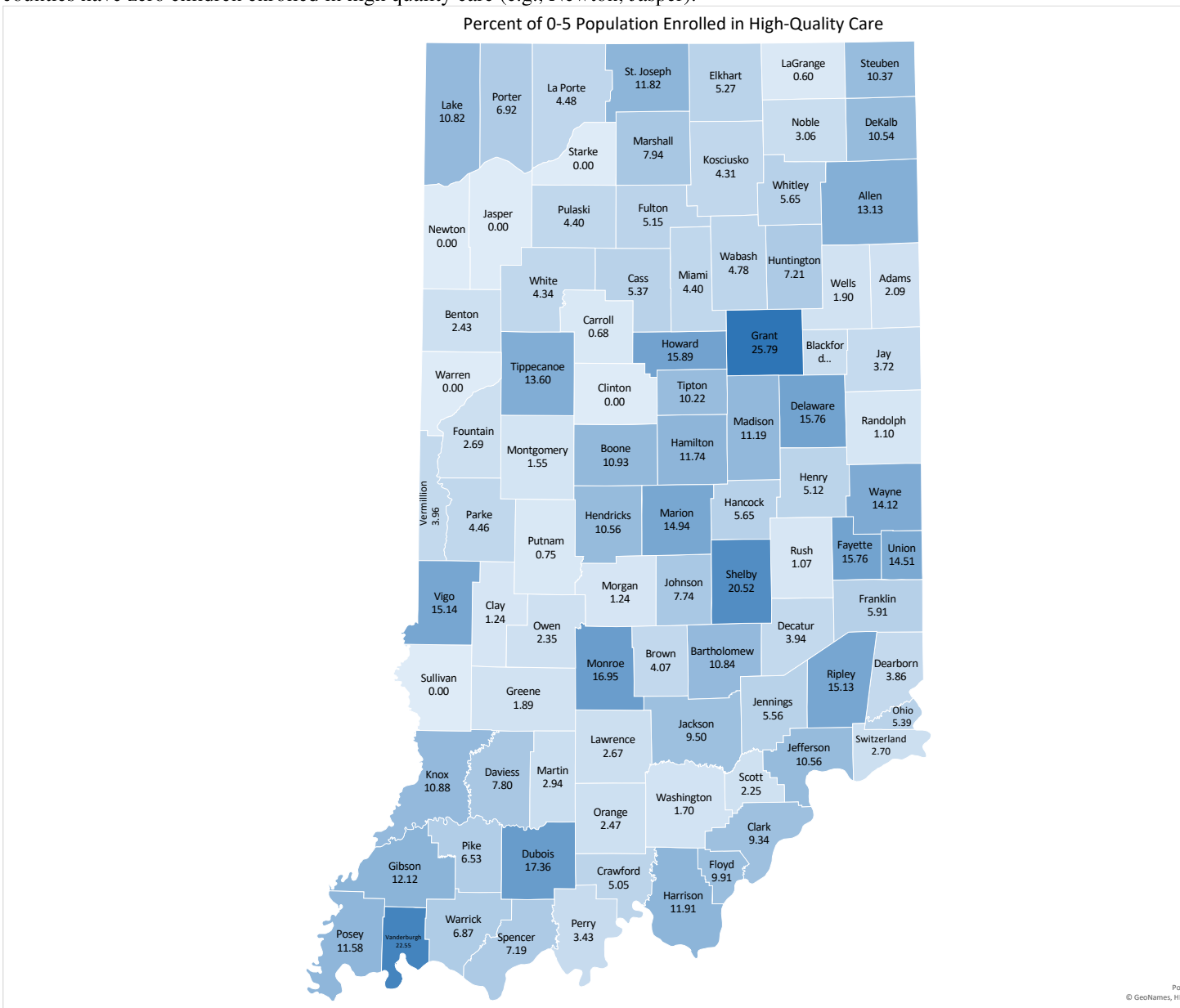


[63] Data source: Early Learning Indiana, received 4/19/19


Total Toddler Enrollment by PTQ Level
Not Participating
Level 1
Level 2
Level 3
Level 4
10448
4340
1459
7220
6559
0
2000
4000
6000
8000
10000
12000
Number of Children

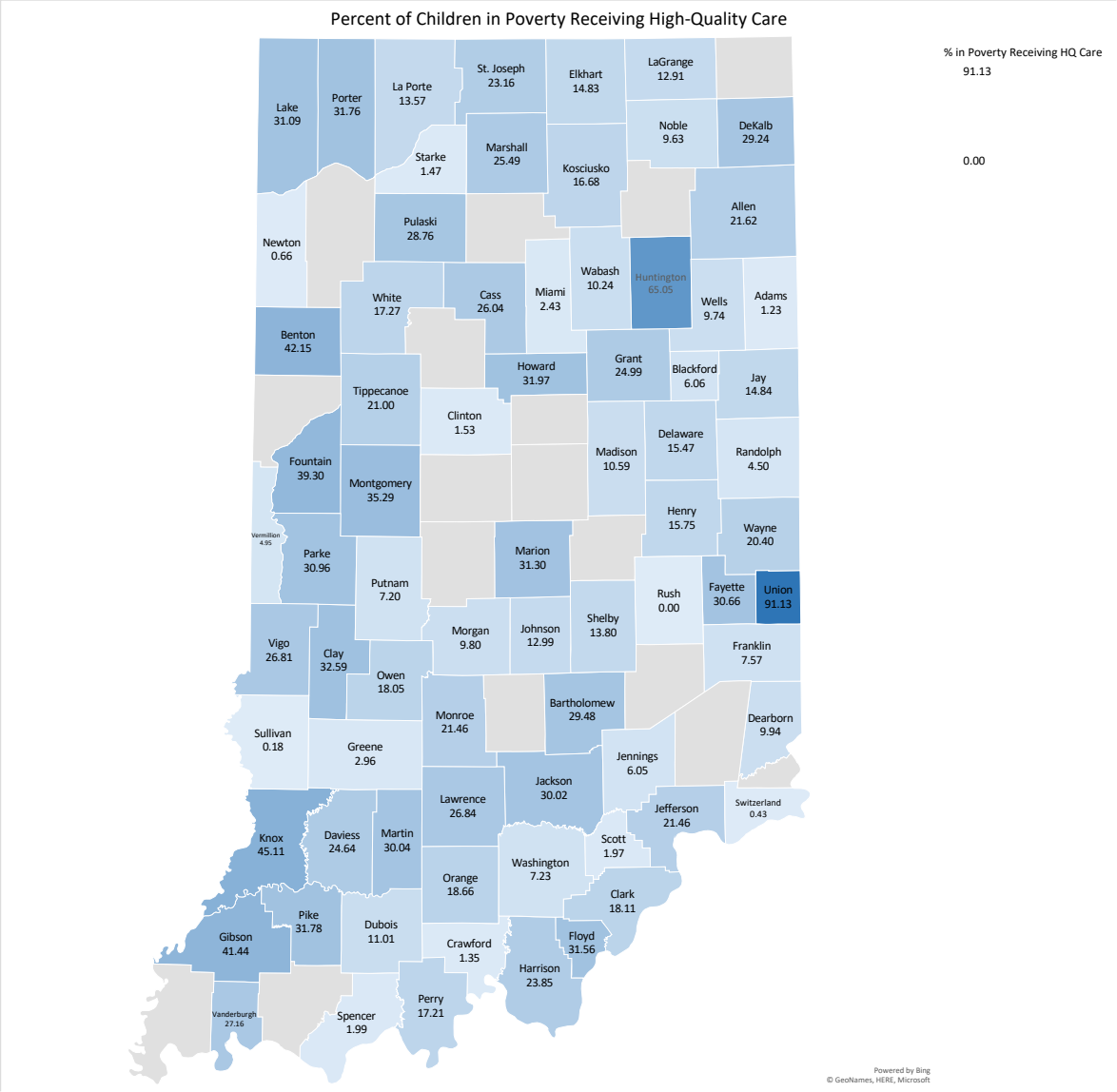

Total Preschool-Age Enrollment by PTQ Level
Not Participating
Level 1
Level 2
Level 3
Level 4
30210
6551
2487
18206
17673
0
5000
10000
15000
20000
25000
30000
35000
Number of Children

The numbers of children enrolled in high quality care also vary by county.[64] As shown below, in some cases, counties have zero children enrolled in high quality care (e.g., Newton, Jasper).



[64] Data source: Early Learning Indiana, received 4/19/19

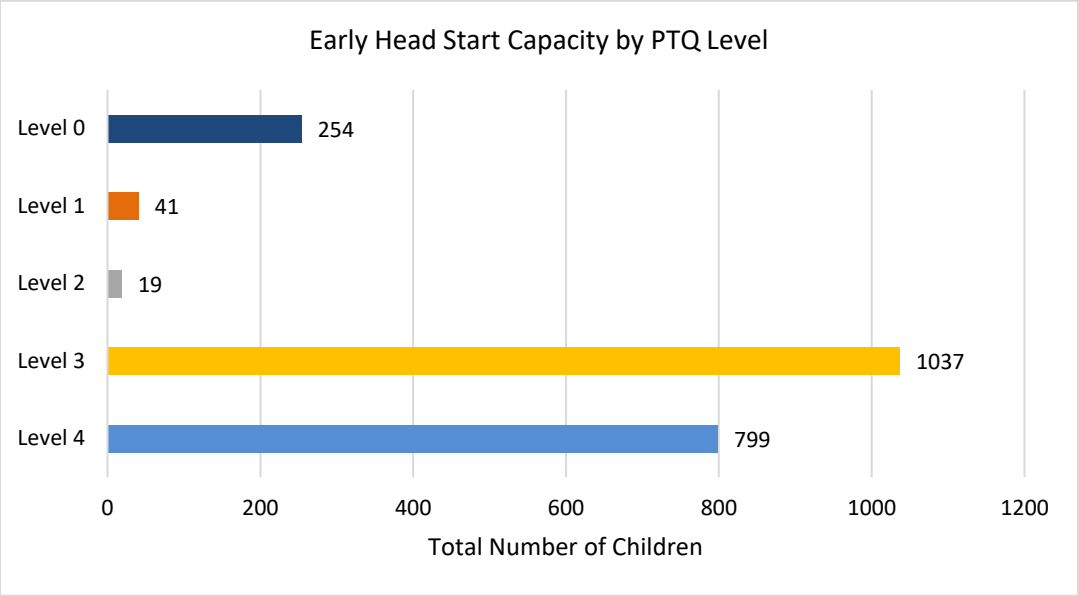
Below is a map of children living in poverty in each county who are receiving high quality care.[65] Counties with less than 10% of children living in poverty are colored in gray. These data are slightly different than what is presented in the above map because they are at the child-level rather than the provider level. As can be seen in the map, the majority of children living in poverty in several counties are not enrolled in high quality programs. It is important to note that in some cases, families who live in certain counties are seeking out high quality care in other counties. For example, in Newton county, there are no high quality programs, yet as can be seen in this map, there is one child who lives in Newton county but is attending a high quality program in another county.

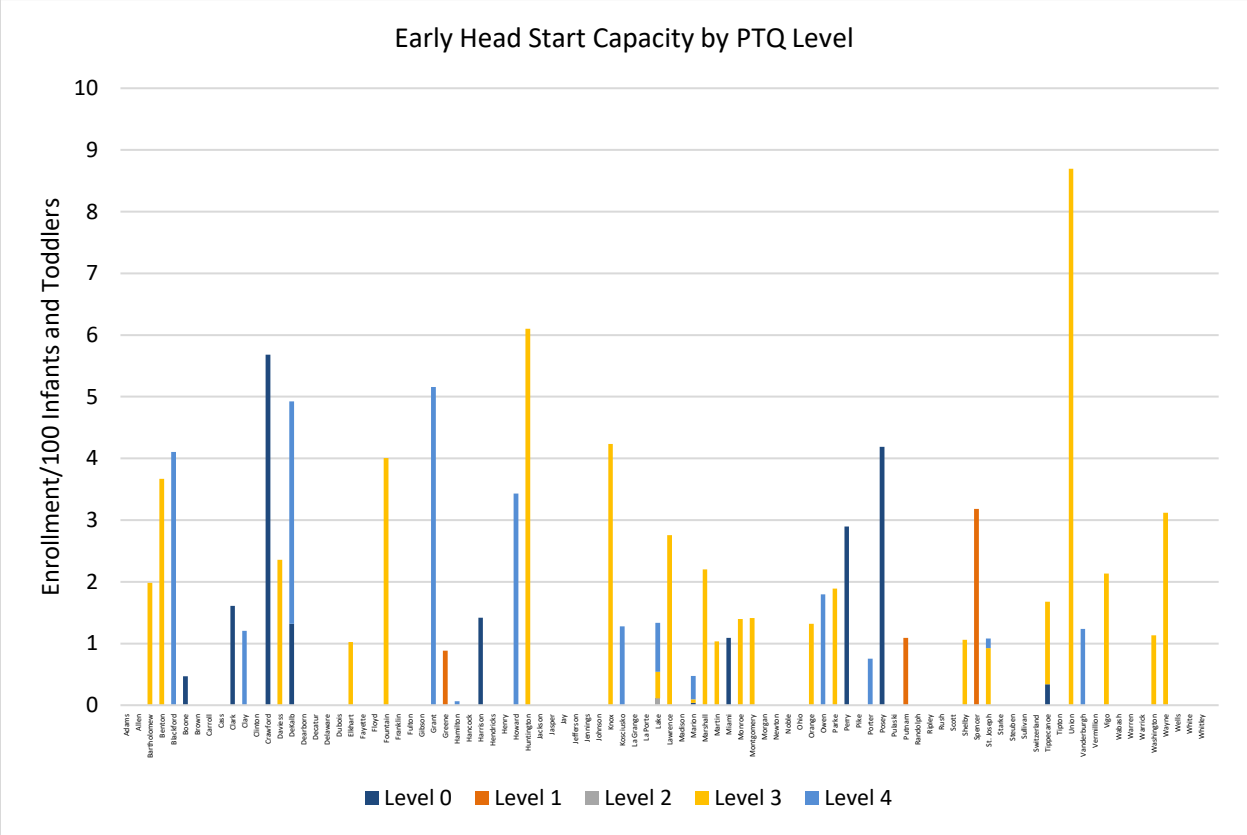


[65] Family and Social Services Administration, received on 2/25/19. American Community Survey (ACS) 5-Year Estimates; Formula for calculating % of children in poverty receiving high-quality care = Total Number of Children Enrolled in a Level 3 or Level 4 Center (through CCDF, OMW, EHS, HS) / [% ACS poverty rate*Total 0-5 Population]

Quality of Head Start

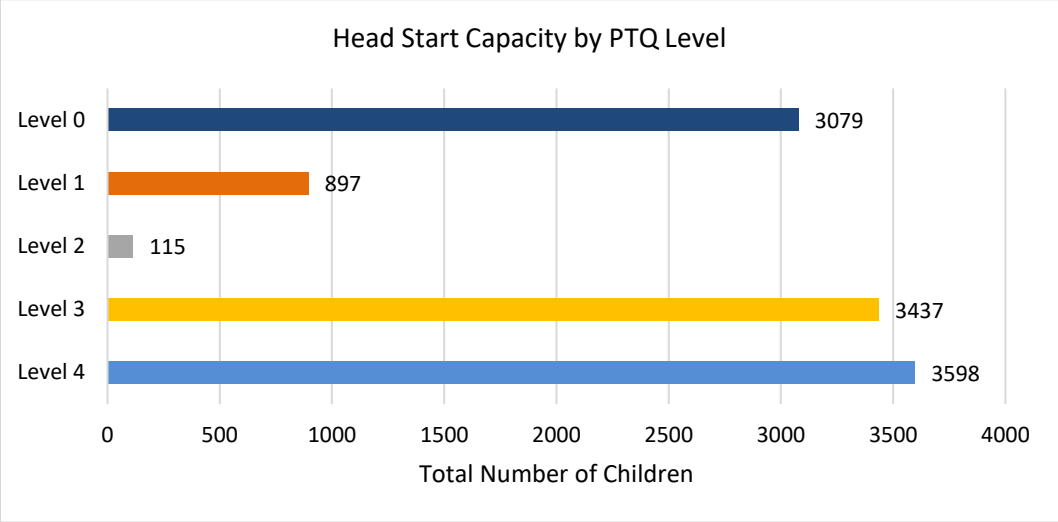
Below are graphs representing the quality of care in Early Head Start at the state level and then broken down by county. The majority (85%) of children being served in Early Head Start are experiencing high quality care (PTQ Level 3 or 4).[66]

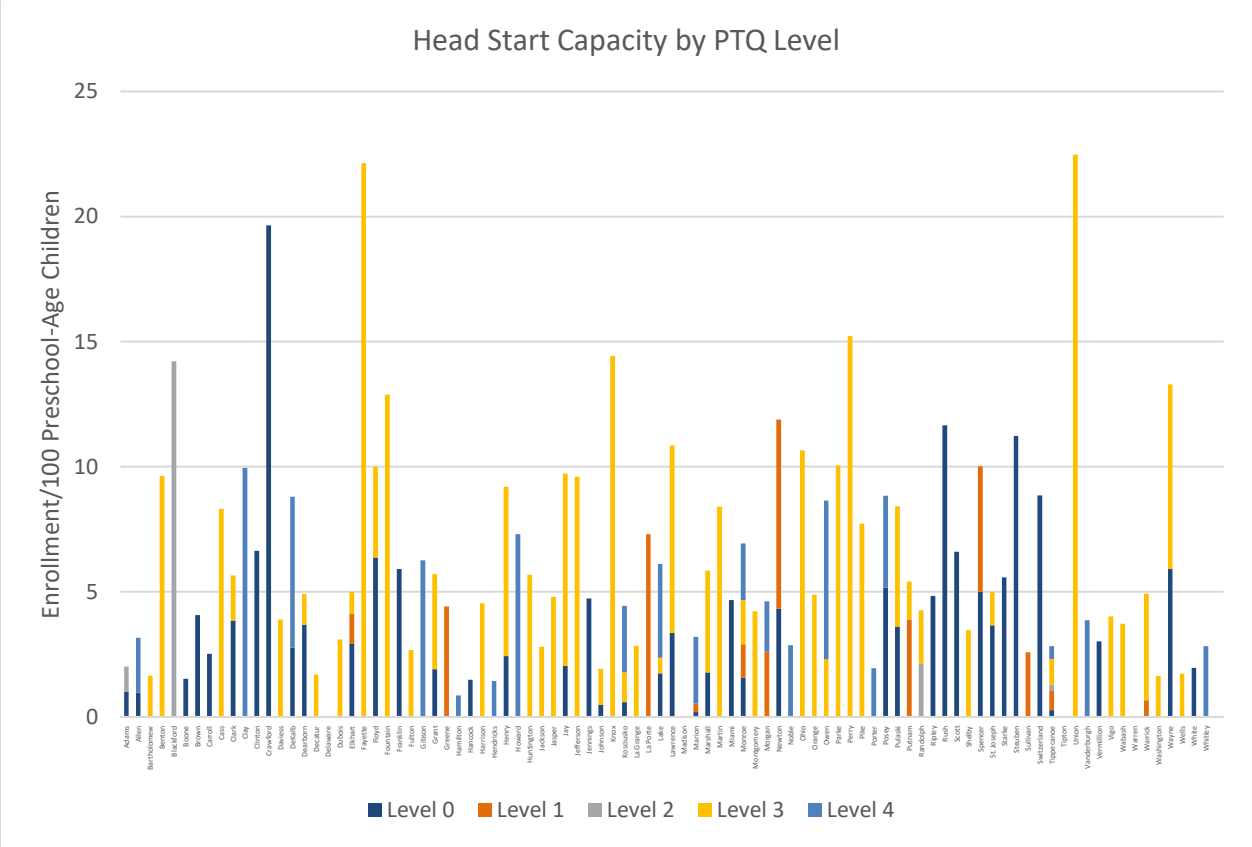




[66] Data source: Head Start, received 6/3/19; Level 0 indicates no involvement with PTQ.

Below are graphs representing the quality of care in Head Start at the state level and then broken down by county. Approximately 63% of children being served in Head Start are experiencing high quality care (PTQ Level 3 or 4).[67]

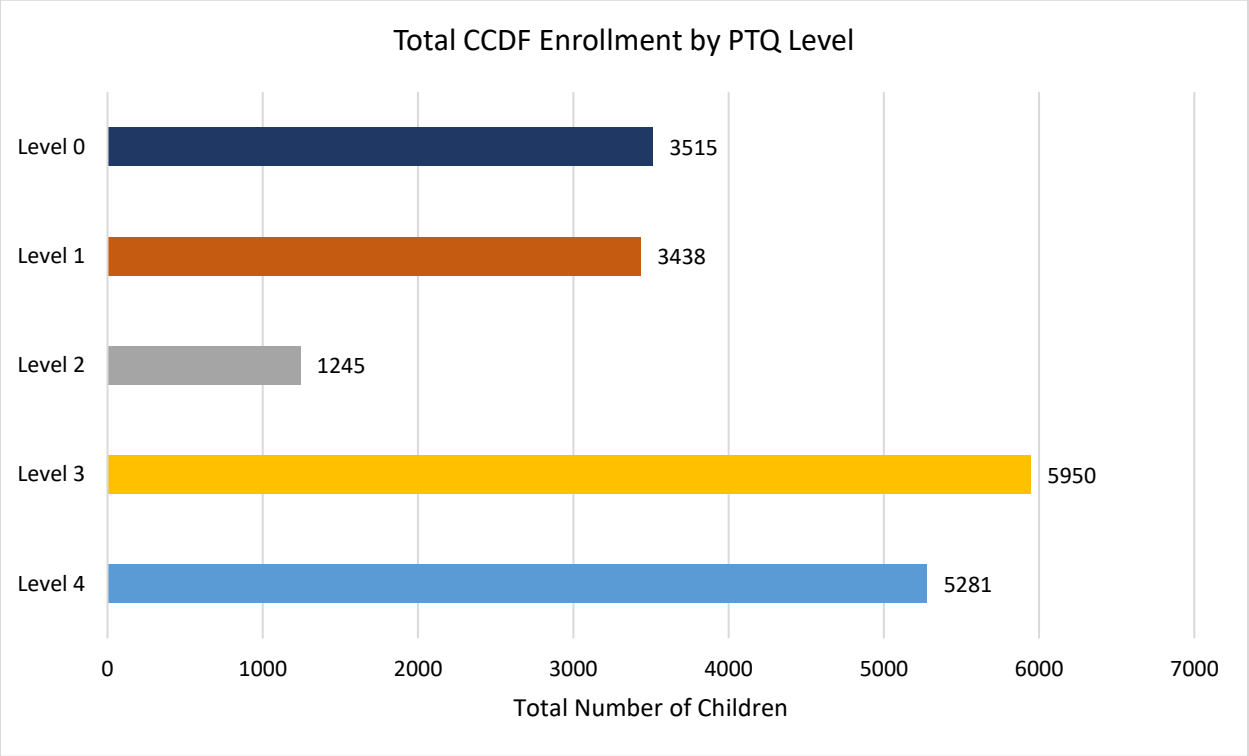




[67] Data source: Data source: Head Start, received 6/3/19

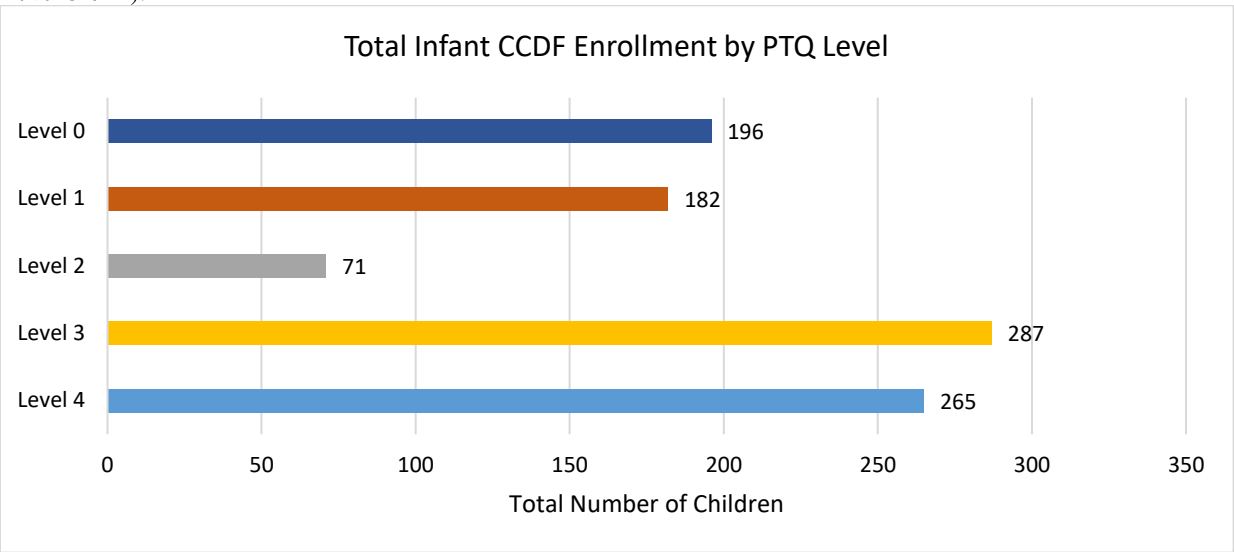
Quality of Care for Children using Child Care and Development Funds (CCDF)[68]

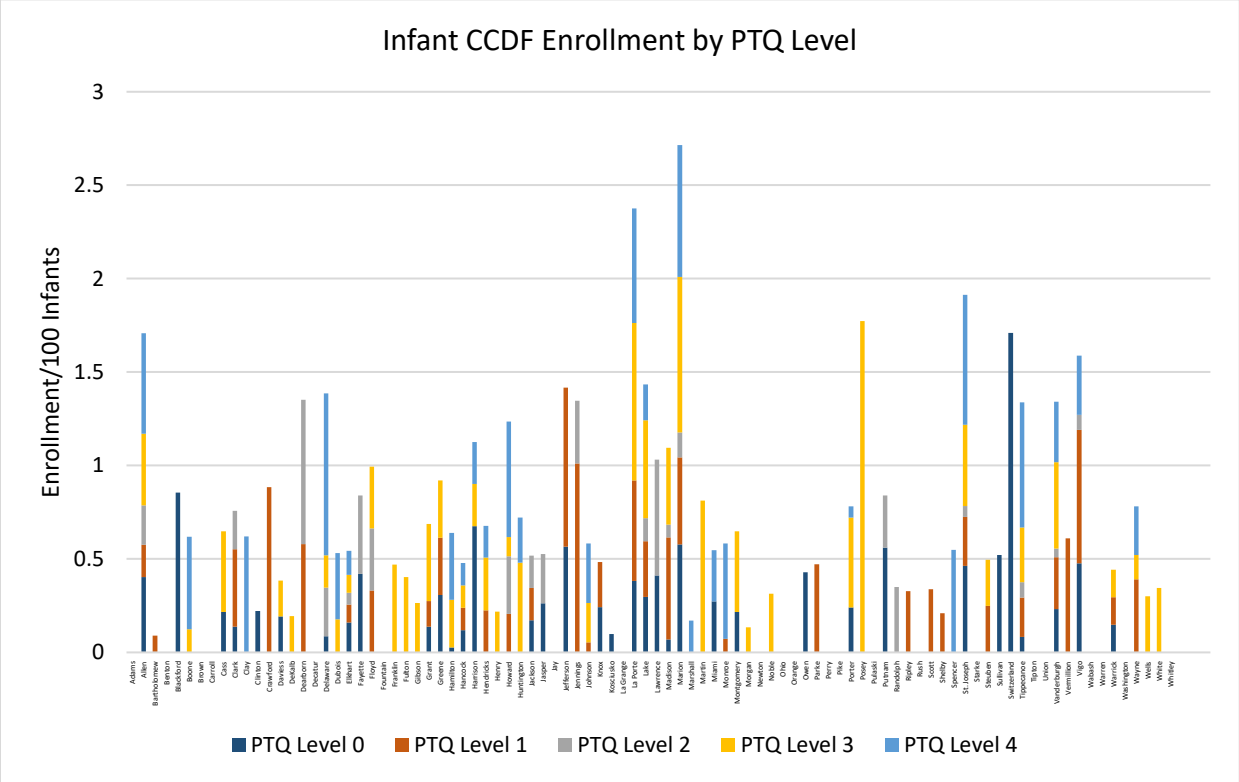
The quality of care that children who are using CCDF vouchers receives varies. Below is a figure of enrollment across the four PTQ levels. Approximately 58% of children receiving CCDF vouchers are attending high quality programs (PTQ Level 3 or 4).



[68] Data source: Family and Social Services Administration, received 2/25/19.

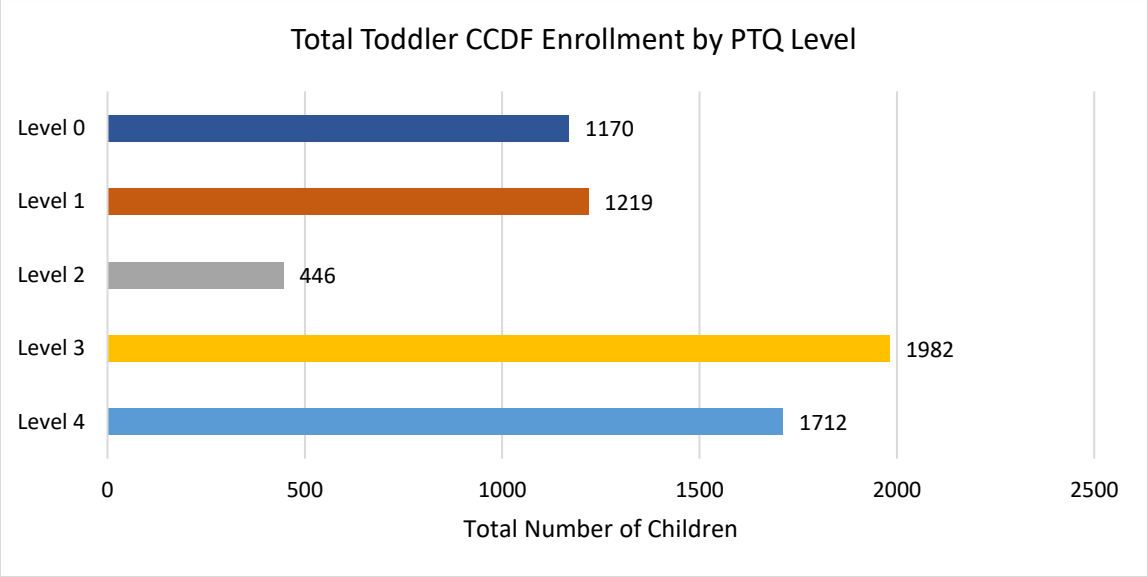
Below are figures of enrollment for infants using CCDF vouchers in the state and for each county across the four PTQ levels. Approximately 55% of infants receiving CCDF vouchers are attending high quality programs (PTQ Level 3 or 4).[69]

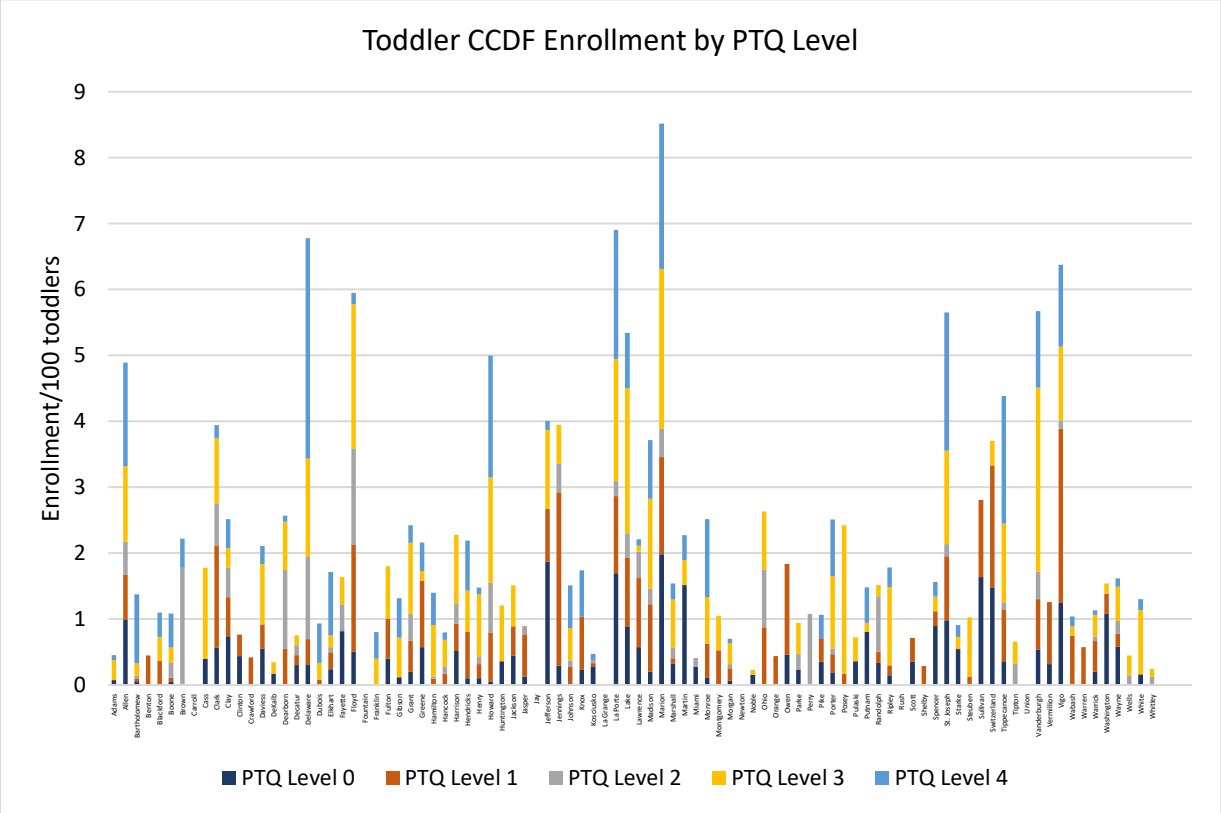




[69] Data source: Family and Social Services Administration, received 2/25/19.

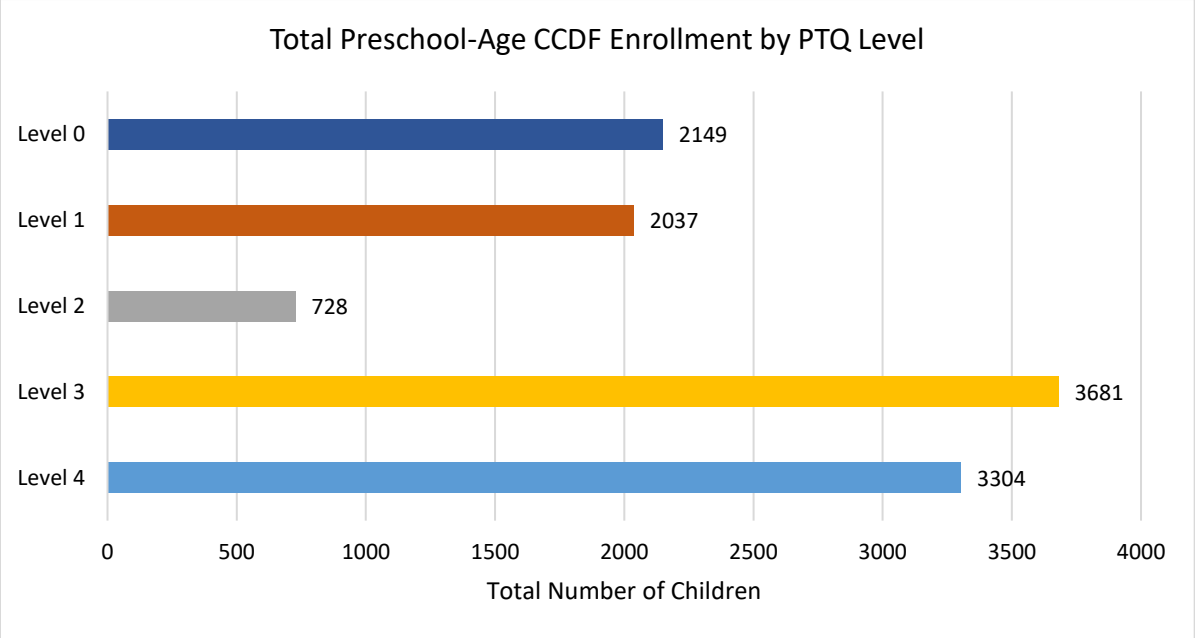
Below are figures of enrollment for toddlers using CCDF vouchers in the state and for each county across the four PTQ levels. Approximately 57% of toddlers receiving CCDF vouchers are attending high quality programs (PTQ Level 3 or 4).[70]

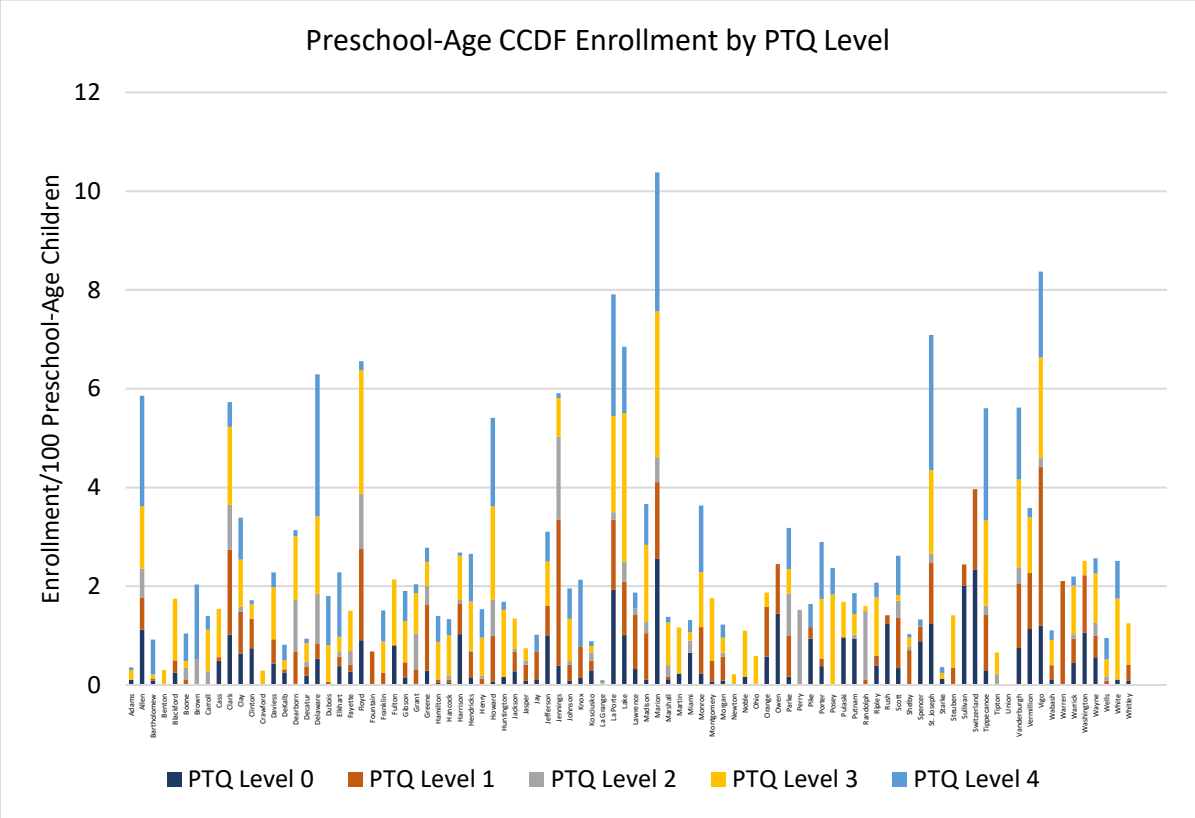




[70] Data source: Family and Social Services Administration, received 2/25/19.

Below are figures of enrollment for preschoolers using CCDF vouchers in the state and for each county across the four PTQ levels. Approximately 59% of preschoolers receiving CCDF vouchers are attending high quality programs (PTQ Level 3 or 4).[71]





[71] Data source: Family and Social Services Administration, received 2/25/19.

Recommendations: Despite substantial increases in PTQ participation in the last several years, a significant portion of ECCE providers are still not participating or are at Level 1 or 2 so are not considered high quality. Furthermore, in some counties, families have no access to high quality programs. Therefore, efforts need to be increased and focused on encouraging providers who are not participating in PTQ to participate and facilitating advancement in PTQ for those who are participating but are at lower levels.

Parent Use of PTQ

Statewide parent surveys in 2015 and 2017 found that more than half of the respondents had heard of PTQ (2015: 57%; 2017: 62%),[72] a large increase in public awareness since 2008 (e.g., in 2009, just 12% of parents reported knowing about PTQ). Most parents who were aware of PTQ reported they would use the PTQ rating to guide their child care decisions (2015: 75%; 2017: 73%) and would consider paying more for higher-rated child care (2015: 74%, 2017: 58%).[11] Parents can find information about PTQ via an accessible website (http://childcareindiana.org/families/). Further, PTQ Level signs, decals, and banners are given to providers to post onsite so that families are aware of their provider's PTQ Level. To our knowledge, however, this information is only presented in English.

PTQ Evaluation Research

Under the direction of Dr. James Elicker, Professor at Purdue University, a series of rigorous evaluation studies took place from 2008 to 2018. There were several aims of these studies, including: 1) comparing rating levels on PTQ with observer ratings on two different measures: the North Carolina Environmental 7-point Environmental Rating Scales (ERS) and the Classroom Assessment Scoring System (CLASS); 2) identifying factors that contributed to providers participating in PTQ and advancing levels; 3) examining whether PTQ was supporting parents' decisions around early care and education; 4) exploring whether children and families at all education and income levels were gaining access to child care at the highest PTQ levels; and 5) testing whether children who were in higher PTQ levels were developing more optimally than children in lower PTQ levels. A summary of this work and recommendations are provided below.

Results and recommendations from Paths to QUALITY evaluation research conducted by Purdue University, 2008-2018

Purdue Evaluation Results	Practice/Policy Recommendations
PTQ Phase 1 Final Report: Implementation & Validation (2008-2011)	
1. Average overall quality of PTQ-rated child care ranged from 3.2 (Level 1) to 4.3 (Level 4) on the North Carolina Environmental 7-point Environmental Rating Scales (ERS). Highest ratings were for Parents and Staff, but most providers, even those at PTQ Level 4, were rated below "Good Quality" (scale point 5). ERS quality was highly variable at each PTQ level. PTQ ratings were positively correlated with the ERS, so *average* quality did show a progression from lower to higher at each PTQ rating level.	There is evidence that PTQ promotes improvements in quality, and Indiana providers are moving up quality levels. However, the aspects and levels of quality attained within PTQ, even at Level 4, are still quite low, and may not be sufficient to produce better child development outcomes. Reduce quality variation within each PTQ level by focusing on a few key quality aspects and rigorous monitoring.
2. The lowest ERS quality ratings in preschool classrooms were for meals/snacks; diapering/toileting; health practices; safety practices; using language to develop reasoning skills; and math/number.	More attention is needed in monitoring hygiene, nutrition, and safety in Indiana PTQ child care providers. (This was addressed by statewide training and program changes.) Language development and early math are important areas that also need more focused attention in quality improvement efforts.
3. Families using CCDF vouchers were just as likely to be found in lower- and higher-PTQ-rated care. CCDF users were apparently able to access Level 3 and 4 care.	Programs that target low-income families (e.g., CCDF-eligible child care centers and Head Start) were successful at providing higher quality care through

[72] Elicker, J., Lane, S., Gold, Z. S., Mishra, A., & Christ, S. (2018). Final Report: Paths to QUALITY Evaluation. https://docs.lib.purdue.edu/cffpub/70

	PTQ, thus providing a potential avenue for all children access to high quality care.
4. Infant-toddlers' cognitive and social-emotional development did not vary according to the PTQ level of their child care.	Wholesale quality improvements are needed in infant-toddler child care.
5. Preschoolers' development did not vary according to the PTQ level of their child care, except for a measure of anxiety/withdrawal, which was lower for children in higher PTQ-rated care. However, when quality measured by the ERS scales was higher, both infants/toddlers and preschoolers showed more advanced cognitive, language and social development. Also when caregivers were observed to interact more positively and less punitively with preschool children, the children displayed higher levels of language and social competence.	The current PTQ system and quality standards may not be focused enough on the particular aspects of child care programs that are most likely to promote positive development in preschoolers. More attention is needed to require high quality adult-child interactions that support early learning and healthy social-emotional development.
6. Providers joined the PTQ system primarily to: improve quality; get professional recognition; make the program more attractive to parents; get new ideas for the program; get the cash incentives; and get the training/technical assistance offered.	Providers in the early years of PTQ were motivated to join for various reasons, including to get support in increasing quality.
7. Providers reported they found most valuable in PTQ: mentoring services; incentives; recognition from parents.	Providers report they value one-on-one mentoring above other forms of T/TA.
8. Providers reported the most challenging obstacles participating in PTQ were: Time and paperwork required to complete tasks required by PTQ; completing the education and training required; and having the financial resources needed to meet the standards.	There are significant barriers to quality improvement, including administrative time, gaining access to higher education classes and in-service training, and paying for education and training.
9. The most common forms of training/technical assistance providers used to improve quality (by more than 50% of providers) were: mentoring; local CCRR training sessions; and local child care conferences. Use of training increased from lower to higher rated levels of PTQ, except that use of mentoring declined at Levels 3 and 4.	For providers who have reached Level 3 or Level 4 in PTQ, the T/TA needs will be different than for providers in lower levels. If the goal of PTQ remains national accreditation, specific resources aimed at accreditation will be most helpful. However, the state should re-examine and re-consider whether accreditation should be the ultimate quality goal. Current evidence is weak for accreditation producing the best child outcomes.
10. More than ½ of parents whose child was attending a PTQ provider reported they had never heard of PTQ. The majority of those who had heard of PTQ reported they learned of it from their child care provider.	Emphasize marketing PTQ through PTQ providers.
11. In the general public in 2009, only 12% of parents of preschool children using child care had heard of PTQ. In 2011, 19% of parents surveyed had heard of PTQ.	Public awareness takes time, and a sustained PR campaign is necessary, because the population of families with young children is always changing.
PTQ Phase 2 Final Report: Child and Provider Outcomes (2011-2018)	
1. Classroom and family child care quality, measured by the CLASS, was highly variable at all PTQ levels.	If increasing CLASS quality is a goal, T/TA, PTQ standards and monitoring of quality should be more aligned with CLASS dimensions.
2. CLASS quality did not differ much between higher- and lower- PTQ-rated settings. Toddlers at 12 mo. and preschoolers 4-5 yrs. were observed	See above.

	in Level 3 and 4 settings that were slightly higher in CLASS quality than lower-rated settings.	
3.	CLASS quality, observed 3 times in a 2 year longitudinal study, did not predict higher gains for either toddlers or preschoolers in cognitive, language, or social-emotional development.	Since the main domains of CLASS quality did not predict children's growth rates in cognitive, language, and social-emotional skills over 2 years, more focused measures of process quality may be needed.
4.	Toddlers in Level 3 or 4 care gained more in early learning skills over 2 years than toddlers in care below Level 3. Preschoolers showed a similar trend, but the gain differences were not statistically significant.	PTQ quality does support some aspects of toddlers' early learning. More attention and T/TA support is needed to provide significant support for toddlers' social-emotional development and preschoolers' development in all domains.
5.	Although all children's social competence (reported by caregivers) increased over 2 years, there were no differences in the gains in social competence for children at different PTQ levels.	See above.
6.	Child care providers continued to enroll in the voluntary PTQ system at high rates and advance through Levels 1, 2, and 3. Many providers decide to stay at Level 3, due to the costs and the need to have higher-educated teachers at Level 4.	PTQ is a viable system in Indiana for reaching child care providers and helping them to improve program quality. However, needed are re-examination of the standards for highest-quality child care and resources to improve quality at the highest levels.
7.	The strongest independent predictors of advancement in PTQ were type of care (centers), PTQ level below 4, education level of the director or family home provider, and years of child care experience.	Education levels of program directors and family child care providers is an important factor in whether a program improves quality or not. Re-examine educational requirements for directors and/or increase T/TA resources focused for directors and FCC owners.
8.	Subgroups of providers had distinctly different PTQ advancement trajectories, which were related to distinctly different characteristics and attitudes.	Important to individualize quality improvement for child care providers, meeting them where they are in experience, education, professionalization, and attitudes toward PTQ and quality improvement.
9.	Statewide parent surveys in 2015 and 2017 found that more than half of the respondents had heard of PTQ (57%; 62%) a large increase in public awareness. Most parents who were aware of PTQ reported they would use the PTQ rating to guide their child care decisions (75%; 73%) and would consider paying more for higher-rated child care (74%, 58%).	Parents are increasingly aware of PTQ and willing to use it as a guide in making child care decisions. It is important to maintain and sustain public awareness efforts, including supporting providers to promote the importance of PTQ, because the client population of families with young children is always changing as children are born and age out of the system.

On My Way Pre-K

In 2014, OECOSL of the Indiana Family and Social Services Administration (FSSA) launched On My Way Pre-K (OMW), a state-funded program designed to increase access to high quality prekindergarten for children from low income backgrounds (family income below 127% Federal Poverty Line [FPL]). In order to qualify to be an OMW provider, providers must be rated 3 or 4 on PTQ. OMW was first piloted and evaluated in five counties (see evaluation results below). Legislation has now expanded the program to all 92 counties in Indiana.

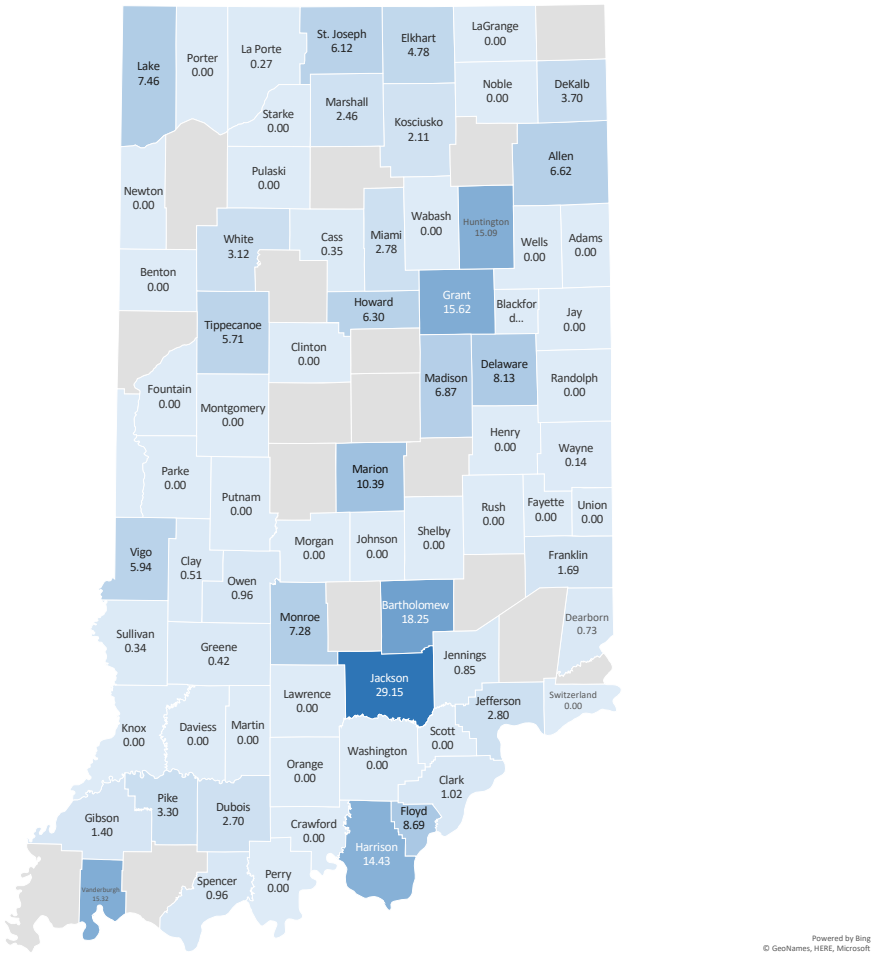
In total, there are 671 OMW providers in Indiana. These providers serve 2,942 4-year-old children whose family income is below 127% of the FPL.[73]

Below is a map of the percentages of 4-year-olds living in poverty (below 100% of the FPL) that are enrolled in OMW programs.[74] The counties with less than 10% of children living in poverty are colored in gray and are not included in the report. Jackson county has the most children living in poverty enrolled in OMW. Several counties have no children enrolled in the program.

[73] Data source: Family and Social Services Administration, received on 2/25/19.

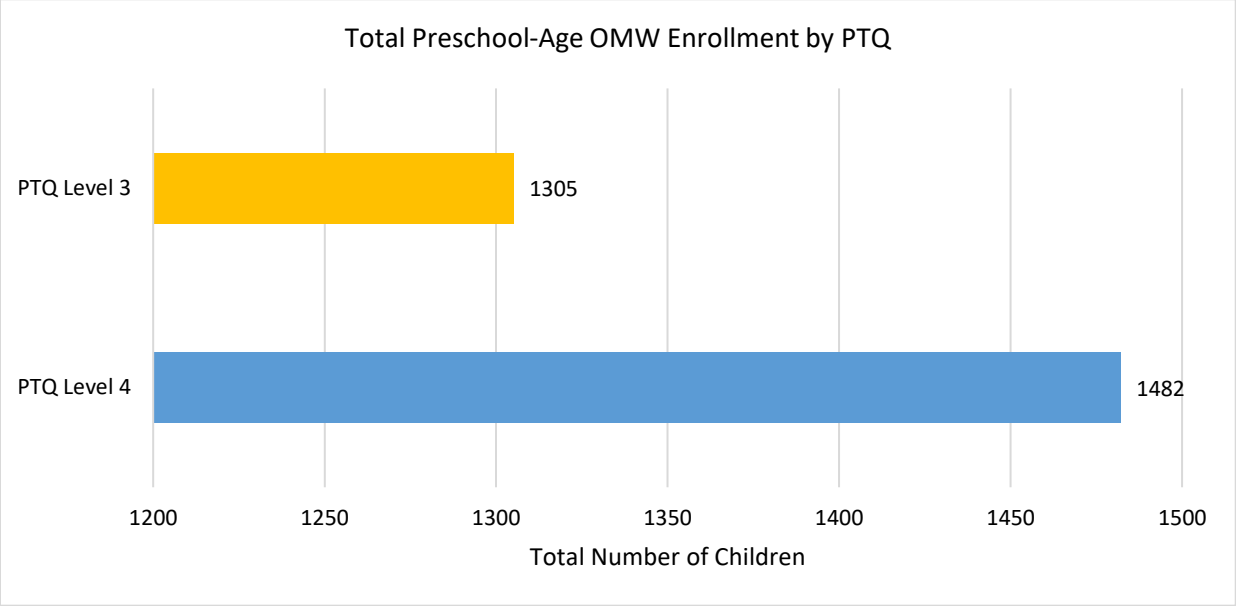
[74] Data sources: Family and Social Services Administration, received on 2/25/19. American Community Survey (ACS) 5-Year Estimates.

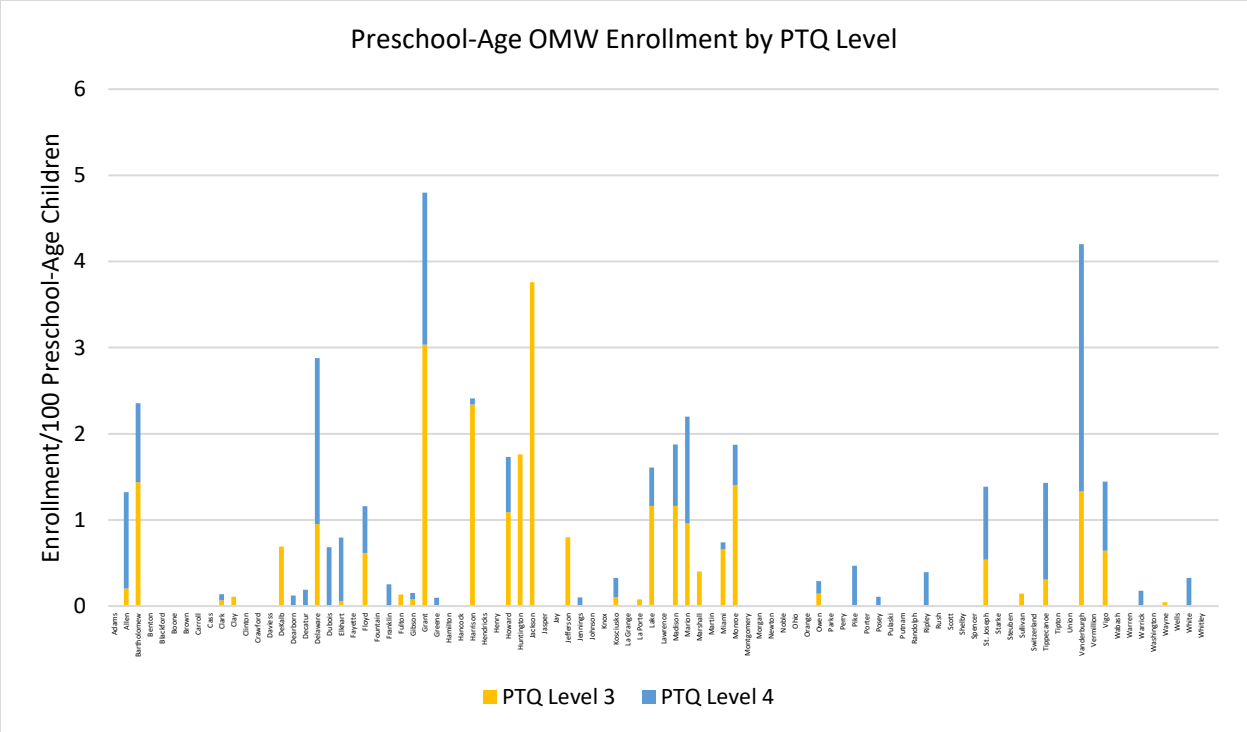
Percentage of Preschool-Age Children in Poverty Served by OMW Pre-K



Quality of OMW

Below are figures of enrollment for 4-year-olds in OMW in the state and for each county across PTQ levels 3 and 4.[75]





[75] Data source: Family and Social Services Administration, received 2/25/19; Only centers that were listed as Level 3 and Level 4 were included. Some centers in the data file were listed as below Level 3 – however, these would be private schools who can be eligible if accredited, but are not in PTQ.

OMW Evaluation Research
Purdue University was contracted by OECOSL to conduct a rigorous evaluation study of OMW. Using a quasi-experimental design and propensity weighting techniques, the goal of this study was to evaluate the effects of OMW Pre-K on children's outcomes in pre-k and kindergarten and on test scores in 3rd grade. At the time of the completion of this needs assessment, data had been collected through kindergarten. Participants include two cohorts of children (N = 558; 51% male). Children in both cohorts were 4-years-old (cohort 1: M = 4.82 years, SD = .31; cohort 2: M = 4.80 years, SD = .31) at the start of the study. The comparison group consisted of children who were attending a community-based child care program that was rated 0 or 1 on PTQ and were using Child Care Development Fund (CCDF) vouchers which have similar income eligibility requirements as the pre-k program (family income below 127% FPL).

Effects of program participation varied across nine school readiness outcomes. Overall, findings indicated that children who participated in the pre-k program experienced greater gains from baseline to one or more time points in language, mathematics, and literacy skills.[76]

In terms of quality, observations of teacher-child interactions were conducted using the Classroom Assessment Scoring System Pre-K (CLASS Pre-K), which consists of three domains: emotional support, classroom organization, and instructional support. Scores on the CLASS were highly variable across both OMW and comparison classrooms. High quality thresholds were not met for OMW or comparison classrooms for classroom organization (score = 5+) or instructional support (score = 3+), but the threshold was met for emotional support (score = 5+) in both groups. OMW classrooms were rated as significantly higher than comparison classrooms on the emotional support domain, but not on the other domains.

Family outcomes were measured through a parent survey. Results suggested that the majority of OMW parents were "very satisfied" or "satisfied" with their pre-k provider. Furthermore, parents reported that having their child in the OMW program enabled them to get a job (35% in cohort 1, 25% in cohort 2), start school or job training (33% in cohort 1, 12% in cohort 2), or work more hours (51% in cohort 1, 30% in cohort 2). Finally, OMW met an important early education need for many families with low incomes. Over half of parents surveyed reported that if they had not been able to enroll their child in OMW, their child would have stayed home, or they were "unsure" whether they could have attended any preschool or child care.

Recommendations:

- ***If an important goal of OMW is to improve children's kindergarten readiness and early educational outcomes, specific efforts by administrators and teachers to increase the quality of classroom organization and instructional support to young children are needed.***
- ***Although OMW classrooms are generally providing higher levels of CLASS quality than comparison classrooms, quality levels are still below those recommended for two domains (classroom organization and instructional support) to produce measurable and lasting gains in school readiness. Recommended methods include more focus on cognitively-challenging language, concept development, quality of feedback, and rich conversations that provide language modeling and experience.***
- ***The use of evidence-based curricula, as well as support in implementing a curriculum effectively, is also recommended. All OMW providers, regardless of type of program or PTQ rating, would benefit from increased training and technical assistance focused on increasing the quality of classroom interactions and organization as well as using evidence-based curricula.***
- ***Nationwide, public pre-kindergarten programs that have produced the strongest gains in school readiness and early school success (e.g., Tulsa, OK and Boston, MA) are those that required lead teachers to have four-year college degrees and certification in early childhood education. Further, in some of these programs (e.g., Boston), teachers are provided with ongoing professional development and coaching as a means to promote high quality instruction. OMW developers should consider ways to raise***

[76] Schmitt, S. A., Elicker, J. G., Purpura, D. J., Duncan, R. J., Schmerold, K. Budrevich, A., & Bryant, L. M. (under review). The effects of a state prekindergarten program situated within a Quality Rating and Improvement System.

the educational qualifications of lead teachers in their classrooms as well as provide additional supports for professional development and coaching.

- ***Further, as is also done in some effective pre-k programs in other states, we recommend developing better partnerships with elementary schools. These partnerships could help better align children's experiences in OMW to their experiences in kindergarten and facilitate a smoother transition to elementary school. Moreover, this partnership could help kindergarten teachers better understand the level of skills children are coming to their classrooms with which could help with differentiating instruction and overall school success.***
- ***Despite recent legislation expanding OMW to all counties, there are several counties with no children enrolled. Efforts around engaging eligible families and ensuring they are aware of the program are needed.***

MEASURABLE INDICATORS OF PROGRESS

Indiana PDG Deliverables and Measurable Indicators

PDG Goal	Funded Activities	Deliverables	Measurable indicators
1	Needs Assessment	Completed needs assessment that informs strategic planning by identifying gaps and opportunities with regard to availability, access, and quality of B-5 services and supports; programs; and policies/practices	Annually updated matrix of B-5 programs and services available to children and families, organized by service type, age group, location, number served, quality, and capacity
	Workforce Study	Completed study of Indiana's mixed delivery system workforce, including personnel demographics, education and ongoing professional development, staff recruitment and retention, and ongoing support needs	# of children and families enrolled in services and waiting for services
	Unduplicated child count	Unduplicated child count of children in services and waiting for services	# and type of gaps in services and service options for vulnerable children and families identified by local stakeholders
			# and type of policies and practices governing B-5 service system
			# and type of B-5 practitioners participating in workforce study(ies)
			# and type of practitioners comprising the B-5 workforce, including new, returning, and departing staff
			# and type of professional development strengths and needs reported by the B-5 workforce
			Replicable survey methodology for conducing periodic unduplicated child counts of children in services and waiting for services

2	Strategic plan Data Roadmap	Comprehensive strategic plan that increases the quality, coordination, alignment, and efficiency of B-5 programs and services; addresses the results of the needs assessment; and reflects the recommendations of broad state and local stakeholders Documentation and analysis of data systems maintained by Indiana's Early Childhood Education (ECE) mixed delivery system, including possible data sharing opportunities and recommendations of implementing a unified data collection system.	# of local and state stakeholders who are informed of the strategic plan # and percent of state and local stakeholders reporting that the strategic plan provides clear and detailed information with regard to short and long term goals, strategies, responsible individuals, timelines, and benchmarks for evaluation # of recommendations that are coordinated or aligned across B-5 partners and initiatives to ensure collaborative impact # of opportunities for collaborating among agencies/community partners in which fiscal and human resources are shared # of system level decisions (e.g. fiscal, data, standards, personnel, monitoring), programmatic decisions (e.g. services and supports) and actions are guided by Indiana's mixed delivery vision and strategic plan # and percent of recommendations for which progress is actively monitored and revisions made as necessary based on progress data and changing context # of opportunities for local and state stakeholders to inform decisions, influence state policy, and improve the system # of possible data sharing opportunities and recommendations for implementing a unified data collection system Percentage of data sharing opportunities and unified data collection system recommendations carried out

3	Gather and review family materials	Documentation of current information dissemination, family intake, and program application policies and practices among B-5 programs, including the extent to which those practices are culturally and linguistically appropriate	# of unique referral and family intake systems among B-5 programs Percentage of referral/intake systems that are culturally and linguistically appropriate
	LIV app	Modification to the Liv mobile pregnancy app that adds a Child Care Finder and a bridge to articles within the Brighter Futures website and enables families to search and engage with associated content	# of intake and application processes that include common elements required across all B-5 programs # and type of resources available for families to access developmental screening for their children
	Help me grow/Brighter futures	Integration of Help Me Grow and Brighter Futures to allow a seamless navigation experience for families	# of families accessing developmental screening services
	TCC online application	Development of an on-line application will facilitate family access to early education options (First Steps)	# of families who access online resources (LIV app, websites) to access child care information
	First Steps Family Assessment	Integration of the First Steps Family Assessment results into their online data system Assessment of families' access to developmental screening, including culturally and linguistically diverse families Documentation of family engagement efforts across B-5 system that have demonstrated positive child and family outcomes Written interagency agreement aligning transition procedures and practices among all B-5 programs and with elementary schools Leaders implement an effective public awareness campaign to ensure families and referral sources are aware of the benefits of the B-5 system and how to access services.	# and percentage of families who report that they are able to find the information they need from those online resources # of families surveyed indicating that they are aware of and know how to access Indiana's mixed delivery system # of family engagement strategies identified by B-5 partners that support children's learning and development # of strategies for engaging vulnerable families and families from diverse cultural and linguistic backgrounds # of B-5 staff who receive PD on effective family engagement strategies # of B-5 staff and programs implementing effective family engagement strategies # of B-5 system efforts to recruit families that are representative of the demographics of the state and local communities and support their leadership development

		# of families, particularly vulnerable families and families representing diverse cultural and linguistic backgrounds, who participate in councils and other opportunities to provide input into decision making # and type of supports provided to families to assume active roles on councils, committees, and task forces to allow their full participation and input into system decisions related to areas such as policies, professional development monitoring, and program improvement.

4	Compass consulting/ Motivational interviewing	Professional development and train the trainer materials to promote motivational interviewing and foundational counseling skills for effectively engaging families, particularly diverse, vulnerable, and/or rural families, is provided and made available	# of best practices by program auspice identified and targeted by PDG # and percentage of best practices with PD materials and support developed and made available (e.g., online module, toolkits, implementation guidelines) to B-5 staff # of B-5 staff informed about best practices and PD materials # of B-5 partners and stakeholders informed and engaged in the PDG project
	Transition to Teach model	Development and piloting of a competency-based ECE transition-to-teach model that markets and incentivizes participation of targeted potential teacher candidates (e.g. paraprofessionals and teachers in K-12 schools, new parents, and near or recent retirees) and accelerates their time to productivity.	
	Apprenticeship model	Development and piloting of a reliable and valid assessment that enables teacher candidates prepared through alternate preparation pathways (e.g. apprenticeship models), to demonstrate Indiana's Core Knowledge and Competencies (CKCs).	
	Online PD modules	Development of 7 high-quality on-line modules that address identified needs and PDG priority topics for professional development of ECE professionals.	
	Infant-Toddler care	Documentation of identified business models/promising practices, including recommendations of scalability, that inform strategic plans to share best practices for affordably supporting high-quality infant and toddler care.	
	Transition practices	Identification of two community-based (birth to preschool) and two school-based transition strategies (preschool to kindergarten) and recommendations for effective use in a local context for replication by ECE and K-12 providers state-wide.	
	Brighter Futures website integration of PDG information	Brighter Futures website integrates and disseminates PDG project information and activities, informing all partners and facilitating stakeholder inclusion and engagement throughout the project	

5	Compass Consulting Leadership model	Eighty B-5 staff complete training and demonstrate competency in using Motivational Interviewing and foundational counseling skills to effectively engage families, particularly diverse, vulnerable, and/or rural families Fifty community/state stakeholders complete an ECE leadership development model and can address significant issues affecting young children and families in their local communities and statewide	# of PD opportunities to improve quality and support the adoption of evidence based practices made available to B-5 staff # of B-5 staff who have received PD and can implement best practices with fidelity # of ECE programs who have adopted the best practices and implement them with fidelity # of TA requests # of families served by ECE programs that have adopted a business model/promising practices for affordable infant/toddler care # of targeted potential teacher candidates recruited and prepared as ECE teachers # of stakeholders completing the ECE leadership development model PD # of stakeholder leaders who address significant issues affecting young children and families in their communities or statewide

ISSUES INVOLVING ECCE FACILITIES

Identified Issues Involving ECCE Facilities
Providers across the state identify and report issues with facilities through a variety of mechanisms, including during the application process for funding and through licensing violations. In terms of issues that have been identified, reported needs for facility improvements are often related to flooring, toilets/bathrooms, fencing, and adding rooms. There are some trends across types of providers. For instance, ministries often report needing scald valves and updated fire systems as per regulations.

Innovative Efforts to Improve Facilities
There have been multiple innovative efforts in the last several years in Indiana designed to improve ECCE facilities across urban and rural communities. The majority of these efforts have centered around supporting providers in either capacity building or advancing in PTQ through improvements to facilities. For example, Early Learning Indiana (ELI) has provided capacity expansion grants to nearly 50 providers across the state (see Table below for a list of grantees).

Early Learning Indiana Grantees[77]

Provider Type	County	PTQ/ CB/ Both	Fencing	Scald valves	AC/ventilation	Lighting	Fire system	Toilets/ bathroom	Outdoor space	Sinks in rooms	Flooring (santizable)	Ceiling tiles	New room (all needs)
Ministry	Adams	PTQ	X						X				
Ministry	Allen	PTQ	X	X									
Ministry	Blackford	Both	X	X									
School	Brown	Both							X				
School	Cass	Both				X		X					X
Ministry	Cass	PTQ						X					
Ministry	Clay	CB						X		X			X
Ministry	Clinton	Both		X		X		X		X	X	X	X
Ministry	DeKalb	PTQ		X			X						
School	Delaware	Both						X		X			
Ministry	Delaware	CB	X								X		X
School	Delaware	Both						X		X			
Ministry	Elkhart	CB				X					X	X	X
Ministry	Elkhart	PTQ						X					
Ministry	Fayette	Both					X			X		X	
Center	Grant	Both							X				
Ministry	Harrison	Both	X	X			X						
Ministry	Harrison	PTQ	X			X				X			
Center	Howard	CB						X					X
Ministry	Jackson	CB		X		X	X			X			X
Ministry	Jackson	Both		X				X					
Ministry	Jackson	PTQ	X					X		X			
School	Jefferson	CB							X				
School	Lake	Both	X			X			X				X
Ministry	Lake	Both		X		X	X	X	X	X	X	X	X
Ministry	Lake	Both						X			X		X
Ministry	Lake	CB						X			X		X
Ministry	Lake	Both	X			X		X		X			
Ministry	Lake	PTQ					X			X			

[77] Data source: Early Learning Indiana, received 6/10/19

Ministry	Lake	PTQ						X					
School	Madison	Both						X	X				
Center	Madison	Both						X			X		X
Ministry	Monroe	Both			X								
Ministry	Montgomery	Both				X		X					X
Ministry	Porter	PTQ		X						X			X
Ministry	Pulaski	PTQ										X	
Ministry	Putnam	Both	X										
Ministry	Shelby	Both						X					
Ministry	St. Joseph	PTQ				X							X
Ministry	St. Joseph	PTQ	X	X									
Ministry	St. Joseph	Both	X										
Ministry	St. Joseph	PTQ		X						X			
Ministry	Starke	Both	X							X		X	
Ministry	Tippecanoe	Both		X				X					
Center*	Vanderburgh	Both	X			X		X	X	X			X
Center	Wabash	Both	X			X	X	X	X	X			X
Ministry	Warrick	Both		X									X
Ministry	Wayne	Both		X		X		X		X			X

PTQ = advancement on Paths to QUALITY
CB = new seats (capacity building)
Note. data only from grantees in Early Learning Indiana projects listed in Table 1: Efforts that received funding for facility improvements

United Way of Central Indiana through the Family Child Care Home Quality Improvement Project, provides funds to Family Child Care Homes for facilities improvements needed to meet licensing requirements. See Table below for additional examples of these efforts.

Efforts for Facilities Improvements[78]

Project	Organization	Timeline	Targeted Audience	Description
Capacity Building Grants	Early Learning Indiana	2015–2019	Non-profit providers (center, school, ministry)	Direct to provider funding for capacity expansion and/or advancement on PTQ including facility improvements
Ministry Grants	Early Learning Indiana	2018-2019	Non-profit ministry providers	Direct to provider funding for advancement on PTQ including facility improvements
Capacity Building Grants – Round One and Two	OECOSL, with support from Early Learning Indiana	2018-2019	All provider types (see RFF for full list of eligibility)	Direct to provider and/or coalition reimbursement for capacity expansion of 4-year-old seats and/or advancement to PTQ 3 or 4
Capacity Building Grants – Round Three	OECOSL, with support from Early Learning Indiana	2019-2020	Providers in counties not funded in rounds one or two (see RFF for full list of eligibility)	Direct to provider and/or coalition reimbursement for capacity expansion of 4-year-old seats and/or advancement to PTQ 3 or 4
Family Child Care Home Quality Improvement Project	United Way of Central Indiana	2016 – 2019	Family child care homes in Boone, Hamilton, Hancock, Hendricks, Marion, and Morgan counties	Funds for providers for quality improvement that includes funding for capital improvements needs to meet licensing requirements
Early Childhood Grant	United Way of St. Joseph County	2019	All provider types in St. Joseph County	Funds for providers for advancement on PTQ

[78] Data source: Early Learning Indiana, received 6/10/19

There have also been private-public partnerships that have been developed to address facilities needs. For example, in partnership with Early Learning Indiana, Ivy Tech, and the city of Evansville, Community Action Program of Evansville Head Start and Early Head Start created 52 new seats for infant – pre-K students in a previous higher education building.

Strengths and Weaknesses of the Available Data on ECCE Facilities

Strengths: Indiana has a number of funding opportunities for providers who seek to improve facilities and data on those requests and grantees are collected. Further, providers who use contractors familiar with child care regulations anecdotally report greater ease with the process.

Weaknesses: There is no consistent or systematic reporting system for tracking facility issues or barriers, other than routine licensing or PTQ rating visits. The data reported here from ELI comes from providers the organization is in direct contact with. Data beyond those providers is limited to licensing violations reported to OECOSL.

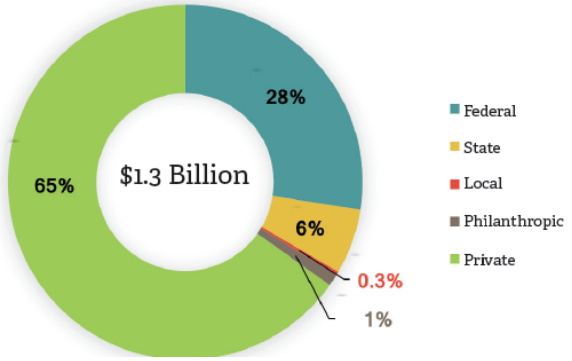
Recommendations: The state should continue efforts related to improving ECCE facilities, particularly with regard to facility issues that could potentially lead to quality improvements. Further, there is a need for a systematic reporting system for tracking facility issues or barriers.

BARRIERS TO THE FUNDING AND PROVISION OF HIGH QUALITY EARLY CHILDHOOD CARE AND EDUCATION SERVICES AND SUPPORTS AND OPPORTUNITIES FOR MORE EFFICIENT USE OF RESOURCES

Federal and State Funding

In the last 10 years, there has been a 62% increase in federal funding to support early childhood care and education.[79] Many of these investments have focused on providing access to high quality child care for vulnerable and underserved populations, including children from low-income backgrounds (e.g., CCDF, Head Start) and children with disabilities (e.g., IDEA). These increases in federal funding, as well as state, local, philanthropic, and private investments, have allowed Indiana to expand ECCE significantly. In a recent funding analysis by the Indiana Early Learning Advisory Committee (ELAC),[80] 25 different sources of funding for the ECCE system were identified. The majority comes from parents who pay for child care (65%) followed by federal funding (see Figure 1), and just over half (51%) of the funding supports preschoolers.

FIGURE 1: INDIANA'S EARLY LEARNING FUNDING SOURCES



Barriers to the Funding and Provision of High Quality Care

One barrier to the funding and provision of high quality care is *cost of care.* For example, the Cost of Preschool Quality Tool (CPQ) indicates that the estimated average cost-per-child slot for OMW Pre-K is $5,158 for half-day programs and $9,158 for full-day programs.[80] However, the OMW voucher for a half-day program is just $2,500 and for full-day is $6,800. Thus, the pre-k vouchers are only covering 48% of the average half-day and 74% of average full day costs, and providers are responsible for covering the remaining costs using other funding sources (e.g., Head Start).

Another barrier is *access.* In more than half of Indiana's counties, programs like the Nurse Family Partnership home visiting program are not available. Further, more than half of Indiana families live in child care deserts,[81] defined as any 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.

A third barrier is related to *facilities.* There are often physical structure issues that prevent programs from reaching high quality status. For example, registered ministries may not be able to meet voluntary certification because of their physical location.

A final barrier is c*ost of continuing education and professional development for the ECCE workforce* that would improve practices and assist programs in achieving a higher level on PTQ. Although there is some support for

[79] https://www.ffyf.org/federal-funding-for-early-childhood-programs-a-decade-of-bipartisan-progress/
[80] Indiana Early Learning Advisory Committee: Indiana's Early Childhood Program Funding Analysis, November 2016
[81] https://childcaredeserts.org/index.html

teachers in terms of accessing and paying for continuing education (e.g., TEACH scholarships), due to budgetary constraints these supports do not reach all teachers who need and/or want degrees and professional advancement.

It is unknown whether there are characteristics of the current governance, financing of the system, regulatory system, or policies that present barriers to funding and provision of high-quality ECCE services and supports.

Strategies that Have Improved the Efficient Use of Resources

There have been a number of recent partnerships developed within the ECCE system in Indiana that have resulted in more efficient use of resources. For example, with regard to enrollment in services, there is a streamlined linkage between TANF and CCDF such that families with young children who are participating in TANF are automatically referred to CCDF and bypass the waitlist for child care services. This partnership has been effectively replicated with families participating in SNAP who are in the voluntary work component and CCDF.

Efforts around funding streams have also been effective in terms of efficient allocation of resources. For example, during the billing process, First Steps examines child eligibility in a number of programs and determines the hierarchy of billing and which agency/program/provider can be billed for services and administrative claiming (e.g., Medicaid, TANF). As another example, a partnership between IDOE and Medicaid has been established to build efficiencies around child services. Within this partnership, IDOE can bill Medicaid for services children receive at school. This partnership is beneficial for schools, Medicaid, and children and families. The services that children receive at school do not count against any cap in services that Medicaid may have in place, and children are more likely to receive services at school than they are when families have to coordinate appointments elsewhere. Further, schools have been able to hire more clinical support staff through Medicaid claiming.

Opportunities for a More Efficient Allocation of Resources Across the ECCE System

Although Indiana has implemented some successful strategies for more efficient use of resources across the ECCE system, there are also opportunities for growth in this area. For instance, Head Start requires that all children enrolled in programs are screened for lead exposure. In some cases, children have had lead screening done through other agencies, and although Head Start grantees are allowed to access the database (CHIRP) that documents child immunizations and lead data, it appears that most grantees are not accessing the database. As a result, children are getting screened multiple times, which is not cost effective.

There are also opportunities for more efficient allocation of resources with regard to child and family assessments. According to a recent report conducted by Indiana University,[82] agencies and programs within the ECCE system are administering child and family assessments that focus on similar domains, and in some cases are administering the exact same assessment across agencies (e.g., Ages and Stages Questionnaire). This results in duplicative efforts to get at the same information across agencies. If agencies shared data and information, this would result in significant cost savings and more efficiency.

Recommendations: With regard to barriers in funding high quality early learning programs, ELAC recommends,[83] "Funding that supports early learning programs should be flexible and guiding policies should ensure the maximum ability to layer all eligible funding for early learning programs. For example, to support working families with full-day care, CCDF/Head Start/OMW Pre-K funding could be layered to efficiently accomplish this goal." In addition, a systematic assessment of any polices, financing, regulatory characteristics, or characteristics of the current governance that may act as barriers to the provision of high quality care is needed.

With regard to efficient use of resources, a unified data system across agencies is needed. For example, First Steps would benefit from having data on lead poisoning to inform resource allocation as well as to potentially have an early alert system that they could then use to proactively reach out to families with children that have elevated lead levels. Moreover, efforts around replicating effective strategies for efficient allocation of resources are needed. The partnership between IDOE and Medicaid, for example, could be a model that Head Start could adopt to enhance efficiencies.

[82] Conn-Powers, M., & Bonifacio, K. Study of child and family assessment in Indiana.

[83] Indiana Early Learning Advisory Committee: Indiana's Early Childhood Program Funding Analysis, November 2016

TRANSITION SUPPORTS AND GAPS

Kindergarten Transition

The overall kindergarten retention rate in Indiana is 5.13%.[84] Although this percentage is smaller than in some other neighboring states (e.g., Michigan's kindergarten retention rate is 10.84%[85]), kindergarten retention remains a problem in Indiana, not just for the children who are retained, but also for the state in terms of cost. As noted in a recent policy brief, Indiana spent approximately $24 million in kindergarten remediation in 2016.[86] Kindergarten retention rates are particularly problematic in certain counties. For instance, in Newton county, 40% of children were retained in kindergarten in 2018. In Ripley county, 31% of children were retained. The table below provides the ten counties with highest level of retained children and the ten counties with the lowest levels of retained children. *Of the counties with the highest levels of retained children, 70% are considered rural and 80% have 0-7% of children enrolled in high quality early care and education.* It is important to note that some school corporations are piloting "transitional" kindergarten programs which may contribute to the retention data reported. The Purdue team was unable to obtain data from the Indiana Department of Education (IDOE) to determine which school corporations were implementing such programs.

Kindergarten Retention Rates[84]		
10 Highest Counties		
County	**Total Children Retained**	**Percentage of Children Retained**
Newton	58	40.00
Ripley	137	30.93
Wabash	95	25.54
Carroll	47	23.62
Parke	44	21.46
Pulaski	25	16.56
White	49	13.73
Vigo	178	13.55
Fountain	26	13.33
Cass	68	12.85
10 Lowest Counties		
County	**Total Children Retained**	**Percentage of Children Retained**
Decatur	8	2.39
Shelby	13	2.37
DeKalb	12	2.33
Johnson	48	2.25
Hendricks	49	2.17
Ohio	1	1.96
Elkhart	51	1.80
Kosciusko	16	1.80
Rush	3	1.80
Hamilton	57	1.30

When children experience a smooth transition to formal schooling, they are less likely to be retained in kindergarten. Thus, having supports in place for a successful transition to kindergarten is paramount for children's success. *However, Indiana does not have any statewide initiatives for transition planning or supports for children as they move between ECCE programs to school entry.*[87] *There are also no initiatives that specifically target vulnerable*

[84] Indiana Department of Education, received 4/1/19

[85] https://www.mischooldata.org/DistrictSchoolProfiles2/StudentInformation/StudentCounts/NewRetention.aspx

[86] Indiana Early Learning Advisory Council, 2017

[87] http://ecs.force.com/mbdata/MBQuest2RTanw?rep=KK3Q1813

children or children in rural areas, despite the fact that research suggests these children may need extra supports.[88] There are, however, several initiatives at the community and/or the school corporation level. In some cases, there are also initiatives at the ECCE program level (e.g., Head Start). Below are examples of such initiatives that could be used in the strategic planning process as ideas for statewide transition supports. Unfortunately, these programs have not been evaluated to determine their success in facilitating successful kindergarten transitions.

Community/School Corporation Initiatives

By 5 (Muncie and Delaware County) and the Indiana Institute on Disability and Community – Early Childhood Center developed the *By5 Kindergarten Essential Skills Checklist.* This checklist reflects what kindergarten teachers believe to be the most vital skills and behaviors children should possess for increased success in kindergarten. As a consistent measure of readiness for all children in Delaware County, the data used from completing this checklist with incoming kindergarteners informs the community on what strengths and gaps in skill attainment exist. Resources can then be focused on certain areas in the community to support and strengthen skills to improve child outcomes and success in kindergarten.

The Child Care Resource Network (TCCRN) and Lafayette School Corporation (LSC) host meetings for local early childhood providers, preschool, and kindergarten teachers to collaborate and discuss content and issues such as high-quality early education, Early Learning Foundations/Kindergarten Standards, and evidence-based supports to improve success in the transition from preschool to kindergarten.

Kindergarten Countdown Camp (KCC) is a free 4-week program for children the summer prior to kindergarten entry. This program is targeted at children who have had little to no preschool experience or those identified as needing more support for the transition into kindergarten. Children learn school routines and receive instructional experiences focused on early literacy and socialization. Throughout Indiana, KCC is sponsored by various United Way locations as well as IU Health.

The Early Learning Alliance Network (ELAN) is a non-profit, grassroots organization designed to engage families, educators, and community stakeholders in vital conversations around early childhood education and assisting families in navigating education systems. ELAN supports transition to kindergarten through the development and dissemination of transition packets for families and children, sponsoring conversations between families and schools, sponsoring conversations between early childhood providers and schools, and demonstrating data sharing capabilities so that kindergarten programs may better understand the skills and strengths of incoming children.

ECCE Program Initiatives

Marion Community Schools Little Giants Head Start Program created a policy and service plan for expected practices and strategies to ensure a smooth and seamless transition from preschool to kindergarten. Activities include but are not limited to:

- Training teachers on supporting and advocating for their children during the transition from preschool to kindergarten.
- Having knowledge of the kindergarten program the children will attend and ensuring appropriate paperwork has been completed in order to share children's records such as assessment outcomes, IEP, etc.
- Advertising and encouraging participation in the various kindergarten round ups of the schools the children will attend.

Evansville Vanderburgh School Corporation Early Childhood Program created a Child Success Team that provides extra supports for children whose teachers have expressed concerns about their school readiness. Those children are then provided with a specific plan and an observation by a team from the school where they will attend kindergarten. For all children, child outcome assessment data (from the program selected instrument - Teaching Strategies GOLD) along with a learner profile (portfolio) is shared with the kindergarten teacher. The Brigance screener is also completed on children entering kindergarten since there is currently no district or statewide kindergarten screener. Families are supported in understanding the location and timing of kindergarten registration for their children. Finally, parent-teacher conferences are held at the end of the year to discuss the transition and give assessment reports.

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[88] Grace, C., Shores, E. F., Zaslow, M., Brown, B., Aufseeser, D., & Bell, L. (2006). Rural disparities in baseline data of the Early Childhood Longitudinal Study: A chartbook. (Rural Early Childhood Report No. 3). Mississippi State, MS: National Center for Rural Early Childhood Learning Initiatives, Mississippi State University Early Childhood Institute.

Day Early Learning (DEL) Centers host kindergarten fairs for their families and have hosted one for all families in Marion County. DEL also employs Family Connect Partners for each site. These staff members assist children and families in whatever transition the child/family may be encountering, including transition to kindergarten.

School Corporation Initiatives
Some school corporations across the state are piloting "transitional" kindergartens as a form of transition supports. The precise format of these programs differs by corporation. For example, in Valparaiso Community Schools, the new transitional kindergarten targets children who meet the age requirement for kindergarten entry but may need some extra supports in terms of their social, emotional, and academic development. The first part of the school year focuses on developing these early learning skills, and the second part of the school year focuses on Kindergarten Standards. The Logansport Community School Corporation has "basic kindergarten" classes (half-day) that primarily serve children who are learning English as a second language and those who are from low socioeconomic backgrounds.

No universal measure of kindergarten readiness at the pre-k or k level
Teachers' understanding of children's kindergarten readiness and specific abilities can have long-term effects on children's cognitive and academic outcomes.[89] It allows them to identify risk factors for later difficulties before they become broader, long-standing problems. Moreover, it allows teachers to better target instruction to children's individual needs so they can maximize instructional benefits. One key method of doing so, is through the use of kindergarten readiness assessments (KRAs) and kindergarten entry assessments (KEAs). KRAs are assessments conducted during preschool to assess the skills that children need to develop to be ready for kindergarten. KEAs are assessments that are conducted at the start of kindergarten to help teachers understand where their class is as a whole and the instructional needs of children individually.

At the present time, Indiana does not have a universal KRA or KEA. In terms of KRAs, a number of measures are currently being used in centers and programs around the state; for example, many Head Start centers use *Teaching Strategies Gold*[90] despite its limited evidence of construct validity.[91] Other providers, particularly those who have children with Individual Education Plans and those enrolling children through state funded programs such as On My Way Pre-K use the Indiana Standards Tool for Alternate Reporting of Kindergarten Readiness (ISTAR-KR); however, although this measure is aligned with the Indiana Foundations, there is limited evidence of validity for the tool and it is being phased out of use by IDOE. In terms of a KEA, there is no universal KEA at the present time, although some schools are using measures such as NWEA as progress monitoring tools in the fall, winter, and spring of each year of elementary school, including kindergarten.

Without a universal KRA, it is not possible to know if children in Indiana as a whole are ready for school or if there are particular communities that need further support to ensure their students are ready for school. Without a universal KEA, it is not possible to determine if the instruction provided at entry to kindergarten is developmentally appropriate and meets the needs of children across the state.

Many other states are currently using KEAs and KRAs to support a successful transition to kindergarten. For example, Florida and California use state-developed KEAs that are administered to all incoming kindergarteners in the beginning of the school year to inform curriculum planning and professional development. These data also provide a statewide snapshot of kindergarten readiness.

Summary and Recommendations

Strengths: The overall kindergarten retention rate in Indiana is relatively low. There are several kindergarten transition support initiatives at the community, the school corporation, and program level.

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[89] Downer, J. T., & Pianta, R. C. (2006). Academic and Cognitive Functioning in First Grade: Associations with Earlier Home and Child Care Predictors and with Concurrent Home and Classroom Experiences. *School Psychology Review*, *35*, 11–30.

[90] Heroman, C., Burts, D.C., Berke, K.., & Bickart, T.S. (2010). Teaching strategies GOLD® objectives for development & learning: Birth through kindergarten. Teaching Strategies, Washington, D.C.

[91] Russo, J. M., Willford, A.P., Markowitz, A. J., Vitiello, V. E., & Bassok, D. (2019). Examining the validity of a widely-used school readiness assessment: Implications for teachers and early childhood programs. *Early Childhood Research Quarterly, 48,* 14-25.

Weaknesses: Indiana does not have any statewide initiatives for transition planning or supports for children as they move between ECCE programs to school entry. There are also no targeted supports for vulnerable or underserved children or children in rural areas, despite the fact that research suggests these children may need extra supports. Further, the community, school corporation, and program level initiatives have not been evaluated to determine their effectiveness. Finally, there are no universal kindergarten readiness or entry assessments used in the state.

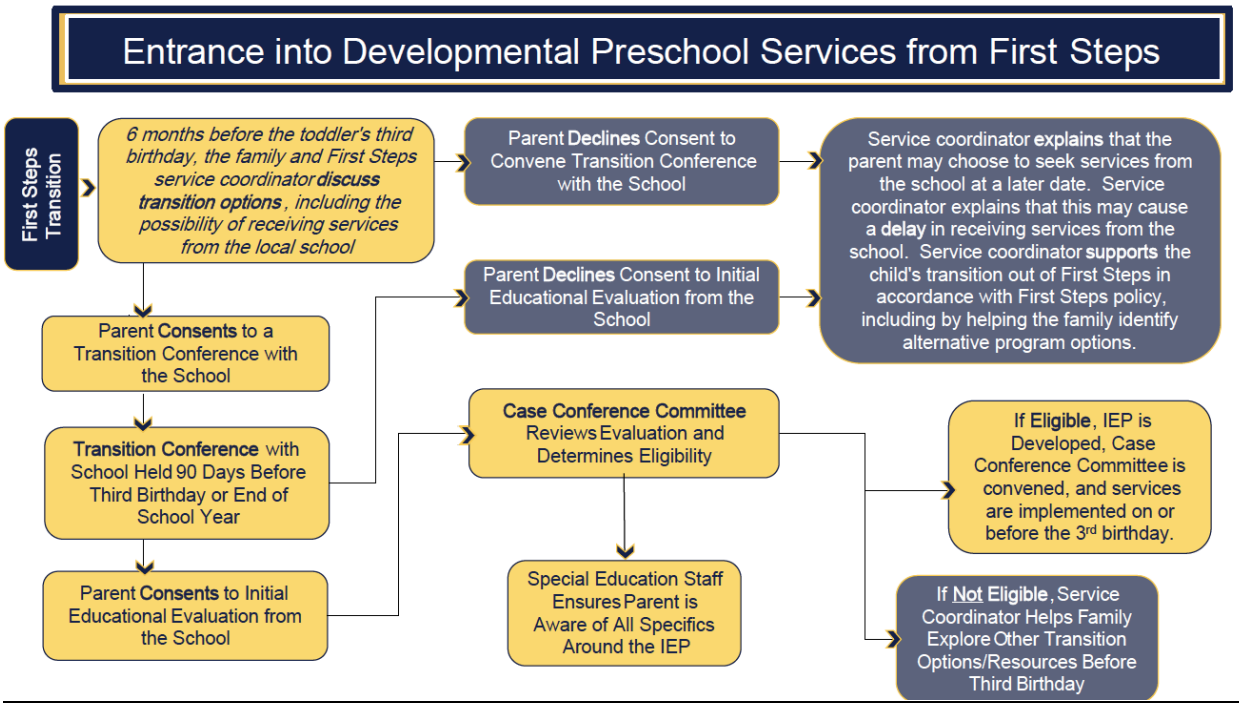
Recommendations:

- ***There is a clear need for better alignment between the ECCE system and the elementary school system. More coordination of kindergarten transition efforts between ECCE providers and kindergarten teachers would likely allow for a smoother transition, more individualized instruction, and stronger school readiness for young children.***
- ***There is also a need for data on which school corporations are offering transitional kindergartens, as these programs likely have an impact on the kindergarten retention data collected by IDOE. As it stands, the IDOE does not have a tracking system for these types of programs or data on the efficacy of these programs or other initiatives in supporting an effective transition to kindergarten.***
- ***There is a clear need for a universal measure of kindergarten readiness and a data sharing system that cuts across the ECCE system and the elementary school system. Any efforts related to kindergarten transition planning and supports need to be collaborative and comprehensive in nature, including agencies and service providers within the ECCE system and the IDOE. Several states have initiatives that Indiana could model these efforts around. For example, in 2017, the Kindergarten Transition Advisory Committee was created in Illinois and was charged with developing a report that focused on recommendations to improve legislation around the transition to kindergarten. In this report (https://www2.illinois.gov/sites/OECD/Documents/Kindergarten%20Transition%20Advisory%20Committee%20Report%20Sept%202018.pdf), a framework for recommended practices for facilitating a successful transition to kindergarten is outlined.***

Disability Service Transition Supports

Part C of the Individuals with Disabilities Act (IDEA) requires transition planning into and out of First Steps, Indiana's early intervention that provides services to children birth to age 3 who have developmental delays or disabilities. On every child's Individualized Family Service Plan, there is a required section regarding transition activities and a checklist for service providers to complete. Example items on this checklist include exploring community program options for the child, sending demographic and the most recent evaluation data to the child's local education agency (with written consent), and convening a transition meeting 60-90 days prior to a child's third birthday. According to First Steps, Indiana is nearly 100% compliant in convening a transition meeting with a corresponding plan. However, although data on transition planning and supports are presumably collected, they are not entered into or stored in a tracking system that is easily accessible (they are likely on a paper form in a child's file). Data on reasons for exit are available, but data on the actual transition plans or supports are not. Moreover, the transition from First Steps into Developmental Preschool (i.e., Part B of IDEA, the IDOE Preschool Special Education program serving children 3-5) or other programs is an individualized plan that is based upon the needs of the child and family.

Unfortunately, there are no systematic data collected at IDOE regarding transition supports into or out of Developmental Preschool, and there is no legally mandated transition plan connected to this program. However, there is a Memorandum of Agreement between First Steps and IDOE that was created to help facilitate a smooth transition from First Steps into Developmental Preschools. As part of this agreement, the First Steps office works with the Office of Special Education and the Local Educational Agency where the toddler will attend Developmental Preschool. For more details on the transition process from First Steps into Developmental Preschools, see the figure below. For more details on the MOA, see this link: https://www.doe.in.gov/sites/default/files/specialed/first-steps-preschool-special-education.pdf



Summary and Recommendations

Strengths: Transition planning and supports are in place for children with developmental disabilities as they move from First Steps (ages 0-3) to Developmental Preschool (ages 3-5). All plans are individualized based on the needs of the child and family.

Weaknesses: Data are not collected on the types or efficacy of the supports that children receive as they transition programs. Data are also not collected on transition supports for programs outside of Developmental Preschool.

Recommendation: A systematic approach for tracking data on individualized transition plans, including the level of support and the efficacy of these plans, is needed. Data are also needed regarding transitions from early intervention services into other ECCE programs.

SYSTEM INTEGRATION AND INTERAGENCY COLLABORATION

More detailed information on system integration and interagency collaboration can be found in the data road mapping project report.

In 2018, the Bipartisan Policy Center (BPC) published a report to understand how states are progressing towards improved integration and governance in early childhood education programs. Specifically, the BPC report included an analysis regarding how each state currently organizes, administers and coordinates early childhood education programs. The information analyzed included:

- Amount of federal and state funds allocated towards early care and learning programs.
- How states have responded to federal requirements, including coordination requirements within various statues.
- The number of agencies and divisions involved in the mixed delivery system.
- The level of coordination and collaboration across programs and the organizational structure of related programs.
- Whether the state has an operational state advisory council
- The state of integration of early childhood data across all programs
- The implementation of a quality rating and improvement system

Based on the study's scoring methodology to determine the level of early childhood education delivery and organization, Indiana tied for 12th in the country along with California, Delaware, and Oregon. One central theme across states was the, "…common tendency of bureaucratic entities to protect their funding streams and their policy prerogatives by resisting integration and sometimes even coordination with other entities…"[92]

Practices to Foster Interagency Collaboration

Indiana has several practices and initiatives in place to support interagency collaboration. For example, unlike many states, the majority of Indiana's ECCE programs are housed within one state agency. The Family Social Services Administration (FSSA) is responsible for the state's IDEA Part C (First Steps), CCDF, the Head Start Collaboration Office, On My Way Pre-K and SNAP/TANF. Additionally, FSSA oversees the Indiana Medicaid program and other social programs that are indirectly involved with supporting the birth through age five population. This type of programmatic structure helps foster collaboration and communication across programs.

Within the Indiana Code, there is a statute which governs the cooperation between FSSA and the Indiana State Department of Health (ISDH).[93] The statue mandates that FSSA and ISDH cooperate to assist each respective agency with related programmatic initiatives and goals. The code further establishes that the agencies shall devise a comprehensive statewide plan for family, health and social services. The ISDH houses programs such as WIC, vital records, and Maternal, Infant and Early Childhood Home Visiting.

In an effort to support interagency collaboration, in 2013, the State of Indiana established the Early Learning Advisory Committee (ELAC). The committee consists of members appointed by the Governor and includes representation from FSSA, Indiana Department of Education (IDOE), and the Indiana Head Start Collaboration Office. One of the chief duties of the committee is "...identify opportunities for, and barriers to, collaboration and coordination among federally and state funded..." ECCE programs.

Funding policies and practices that support or hinder interagency collaboration

Indiana utilizes a mix of federal, state, and local mechanisms to fund ECCE programs. In addition, the state benefits from funding provided via private and philanthropic sources. The United Way is one such example of philanthropic support. United Way agencies provided financial support as well as 'kind-in' support for ECCE programs through a variety of efforts aimed at promoting collaboration, professional development, and quality.

92www.bipartisanpolicy.org

[93] Refer to Indiana Code 12-8-1.5-6

The funding policies and practices vary based on the respective ECCE program. In a recent analysis, there were 44 separate programs that to some extent fund or support early learning at the federal level.[94]

The National Academies of Science, Engineering and Medicine published a report citing the challenges involved with the myriad of funding streams. "[ECCE] Programs have evolved with very different goals and are situated across different areas of the government and across public and private sectors and funders. As a consequence of this piecemeal approach, the financing structure for ECE is not cohesive, with a myriad of eligibility requirements across programs. Each funding source has varying eligibility requirements, quality standards, and data collection and reporting requirements. As such, data has become siloed based on the requirements set forth by the multitude of funding mechanisms." [B] These data siloes have significant implications for interagency collaboration as they can impede data sharing and alignment.

A brief issued by the PDG documented the challenges this piecemeal approach presents ECCE providers. To secure sustained funding, providers must do what is known as blending, braiding or layering multiple federal, state or local sources. Furthermore, since eligibility and reporting requirements vary based on funding source, providers must be able to account for funds to ensure compliance with regulations on how those funds ought to be spent.[95]

Due to the lack of comparable data across ECCE programs, the report by the National Academics of Science, Engineering and Medicine recommends that the Federal government align data collection and reporting requirements across all federally funded ECCE streams. Additionally, a report published by the BUILD Initiative recommends that states also work with federal agencies to align categorical funding mechanisms.[96]

Examples of Effective and Supportive Interagency Collaboration Supporting Young Children and Families
Indiana has embarked on several innovative data projects that have required effective and supportive collaboration across agencies and their respective programs. One such example is Indiana's work with regards to the opioid crisis. Data analyzed in 2013 revealed that opioid misuse is strongly correlated with infant mortality rates. With the assistance of the Management Performance Hub, an executive state agency, datasets from various government programs were compiled to complete the analysis. As a result, the state is using this information to engage Medicaid beneficiaries in the Right Choices Program. The analysis also informed the state on where to allocate opioid treatment resources.

Cross-agency data sharing is a vital component to effective collaboration. Indiana Medicaid has demonstrated the impact meaningful data sharing through their collaboration with the Indiana Department of Corrections (DOC). Although this example does not directly impact young children, it does help family members who were recently released from incarceration receive continual care. To address this issue, Medicaid undertook a process to connect disparate and isolated data sets which led to an expediated process to re-activate Medicaid benefits upon an incarcerates release. A key factor to the success of this initiative was FSSA's use of the Medicaid Information Technology Architecture framework. One of the objectives of this national framework is to develop a practice to seamlessly integrate data systems that communicate effectively through a common process. This same practice ought to serve as a model in the development an early childhood integrated data system.

Another program that reflects effective and supportive interagency collaboration is Indiana's OB Navigator program. The program was established through Indiana House Bill 1007 in 2019 and requires ISDH to establish a referral and treatment process involving healthcare providers across the state. Furthermore, it requires ISDH to

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[94] U.S. Government Accountability Office. (2017). *Early Learning and Child Care: Overview of Federal Investment and Agency Coordination*. GAO-17-671T. Washington, DC: Author.

[95] Washington, DC: Preschool Development and Expansion Grant Technical Assistance Program. Retrieved from https://pdg.grads360.org/services/PDCService.svc/GetPDCDocumentFile?fileId=26705

[96] Wallen, M., & Hubbard, A. (2013). Blending and braiding early childhood program funding streams toolkit: Enhancing financing for high-quality early learning programs. (Version 2). Chicago: Ounce of Prevention Fund. Retrieved fromhttp://qrisnetwork.org/sites/all/files/resources/mrobinson@buildinitiative.org/2014-01-17 11:36/ Blending%20and%20Braiding%20Early%20Childhood%20Program%20Funding%20Streams%20Toolkit.pdf

provide healthcare providers with guidelines to treat substance abuse disorder during pregnancy. The program will work with Indiana Medicaid to identify pregnant women who live in the highest risk areas to connect them with a community-based healthcare provider.

To replicate efficient and supportive practices, a data governance body representative of all ECCE programs would be required to establish the necessary communication streams across agencies. This body would serve as a centralized focus around the commonality and communication between programs to improve the quality of services.

Barriers to Interagency Collaboration

Data linkages and commonality between ECCE programs are vital practices that support interagency collaboration. Currently, linkages are more likely to exist between data systems within the same state agency for the sole purpose of performing mandated reporting or ad hoc requests. This is an example of what is known as a 'data silo'. Today, funding mechanisms and reporting requirements dictate many agencies' data collection efforts. As a result, agencies constructed systems out of necessity. The unintended consequences have impeded the free flow of data and stunted analytic capabilities; and, therefore, have limited the degree of unity between agencies. Interagency linkages are intended to remedy the traditional silo approach and provide greater efficiencies across agencies instead of just within a respective agency.

Commonality between systems is lacking in terms of standardization in data collection and storage. As noted previously in this needs assessment, although several data sources exist within the ECCE system in Indiana, inconsistencies are prevalent across these sources in terms of data collected and how variables are conceptualized. Further, there are no unique identifiers for children that are linked across agencies, making interagency data sharing and collaboration challenging.

The current practices pertaining to referrals between agencies also hinder interagency collaboration. Referrals to and from programs are largely paper-based and require manual entry. As a result, feedback on referrals generated or received from a respective program are limited or non-existent. An integrated, coordinated system is recommended to facilitate referrals between agencies.

Recommendations: Implement a unified data system that assigns a unique identifier for children, providers, and facilities. These numbers would allow Indiana to track the progress of children over time across programs and databases to reduce burdensome administrative processes as well as provide quality data for research purposes.

GAPS IN DATA OR RESEARCH TO SUPPORT COLLABORATION BETWEEN PROGRAMS/SERVICES AND MAXIMIZE PARENTAL CHOICE

As indicated previously in this needs assessment, data on the service use of families with children in the ECCE system are collected across several agencies, and we report on available data in previous sections. Below, we provide a table with the various agencies and examples of the types of data that are collected.

Agency/Organization	Examples of Data
Family and Social Services Administration	Child care availability and enrollment; Quality of child care; Enrollment in state child care subsidy programs; Family health coverage; Supplemental Nutrition Assistance Program (SNAP) participation; Temporary Assistance for Needy Families (TANF) participation; Indiana Manpower and Comprehensive Training (IMPACT) participation
Indiana Department of Education	Developmental Preschool enrollment; Title 1 preschool enrollment; Grade retention
Indiana Department of Health	Child (ages 19-35 months) immunization rates; Maternal smoking during pregnancy; Low birthweight infants; Prenatal care in the first trimester
Department of Child Services	Out of home care placements; Duration of placements; Healthy Families participation; Substantiated abuse/neglect cases; adoption statistics;
Head Start	Early Head Start and Head Start availability and enrollment
First Steps	Participation in First Steps program; Services received
Early Learning Indiana	Child care availability and enrollment; Quality of child care; Facilities issues

Despite the fact that data are collected, there are several important gaps in data or research about the programs and supports that are available to families and children from birth to age five. Many of these gaps have been noted previously in this report; however, we summarize them again here.

Critical Gaps in Data on Child Care Programming

- There are no available data on the availability of or participation in *all* of the ECCE programs across the state. There are some data on regulated programs, but very little data on unregulated or exempt programs. Thus, the data reported are likely an underrepresentation of what is currently available.
- There is no way to know from the data whether the final enrollment counts represent the *unduplicated* number of children being served in existing programs. It is possible that children are receiving services from multiple providers who are including them in their enrollment counts, in which case, these children could be duplicated.
- There are no reliable data on total available ECCE slots broken down by age in Indiana due to inconsistencies in reporting.
- There are no data available on the number of children in the general population awaiting ECCE services.
- In some counties, there are no recent data (i.e., within the two years) on availability of or participation in ECCE programming.
- There is a gap in data regarding accurate counts for the frequency of services children are receiving (e.g., participating in a full time ECCE program, participating in a half-day program three days per week).
- Important gaps regarding child care desert data are as follows:
    - The data used to assess the issue of child care deserts only include licensed child care centers, licensed family child care homes, and registered ministries. It is reasonable to assume that some

families may have access to unlicensed or exempt child care providers in census tracts/counties considered to be child care deserts; however, there are no available data on unregulated care options.
    - The data also are only broken down by census tract, not by county specifically. In some cases, census tracts cover one county in full so inferences can be made about particular counties and plans could be put in place to address barriers to child care in those counties. In other cases, there is more than one census tract that covers a particular county and the child care capacity category is not the same across the tracts, making the development of a plan forward for addressing potential capacity issues by county challenging.
- There is no consistent, systematic, and comprehensive reporting system across agencies and in some cases, within agency. For example, there are inconsistencies with how providers are reporting data (e.g., capacity numbers for desired capacity) across some of data sources.
- There are no data across the state with regard to parental choice in terms of selecting to utilize ECCE programming, potential reasons parents choose particular types of care, or potential reasons parents may choose to utilize ECCE programming during certain developmental stages and not others. Parental choice may play a significant role in the level of participation in ECCE programming in some counties. For instance, in some counties where there are few infants enrolled in ECCE programs, it may be that parents are *choosing* to stay home with their infants, and thus, any identified problems with infant capacity or enrollment may be overestimated. Further, in other counties with few child care centers for example, it may be that parents are choosing family child care homes or other arrangements, and thus, there is not a market or need for center-based care. Again, this may be identified as a problem that may not actually require attention.
- There are no easily accessible or consistently collected data on parent engagement or involvement in ECCE programming. Although some programs (e.g., On My Way Pre-K) require a family engagement component, there are no data collected from all programs reflecting existing strategies or initiatives for engaging or involving families.

Critical Gaps in Data on Transition Supports

- Indiana does not have universal Kindergarten Readiness or Kindergarten Entry Assessments (KRA, KEA), and thus does not have comprehensive data on the skills that children possess upon entering kindergarten. Without a universal KRA, it is not possible to know if children in Indiana as a whole are "ready for school" or if there are particular locations/communities that need further support to ensure their children are prepared. Without a universal KEA, it is not possible to determine if the instruction provided at entry to kindergarten is developmentally appropriate and meets the needs of children across the state.
- There are no data regarding which school corporations are offering transitional kindergartens, and these programs likely have an impact on the kindergarten retention data collected by IDOE. Further, there is no tracking system for these types of programs or data on the efficacy of these programs or other initiatives in supporting an effective transition to kindergarten.
- Although some data are collected on transition supports out of Part C into Part B programs, data are not collected on the types or efficacy of the supports that children receive as they transition out of Part C programs into other ECCE programs.

Critical Gaps in Data on Quality

- Data collected from coaches during PTQ onsite visits do not provide information that could be used to build comprehensive supports for providers for quality improvements. Further, there is not a consistent reporting system that is used by PTQ coaches so that aggregate data on quality advancement supports could be accurately documented.
- More data are needed on why PTQ level of quality does not always align with other indicators of high quality (e.g., Classroom Assessment Scoring System) and whether other indicators of quality (e.g., use of evidence-based curriculum) are more related to child outcomes.

Critical Gaps in Data on Vulnerable populations

- Comprehensive data on family income, demographic information, and other vulnerabilities are not collected from all families in the ECCE system in a systematic fashion. Thus, the state does not have a complete picture of participation rates in the system for vulnerable populations.

- Data on vulnerable populations are not aligned or integrated across state agencies so child care participation rates in this report likely represent duplicated numbers of children. For example, there are likely children who are enrolled in Head Start programs and are utilizing CCDFS vouchers, and thus, these children would be duplicated across data sets from Head Start and FSSA. Similarly, this tends to be a highly mobile population, so enrollment numbers even within one organization (e.g., Head Start) likely represent duplicated children (e.g., children who move from one Head Start program to another).
- With the exception of statewide data on Healthy Families Indiana participation, there are no publicly available data on participation in any Department of Child Services (DCS) programs or involvement in child welfare services for children birth to age 5. There are some statewide data on participation rates for children 0-18, but these data are not broken down by age. Furthermore, none of the data available data are broken down by county.
- Data from some organizations and agencies are not stored in a systematic or easily accessible way. For example, some demographic First Steps data are collected and stored in paper form in children's files, and therefore, are not easily accessible.

ADVERSE CHILDHOOD EXPERIENCES (ACES)

This section addresses a request from the Office of Early Childhood and Out of School Learning (OECOSL) on Adverse Childhood Experiences (ACEs) in Indiana. This section includes reports on ACEs for children in Indiana as well as initiatives for addressing ACEs and chronic/toxic stress. Unfortunately, comprehensive data on ACEs with young children are not available. Data reported in this deliverable will be state level only. However, the data reported still "paint a picture" of need in Indiana.

Research conducted by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente indicates a strong relation between exposure to abuse and/or household dysfunction as a child and multiple difficulties later in life, such as emotional and physical health concerns as well as work and education related challenges.[97] This research laid the foundation for the development and study of Adverse Childhood Experiences (ACEs), which include a set of indicators that, when they occur in the life of a child, may lead to short- and long-term emotional, behavioral, and physical health challenges. The indicators are divided into personal experiences (physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect) and behaviors associated with family members in the household (a parent who is an alcoholic, a mother who is a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment).[98] The more ACEs an individual experiences, the more significant the impact on emotional, behavioral, and physical health.[99]

Currently, knowledge of an individual's adverse experiences is gathered through the ACEs module[100] included with the Behavioral Risk Factor Surveillance System (BRFSS) established by the CDC.[101] The BRFSS is conducted via a random selection telephone survey. Individuals who agree to participate must be over the age of 18 and respond to the survey questions based on their current and prior experiences. The sections of the BRFSS include:[102]

1. A fixed core of standard questions to be collected annually.
2. Rotating core questions collected every other year. States may "opt in" for these questions to be asked annually as an optional module.
3. Optional modules (e.g., ACEs) that include standard questions on specific topics so that consistent data can be gathered across states.
4. State added questions for topics of special interest.

According to the CDC, 42 states have conducted the ACEs module at least once in the past 10 years (Indiana has completed the module once in 2018). Some states (such as, Iowa, Nevada, and Oregon) conduct the ACEs module annually or semiannually.[103]

The BRFSS along with the ACEs module is conducted with individuals 18 years or older regarding their own experiences. However, specific data reporting current experiences of children under the age of 18 are gathered through the National Survey of Children's Health (NSCH).[104] The NSCH is administered online and by mail through randomly selected addresses. Those that are randomly selected complete a screener to determine eligibility for the survey including having at least one child in the home under the age of 18. Then, if deemed eligible and willing to participate, the survey process randomly selects a child from the home (if there is more than 1 child) and the respondent completes the questionnaire according to that child's age and experiences.

What Do We Know About the Nine Adverse Childhood Experiences and Hoosier Children?

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[97] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

[98] Ibid.

[99] Ibid, 249-251.

[100] ACEs module survey can be downloaded at https://www.cdc.gov/violenceprevention/acestudy/pdf/BRFSS_Adverse_Module.pdf.

[101] Information about the Behavioral Risk Factor Surveillance System can be found at https://www.cdc.gov/brfss/index.html.

[102] Ibid.

[103] Data source: Center for Disease Control and Prevention Behavioral Risk Factor Surveillance System ACE Data https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-brfss.html.

[104] Information about the National Survey of Children's Health can be found at https://www.childhealthdata.org/learn-about-the-nsch/NSCH.

According to the Data Resource Center for Child & Adolescent Health, the below data reflects analysis from the National Survey of Children's Health for children under the age of 18 in Indiana in 2017. The data from the National Survey of Children's Health are reported only for the state and are not publicly available by county or community. In order to give context to the data, rank and comparative state data have been provided.[105]

Note: given the methodology of collecting these data, these percentages may be underreported.

Indicator	Ages*	Indiana	Indiana Rank**	"Best" State (Lowest % of Children)	"Worst" State (Highest % of Children)
Child's family finds it *somewhat often* hard to get by on family income	0-5	17.1%	29	Rhode Island 7.2%	New Mexico 27.9%
	6-11	18.5%	33	Minnesota 8.9%	Wyoming 32.7%
	12-17	18.0%	20	Wisconsin 6.1%	Michigan 29.7%
Child's family finds it *very often* hard to get by on family income	0-5	2.9%	8	Iowa 0.6%	South Dakota 16.0%
	6-11	1.5%	2	Utah 1.0%	Alabama 16.5%
	12-17	8.3%	39	California 1.1%	Louisiana 18.2%
Child's parents or guardians divorced	0-5	15.8%	44	Connecticut 3.4%	North Carolina 20.2%
	6-11	20.8%	14	District of Columbia 13.8%	Kansas 39.4%
	12-17	38.2%	41	Nebraska 19.3%	West Virginia 49.7%
Child's parent or guardian died	0-17	5.2%	46	Idaho 1.1%	Mississippi 6.4%
Child's parent or guardian served time in jail	0-17	9.6%	38	New Hampshire 2.3%	Oklahoma 17.5%
Child witnessed domestic violence in the home	0-17	5.1%	24	New Jersey 1.1%	Oklahoma 12.0%
Child was a victim of or witnessed violence in the neighborhood	0-17	3.6%	19	California 1.3%	West Virginia 9.8%
Child lived with someone who has mental illness, is suicidal, or severely depressed	0-5	7.1%	36	South Carolina 0.8%	North Carolina 12.8%
	6-11	11.0%	43	Iowa 1.6%	Oklahoma 18.2%
	12-17	8.7%	14	New Jersey 3.4%	Idaho 20.8%
Child lived with someone who has a problem with drugs/alcohol	0-5	1.7%	8	New York 0.4%	Kentucky 10.8%
	6-11	9.2%	23	South Carolina 1.4%	Alaska 17.9%
	12-17	15.6%	40	New Jersey 3.5%	Montana 27.6%
Child has been treated or judged unfairly because of his/her race or ethnic group	0-17	2.5%	14	Maine 0.6%	District of Columbia 7.5%

*Divided by three age ranges, where available.

**Ranking is out of 51 including all states plus the District of Columbia with a rank of 1 being the "best" with the lowest percentage of children with that experience and a rank of 51 being the "worst" with the highest percentage of children with that experience.

[105] Data Source: Child and Adolescent Health Measurement Initiative. Child and Family Measures, Adverse Childhood Experiences (2017). Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [6/16/2019] from www.childhealthdata.org.

Additionally, according to the Data Resource Center for Child & Adolescent Health, in Indiana in 2017:[106]

- 12.5% of children ages 0-5 had experienced 2 or more adverse childhood experiences
- 16.5% of children ages 6-11 had experienced 2 or more adverse childhood experiences
- 31.9% of children ages 12-17 had experienced 2 or more adverse childhood experiences

Lastly, the United Health Foundation ranks ***Indiana 31 out of 50 states (with 50 being the highest) for percentage of children (from 0-17 years of age) experiencing two or more ACEs.***[107]

Trauma Informed Care

Since the original ACEs study in the 1990s, researchers have been evaluating approaches to prevent and "combat" the negative impact of child abuse and chronic/toxic stress and build resilience. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has defined four main points defining Trauma-Informed Care:[108]

1) Realizes that trauma has a widespread impact on individuals, families, groups, organizations, and communities and understands paths to recovery;
2) Recognizes the signs and symptoms of trauma in clients, staff, and others in the system;
3) Integrates trauma knowledge into policies, programs, and practices; and,
4) Seeks to avoid re-traumatization.

Additionally, in the CDC's "Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities" (2016), five strategies were identified to prevent child abuse and neglect:[109]

1) Strengthen economic supports to families
2) Change social norms to support parents and positive parenting
3) Provide quality care and education early in life
4) Enhance parenting skills to promote healthy child development
5) Intervene to lessen harms and prevent future risk

How is Indiana Currently Responding?

Although Indiana engages in the BRFSS annually,[110] the ACEs module data were first collected in 2018. These data and reports should be available in 2019.

Franciscan Health is sponsoring two free, one-day conferences in Indiana (Hammond and Indianapolis) in July 2019 featuring Dr. Anda, co-author of the original ACES study. The focus audience is anyone working with youth or families to learn more about ACEs and the impact of trauma.

In 2018, the Indiana Early Learning Advisory Committee disseminated an ACEs Issue Brief[111] highlighting several initiatives in Indiana that are addressing ACEs. For example:

> *Great KIDS Make Great COMMUNITIES, Ft. Wayne:* Allen County Superior Court leads this initiative that has sponsored training for child and youth providers on trauma and ACEs and brought in national speakers on trauma and ACEs for their Conference on Youth.

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[106] Ibid.

[107] Data Source: America's Health Rankings https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ACEs/state/IN.

[108] Leitch, L. (2017). Action steps using ACEs and trauma-informed care: A resilience model. *Health & justice, 5*(1), 5. https://doi.org/10.1186/s40352-017-0050-5.

[109] Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). *Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/communicationresources/pub/technical-packages.html.

[110] For more information about Indiana's BRFSS process, see Indiana State Department of Health at https://www.in.gov/isdh/25194.htm.

[111] Early Learning Advisory Committee. (2018). *ACEs issue brief*. Retrieved from http://www.elacindiana.org/resources/.

One Community One Family, Batesville, has been focusing on trauma informed care for 10 years. They have provided trainings for child and youth providers on trauma informed care and how to identify and reach out to children and families experiencing ACEs.

Beacon Health System, St Joseph, Elkhart, and La Porte Counties, created the ACEs Interface to increase community knowledge of trauma and its effects, increase the number of trained professionals, engage more professionals in providing community sessions, and increase Beacon Community Impact's knowledge of ACEs.[112]

Riley Physicians, Bloomington: A local Psychiatric and Mental Health Clinical Nurse Specialist has educated herself on ACEs and connects with local schools offering professional development and awareness.

Recommendations:

- ***Annually or bi-annually collect data through the ACEs module via the Behavioral Risk Factor Surveillance System. With the consistent implementation of this module, more data will be available in which to disaggregate by county (community). The state will then have a clearer picture of the locations and individuals with the most impact of traumatic and adverse experiences as well as specifically which ACEs may be the most frequently occurring in order to focus resources and efforts.***
- ***Develop a state-wide, cross sector leadership team, philosophy, approach, and coordination of initiatives on ACEs and the impact of trauma as well as trauma informed practices and care that goes beyond the early care and education arena (such as, medical, mental health, PreK-12 education, child protective services, etc.). Initiatives are in action across the state but there is no coordinated effort to understand the outcomes and impact of ACEs and trauma informed practices state-wide.***
- ***Provide evidence based individual, community, and state-level professional development and leadership training on ACEs/trauma, the impact of trauma, and trauma informed care for providers, administrators, and families.***
    - For example:
        - *Roots of Resilience: Teachers Awakening Children's Healing* out of Oregon (http://blogs.oregonstate.edu/earlychildhood/current-projects/roots-of-resilience/). This evidence based professional development program supports teachers in promoting resilience with children impacted by trauma through workshops, online courses, and video-based coaching.
        - The state of Iowa annually collects ACEs module data from the BRFSS and offers summits for providers, families, and the community-at-large and supports coalitions such as Central Iowa ACEs 360 Coalition https://www.iowaaces360.org/ targeted at the locations and needs identified through the data.

[112] Beacon Health System. (2018). *Community benefit 2018 report*. Retrieved from https://www.beaconhealthsystem.org/community-impact/chna-community-health-resources/.