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Report to Congress: The Nebraska Rural Area Eligibility Determination Pilot for the CACFP

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EXECUTIVE SUMMARY

The Child Nutrition and Women, Infants, and Children (WIC) Reauthorization Act of 2004 (Public Law 108-265) authorized a demonstration pilot of the Child and Adult Care Food Program (CACFP) in rural areas in Nebraska.[1] The Nebraska Rural Area Eligibility Determination for Day Care Homes Pilot (NeRAED Pilot) made it easier for family day care home providers in rural Nebraska to qualify for higher rates of reimbursements for meals and snacks provided under the program.

This report presents the findings of an evaluation of the NeRAED Pilot. The evaluation was designed to determine whether lowering the threshold for area eligibility increased the number of rural family day care homes participating in the CACFP in Nebraska and, if so, by how much. It also was designed to assess any differences between the characteristics of providers brought into the program as a result of the pilot and all other providers, as well as differences in the characteristics of children served.

Background to the Pilot

The CACFP subsidizes nutritious meals and snacks to participants in child care centers, day care homes, and adult day care centers nationwide. In fiscal year (FY) 2006, the family day care home (FDCH) component of the program subsidized over 638 million meals and snacks at a cost of $1.9 billion.

Family day care home providers can apply to participate in the program by contacting an approved CACFP "sponsoring organization" within their State. Sponsoring organizations provide oversight, training on program requirements, claims administration, technical assistance, and monitoring of family day care homes.

Federal subsidies to participating family day care home providers are based generally on the number and types of meals served to children and whether or not the children are from low-income families.[2] Meals served to children of low-income families are reimbursed at a "tier I" rate that is higher than the "tier II" rate established for children from higher-income families. Family day care home providers who reside in low-income areas qualify for tier I reimbursement rates regardless of the income levels of the families of the children they serve. Program regulations specify that low-income areas may be either: (a) areas served by a school enrolling elementary students in which at least 50 percent of the total number of children enrolled are certified eligible to receive free or reduced-price (FRP) meals in the National School Lunch Program (NSLP); or (b) census tracts in which at least 50 percent of the children residing in the area are members of households whose incomes meet eligibility guidelines for FRP meals in the NSLP. Family day care home providers also may qualify for tier I status based on their own income being below the 185-percent threshold.

[1] Public Law 108-265 authorizes the Nebraska demonstration pilot by amending Section 17 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1766).

[2] "Low-income families" are those with household incomes at or below 185 percent of the Federal income poverty guidelines.

A continuing concern regarding the CACFP, as in other entitlement food programs, is that eligible children in rural areas are disproportionately less likely to participate than eligible children in urban areas. Several factors affecting the demand and supply of child care may contribute to this difference. On the demand side, rural families needing child care services may have difficulty traveling to existing child care centers or family day care homes, given the longer distances and lack of public transportation in rural areas compared to denser, urban areas. On the supply side, it may be harder for child care centers and family day care homes to operate efficiently in rural areas because of difficulties in recruiting enough children from nearby communities. This issue of efficiency may affect sponsoring organizations as well. Sponsors are required to visit their family day care providers several times each year for training, technical assistance, and monitoring functions. It may not be cost effective for a sponsor to travel to a distant, rural community to visit only one or two providers during a day, whereas visiting a group of three or four providers in one day may be cost effective, even if they are distant from the sponsor's office.

Concerns about sponsor management of family day care homes and the demand for and supply of child care services formed the impetus for testing a change in the program's eligibility threshold. By lowering the threshold for area-based higher reimbursement rates, it was hoped not only that more day care providers would become interested in participating in the CACFP,[3] but that sufficient concentrations of such interested providers would make it more attractive for sponsoring organizations to operate in more rural areas.

In 2004 Congress authorized a pilot to test a lower eligibility threshold in Nebraska and specified that it was to be implemented in fiscal years 2006 and 2007. The Nebraska Department of Education (NDE) conducted the two-year pilot between October 1, 2005 and September 30, 2007.

Research Methods

The findings presented in this report rely on an analysis of several data sources: (1) CACFP administrative records maintained by the Nebraska Department of Education (NDE); (2) administrative records maintained by the program's sponsoring organizations in Nebraska; (3) a Statewide survey of a random sample of 588 family day care home providers in the last quarter of 2007; (4) interviews with program officials in the NDE and the sponsoring organizations; and (5) focus groups with providers and parents of children attending family day care in Nebraska.

As noted above, family day care home providers may qualify for tier I status through any one of several means, including their own income; the income levels of the families for whose children they provide care; residence within the boundaries of a census tract in which at least 50 percent of children are in households with income at or below 185 percent of the Federal poverty level; and residence within the boundaries of a school that meets the 50-percent threshold for FRP meals or, for the two years of the pilot, the 40-percent threshold for schools in rural areas.

[3] The financial incentive to qualify as a tier I provider can be substantial. A hypothetical tier II day care provider serving an average of three meals (breakfast, lunch, and PM snack) a day to six children would have received a reimbursement of about $207 a month at the start of the Nebraska pilot. A tier I provider serving the same meals to the same number of children would have received about $432 each month.

It is not possible for the evaluation to distinguish among providers who qualify for tier I status based on their own income, the incomes of the families of all the children under care, or by their residence in a 50-percent threshold area. It is possible, however, to separately identify providers who qualified for tier I status by residing in a 40-percent threshold area because the sponsoring organizations maintained separate lists of these providers at the request of FNS, NDE, and the evaluation contractor. This final report therefore uses the following nomenclature when identifying providers:

- "***40% providers***" – family day care home providers residing in rural areas served by schools serving elementary school children in which the percentage of students certified for FRP meals is less than 50 percent but equal to or greater than 40 percent—all 40% providers are tier I providers;
- "***non-40% providers***" – family day care home providers with tier I status that are not 40% providers (i.e., providers in 50-percent areas plus providers who are income-eligible for tier I status regardless of location);
- ***"tier II providers***" – family day care home providers with tier II status;
- ***"mixed-tier providers"*** – family day care home providers with some, but not all, of their children under care income-eligible for tier I reimbursement; and
- ***"not-tier I providers"*** – family day care home providers with either tier II or mixed-tier status.

Table ES-1 summarizes the membership conventions for the provider groups in rural areas. The "non-40%" and "not-tier I" provider groups exist within urban areas as well.

Table ES-1: Membership within Provider Groups

Provider Types	Provider Group		
	40%	Non-40%	Not-Tier I
Tier I, income-eligible	x	x	
Tier I, area-eligible (50%)		x	
Tier I, area-eligible (40%)	x		
Tier II			x
Mixed-tier			x

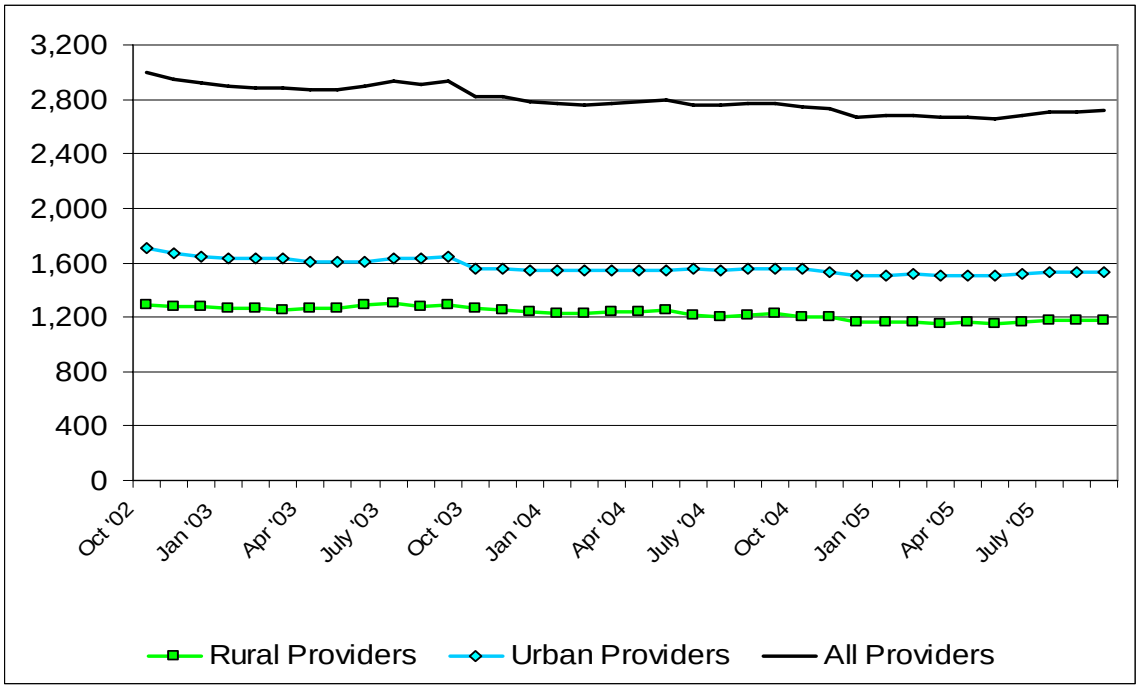
Research Findings

Implementation of the Pilot

In the three years prior to the pilot, the total number of family day care homes in Nebraska had been declining. In October 2002, there were 2,818 family day care homes participating in Nebraska's CACFP. By September 2005, the month prior to the start of the Nebraska Pilot, the

number of family day care homes had declined by 3.7 percent to 2,715. As shown in graph ES-1, the program had more providers in urban areas than in rural areas. Although the monthly patterns of change for urban and rural providers appear similar, the number of rural providers dropped by 6.6 percent during this period, compared to a 1.2-percent drop for urban providers.

Graph ES-1: Monthly Counts of Rural and Urban Providers Prior to the Start of the NeRAED Pilot

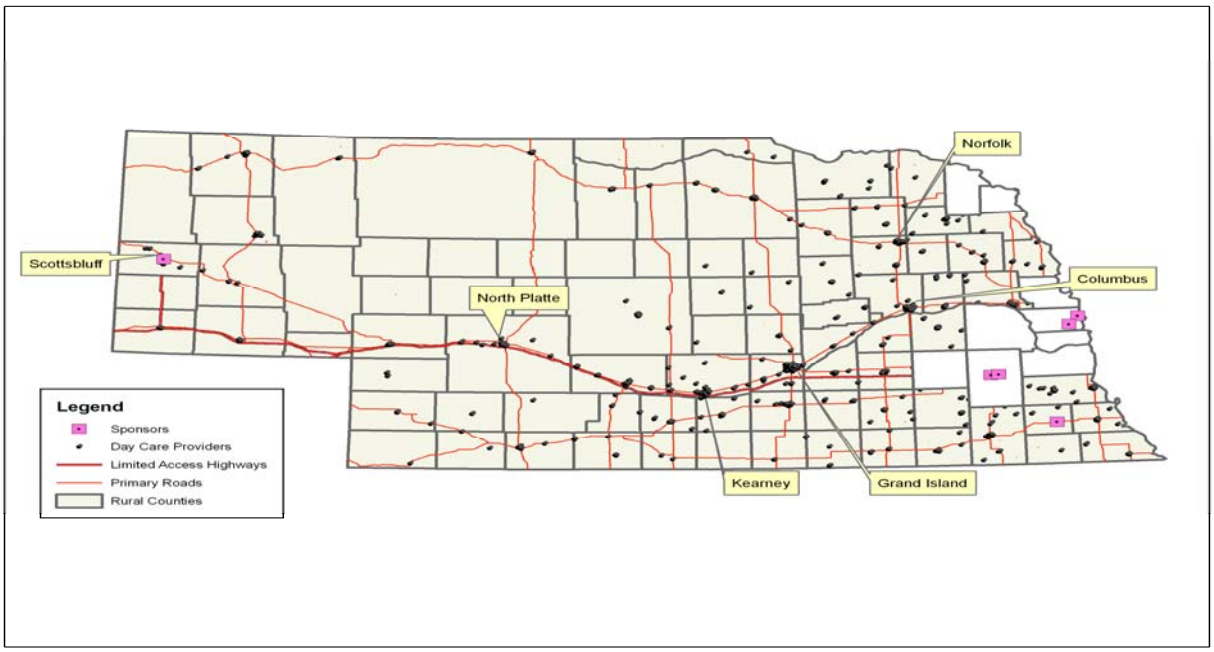


Source: NDE administrative data, 2002-2005.

Map ES-1 shows the geographic location of the rural providers relative to population centers and the transportation network. The blue lines in the map show county boundaries. The red line crossing east-west is Interstate 80. Primary and secondary roads are shown as indicated in the legend. Several of the larger towns and small cities in rural Nebraska are marked. The nine urban counties in the eastern part of the State have been blanked out because only rural areas were eligible for the pilot, and the NDE defined rural areas as non-metropolitan counties.

Upon notification of the upcoming pilot, the Administrator of NDE undertook several major tasks to ensure a smooth integration of the pilot into CACFP operations. The NDE chose to include as rural areas only complete counties that were not part of either the Lincoln, Omaha-Council Bluffs, or Sioux City Metropolitan Statistical Areas (MSAs). It also continued its use of elementary school district information to identify areas eligible for tier I reimbursement. NDE staff used data on FRP meals from the 2004-2005 school year to identify rural areas meeting the 40-percent to 50-percent threshold at the beginning of the pilot. Thereafter, updated information on percent of children certified for FRP meals became available each January.

Map ES-1: Location of Family Day Care Home Providers in Rural Nebraska Prior to the Start of the NeRAED Pilot



NDE informed its sponsoring organizations about the pilot by e-mail and at its regularly scheduled quarterly meetings with the sponsors. Sponsors, in turn, informed eligible providers via mail and newsletters of the upcoming changes in reimbursement. Several recruiting efforts occurred during the two-year period of the pilot. Sponsoring organizations advertised the pilot when it was first announced by sending flyers to about 70 towns it affected (i.e., towns having schools with from 40 to 49.9 percent of students certified for FRP meals). Information about the pilot also was published in local newspapers and sponsor letters. Subsequently, five of the six participating sponsoring organizations[4] collaborated and formed the Nebraska Sponsors Expansion Consortium, pooling their financial resources to create an extensive public relations campaign, including television and radio ads. Outreach letters were sent out to school principals, and flyers were published and distributed to parents and the general community. The Consortium also worked closely with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to inform their clients about the CACFP and the NeRAED Pilot.

At the start of the pilot in October 2005, sponsors reclassified the tiering status of all their family day care home providers who resided in rural school boundary areas meeting the new 40-percent threshold. A total of 220 providers were classified as 40% providers that month. The number of 40% providers grew to a maximum of 291 in March 2007 and then dropped to 284 at the conclusion of the pilot in September 2007.

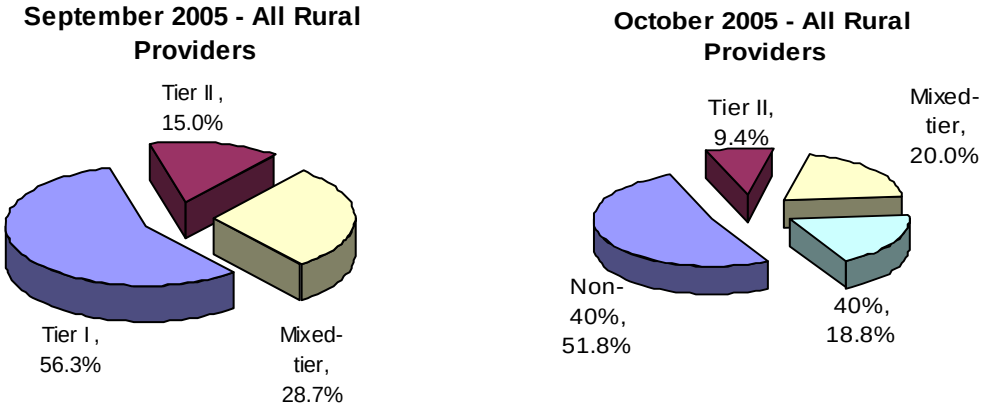
[4] There are seven CACFP sponsoring organizations in the State of Nebraska with six that are participating in this pilot. The Offutt Air Force Base Child Development Center is not a participant because the base is located in an urbanized area not affected by the pilot.

Key Findings

Impacts on Number of Family Day Care Homes Participating in the CACFP

Immediately upon implementation, the pilot increased the relative proportion of tier I providers operating in rural areas of Nebraska, but did not affect the total number of providers. In September 2005, the month prior to the start of the NeRAED Pilot, the NDE database had 1,181 rural providers listed as active: 56.3 percent were tier I; 15.0 percent were tier II; and 28.7 percent were mixed-tier. The next month there were only 1,171 active, rural providers: 51.8 percent were non-40%; 9.4 percent were tier II; 20.0 percent were mixed-tier; and 18.8 percent were in the new category of 40% providers. Graph ES-2 shows these percentage compositions as pie charts. Together, the tier II and mixed-tier providers (i.e., the not-tier I providers), represented 43.7 percent of the September providers and 29.4 percent of the October providers.

Graph ES-2: Composition of Two Groups of Providers



Source: NDE Administrative data, 2005-2007.

The changes in provider group membership reflect the following actions taken by sponsoring organizations to implement the pilot on October 1, 2005:

- 87 providers who were already tier I were reclassified as 40%. These 87 providers represented 40 percent of the total group of 220 providers in the 40% group.
- 46 tier II providers were reclassified as 40% (representing 21 percent of the total group)
- 80 mixed-tier providers were reclassified as 40% (representing 36 percent of the total group), and
- There were 7 new providers (representing 3 percent of the total group).

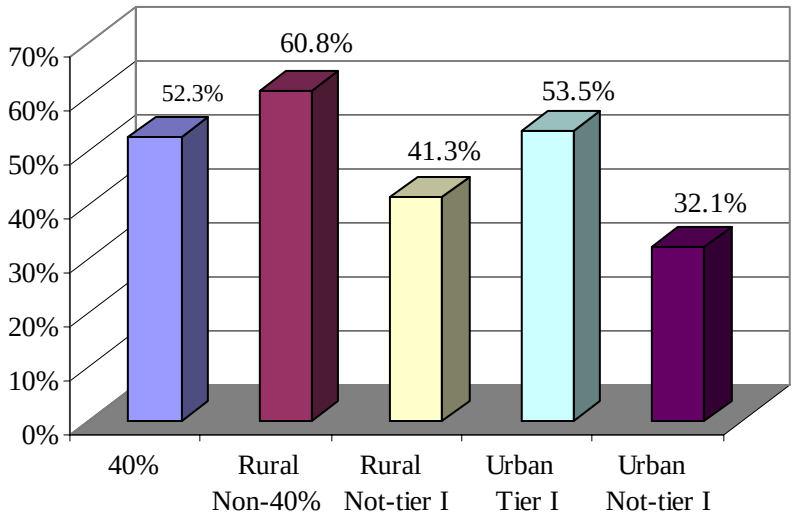
During the term of the pilot, the total number of family day care homes in rural Nebraska increased by 10.5 percent. After the 6.6-percent decline in the number of family

day care homes in rural Nebraska in the three years prior to the pilot, the total number of family day care homes was 1,171 in October 2005. The number held steady through the first nine or ten months of the pilot and then began a steady increase, reaching a maximum of 1,294 in September 2007. This 10.5-percent gain in rural providers contrasts with a 2.9-percent decline in urban providers, whose numbers fell from 1,541 in October 2005 to 1,496 in September 2007.

The pilot does not appear to have encouraged many <u>new</u> providers to join the CACFP. By lowering the percent-FRP threshold for tier I eligibility in rural areas, the NeRAED Pilot was expected to encourage more providers to join the CACFP through two mechanisms. First, by offering higher reimbursement levels for providers, the pilot was expected to increase provider demand for joining the CACFP. In turn, by increasing the number of potential providers in rural areas, the pilot was expected to increase the willingness of sponsoring organizations to sponsor new rural providers.[5]

As shown in graph ES-3, however, the number of family day care home providers in 40-percent areas who joined the CACFP during the 24 months of the pilot was not higher—on a percentage basis—than two other provider groups: other tier I providers (i.e., non-40% providers) in rural areas and tier I providers in urban areas. This suggests that the increase in family day care homes in 40-percent areas was ***not*** due to an above-normal rate of new providers from these areas.

Graph ES-3: Percentage of Providers Who Were New During the Pilot



Note: Percentage of new providers excludes providers who joined the CACFP in October 2005—the first month of the pilot.

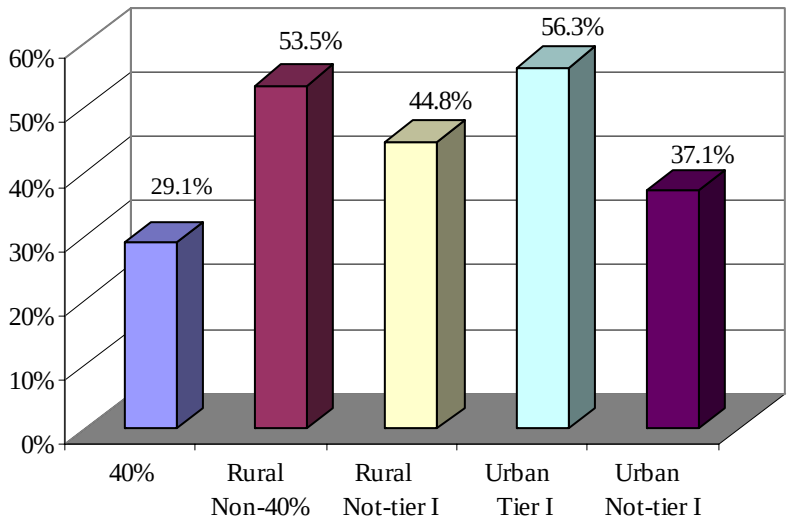
Source: NDE Administrative data 2005-2007.

[5] With more providers located in a given geographic radius, multiple providers could be visited during a single monitoring trip to the area, thereby lowering the sponsor's administrative costs on a per-provider basis.

The pilot appears to have kept many previously participating providers in 40-percent areas in the CACFP for longer periods. Graph ES-4 shows the numbers and rates of providers ***leaving*** the CACFP during the pilot, by provider group.[6] The 40% provider group is notable in the graph for its low rate of departures (29.1 percent) relative to ***all*** other groups, sometimes substantially. For instance, other rural, tier I providers (i.e., the "Rural Non-40%" group) had a departure rate of 53.5 percent, and tier I providers in urban areas had a departure rate of 56.3 percent.

While it cannot be concluded definitively that the NeRAED Pilot ***caused*** providers in 40-percent areas to remain in the CACFP longer[7], the evidence in graph ES-4suggests that providers in the 40-percent areas of rural Nebraska were less likely to depart the CACFP than they would have been had the pilot not been implemented. Table ES-2 provides corroborative evidence in the form of how long providers remained in the program after the start of the pilot. More providers in 40-percent areas (86.2 percent) were likely to remain in the CACFP for the entire 24 months of the pilot than were other rural providers (69.8 percent) or urban providers (67.0 percent). In addition, 40% providers who were active in October 2005 (including those who left the CACFP before the end of the pilot) remained active, on average, for longer periods during the pilot (22.7 months) than other providers who were active in October 2005.

Graph ES-4: Percentage of Providers Who Left the CACFP During the Pilot



Source: NDE Administrative data 2005-2007.

[6] The evaluation has no information on the number of providers who left the CACFP but continued to provide child care versus those that left the day care business altogether.

[7] Such an inference could not be made without a stronger research design than provided by the Nebraska pilot. For instance, if all providers in 40-percent areas had been randomly assigned to either a tier I or a tier II status, then one could better attribute any differences in their behaviors as a result on the pilot.

Table ES-2: Length of Time that Providers Remained in the CACFP During the Pilot

Area of State and Provider Status	Number of Providers in October 2005	Average Number of Active Months During Pilot	Percentage Active for Entire 24 Months
Rural			
40%	220	22.7	86.2%
Not 40%	951	19.7	69.8%
All Rural	1171	20.0	72.9%
Urban			
Tier I	837	18.8	61.3%
Not Tier I	704	20.5	73.9%
All Urban	1541	20.3	67.0%

Source: NDE Administrative data 2005-2007.

Although these results are somewhat unexpected, plausible logic supports the hypothesis that the pilot could have a greater effect on reducing the number of departures than on increasing the number of new providers. There are substantial obstacles to starting a family day care home, or to enrolling an existing home in CACFP. Tier I reimbursement rates are more of an economic incentive to join the CACFP than are tier II rates, but even the tier I rates may not be enough of an incentive for some providers to join the CACFP. For providers already in the CACFP, however, the "cost" of staying in the program is relatively low. *In this environment, postponing a decision to leave the CACFP may be more strongly influenced by increased reimbursement rates than the decision to enter the program.*

The pilot had limited success in encouraging providers from more remote areas of the State to join the CACFP. Map ES-2 shows the location of the 213 previously participating providers who became 40% providers at the start of the pilot.[8] It also differs from map ES-1 by including Bureau of the Census information on level of poverty at the census block group level.[9] As indicated in the legend, the three shades of green indicate census block groups with varying percentages of the population living within 185 percent of the Federal Poverty Level (FPL). The deepest shade of green shows areas where 50 percent or more of the population is below the 185-percent FPL threshold, and the medium shade shows block groups where 40 to 50 percent of the population is below the threshold. The lightest shade is for areas with less than 40 percent of the

[8] Because of the proximity of the providers and the scale and resolution of the map, the 55-65 visible dots represent clusters of providers.

[9] A census "block group" is a group of census blocks having the same first digit of their four-digit identifying numbers within a census tract.

population in poverty. Thus, the breakpoints for the shading match the pilot's area-eligibility rules for tier I status.

About 11 of the provider dots in map ES-2 are located in or very near the highest poverty census block groups, and another ten or so are located in or very near the medium-shaded areas depicting 40-50 percent of the population below 185 percent of the FPL. Thus, most of the pre-existing 40% providers (i.e., the remaining 40 or so dots) are located in areas of lowest poverty on the map. Many, however, are located away from the larger population centers in rural Nebraska and therefore served some of the least densely populated areas of the State—a key objective of the pilot.

Map ES-3 shows the locations of the 122 providers in 40-percent areas who joined the CACFP after the start of the pilot. Approximately 50 individual dots may be seen on the map, indicating that many of the dots represent two or more providers. Most of the newly added providers are located close to where the pre-existing providers resided, although there are about 10 provider dots on map ES-3 that have no corresponding pre-pilot dots on map ES-2. Of course, even in areas with CACFP providers prior to the pilot, the addition of more program providers in the same or nearby areas would be of value if demand for day care services in these areas exceeded the supply.[10]

Impacts on Characteristics of Family Day Care Homes Participating in the CACFP

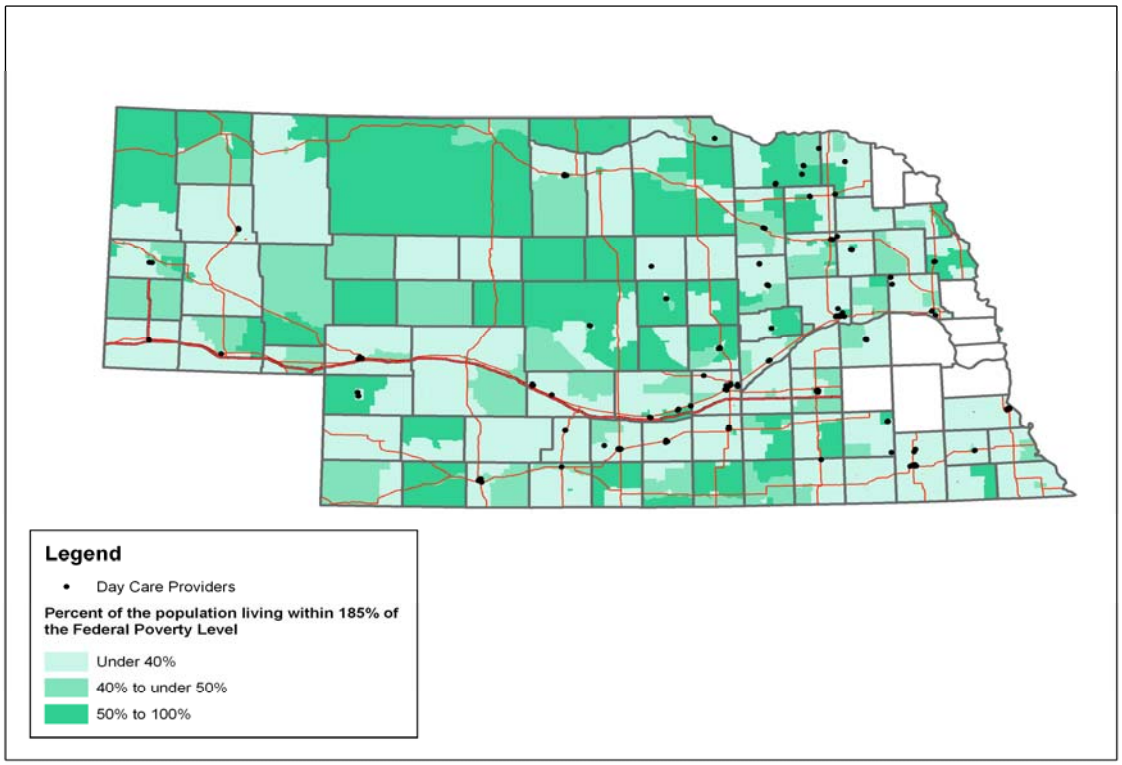
The evaluation conducted a survey of a random sample of 588 family day care home providers throughout Nebraska in the last quarter of 2007.[11] Based on this survey:

- The average size of family day care homes throughout Nebraska was 8.1 children, with no statistically significant differences in size among provider groups. The 40% providers, however, were more likely than other providers both to be operating at capacity (60 percent vs. 46 percent overall) and to have waiting lists (51 percent vs. 42 percent overall).
- Like other providers, the main reason 40% providers are operating family day care homes is to ensure that their own children receive desired care. Providers in the 40% group were less likely than other providers to cite financial reasons as a main reason, and they (together with not-tier I providers) were less likely to cite helping out a friend or relative as a main reason.
- The 40% providers were more likely than other providers to have their child care certificate (63 percent), to have taken nutrition classes (also 63 percent), and to report having received sponsor training (44 percent).
- Both 40% providers and not-tier I providers were less likely than non-40% tier I providers to be taking care of children in special populations (i.e., special-needs, migrant, bilingual).

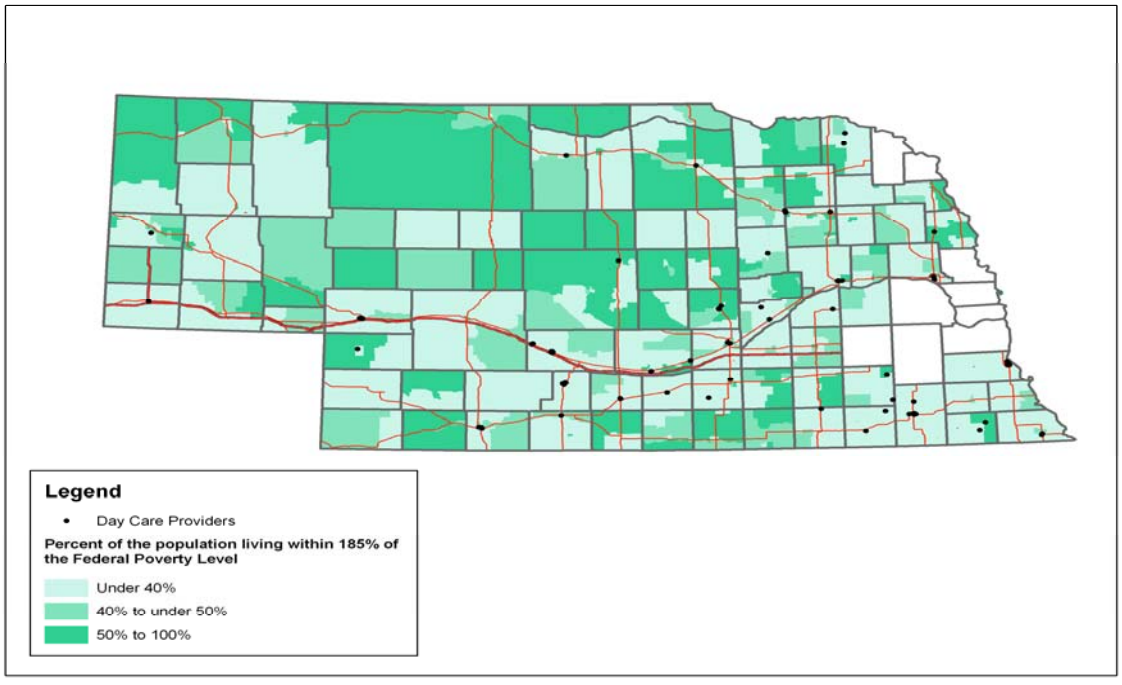
[10] Data from the Provider Survey indicate that 51 percent of all 40% providers near the end of the pilot had waiting lists, demonstrating the demand for day care services in these areas of rural Nebraska.

[11] The response rate to the survey was about 53 percent, with older and more experienced providers being more likely to respond to the survey than younger, less experienced providers.

Map ES-2: Locations of Previously Participating 40% Providers



Map ES-3: Locations of 40% Providers Who Joined the CACFP During the Pilot



- Both 40% providers and not-tier I providers were less likely to be providing transportation services for their children than non-40% tier I providers.
- Finally, when asked if they had changed their day care operations during the pilot, 40% providers were more likely to have done so than were other providers, especially in the area of food operations (29 percent vs. 19 percent overall). The 40% providers were more likely than other providers to report providing higher quality food (71 percent vs. 45 percent overall) or greater quantities of food (31 percent vs. 24 percent overall) since the start of the pilot.

Table ES-3: Summary of Characteristics of CACFP Family Day Care Homes in Nebraska, by Provider Group

Characteristic	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Average number of children in care	8.6	8.3	7.5	8.1
Percent at capacity*	60%	48%	36%	46%
Percent with waiting lists*	51%	40%	42%	42%
Percent citing financial support as a main reason for providing day care*	49%	56%	64%	58%
Percent citing helping a friend or relative as a main reason for providing day care*	24%	33%	23%	29%
Average years of CACFP participation	13.6	11.8	12.6	12.2
Percent licensed as day care provider	95%	88%	96%	91%
Percent with child care certificate*	63%	51%	48%	51%
Percent taking care of special populations*	13%	23%	10%	18%
Percent providing transportation services*	29%	34%	28%	32%
Percent making changes to food operations during pilot*	29%	17%	21%	19%
Of those making changes to food operations, percent offering higher quality food	71%	51%	23%	45%
Of those making changes to food operations, percent offering greater quantities of food	31%	16%	33%	24%

Note: Characteristics marked with an asterisk (*) have statistically significant differences in value among the three provider groups.
Source: NeRAED Provider Survey, 2007.

Impacts on Characteristics of Children Attending Family Day Care Homes Participating in the CACFP

The pilot appears to have had very little impact on the characteristics of children attending family day care homes participating in Nebraska's CACFP. Specifically:

- Boys and girls attend family day care in Nebraska in nearly equal proportions, and the gender split for children at 40% providers was statistically no different than for non-40% providers or not-tier I providers.

- The age distribution of children at 40% providers is statistically no different than the distributions at other providers. Statewide, about 38 percent of all children in care are 3- to 5-year olds and 27 percent are toddlers. Six- to 12-year olds represent 20 percent of all children, followed by infants (14 percent). Less than one percent of all children in family day care are teenagers.

- Despite the exclusively rural environment of the 40% providers, these providers estimated shorter average distances for their children to travel to day care than did non-40% providers or not-tier I providers. About 22 percent of 40% providers said the children in their care lived within one mile of them, compared to 18 percent for non-40% providers and 13 percent for not-tier I providers.

The findings that the age distribution and gender of children attending 40% providers are no different than for children in other parts of Nebraska are consistent with the finding that the main effect of the pilot was to encourage existing providers in 40-percent areas to remain in the CACFP longer that they would have otherwise. Thus, except for the normal turnover in day care homes as older children left and new ones arrived, and the normal addition of new homes to the program for reasons unrelated to the pilot, there were few or no "new" children as a result of the pilot. Instead, family day care home providers in Nebraska continued to take care of the same types of children they had before the pilot.

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CHAPTER 1: INTRODUCTION

The Child Nutrition and Women, Infants, and Children (WIC) Reauthorization Act of 2004 (Public Law 108-265) authorized a demonstration pilot of the Child and Adult Care Food Program (CACFP) in rural areas in Nebraska.[12] The Nebraska Rural Area Eligibility Determination for Day Care Homes Pilot (NeRAED Pilot) made it easier for family day care providers in rural Nebraska to qualify for higher rates of reimbursement for meals and snacks provided under the program. This report presents the findings of an evaluation of the NeRAED Pilot that was designed to determine whether lowering the threshold for area eligibility increased the number of rural family day care providers and children participating in the CACFP in Nebraska and, if so, by how much.

1.1 Overview of the Child and Adult Care Food Program

The CACFP is a Federal program that subsidizes nutritious meals and snacks to participants in such day care facilities as child care centers, day care homes, and adult day care centers nationwide. It also provides meals to children in emergency shelters and snacks (and sometimes meals) to youth in after-school programs. The Food and Nutrition Service (FNS) of the U.S. Department of Agriculture (USDA) administers the CACFP through annual grants to States. The program is administered within most States by the State educational agency.

In fiscal year (FY) 2006, the family day care home (FDCH) component of the program subsidized over 638 million meals and snacks at a cost of $1.9 billion. Family day care home providers can apply to participate in the program by contacting an approved CACFP "sponsoring organization" within their State. Sponsoring organizations, which consist primarily of community and faith-based nonprofit organizations, provide oversight, training on program requirements, claims administration, technical assistance, and monitoring of family day care homes.

Federal subsidies to participating FDCH providers are based generally on the number and types of meals served to enrolled children and whether or not the children are from low-income families. Meals served to children of low-income families (i.e., those with household income at or below 185 percent of the Federal income poverty guidelines) are reimbursed at a "tier I" rate that is higher than the "tier II" rate established for children from higher-income families.

Day care providers who reside in low-income areas qualify for tier I reimbursement rates regardless of the income levels of the families of the children they serve. Program regulations specify that low-income areas may be either: (a) areas served by a school enrolling elementary students in which at least 50 percent of the total number of children enrolled are certified eligible to receive free or reduced-price (FRP) meals in the National School Lunch Program (NSLP); or (b) census tracts in which at least 50 percent of the children residing in the area are members of households whose incomes meet the income

[12] Public Law 108-265 authorized the Nebraska demonstration pilot by amending Section 17 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1766).

eligibility guidelines for FRP meals in the NSLP. Day care providers with incomes less than or equal to 185 percent of poverty also may qualify for tier I rates based on their income, even if they are not in a low-income area.

1.2 Impetus for the Nebraska Pilot

A continuing concern regarding the CACFP, as in other entitlement food programs, is that eligible children in rural areas are disproportionately less likely to participate than eligible children in urban areas. Several factors affecting the demand and supply of child care may contribute to this difference. On the demand side, rural families needing child care services may have difficulty traveling to existing child care centers or family day care homes, given the longer distances and lack of public transportation in rural areas compared to denser, urban areas. On the supply side, it may be harder for child care centers and family day care homes to operate efficiently in rural areas because of difficulties in recruiting enough children from nearby communities. This issue of efficiency may affect sponsoring organizations as well. Sponsors are required to visit their family day care providers several times each year for training, technical assistance, and monitoring functions. It may not be cost effective for a sponsor to travel to a distant, rural community to visit only one or two providers during a day, whereas visiting a group of three or four providers in one day may be cost effective, even if they are distant from the sponsor's office.

The above concerns about sponsor management of family day care homes and the demand for and supply of child care services formed the impetus for testing a change in the eligibility threshold. By lowering the eligibility threshold for area-based higher reimbursement rates, it was hoped not only that more day care providers would become interested in participating in the CACFP, but that sufficient concentrations of interested providers would make it more attractive for sponsoring organizations to operate in more rural areas.

In 2004 Congress authorized a pilot to test a lower eligibility threshold in Nebraska and specified that it was to be implemented in fiscal years 2006 and 2007. The Nebraska Department of Education (NDE) conducted the two-year pilot between October 1, 2005 and September 30, 2007.

1.3 Evaluation Objectives

The authorizing legislation for the pilot[13] specified that its evaluation should assess the impact of the change in eligibility requirements on:

- The number of family day care homes offering meals under the new eligibility criterion;
- The number of family day care homes offering meals under the new criterion that would otherwise be classified as tier II homes in the absence of the pilot;
- The geographic location of the family day care homes; and
- Services provided to eligible children.

[13] Public Law 108-265, Section 119(e).

These identified areas of possible impact formed the basis for the evaluation's six research objectives:

1. Describe the process by which the State of Nebraska and sponsoring organizations implemented the NeRAED Pilot, including (a) identification of geographic areas eligible under the 40-percent threshold[14] but not the 50-percent threshold; (b) communication of new threshold limits to sponsors and family day care homes in rural areas; (c) assignment of tier I status to family day care homes; and (d) monitoring of program operations and reimbursements.
2. Determine the numbers, types (i.e., tiering status), and sizes (i.e., number of children served) of family day care homes offering meals through the CACFP in rural areas of Nebraska, and compare to monthly historical data. Compare family day care homes selected under the 40-percent eligibility criterion with corresponding entities under the 50-percent criterion.
3. Determine the numbers and characteristics of children served, by age, gender, and other factors. Compare the characteristics of children served under the 40-percent and 50-percent thresholds, and assess the characteristics of new children being served by the CACFP under the 40-percent criterion.
4. Describe the geographic locations of participating family day care homes, including county, zip code location, relative distance of site from nearest urban center, or other major activity centers such as schools, sports and recreation centers, shopping centers, etc. Compare geographic locations and concentrations of tier I family and family day care homes under the 40-percent and 50-percent thresholds.
5. Describe the types of services provided for children at tier I family day care homes. Compare services provided at family day care centers under the 40-percent and 50-percent thresholds.
6. Estimate the impact of the pilot on the number, types, and sizes of family day care homes participating in the CACFP in designated rural areas of the State of Nebraska.

1.4 Report Organization and Nomenclature

The remainder of this report is divided into six chapters, plus seven appendices. Chapter 2 presents the evaluation's research approach and discusses the data collected. Chapter 3 covers the structure and operations of the CACFP in Nebraska prior to the pilot, and planning implementation of the pilot, and a summary of key findings from this process study.

Chapter 4 addresses the evaluation's primary research question—did the pilot lead to an increase in the number of family day care homes participating in the CACFP in rural Nebraska? Chapters 5 and 6, respectively, examine the characteristics of day care providers

[14] To avoid confusion, throughout this report we use the "%" symbol when referring to categories of providers and reserve the word "percent" for statistical findings (e.g., "Forty percent of the 40% providers have this—or that—characteristic.").

and the children under their care, paying special attention to possible differences between tier I providers in the 40-percent threshold areas and elsewhere.

Finally, in order to present a more readable discussion about the Nebraska pilot and its effects, a number of acronyms and "short-hand" references are used throughout the report. A list of acronyms is provided at the end of the report to help the reader, but some of the more commonly used references are listed here:

- CACFP – the Child and Adult Care Food Program;
- NeRAED Pilot – an abbreviation of the official name for this project, the Nebraska Rural Area Eligibility Determination for Day Care Homes Pilot;
- NDE – the Nebraska Department of Education, whose Nutrition Services Division is responsible for administering the CACFP in Nebraska;
- FDCH – family day care home; and
- FRP – the acronym stands for "free and reduced-price meals" in the National School Lunch Program.

As a result of data limitations described in chapter 2, it is not possible to distinguish whether FDCH providers who qualify for tier I status do so based on their own income, the incomes of the families of all the children under care, or by their residence in a 50-percent threshold area. (It is possible to separately identify FDCH providers who qualify for tier I status by residing in a 40-percent threshold area.) Thus, the report uses the following nomenclature when identifying providers:

- "***40% providers***" – family day care providers residing in rural areas served by schools serving elementary school children in which the percentage of students certified for FRP meals is less than 50 percent but equal to or greater than 40 percent—all 40% providers are tier I providers;
- "***non-40% providers***" –family day care home providers with tier I status that are not 40% providers (i.e., providers in 50-percent areas plus providers who are income-eligible for tier I status regardless of location);
- ***"tier II providers***" –family day care home providers with tier II status;
- ***"mixed-tier providers"*** –family day care home providers with some, but not all, of their children under care income-eligible for tier I reimbursement; and
- ***"not-tier I providers"*** –family day care home providers with either tier II or mixed-tier status.

For purposes of the evaluation, tier II and mixed-tier providers are almost always grouped together, leading to three mutually exclusive provider groups that cover all FDCH providers in the State: 40% providers, non-40% providers, and not-tier I providers. Table 1 shows the membership of each group.

Table 1: Membership within Provider Groups

Provider Types	Provider Group		
	40%	Non-40%	Not-Tier I
Tier I, income-eligible	x	x	
Tier I, area-eligible (50%)		x	
Tier I, area-eligible (40%)	x		
Tier II			x
Mixed-tier			x

Note: The 40% provider group includes only rural providers, whereas the non-40% and not-tier I groups include both rural and urban providers.

The limitation of the administrative data available for the evaluation means that the analyses cannot strictly compare providers qualifying for tier I status under the 40-percent and 50-percent criteria. It is useful to note, however, that even if all FDCH providers residing in 50-percent areas could be separately identified, this group of providers is not necessarily homogeneous with respect to their tier I qualifications. That is, even in the absence of area eligibility, some might qualify for tier I status on the basis of their own income level or the income levels of their children's families. The same is true for tier I providers in the 40-percent areas. It is therefore appropriate for the evaluation to compare 40% providers to non-40% providers in rural Nebraska.

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CHAPTER 2: RESEARCH APPROACH

Under a competitive procurement process, FNS awarded a contract to evaluate the NeRAED Pilot to McFarland & Associates, with Exceed Corporation as a subcontractor. The McFarland project team used a multi-method approach to evaluate the effects of the NeRAED Pilot on the CACFP.

The project team collected data from both primary and secondary sources to respond to the six research objectives outlined in chapter 1. Primary data collection included administrative data from NDE; interview and focus group data from State officials, program sponsors, providers, and parents; and data from a formal survey of family day care home providers throughout the State. Secondary data collection included demographic, geographic, and socioeconomic data from the Bureau of the Census and the Bureau of Labor Statistics.

The data collection activities for this evaluation fall into three groups:

1. Initial, on-site interviews with NDE and CACFP sponsors and providers;
2. Focus groups with providers and parents; and
3. Outcome data, including: administrative data from NDE and sponsors; a survey of rural family day care providers; and post-pilot interviews with State CACFP officials and sponsors.

Data collection activities involving sponsoring organizations and NDE continued during the pilot on an ongoing, as-needed basis.

The following sections describe the purpose and timing of each data collection task.

2.1 Interviews with State Officials

Discussions with State officials provided the groundwork for the evaluation of the pilot. Initial interviews were conducted in Nebraska in September 2006, shortly after award of the evaluation contract. Evaluation staff conducted a post-pilot wave of telephone interviews with State officials during the first week of January 2008. Between the two sets of interviews, evaluation staff had ongoing communication with State officials as needed.

The semi-structured interviews with State officials at the beginning and end of the evaluation were designed to provide information on the following topics:

- Information about the CACFP in Nebraska;
- Available sources of administrative data, what they contained, and any idiosyncrasies in their definition or use;
- The background for the pilot and the State's plans for implementation;
- Identification of the primary players in the Nebraska CACFP and pilot, and their respective roles;
- Contractor plans for data collection and evaluation; and

- A post-pilot review of the entire effort.

Discussions also provided information on the licensing of FDCHs; the mix of providers in the State; "underground" providers; tiering; communication among pilot participants; recruitment of providers; State monitoring activities; and sub-cultural background and contextual factors in the State of Nebraska.

On September 25, 2006, four members of the project team met in Lincoln with six officials of NDE, two staff members from FNS, and a Fellow from the Nebraska Appleseed Center for Law in the Public Interest (Appleseed).[15]

The project team also collected administrative and program operations data during the visit, including information on State monitoring procedures for the CACFP; the identification of rural areas and elementary schools meeting the new 40-percent threshold; the number and location of providers; and provider claim information. Other collected materials included quarterly meeting reports from NDE and pilot marketing information. These data were updated and refreshed as needed throughout the pilot timeframe.

2.2 Interviews with Sponsors and Providers

Preliminary interviews with all participating sponsors and a small sample of selected providers were administered to gather background information on the organizations involved and to ascertain the methods by which both groups learned of the pilot; the ways in which the pilot had been implemented by these groups; and any anecdotal changes or results that had occurred to that point. This information affected the development of the more formal data collection survey scheduled for the fall of 2007. The initial interviews were conducted from September 25 to 29, 2006, in person with six sponsors and four providers. Two additional sponsor interviews were conducted by telephone shortly thereafter.

During the first week of January 2008, post-pilot telephone interviews were held with all sponsors, as well as with Appleseed staff and a representative from the Food Research and Action Center (FRAC) who worked with Appleseed during the NeRAED Pilot.

2.3 Focus Groups with Providers

Focus groups with family day care providers were conducted to elicit background information for the evaluation and to inform the development of the provider questionnaire. Seven themes guided the focus groups' discussions:

1. Reasons for becoming an FDCH provider.
2. Recruitment of families.
3. A typical day in the home day care environment.
4. Meals provided.

[15] According to its website, Appleseed is a "non-profit network of 16 public interest justice centers in the U.S. and Mexico dedicated to building a society where opportunities are genuine, access to the law is universal and equal, and government advances the public interest." (http://www.appleseeds.net/ accessed on June 8, 2008.)

5. Thoughts about and interactions with the CACFP.
6. The State's role in increasing provider participation and child enrollment.
7. Providers' plans for when the pilot ends.

Three provider focus groups were held in Nebraska on October 23, 2006 – in Scottsbluff, Lincoln, and Nebraska City. Thirteen providers attended the three focus groups. The providers who attended the focus groups had been providing day care for a range of 3 to 35 years. As planned, these providers had tier I status as a result of the pilot; all had formerly been tier II CACFP providers. Thus, although the presence of the pilot did not induce these providers to join the CACFP, they believed that the pilot's increased reimbursements were a sufficient inducement for existing providers to remain in the program and for others to join the food program.

A summary of provider responses to the above issues is presented as Appendix A. Of particular interest to the pilot and its evaluation:

- Disagreement existed as to the importance to parents of the food that providers serve to the children: Some providers said that the food they served was not a particularly important issue for parents, and that most parents do not even inquire about meals. Others believed that parents are interested in whether good meals are being served. A few providers stated that the meal/food issue was more important to them wanting to serve better food than it was for the parents.
- A number of providers expressed ambivalence about the CACFP. They believed the program's paperwork requirements were too burdensome and that they might leave the program if reimbursement rates returned to their pre-pilot levels.

2.4 Focus Groups with Parents

One focus group was conducted with parents in Scottsbluff on October 24, 2006. Three parents of children attending family day care participated in the parent focus group, with a fourth parent joining by speakerphone.

Parents generally had very little information, if any, about the NeRAED Pilot. Their concerns focused mostly on:

- Finding a qualified family day care provider who could provide adequate time with their child;
- Finding a home with ample space for activities – both inside and out – and a safe and clean environment;
- Providers' requirements for a monthly enrollment fee instead of a daily or hourly rate for the provision of day care.

When probed about the pilot, parents thought that the greater availability of tier I reimbursement rates would lead to an increase in the number of day care providers in rural Nebraska. They were pleased to discover the source of additional revenue for the providers

and hoped that it might relax the monthly "payment in advance" rule that many providers enforced.

Perhaps surprisingly for rural communities, transportation was not cited by parents as a challenge.

2.5 Administrative Data

Concurrent with the meetings with State program staff in September 2006, other meetings were held with State staff responsible for managing the State's administrative and program operation databases. Access to these databases enabled the project staff to ascertain what information relevant to the pilot was lodged in the State's existing database; identify areas where data were not already collected by the State and which would, therefore, need to be collected from sponsors or during the provider survey; and provide insight into possible idiosyncrasies or limitations in the Nebraska databases.

After consulting with State and sponsor staffs, three separate administrative databases were identified:

1. NDE administrative database
2. Sponsor administrative databases
3. Sponsor identification of 40% providers during the pilot

Each database has strengths and limitations with respect to the needs of the evaluation. The NDE database is the best of the three for identifying all active FDCH providers in a given month. Although the NDE database also has a variable indicating the provider's tiering status, this variable was not always current in the copies of the database obtained for the evaluation (see section below on processing of data for how this limitation was addressed).

NDE Administrative Database

The evaluation contractor received copies of NDE's CACFP administrative database at several points during the pilot, with initial test copies of the database being provided shortly after the evaluation contract was awarded. The NDE administrative database has several notable strengths with regard to its use for the evaluation:

- It contains a single record per active FDCH provider per month for the requested five-year period of October 2002 through October 2007.
- It contains an identifier for the provider's sponsoring organization, which proved useful in later data matching.
- It contains the provider's address including county, thereby allowing identification of "rural" versus "urban" providers.
- It includes the date the provider entered the CACFP and the date of birth of the provider.

The NDE administrative database also has a code designating a provider's tiering status, but this code did not appear to be updated on a regular basis. Because the pilot changed

providers' tiering status over time, the tiering information on the NDE database was deemed generally insufficient for purposes of this evaluation.

Although the provider's address was included in the database, there was no mapping of provider to school districts or individual schools serving elementary children. Thus, the NDE database could not be used to distinguish tier I providers in 50-percent versus 40-percent areas.

The NDE data contained no information useful to the evaluation on the number or characteristics of children in care at the provider level.

Sponsor Administrative Databases

Each of the six sponsoring organizations in the pilot cooperated with the evaluation's request for copies of their CACFP administrative databases. Although the monthly database extracts that were provided were not always consistent over time or across sponsors, they proved to be invaluable to the evaluation.

Most importantly, the sponsor administrative databases had current information on each provider's tiering status, although the data that were provided did not indicate the reason for classifying providers as tier I (i.e., whether the provider was area- or income-eligible for tier I reimbursements). Furthermore, even though sponsors clearly had provider-specific information on provider characteristics and the number, ages, and gender of enrolled children, these data generally were not easily retrievable for the monthly extracts. The evaluation relied instead on the Provider Survey for information about the provider and the children in care.

The sponsor databases provided for the evaluation had two notable limitations. First, their databases were not set up as one record per provider per month.[16] Sponsors therefore provided monthly extracts, and the evaluation team sorted the records of each of 288 administrative extracts (48 monthly extracts from each of six sponsors) to identify and process providers with multiple records. This exercise was difficult because, even within a given month, spellings of provider names and addresses were sometimes inconsistent. Second, the sponsors' administrative files were not set up to distinguish between 40% and 50% providers—both appeared on the monthly extracts as "tier I" providers (as did providers who were tier I through income eligibility).[17]

[16] Of particular note, some sponsors establish two records each month for mixed-tier providers. One record contains information for the provider's tier I meals while the second record contains similar information pertaining to the provider's tier II meals. Furthermore, the tiering codes on the two records are not for "mixed-tier;" rather, one record has a tier I code and the other record a tier II code. The only way to identify a mixed-tier provider in these monthly extracts is to sort by provider name and address and identify adjacent records with tiering codes of "1" and "2" respectively.

[17] Note that, for purposes of program administration, sponsor databases had no need to distinguish between 40% and 50% providers; only the provider's tiering status needed to be maintained.

Sponsor 40% Provider Databases

Because the sponsor databases could not identify providers who gained tier I status due to area eligibility in 40-percent areas, the evaluation contractor requested that each sponsor maintain a separate list of its 40% providers each month. This was possible because justification for the tiering decision is maintained in the sponsor's provider files even if not maintained in the administrative database.

Processing of the Administrative Databases

The NDE database is the most accurate of the three databases in terms of having one record per active FDCH provider each month, and the NDE database serves as the primary administrative database for the evaluation. To gain current, monthly information on each provider's tiering status, the sponsors' monthly extracts were merged to the NDE database using provider name, sponsor name, and date as the common variables. Finally, to identify which tier I providers were 40% providers, the special 40% data provided by the sponsors were merged with the NDE database.

As with nearly any effort to merge administrative databases from disparate sources, the two merges described above were not perfectly successful, and the frequency of unmatched records increased going back in time. For the most recent 30 months of data (i.e., from May 2005 through October 2007), 83.0 percent of the 36,438 State administrative records for rural providers were successfully merged with sponsor data. Of the 30,229 merged records, the tiering status variables on the two data sources were in agreement 74.8 percent of the time.

Counts of the number of providers, by month, location, and tiering status were therefore estimated using the following procedure:

1. For the 83.0 percent of rural provider records in the State's database that merged with sponsor records, the sponsor's tiering status value was preliminarily used.

2. For the 17.0 percent of rural provider records in the State's database that did not merge with a sponsor record, the State's tiering status value was preliminarily used.

3. The sponsors' lists of 40% providers were then used to differentiate 40% from non-40% tier I providers. Note that the non-40% tier I providers include the following types of tier I providers:

    a. those in areas meeting the 50-percent threshold for FRP eligibility;

    b. those that qualify for tier I status on the basis of their own income; and

    c. those that qualify for tier I status on the basis of the family incomes of all the children in their care.

2.6 Provider Survey

The Provider Survey was a mixed-mode survey of a random sample of family day care home providers throughout Nebraska. Providers had the option of responding to either a web-

based or mail-out version of the survey.[18] The survey was conducted in the fall of 2007, near the end of the two-year pilot, and collected information on the following main topics:[19]

- Characteristics of day care operations (e.g., hours, size, licensing, services provided);
- Experience and training as a day care provider;
- Reasons for becoming a day care provider;
- Characteristics of children under care;
- Capacity and demand for day care services;
- Experience with the CACFP and meals served;
- Awareness of the Nebraska Pilot; and
- Changes in operations since start of pilot;

The sampling plan for the Provider Survey was stratified according to provider tiering status. Table 2 shows the details of the sampling plan and outcomes.

Table 2: Sampling for the Provider Survey

Tiering Status	Size of Sample Universe	Number Sampled	Sampling Rate	Number of Responses	Response Rate
Non-40%	1,648	666	40.4%	295	44.3%
40%	290	244	84.1%	156	63.9%
Tier II	727	159	21.9%	113	71.1%
Mixed	126	32	25.4%	24	75.0%
Total	2,791	1101	39.4%	588	53.4%

Repeated mailings and follow-up telephone calls were used to remind sampled providers to complete the survey, and the contractor offered to complete interviews by telephone if providers preferred. Despite these efforts, the survey's overall response rate of 53.4 percent was disappointingly low and leads to concern about the possibility of non-response bias in the survey results. That is, if non-responders to the survey were systematically different from responders along dimensions of interest to the evaluation, then the survey responses obtained may be different from those that would have been gathered had a larger percentage of providers responded to the survey.

The primary method for investigating the possibility and nature of response bias is to compare known characteristics of responders and non-responders. In this situation the known characteristics are limited to just three categorical descriptors on the Nebraska Department of Education's database: (1) age of provider; (2) years of service as a CACFP

[18] Eighty-one of 588 providers (14 percent) completed the survey on-line.
[19] A copy of the survey is included as appendix G.

provider; and (3) tiering status (supplemented with the sponsors' identification of 40% providers). Table 3 presents survey response rates by groups of providers defined by these categorical descriptors.

Response rates varied among the different tiers, ranging from a low of 44.3 percent among non-40% tier I providers to a high of 75.0 percent among mixed-tier providers. The response rate for the 40% providers was 63.9 percent.

Table 3: Characteristics of Responders to the Provider Survey

Group	Number of Responders in Group	Percentage of Group that Responded
Tiering Status		
Non-40%	295	44.3%
40%	156	63.9%
Tier II	113	71.1%
Mixed-tier	24	75.0%
Total	588	53.4%
Age of Provider (years)		
<30	66	43.4%
30-39	155	49.5%
40-49	167	60.9%
>=50	164	56.2%
Missing	36	51.4%
Total	588	53.4%
Experience as a CACFP Provider (years)		
<5	224	49.0%
5-9	132	53.4%
10-14	109	51.9%
>=15	73	74.5%
Missing	50	56.2%
Total	588	53.4%

In the other two dimensions, response rates varied by age of provider and the number of years the provider had participated in the CACFP. Response rates generally increased with the age of the provider, although there is a fall-off among providers aged 50 or more. When looking at the variable measuring years of CACFP participation, the response rate is generally around 50 percent except for those providers with 15 or more years of participation. Their response rate was nearly 75 percent. Thus, when assessing the survey results presented in later chapters, descriptors that would be expected to vary by age of provider or years of CACFP participation should be interpreted with caution.

Table 4 uses information from the previous tables to compare the characteristics of survey responders and non-responders.

Table 4: Comparison of Characteristics of Responders and Non-responders to the Provider Survey

Group	Respondent Group	Non-Respondent Group
Tiering Status		
Non-40%	50.2%	72.3%
40%	26.5%	17.2%
Tier II	19.2%	9.0%
Mixed-tier	4.1%	1.6%
Total	100.0%	100.0%
Age of Provider (years)		
<30	11.2%	16.8%
30-39	26.4%	30.8%
40-49	28.4%	20.9%
>=50	27.9%	24.9%
Missing	6.1%	6.6%
Total	100.0%	100.0%
Experience as a CACFP Provider (years)		
<5	38.1%	45.4%
5-9	22.4%	22.4%
10-14	18.5%	19.7%
>=15	12.4%	4.9%
Missing	8.5%	7.6%
Total	100.0%	100.0%

Sample weights for survey respondents are used to weight the sample up to the population counts in the sample universe. These sample weights, which are uniform within a provider group, account for variations in both sampling rates and response rates. For example, there were 1,648 non-40% tier I providers throughout the urban and rural portions of Nebraska at the time of the survey, and the evaluation obtained responses from 295 of these providers. The sampling weight for each non-40% provider is 5.586 (i.e., 1,648÷295).

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CHAPTER 3: THE CACFP IN NEBRASKA AND IMPLEMENTATION OF THE PILOT

This chapter begins with a basic description of the CACFP and how it operates in Nebraska. The chapter then describes how NDE planned for and implemented the NeRAED Pilot, thereby addressing the evaluation's first research objective:

> *Describe the process by which the State of Nebraska and sponsoring organizations implemented the NeRAED Pilot, including (a) identification of school areas eligible under the 40-percent threshold but not the 50-percent threshold; (b) communication of new threshold limits to sponsors and family day care homes in rural areas; (c) assignment of tier I status to family day care homes; and (d) monitoring of program operations and reimbursements.*

3.1 Overview of the Nebraska CACFP

The CACFP is a Federal program that provides healthy meals and snacks to children and adults who are receiving day care. It began as a pilot in 1968 and later became a permanent nutrition program administered by the USDA. The CACFP subsidizes meals and snacks in nonresidential day care facilities (including emergency shelters, family and some adult day care centers, child care centers, and after-school-hours child care centers) that provide nutritious meals which meet meal pattern requirements.[20] Program regulations specify that reimbursement shall not be claimed for more than two meals and one supplement (snack), or one meal and two snacks, daily for each participant in the program.[21]

When the CACFP was first established by Congress in 1968 under Section 17 of the National School Lunch Act (NSLA) (42 U.S.C. 1766), participation was limited to center-based child care in areas where poor economic conditions existed. Beginning in 1976, family day care homes became eligible to participate provided that they met State licensing requirements, where these exist, or otherwise obtained approval from an appropriate State or local agency. In addition, homes must be sponsored by a public or private nonprofit organization that assumes administrative and financial responsibility for sponsored facilities, ensures compliance with Federal and State regulations, and acts as a conduit for meal reimbursements.

The CACFP generally limits eligibility for child recipients through age 12, with some exceptions. Children of migrant workers may participate through age 15, and children residing in emergency shelters or participating in at-risk, after-school programs are eligible through age 18. Additionally, disabled persons of any age may be eligible for program benefits.[22]

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[20] Part 226.20 of Title 7 of the Code of Federal Regulations (CFR) specifies requirements for meals and snacks served in the CACFP. Detailed information may be found on the following program Web site: http://www.fns.usda.gov/cnd/care/ProgramBasics/Meals/Meal_Patterns.htm.

[21] 7 CFR 226.18.

[22] 7 CFR 226.2.

There are four groups of stakeholders in the Nebraska CACFP. First, the NDE administers the program statewide. Second, NDE enters into contracts with, at present, seven sponsoring organizations. Third, the sponsoring organizations, in turn, recruit, monitor, and support approximately 2,790 family day care home providers throughout the State. The fourth group is the children enrolled for care and their parents.

Family day care home providers take care of children enrolled for childcare, with each provider specifying the days and times of the week for which services are provided to each child (including their own, if eligible and enrolled). Day care providers are reimbursed by their sponsors for the meals and snacks they provide to enrolled children. Sponsors, in turn, submit monthly claims to NDE to cover their own administrative costs and the cost of their providers' meal subsidies. The NDE pays the monthly claims to the sponsoring organizations, and the sponsors write checks to individual providers covering their reimbursements for allowed meals.

Background and Contextual Factors in the State

A variety of regions and subcultures exists within the State of Nebraska. In the northern portion of the State (known as Sand Hills) are Cherry, Grant, Hooker, Thomas, Brown, and Rock Counties – primarily ranching areas with fine grass. The southern and eastern parts of the State are predominantly agricultural, growing corn (used primarily for ethanol) and Milo, a variety of sorghum grain that resembles millet and is known for growing early and resisting drought. The western areas are agricultural as well, known for sugar beets and wheat. The Panhandle counties grow sugar beets, corn, Milo, and other crops. There are cattle ranches throughout the State.

Several Native-American reservations are located in the northeastern areas of Nebraska – in Knox and Thurston Counties. The preponderance of African Americans in Nebraska live in the urban areas such as Omaha and Lincoln, and the highest populations of Hispanic and Latino residents generally reside in cities such as Omaha, Scottsbluff, and Lexington, in proximity to meatpacking plants, one of the State's core industries for employment.

State Administration

As noted, the CACFP in Nebraska is administered by NDE, Nutrition Services, with funding provided by the USDA. Although the CACFP serves both adults in adult care centers and children in child care centers, family day care homes, and outside-school-hours centers; the sole focus of the NeRAED Pilot was on FDCHs in rural portions of the State. At the start of the pilot, there were 1,181 family day care home providers operating in rural areas of Nebraska.

The NDE does not license family day care homes. Rather, it administers a program to which family day care home providers may apply and receive subsidies for nutritious meals and snacks served to children who enroll for child care and meet the CACFP's eligibility rules.

Most family day care homes in Nebraska are licensed by the Nebraska Department of Health and Human Services (NDHHS). Day care homes that serve fewer than four children are required to be approved by NDHHS as "license-exempt" day care sites before participating in the CACFP.

Administrative Cost Reimbursement

The NDE uses part of its annual CACFP grant from the USDA to reimburse sponsoring organizations for their CACFP-related operating expenses, which can include:

- Recruiting and enrolling new providers;
- Providing training to key staff, monitors, and providers;
- Processing providers' monthly claim forms for reimbursement;
- Submitting reports to the State agency and processing payments from the State agency;
- Processing providers' reimbursement payments; and
- Monitoring providers through announced and unannounced visits.

The sponsor's monthly administrative reimbursement is computed using the method that is least costly to the program from among the following:

- The sponsor's net allowable administrative costs;
- The sponsor's approved administrative cost budget; or
- The number of participating providers multiplied by a graduated reimbursement rate based on the number of providers being sponsored.

Sponsors generally receive greater overall monthly reimbursements as they enroll more family day care homes into the program. Table 5 displays the rates in effect for day care homes when the Nebraska pilot began in October 2005 and for subsequent years.

Table 5: CACFP Reimbursement Rates for Sponsors

Number of Homes	Monthly Rate per Home		
	July 1, 2005 – June 30, 2006	July 1, 2006 – June 30, 2007	July 1, 2007 – June 30, 2008
Initial 50 Homes	$91	$ 95	$ 97
Next 150 Homes	$69	$ 72	$ 74
Next 800 Homes	$54	$ 56	$ 58
Each Additional Home	$48	$ 50	$ 51

Source: CACFP agreement, NS-407-G, Revised 4/2006.
Note: Higher reimbursement rates apply in Alaska and Hawaii.

Licensing

The majority of FDCHs in Nebraska are State licensed. The NDHHS classifies its licensed homes as "Home I" or "Home II." Home I providers can serve up to 8 children with 1 adult present, and Home II providers can serve up to 12 children with 2 adults present.

Day care homes serving three or fewer children or serving only one family other than their own are called "license-exempt" day care homes, which means they are exempt from State licensing requirements.[23] These license-exempt homes in the CACFP receive meal and snack reimbursements and monitoring visits similar to licensed homes. All day care homes – independent of exemption – must have current agreements with NDHHS to accept Child Care Subsidy Payments.

Fewer FDCHs exist in the more remote areas of the State. There are fewer children per square mile in these areas, and parents have longer distances to travel to drop children off at provider homes. Challenges exist for remote providers who may desire to join the CACFP or become licensed, because access to licensing requirements, such as CPR training, may not be available near their homes. Reportedly, in these areas, unlicensed day care homes that operate outside of State oversight and regulations exist. Such unlicensed day care homes may not participate in the CACFP.

Determining Area Eligibility

Federal regulations allow States to use either school enrollment or census data to identify geographic areas where providers are eligible for tier I reimbursement rates. The NDE provides the sponsors with information about the percentages of children certified for FRP meals in the NSLP for each of the State's school districts serving children in elementary grades. The eligibility for FRP meals is family income less than or equal to 185 percent of the Federal poverty guidelines. Sponsors may use this information to identify school-based areas eligible for tier I status, although they are also permitted to use Census data.

The NDE data on student percentages certified for FRP meals are collected on September 30 each year, resulting in data from the same single point in time annually. The NDE distributes this list to sponsors in January of the following year. The sponsor identifies the elementary school attendance area where each of its providers is located, to identify those providers eligible for tier I reimbursement rates.

Once classified as eligible for tier I funding, providers in 50-percent sites keep their tier I designations for 5 years – even if the elementary school attendance areas in which they are located no longer qualify after new data are collected. This policy avoids an annual change in tiering status (and subsequent disruption in reimbursement levels) that could occur from year-to-year variations in the percentage of children certified for FRP meals in areas close to the 50-percent threshold.

Sponsoring Organizations

To participate in the CACFP, family day care home providers must sign an agreement with a sponsoring organization. The sponsor then supports the day care providers with technical assistance and training, as well as monitoring. Each month, day care providers submit to

[23] In Nebraska, a child care license is required when care is provided to four or more children under age 13 at any one time, from families other than that of the provider, for compensation, either direct or indirect. Information accessed on February 13, 2006, from http://www.sos.state.ne.us/business/regsearch/Rules/Health_and_Human_Services_System/Title-391/Chapter-2.pdf.

their sponsor documentation of meals and snacks served to children under their care. The sponsors check the documentation, compute reimbursement levels based on each child's "tiering status" and meals, and reimburse their FDCHs according to program-specified rates, which also are updated annually.

Sponsoring Organizations in Nebraska

Table 6 displays the names, locations, and number of providers served by the seven sponsoring organizations in Nebraska.[24] Multiple sponsors are, in some cases, active in the same general areas. The Offutt Air Force Base (AFB) Child Development Center, located on base and not serving any rural areas, was not affected by the pilot. Two of the six remaining sponsoring organizations are located in Lincoln, two in Omaha, one (an Indian Tribal Organization or ITO) in Tecumseh, and one in Scottsbluff at the western edge of the State. Map 1 on the next page shows the location of the six sponsors' offices.

Table 6: CACFP Sponsoring Organizations in Nebraska

Sponsoring Organization	Location	Total FDCHs Served	Rural FDCHs Served
Child Nutrition Services	Tecumseh	124	88
Family Service	Lincoln	1,093	775
Heartland Family Service	Omaha	275	3
Midwest Child Care Association	Omaha	749	99
Offutt AFB Child Development Center	Offutt AFB	28	0
Panhandle Family Day Care Center	Scottsbluff	135	135
Provider's Network, Inc.	Lincoln	312	81

Note: Provider counts as of March 2006.

Source: CACFP agreement, NS-407-G, Revised 4/2006.

Recruiting

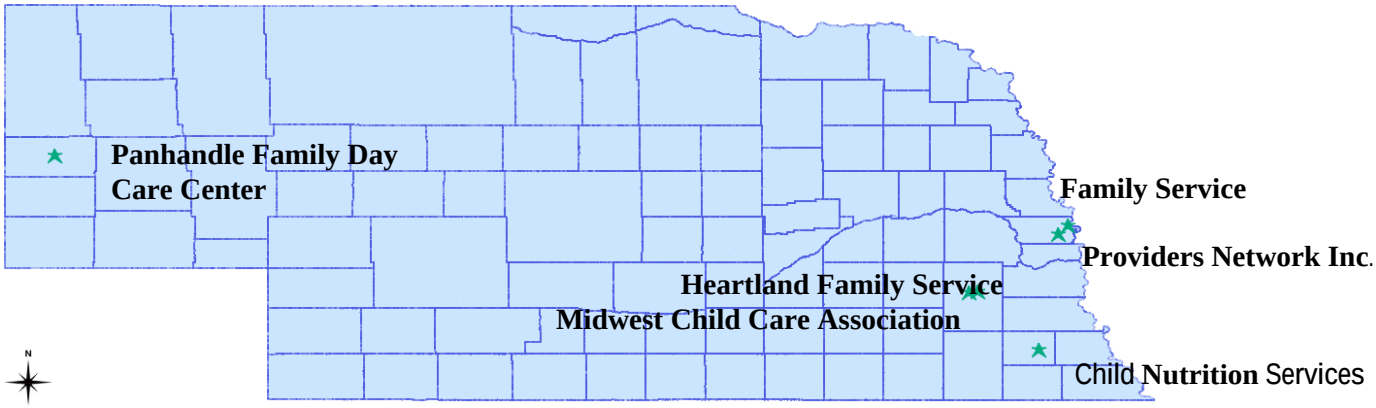
Sponsors are responsible for recruiting day care home providers into their organizations. By agreement among themselves, the seven sponsors in Nebraska do not recruit providers who currently have a relationship with another sponsor, but they can compete for new providers who express an interest in entering the program. In addition, providers sometimes change sponsors because it is the provider's prerogative to choose the sponsoring organization with which it prefers to work.[25] In the event of conflicts between sponsors concerning recruitment of providers, NDE's document, *Management Standards for Nebraska Family Day Care*

[24] Appendix B provides further information about the sponsoring organizations, including maps showing the counties they serve in terms of recruiting and supporting family day care homes.

[25] 7 CFR 226.6(p) limits transfer by a provider to one time per year.

Home Sponsors, is used to resolve the conflict. In the past, there were reportedly periods of considerable conflict among sponsors. Currently, however, the NDE Administrator reports that these organizations tend to work together cooperatively.[26] The NDE staff believes that there are more similarities than differences among sponsors, with the main difference being the level of training and technical assistance they offer to their participating providers.

Map 1: Location of the Six CACFP Sponsors with Rural Providers



Family Day Care Homes

Family day care providers are small business operators. They offer a service (child care) for which they are paid by the children's parents or guardians (or perhaps, in some cases, by the NDHHS). Part of their operating expenses is the cost of purchasing food for the meals and snacks they serve to the children. The subsidies provided by the CACFP are designed to offset part of this operating expense while ensuring that the meals and snacks served are nutritious and meet program standards.

Tiering Status

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 instituted a tiered system of reimbursements for family day care home providers in the CACFP. Day care providers are classified as either tier I, tier II, or mixed tier, based primarily on the percentage of children living in low-income areas, with tier I providers receiving larger reimbursements than tier II providers.

A family day care home may qualify as a tier I entity if it meets any of the following three criteria:

1. It is located in an area served by a school enrolling elementary students in which at least 50 percent of the total number of children enrolled is certified eligible to receive FRP meals in the NSLP.
2. It is located in a geographic area as defined by the Secretary of the USDA, based on Census data, in which at least 50 percent of the children residing in the area are

[26] Interview with NDE Nutrition Services Administrator, September 25, 2006.

members of households whose incomes meet the income eligibility guidelines for FRP meals in the NSLP.

3. It is operated by a provider whose household income meets the income eligibility guidelines for FRP meals and whose income is verified by the sponsoring organization under regulations established by the Secretary of the USDA.

If none of the above criteria are met, providers may qualify for tier I reimbursement levels based on the income eligibility for FRP meals of the children in their care. If some, but not all, children under care qualify for FRP meals, the provider is a "mixed-tier" provider. By law, the provider is not permitted to know the income eligibility status of the children in care, and income eligibility paperwork is submitted to and processed by the provider's sponsoring organization.

Table 7 shows the CACFP reimbursement rates in the contiguous United States, by tiering status and meal type for July 2005–June 2008, the three-year period encompassing the Nebraska pilot. All reimbursement rates are updated each July by the FNS.[27]

Table 7: CACFP Reimbursement Rates per Meal for Family Day Care Homes (July 2005–June 2008)

Year	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Tier I						
2005-2006	$1.06	$0.58	$1.96	$0.58	$1.96	$0.58
2006-2007	$1.07	$0.58	$1.97	$0.58	$1.97	$0.58
2007-2008	$1.11	$0.61	$2.06	$0.61	$2.06	$0.61
Tier II						
2005-2006	$0.39	$0.16	$1.18	$0.16	$1.18	$0.16
2006-2007	$0.40	$0.16	$1.19	$0.16	$1.19	$0.16
2007-2008	$0.41	$0.17	$1.24	$0.17	$1.24	$0.17

Note: Higher reimbursement rates apply in Alaska and Hawaii.

Source: CACFP agreement, NS-407-G, Revised 4/2006.

As can be derived from the table, the financial incentive to qualify as a tier I provider can be substantial. A hypothetical tier II day care provider serving an average of three meals (breakfast, lunch, and PM snack) a day to six children would have received a reimbursement of about $207 a month at the start of the Nebraska pilot. A tier I provider serving the same meals would have received about $432 each month. The pilot was designed to determine whether the increased tier I reimbursements would induce greater participation of rural providers in the CACFP.

[27] Current and historical reimbursement rates for the CACFP may be accessed at: http://www.fns.usda.gov/cnd/care/ProgramBasics/Rates/071106.htm.

Characteristics of Family Day Care Home Providers in Nebraska

In September 2005, the month prior to the start of the NeRAED Pilot, there were 2,715 active providers in the Nebraska CACFP, with 1,171 of these providers (43.2 percent) residing in rural counties. Statewide, 55 percent of providers were tier I, 26 percent were tier II, and 19 percent were mixed-tier.

According to NDE staff, the total number of CACFP providers in Nebraska decreased somewhat when Congress mandated tiering and differential subsidies in FY 1997. Since then, however, the number of day care home providers has stabilized. Turnover among providers, according to NDE staff, usually occurs when providers' own children have grown or when they pursue alternate career paths and leave the day care business.

Monitoring

Sponsoring organization staffs conduct home visits to each provider day care home three to four times per year. At least one visit is unannounced. Home visits consist of record reviews, attendance checks, menu reviews, provider interviews, observations, and provision of training or technical assistance.

Submission of Claims

Sponsors use the Internet, as well as traditional paper methods, to collect monthly provider reports of the number of CACFP-eligible meals and snacks they served, by date and child. Some sponsoring organizations have developed their own software to track provider information. After reviewing and, if necessary, correcting these reports, the sponsor submits a claim to NDE with aggregated counts of meals and snacks reported by providers, by tiering status. After the State pays the sponsor for the claimed amount, the sponsor distributes the funds to the providers based on their corrected report numbers. The process takes about one month.

3.2 Planning for the NeRAED Pilot

The legislation authorizing the NeRAED Pilot specified that it was to be implemented during FYs 2006 and 2007. Thus the start date of the pilot was October 1, 2005, the beginning of Federal FY 2006. FNS officially notified its Mountain Plains Regional Office of the Nebraska Pilot in a letter dated March 31, 2005. The letter cited the legislation authorizing the pilot and indicated that, for purposes of the pilot, the definition of "rural" would be consistent with CACFP regulations. The letter also indicated that the pilot would be evaluated, and it requested that certain data be maintained for the evaluation.

Federal and State officials, however, were aware of the upcoming pilot well before the official notification. The Administrator for Nutrition Services of NDE discussed the pilot with FNS Headquarters and Regional staffs following a regularly scheduled meeting with USDA in September 2004 in Kansas City. Thus, NDE staff had a little over one year advance notice to prepare for the pilot.

Early Activities

Upon notification of the upcoming pilot, the Administrator of NDE had several major tasks to ensure a smooth integration of the pilot into CACFP operations. These tasks included:

- Identifying which State areas were "rural" and therefore eligible to participate in the pilot;
- Deciding whether to use census tract information and/or elementary school district information to identify areas meeting the new 40-percent threshold for establishing tier I status for reimbursement levels;
- Identifying the exact areas affected by the lowered threshold;
- Notifying sponsors about the pilot and the new 40-percent areas; and
- Determining how to publicize the pilot to encourage more providers in rural areas to contact a sponsor and enroll in the program.

The following sections describe how NDE accomplished these tasks. Before doing so, however, it is useful to note that which the pilot did not change:

- The relationship between NDE and the seven sponsoring organizations remained largely unchanged. Although the topic and plans for the pilot were discussed at the State's quarterly meetings with the sponsors, the pilot did not change the fundamental relationship between NDE and the sponsors. The pilot introduced no new reporting requirements and no new monitoring requirements.
- The pilot did not alter any CACFP requirements regarding meal planning or the nutritional aspects of meals or snacks.
- Sponsors continued to process provider claims for reimbursement exactly as before (except that more providers may have qualified for tier I reimbursements levels than before).

Defining Rural Areas for the Pilot

Program regulations define a "rural area" as any geographical area in a county which is not a part of a Metropolitan Statistical Area (MSA) or any ''pocket'' within a Metropolitan Statistical Area which, at the option of the State agency and with FNSRO concurrence, is determined to be geographically isolated from urban areas.[28] For the pilot, the NDE chose to include as rural areas only complete counties that were not part of either the Lincoln, Omaha-Council Bluffs, or Sioux City MSAs. Thus, providers in "geographically isolated" areas of either MSA did not qualify for tier I eligibility under the pilot. Because such areas were never administratively identified, however, it is not known whether any such areas even exist in either MSA or the number of providers that might reside there.

Of the 93 counties in Nebraska, 84 do not belong to an MSA and were therefore treated as "rural" for purposes of the pilot. As shown on map 2, the nine urban counties are grouped on the eastern edge of the State. The urban counties are Dakota and Dixon (Sioux City MSA),

[28] 7 CFR § 226.2.

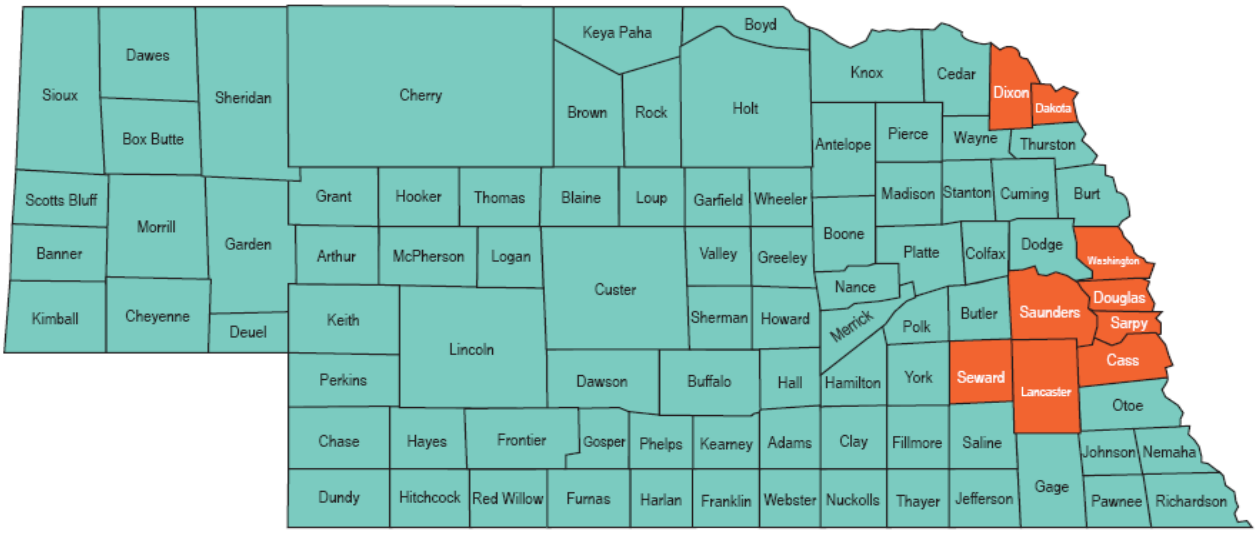
Cass, Douglas, Sarpy, Saunders, and Washington (Omaha-Council Bluffs MSA), and Lancaster and Seward (Lincoln MSA).

Notifying Sponsors and Providers about the Pilot

Several documents served to communicate the pilot's new tier I eligibility threshold limits to sponsors and family day care homes in rural areas.

In the August 2004 *Child Care Outreach* newsletter published by the Family Service Child Care Food Program (one of the sponsors), the front page was devoted to an article entitled "Nebraska Named as Pilot State for 40% Tier I School Areas." This article revealed that "on June 22, 2004, Senator Ben Nelson announced the creation of a State pilot project in Nebraska that will expand eligibility for day care homes in rural areas." The article continued by indicating that Senator Nelson had requested the Pilot CACFP for Nebraska during the Committee on Agriculture, Nutrition and Forestry's reauthorization of the Richard B. Russell National School Lunch Act (NSLA) and the Child Nutrition Act of 1966. A description of the pilot ensued by defining the 50- to 40-percent thresholds and informing readers that the change would be effective beginning October 1, 2005.

Map 2: Map of Rural and Urban Areas in Nebraska



Legend: "Rural" counties are shown in light green, "urban" counties in orange.

At the February 23, 2005, Nebraska CACFP sponsor meeting with NDE, the Administrator of Nutrition Services reported that no new information had been received regarding the upcoming pilot project. The Administrator promised she would notify the sponsors as soon as she received any additional information.

Several months later, on May 26, 2005, the Administrator issued an e-mail informing sponsoring organizations and NDE staff that the USDA had made its first request for future data for the NeRAED Pilot. A number of items were requested to be remitted, including (a) the number of day care homes located in rural areas as of September 30, 2005, (b) the number of day care homes in rural areas for FYs 2006 and 2007, (c) the number of day care homes that changed from tier II to tier I due to being located in the new 40-percent areas, (d) the names, addresses, and counties of the homes in the list above, and (e) a description of services provided to the children by the homes.

At the State's quarterly meeting with sponsors on June 22, 2005, sponsors were reminded that the NDE Administrator had e-mailed them the information that needed to be reported on the pilot project. Sponsors were informed that a new list of schools—including those meeting the 40-percent threshold--would be provided annually, that the pilot was for two years only, and that it would conclude at the end of FY 2007.

3.3 Implementation of the Pilot

In the first quarterly NDE/sponsor meeting after the pilot had commenced, held October 25, 2005, a staff member from Provider's Network reported a conversation with staff from the Food Research and Action Center (FRAC) that indicated reclassifying existing tier II homes to tier I as part of the pilot might be viewed as a "black mark," because the intention of the project was to add new low-income homes to the program rather than move currently participating homes to tier I status. There was a concern that the pilot might be discontinued if this occurred. The NDE Administrator replied that she had not heard such comments when meeting with the USDA.

A question was raised at the meeting about the number of providers in the State who were not participating in the CACFP; the response was that many approved homes were not participating and that NDHHS had not made available a list of these providers to the sponsors. It was also stated that some barriers remained with NDHHS to obtain information about approved homes. Sponsors reported the number of their reclassifications from tier II to tier I.[29]

In a letter dated October 28, 2005, the Family Service sponsor organization in Lincoln sent letters to inform affected providers that their locations had been determined to be within the boundaries of a particular school that had been placed on the 40- to 49-percent threshold list for the pilot. Providers learned that they would receive tier I rates for all program-eligible meals served to day care children effective October 1, 2005, and that the designation would remain in effect until September 30, 2007, or until the provider changed location.

Nearly six months later on March 1, 2006, NDE issued a news release with the title, "Rural Nebraska Child Care Providers May Receive Meal Reimbursements." NDE also enlisted the

[29] Although sponsors reported that 163 tier II providers in rural areas were reclassified to tier I status as a result of the pilot, administrative data indicate that 46 tier II providers and 80 mixed-tier providers were reclassified. These 126 providers represented approximately 11 percent of the 1,181 rural providers participating at that time.

support of school communities by asking principals to send letters home with the students with a flyer describing the pilot.[30]

Identification of 40-percent Areas for the Pilot

NDE staff used data on FRP meals from the 2004-2005 school year to identify rural areas meeting the 40-percent to 50-percent threshold at the beginning of the pilot. About four months after the pilot began, however, NDE notified the USDA Regional Office that it had mistakenly identified some counties as rural for the pilot when they were instead part of either the Lincoln or Omaha-Council Bluffs MSA. The State notified the affected sponsors, who determined that 16 providers had been classified erroneously as 40% tier I. These providers were reclassified as tier II providers beginning in January 2006.[31]

Identification of School Areas Eligible for Tier I Status

As previously noted, the NDE distributes a list of Nebraska school districts serving elementary students to its CACFP sponsoring organizations each year. The list includes the percentage of each school's enrollment certified for free or reduced-price (FRP) meals. Sponsors use these lists to identify which of their family day care providers are area-eligible for tier I reimbursement rates.

Prior to the pilot, the list of schools provided by NDE included only those with FRP percentages of 50 percent or greater. With implementation of the pilot, NDE expanded the list to include all schools with FRP percentages equal to or greater than 40 percent. At the beginning of School Year (SY) 2005-06, there were 832 "elementary" schools in the State,[32] of which 665 were located in rural areas. Under the 50-percent criterion, 179 rural elementary schools (26.9 percent of all rural elementary schools) met the area-eligibility criterion for tier I status; under the pilot's 40-percent threshold, an additional 78 schools (11.7 percent) met the criterion. Thus, as a result of the pilot, the number of rural elementary school areas eligible for tier I status immediately rose to 257 from 179, an increase of 43.6 percent.

Changes in School District Boundaries and Tiering Status

It is not uncommon for the percentage of FRP students in a school to fluctuate over time, and the NDE expected that, in the second year of the pilot, some elementary school areas that were below the 40-percent threshold in School Year (SY) 2005-06 would rise above the threshold in SY 2006-07. In addition to this normal fluctuation, however, the State of Nebraska reorganized its school districts at the end of SY 2005–06, converting separate districts for elementary and high schools to unified school districts. This reorganization resulted in changes in the attendance areas of schools serving elementary students. The NDE notified the sponsoring organizations of these changes in January 2007. Taken together, the reorganization and the normal fluctuation of percentage of students eligible for free or reduced-price meals led to the following changes:

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[30] Copies of the letter to principals and the flyer are presented as appendices D and E respectively.

[31] Correspondence from the Regional Office to FNS Headquarters on February 6, 2006. In the data extracts provided for the evaluation, sponsors did not include these 16 providers as 40% providers.

[32] "Elementary" schools are defined herein as schools serving children in the elementary grades, regardless of what other grades also may attend the school.

- Of the 179 rural elementary schools meeting the 50-percent threshold in SY 2005-06:
    - 18 schools (10.1%) dropped below the 50-percent threshold but remained above the pilot's 40-percent threshold for SY 2006-07;
    - 3 schools (1.7%) dropped below the 40-percent threshold;
    - 8 schools (4.5%) closed;
    - 3 schools (1.7%) became ineligible for determining tiering status because they no longer served elementary school children; and
    - the remaining 147 schools (82.1%) remained at or above the 50-percent threshold.

- Of the 78 rural elementary schools meeting the 40-percent threshold in SY 2005-06:
    - 20 schools (25.6%) rose to or above the 50-percent threshold for SY 2006-07;
    - 13 schools (16.7%) dropped below the 40-percent threshold;
    - 1 school (1.3%) closed;
    - 3 schools (3.8%) became ineligible because they no longer served elementary school children; and
    - the remaining 41 schools (52.6%) remained at or above the 40-percent threshold and below the 50-percent threshold.

Furthermore, 13 schools that were below the 40-percent threshold in SY 2005-06 rose above the threshold in SY 2006-07. Thus, over the two-year duration of the pilot, the total number of elementary school districts meeting the 40-percent, tier I threshold requirements was 91 (78 in the first year and 13 more in the second), or 13.7 percent of the 665 rural elementary school districts at the beginning of the pilot. Thirteen other 40% schools fell ***below*** the 40-percent threshold at the beginning of the second year, but existing providers in these districts continued to be eligible for tier I reimbursements until the end of the pilot. (Any new providers in these 13 school areas, however, did not qualify for tier I status based on area eligibility.)

Identification of License-Exempt Providers

The inclusion of license-exempt FDCHs in the CACFP might have affected the number of homes participating in the CACFP as tier I providers during the pilot. In early January 2006, the NDHHS provided NDE with a list of 2,100 day care providers in the State who were exempt from State licensing requirements. The NDE passed this information on to the seven CACFP sponsors, who used the list to recruit new providers into the CACFP program. To the extent that these license-exempt providers were located in urban areas, there would have been no likely impact on the pilot. A number of these license-exempt providers were located in rural areas, however, and sponsors were successful in recruiting a number of them into the CACFP. Chapter 4 examines the relative impacts of these license-exempt providers and the pilot on changes in the number of rural providers during the pilot.

Recruitment and Promotions

When the pilot was first announced, sponsoring organizations used a focused outreach to advertise the NeRAED Pilot, sending flyers to 70 targeted towns encompassed by the 40-percent school districts. According to initial interviews with sponsors, many devised different ways to communicate with providers in far rural areas. Information about the pilot was published in local newspapers and sponsor newsletters. The NDE supported the work of the sponsoring organizations as they communicated with providers; it served as the main source of information about the pilot. Quarterly meetings and availability via e-mail allowed an exchange of information between the sponsors and the NDE office.

Subsequent to the initial marketing effort, on October 1, 2006 (the start of the second year of pilot operations), five of the six participating sponsoring organizations formed the Nebraska Sponsors Expansion Consortium, a nonprofit, nonpartisan advocacy group that focuses on social issues within the State of Nebraska. Consortium sponsors pooled their financial resources in an attempt to increase awareness of the CACFP and participation in the 40-percent pilot project areas.[33] The sponsors thereafter began working with the Appleseed Center and developed a plan to publicize the CACFP and the NeRAED Pilot in rural communities. The Consortium pooled $37,000 of its recruitment funds for the publicity campaign, which included radio and television advertisements, newspaper articles, and mailings to school principals and home day care providers. Materials from the group of five sponsors were distributed on a common letterhead with all participating sponsors listed. None of the materials were identified as coming from one sponsor, and all information was reviewed and approved by all five of the sponsors prior to distribution. Inquiries for further information were referred to NDE, and materials were also available in Spanish.

In January 2007, the campaign referenced above began informing Nebraskans about the CACFP and NeRAED Pilot. Radio and television spots were widely aired with the tagline "Kids Benefit, You Benefit," and mailings were sent to 75 schools to educate parents about the CACFP.[34] The Consortium reported that all of the school principals to whom the letter was sent had an overwhelmingly positive response; they willingly distributed flyers to parents and were generally supportive and pleased to cooperate in any way.

A second round of marketing, with ads and public service announcements, began in April 2007. Sponsors were questioned about the perceived impact of these campaigns in post-pilot interviews, with sponsors reporting little apparent impact. It was thought that the campaigns generated some interest and that they had raised awareness, perhaps resulting in a discernable impact in the future. Sponsors generally reported that the overall time they had to inform the public and affect the intended outcomes for this pilot seemed severely limited. Startup time for the pilot did not allow for ample recruitment strategies that would effect a major change.

The NDE reported in excess of 50 calls received as a result of the public campaign.

[33] A copy of the Consortium's agreement is provided as Appendix C.

[34] A sample copy of the letter is provided as Appendix D.

The Nebraska Appleseed Center for Law in the Public Interest

The Nebraska Appleseed Center for Law in the Public Interest was integrally involved with the NeRAED Pilot. The Center formed partnerships with NDHHS and the WIC supplemental nutrition program offices in an effort to reach low-income families more effectively. In November 2006, the Appleseed Center conducted a training session for sponsors on working with low-income child care providers, in which it provided information about the pilot. Appleseed also employed a Congressional Hunger fellow, who worked closely with the sponsors. The Center completed a report on the NeRAED Pilot, which included provider case studies, with the goal of "facilitating the expansion of the [CACFP] program here and in other States."[35] The Center remained involved with the sponsoring organizations for the duration of the pilot.

3.4 Key Findings of the Process Study

Several important points about planning for and implementing the Nebraska Pilot have been presented in this chapter. Interviews and focus groups with sponsors, providers, and parents provided other information of use when assessing the results of this pilot. These key findings are listed below, organized by topic:

Preparations for the Pilot

- There did not appear to be any breakdowns in communications about the upcoming pilot among the parties involved. The USDA informed NDE that the pilot would take place via meetings and a letter; NDE informed its sponsoring organizations of the pilot at a quarterly sponsor meeting and by e-mail. Sponsors, in turn, informed their providers via mail and newsletters of the upcoming changes in eligibility determination and reimbursement.
- The NDE chose to define "rural area" as any county in the State that was not part of an MSA; "geographically isolated" areas within either of Nebraska's three MSAs (if any) were not treated as rural.[36]

Pilot Implementation

- As a result of the pilot, five of the six sponsoring organizations affected by the pilot collaborated and formed the Nebraska Sponsors Expansion Consortium, pooling their financial resources to create an extensive public relations campaign, including television and radio ads. Outreach letters were sent out to school principals, and flyers were published and distributed to parents and the general community. The Consortium also worked closely with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to inform their clients about the CACFP and the NeRAED Pilot.
- Most of the coordinated outreach effort did not occur until the second year of the pilot. The lack of time and adequate staff resources to devote to recruitment was seen as a challenge. Sponsors reported that they would have appreciated assistance with

[35] *Appleseed in Action* 1/19/07, "Young Public Interest Leaders Fight Hunger on the Plains."

[36] This pilot and its evaluation, therefore, cannot address what the impact of a 40-percent threshold for tier I eligibility would be in geographically isolated areas within urbanized areas.

monitoring and marketing of the pilot, including additional funding for recruitment activities.

Perceptions of Pilot Impacts

- Providers reported that their recruitment efforts were accomplished mostly via networking with other parents, neighbors, and friends.
- Although the CACFP added new family day care homes during the pilot, sponsors reported only small net changes in their numbers of providers, given steady exits and entries of providers into the program on a monthly basis.
- Providers expected that the pilot would have little impact on the number of children participating in the CACFP ***per provider*** because so many were already operating at "capacity" (either as defined by their State license or self imposed).[37]
- Providers thought that the pilot's larger, tier I reimbursements would be a motivating factor for inducing greater provider participation in the CACFP.
- Providers said that the higher reimbursements enabled them to serve a greater variety of foods at meal services and to purchase brand-name rather than generic products.
- A number of providers said they might leave the CACFP after the pilot ended and reimbursement levels returned to their lower, tier II status. This often-voiced expectation seemed to arise from two distinct factors: (a) the paperwork burden in CACFP is high and not worth the effort if reimbursements are based on tier II status; and (b) there is a lingering resentment at the reduction in reimbursements many providers experienced when USDA implemented tiering in 1996. Several sponsors also thought that some providers would leave the CACFP after the pilot ended.

The above results serve to inform the analyses that follow, especially the realization that coordinated recruitment efforts by the Nebraska Sponsors Expansion Consortium did not begin until October 2006, and that the Consortium's actual outreach efforts did not begin until January 2007—only nine months before the end of the pilot.

With regard to concerns that providers would stop providing day care or leave the CACFP after the pilot when their reimbursement levels returned to tier II levels, the study was not designed to collect data past the end of the pilot. Only 1.8 percent of respondents to the Provider Survey, however, said they would leave the CACFP if their reimbursements were reduced, and 18.8 percent said they did not know if they would leave or stay within the program. The remaining 79.4 percent of providers said they would remain in the CACFP, and the percentage was even higher in the group of 40% providers.

[37] Anticipating results to be presented in more detail in chapter 5, over 48 percent of providers responding to the Provider Survey said they were operating at capacity.

CHAPTER 4: PILOT IMPACTS ON NUMBER OF RURAL DAY CARE HOME PROVIDERS

This chapter uses administrative data collected from the NDE and the six CACFP sponsoring agencies participating in the NeRAED Pilot to address two of the evaluation's six research objectives:

> *Estimate the impact of the pilot on the number, types and sizes of family day care homes participating in the CACFP in designated rural areas of the State of Nebraska (Objective 2).*
>
> *Describe the geographic locations of participating family day care homes, including relative distance of site from urban centers or other major activity centers. Compare geographic locations and concentrations of family day care homes. (Objective 4)*

The administrative data available for the evaluation, however, do not include data on the sizes of family day care homes, as measured by the number of children under care. Descriptors of the size of family day care homes and a discussion of the pilot's possible impacts on provider size are presented instead in Chapter 5, whose analyses are based on data from the evaluation's Provider Survey.

4.1 Changes in Number and Type of Providers

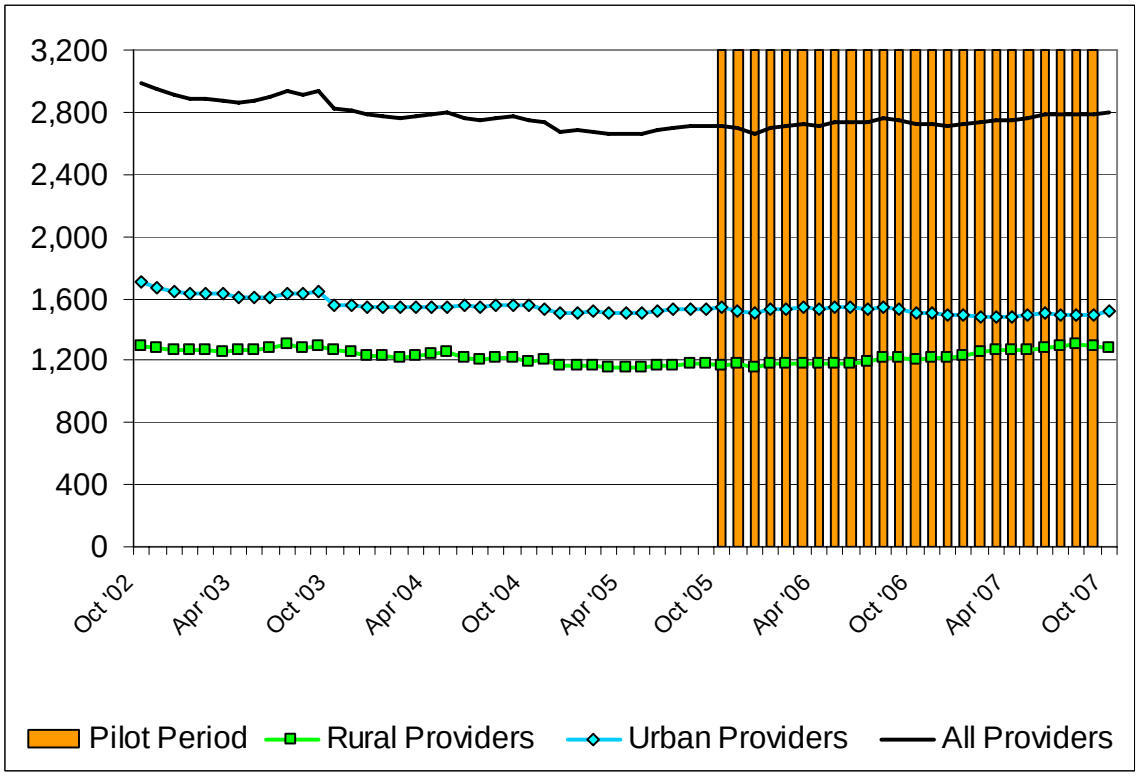
The number of rural Nebraska family day care home providers participating in the CACFP expanded by 123, or 10.5 percent, during the 24-month period of the NeRAED Pilot. During the same time period, the number of urban FDCH providers decreased by 45, or 2.9 percent.

To examine changes in the number and types of family day care home providers in Nebraska, monthly administrative data in the NDE database were obtained and supplemented with data from the sponsoring organizations. Just over five years of data were collected, extending from October 2002 through October 2007. Thus, the evaluation uses three years of data prior to the start of the NeRAED Pilot in October 2005, two years of data during the pilot, and one month of data following the end of the pilot in September 2007.

Numbers of Urban and Rural Providers

Graph 1 displays monthly counts of the total number of rural and urban FDCH providers in Nebraska during the 61-month period. Shaded vertical bars are used to designate the 24 months of the pilot beginning in October 2005 and ending in September 2007.

Graph 1: Number of Rural and Urban Providers, by Month



Source: NDE administrative data, 2002-2007.

The total number of day care providers in Nebraska, represented by the black line at the top of the graph, declined about 6.5 percent over the full 61-month period. From a peak of 2,992 providers in October 2002, the total number remained fairly constant through September 2003, dropped a bit and then held steady during the next 14 months (through November 2004), again dropped a bit and held fairly steady for the 10 months preceding the pilot, increased somewhat during the first 10 months of the pilot (through July 2006), and then vacillated until increasing and ending at 2,798 one month after the end of the pilot.

The first two rows of table 8 present the actual numbers. Overall, the average monthly number of providers throughout Nebraska was 2,911 from October 2002 through September 2003. The number dropped an average of 4.7 percent (to 2,775 providers) from October 2003 through November 2004, dropped another 3.3 percent (to an average of 2,683 providers) from December 2004 until the start of the pilot, increased 1.1 percent (to an average of 2,711 providers a month) during the first 10 months of the pilot, and increased another 1.5 percent (to an average of 2,752 providers) during the final 14 months of the pilot. Over the 60 months covered in the table (the one month following the pilot is too short to establish a trend), the total number of FDCH providers in Nebraska declined by 202 (6.8 percent), with most of that decrease occurring during 2002 and 2003. During the 24 months covered by the NeRAED Pilot, the total number of providers increased by 78 (2.9 percent).

Table 8: Average Numbers and Growth Rates of Urban and Rural Family Day Care Home Providers in Nebraska During 2003–2007

	Periods of Relative Change or Stability						
	Oct 02 – Sept 03	**Oct 03 – Nov 04**	**Dec 04 – Sept 05**	**Oct 05 – July 06**	**Aug 06 – Sept 07**	**Oct 02 – Sept 07**	**Pilot Period**
Total	2,911	2,775	2,683	2,711	2,752	-202	74
Change		*-4.7%*	*-3.3%*	*1.1%*	*1.5%*	*-6.8%*	*2.7%*
Rural	1,276	1,228	1,166	1,178	1,252	7	113
Change		*-3.8%*	*-5.0%*	*1.1%*	*6.2%*	*0.5%*	*9.6%*
Urban	1,636	1,547	1,517	1,533	1,500	-209	-39
Change		*-5.4%*	*-2.0%*	*1.0%*	*-2.1%*	*-12.3%*	*-2.5%*

Notes: The time periods in the first four columns vary in duration to match periods of relative change or stability in the numbers of family day care home providers in Nebraska (as identified by graph 1). The last two columns cover time periods that overlap with one another and with some of the other columns in the table.

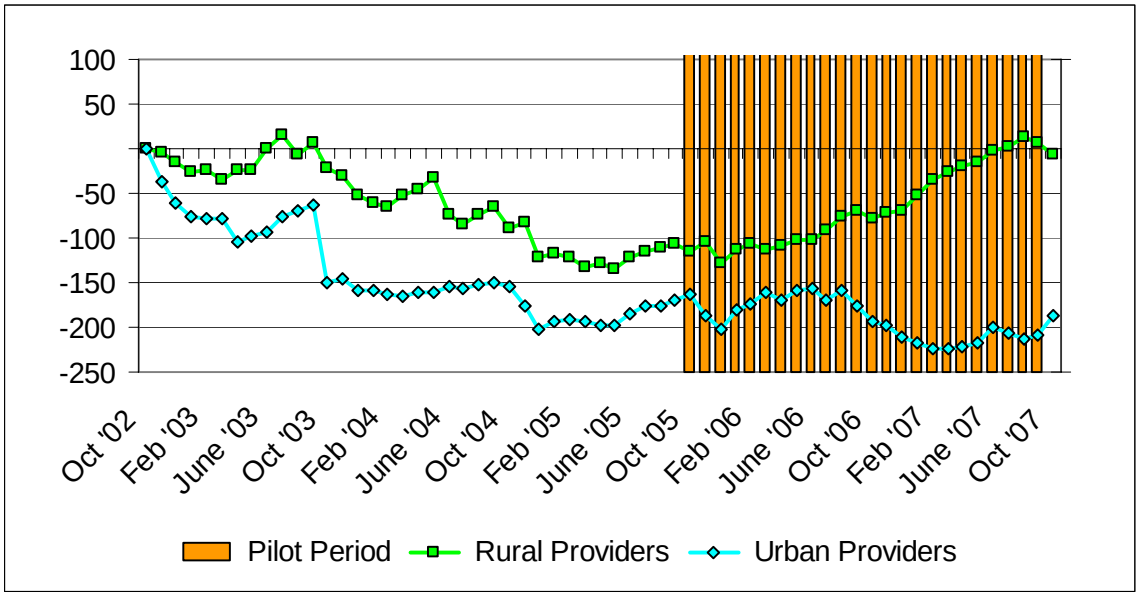
Source: NDE Administrative data, 2002-2007.

Graph 1 and table 8 also show the patterns of decline and growth separately for urban and rural providers (lines with "diamonds" and "squares," respectively). From October 2002 through July 2006 (10 months after the start of the pilot), the patterns of change for urban and rural providers were similar to one another, and their lines in the graph therefore closely mirror the pattern for all providers. This is also seen in graph 2, which displays ***changes*** in counts of urban and rural providers over the full 61-month period relative to provider counts in October 2002. Urban providers experienced a larger decline in numbers (5.4 percent) than rural providers (3.8 percent) in the October 2003 – November 2004 period, but rural providers declined more (5.0 percent) than urban providers (2.0 percent) the following period.

During the first 10 months of the pilot, both urban and rural providers experienced about a 1-percent gain in average monthly counts. Thereafter, however, the numbers of rural and urban providers followed very different pathways. The average monthly number of rural providers increased 6.2 percent to 1,252 during the last 14 months of the pilot, whereas the average monthly number of urban providers declined 2.1 percent to 1,500.

Over the full two-year period of the pilot, the total number of rural FDCH providers in Nebraska increased by 123, from 1,171 in October 2005 to 1,294 in September 2007. This 10.5-percent gain in rural providers contrasts with a 2.9-percent decline in urban providers, whose numbers fell from 1,541 in October 2005 to 1,496 in September 2007. The net change was an increase of 78 providers. As noted in chapter 3, the sponsoring organizations reported only "slight" overall changes in their numbers of providers, given steady exits and entries of providers into the program on a monthly basis. This is perhaps not surprising as most of the sponsors operate in both rural and urban areas of the State. The gain of 123 providers in rural areas represents a net increase of less than 5 percent in the ***total*** number of providers (both urban and rural) being sponsored over the two-year period.

Graph 2: Change in Number of Urban and Rural Providers in Nebraska since October 2002



Note: Vertical axis measures the ***change*** in number of providers from the starting point. For example, urban providers (diamond line) started at 1,705 in October 2002 and, by June 2003, had decreased a net amount of 93 providers (to 1,612). Rural providers (green line with squares) started at 1,287 in October 2002 and, by June 2003, had decreased a net amount of only one provider (to 1,286).

Source: NDE Administrative data, 2002-2007.

Tiering Status of Rural Providers

In September 2005, the month ***prior*** to the start of the NeRAED Pilot, the NDE database had 1,181 rural providers listed as active. Of these 1,181 providers, 56.3 percent were tier I, 15.0 percent were tier II, and 28.7 percent were mixed-tier.[38] The next month there were 1,171 active, rural providers: 51.8 percent were non-40%, 9.4 percent were tier II, 20.0 percent were mixed-tier, and 18.8 percent were in the new category of 40% providers.[39] Graph 3 shows these percentage compositions as pie charts. Together, the tier II and mixed-tier providers (i.e., the not-tier I providers), represented 43.7 percent of the September providers and 29.4 percent of the October providers.

There were 220 providers in the 40% group in October 2005. They were drawn from:

- 87 providers who were already tier I (representing 40 percent of the total group of 40% providers)
- 46 tier II providers (21 percent)
- 80 mixed-tier providers (36 percent), and

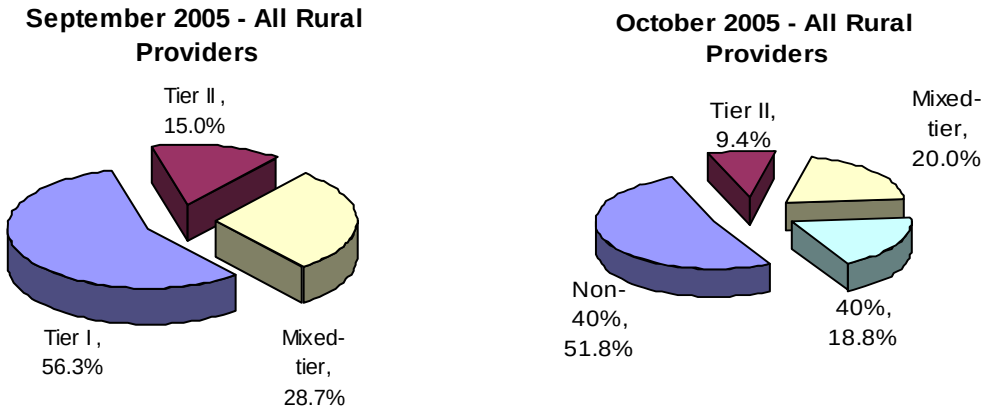
[38] Identification of each provider's tiering status is based on information in both the NDE and sponsor databases, as described in chapter 2.

[39] The net decline of 10 providers from September to October 2005 resulted from 35 providers who departed the CACFP at the end of September and 25 providers who joined the Program.

- 7 new providers (3 percent).

Thus, 126 of the 220 40% providers at the start of the pilot (57 percent) were tier II or mixed-tier the month before, explaining their drop in overall provider composition in graph 3.[40] There is no information on what the status of the 7 new providers would have been in the absence of the pilot.

Graph 3: Composition of Two Groups of Providers



Source: NDE Administrative data, 2005-2007.

Table 9 provides more detail on the changes in tiering status as the NDE implemented the pilot. Whereas the percentages presented in the bullets above represent the ***components*** of the 220 40% providers at the beginning of the pilot, the provider counts and percentages in table 9 show what happened to the tiering status of providers between September and October 2005. Thus, for instance, 13 percent of tier I providers in rural Nebraska became 40% providers in October 2005 (their reimbursement levels did not change because they were already tier I). Nearly three-quarters (74 percent) remained non-40% tier I providers, with 1 percent converting to tier II, 9 percent converting to mixed-tier, and 3 percent leaving the program.

The remainder of the table reveals that, of the 177 tier II rural providers in September 2005, sponsors converted 26 percent of them to 40% status at the start of the pilot; sponsors also converted 24 percent of the 339 mixed-tier providers to 40% status.

[40] Of the 220 40% providers, 14 (6.4 percent) were license-exempt. Two of the 14 license-exempt providers were new to the CACFP in October 2005, 8 had been tier I prior to the pilot, two had been tier I, and two had been mixed-tier.

Table 9: Tiering Status of Rural Providers in September and October, 2005

Tiering Status in September 2005	Tiering Status in October 2005					
	40%	Non-40%	Tier II	Mixed	Leavers	Total
Tier I Number	87	494	4	58	22	665
Tier I Percent	13%	74%	1%	9%	3%	100%
Tier II Number	46	5	95	22	9	177
Tier II Percent	26%	3%	54%	12%	5%	100%
Mixed Number	80	94	10	151	4	339
Mixed Percent	24%	28%	3%	45%	1%	100%
Total	213*	593	109	231	35	1181

Note: * There were 220 40% providers in October 2005. This table does not include the 7 that were new to the program that month because we do not know what tier they might have been had they participated prior to the pilot. There also were 14 new providers in the non-40% group, 1 in tier II, and 3 in mixed-tier, for a total of 25 providers new to CACFP in October 2005. With 25 new providers and 35 departing providers, the total number of providers in October 2005 was 1,171.

Source: NDE Administrative data, 2005-2007.

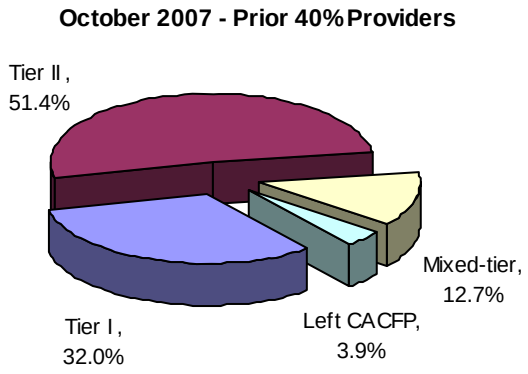
Change in the Number of 40% Providers

Starting at 220 in October 2005, the number of 40% providers climbed steadily through the first 18 months of the pilot, reaching a maximum of 291 providers in March 2007. The number of 40% providers dropped a little after March 2007, ending at 284 providers at the conclusion of the pilot in September 2007. Throughout the 24 months of the pilot, 335 different providers participated as 40% providers. This number includes the 213 providers

who were converted to 40% status in October 2005, the 7 new providers in October 2005, and 115 new entrants into the CACFP as 40% providers after October 2005.[41]

The available data do not allow one to determine whether any of the 122 (i.e., 115 plus 7) new 40% providers during the pilot would have qualified for tier I status on the basis of income-eligibility in the absence of the pilot.[42] In October 2007, the month after the pilot, about 32 percent of the 284 remaining 40% providers continued as tier I providers (graph 5). An unknown percentage of these providers, however, may have changed tiering status in subsequent months as State and sponsoring organization databases were updated. It is also possible that providers who changed to tier II or mixed-tier status in October 2007 might have thereafter submitted paperwork documenting their income eligibility for tier I reimbursements, and others might have decided to leave the CACFP. Thus, the evaluation data do not permit a determination of any long-term effects of the end of the pilot on provider behavior.

Graph 5: Destination of 40% Providers at the End of the Pilot



Source: NDE Administrative data, 2005-2007.

4.2 Geographic Locations of Rural Providers

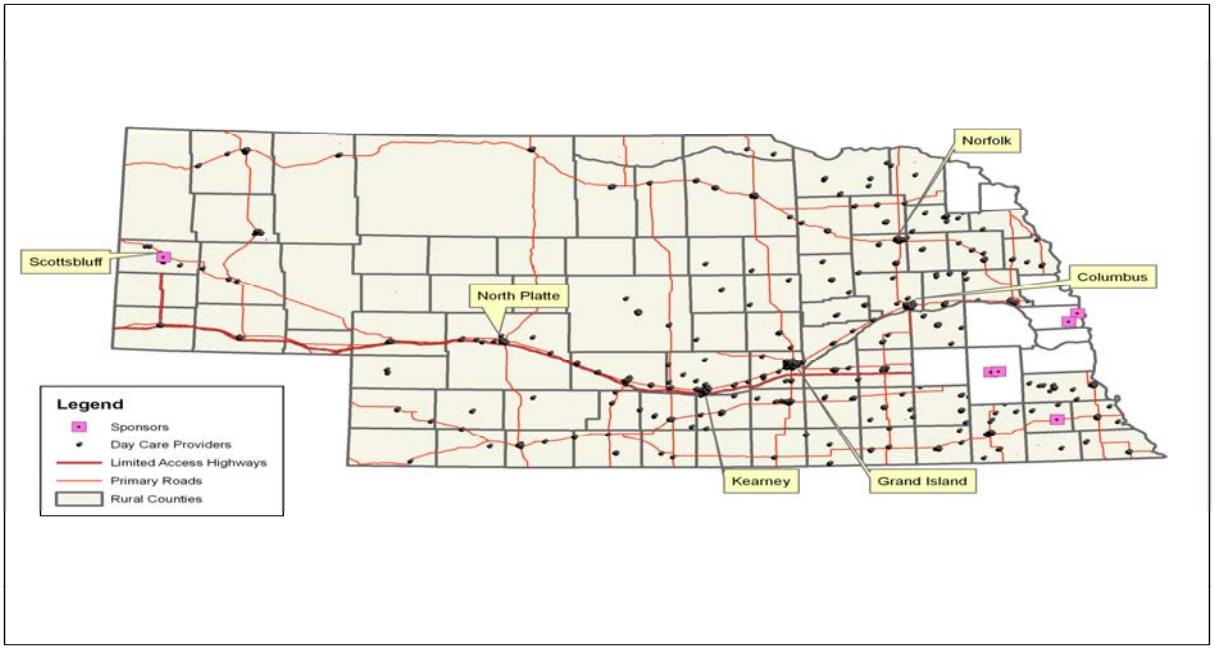
Using address information from the NDE database, the evaluation mapped the geographic locations of all rural family day care homes. Most of the homes are concentrated in rural towns and small cities close to transportation routes. There are not many family day care homes participating in the CACFP from the most rural areas of Nebraska, particularly the north-central part of the State. These are also the poorest and most rural areas of the State, as measured by data from the 2000 Census.

[41] There were actually 116 instances of a provider joining the CACFP as a 40% provider after October 2005, but one of the providers rejoined after a short spell of inactivity. There were a total of 335 ***unique*** 40% providers during the pilot.

[42] The 120 new 40% providers include the 7 providers that joined the CACFP in October 2005. Thus, of the 333 providers who were ever 40% providers, 213 were active in September 2005, 7 joined in October 2005, and 113 joined the CACFP thereafter.

Map 3 shows the locations of all rural family day care homes in Nebraska that were active both at the start of the NeRAED Pilot in October 2005 and in August 2007,[43] the date of the administrative database used to create the maps in this chapter. The map shows the geographic location of these rural providers relative to population centers and the transportation network. The blue lines in the map show county boundaries. The red line crossing east-west is Interstate 80. Primary and secondary roads are shown as indicated in the legend. Several of the larger towns and small cities in rural Nebraska are marked. The nine urban counties in the eastern part of the State have been blanked out because only rural areas were eligible for the pilot, and the NDE defined rural areas as non-metropolitan counties. The only information shown for urban counties is the locations of four of the six sponsor organizations that participated in the pilot (originally presented in chapter 3); the other two sponsor organizations are located in rural counties.

Map 3: Location of Family Day Care Home Providers in Rural Nebraska Prior to the Start of the NeRAED Pilot



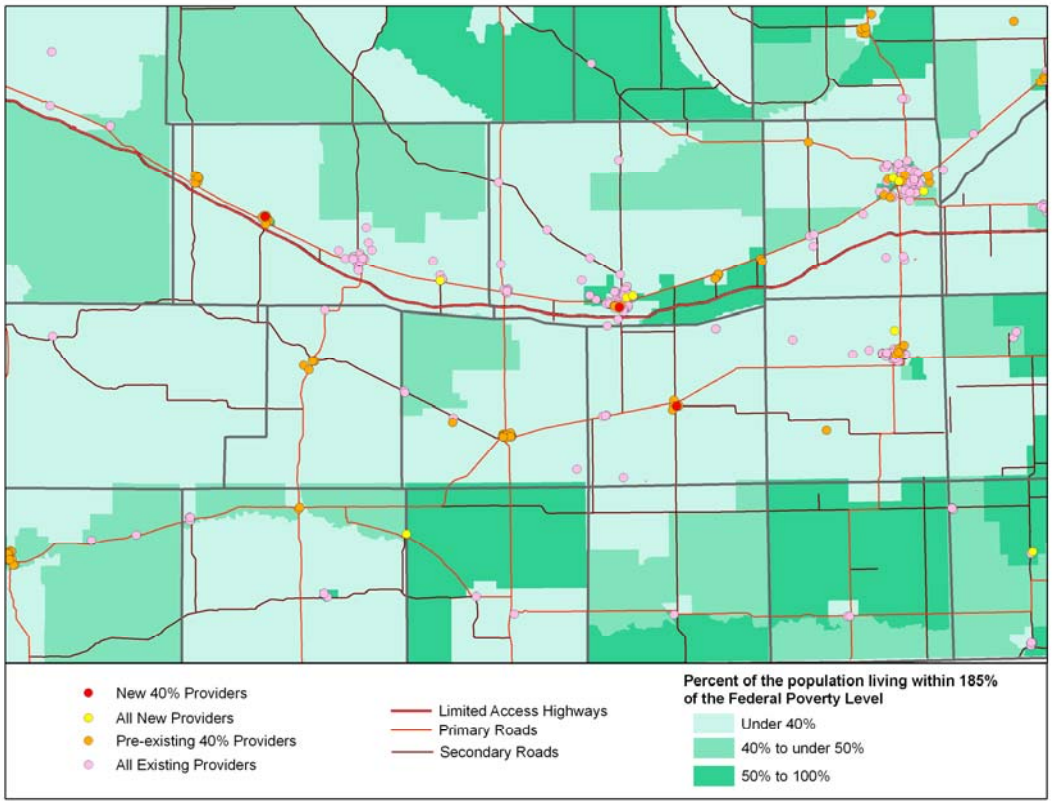
Note: Locations on the map with black dots represent 1,181 family day care home providers; some dots represent more than one provider.

Map 4 displays a close-up of a centrally located region of the State along Interstate 80 that contains the towns of Kearney and Grand Island. This map differs from map 3 in several respects besides scale. First, Bureau of the Census information on level of poverty has been

[43] The map does not display any providers active in September 2005 who left the Program before August 2007. Administrative records indicate that there were 479 such providers, compared to the 1,181 providers active in September 2005.

added at the census block group level.[44] As indicated in the legend, the three shades of green indicate census block groups with varying percentages of the population living within 185 percent of the Federal Poverty Level (FPL). The deepest shade of green shows areas where 50 percent or more of the population is below the 185-percent FPL threshold, and the medium shade shows block groups where 40 to 50 percent of the population is below the threshold. The lightest shade is for areas with less than 40 percent of the population in poverty. Thus, the breakpoints for the shading match the pilot's area-eligibility rules for tier I status.

Map 4: Location of Family Day Care Home Providers in Central Region of Rural Nebraska Prior to the Start of the NeRAED Pilot



Another difference between maps 3 and 4 is that the dots showing provider locations are color-coded in map 4 to reflect their tiering status (i.e., tier I as a result of the 40-percent threshold or not) and date they joined the CACFP (i.e., before or during the pilot). The orange and red dots indicate providers in areas that qualified for 40-percent area eligibility during the pilot, with orange dots representing "pre-existing" providers active before the start of the pilot and red dots representing "new" providers who joined the CACFP after the pilot started.[45] The pink and yellow dots represent, respectively, all "other" pre-existing and new

[44] A census "block group" is a cluster of census blocks having the same first digit of their four-digit identifying numbers within a census tract.

[45] The CACFP start date in the mapping file includes only year, not month, so providers starting in 2006 and 2007 are considered "new" for this analysis and providers starting in 2004 or earlier are considered "pre-

providers ("other" contains 50% tier I providers, income-eligible tier I providers, tier II providers, and mixed-tier providers).

Although map 4 is meant primarily to be illustrative of the distribution of providers in rural Nebraska, it is notable that there is little correspondence between the location of the red and orange dots (the 40% providers) and the census block groups with a medium shade of green (areas with 40 to 50 percent of the population below 185 percent of the FPL). Recall that the 40-percent areas for the pilot are defined by school boundary areas in which from 40 to 50 percent of students are certified eligible for free- or reduced-price meals. The lack of correspondence between the school- and census block group-defined areas simply demonstrates that small pockets of relative poverty (e.g., at the scale of catchment areas for schools serving elementary students) can exist within larger areas of less poverty.[46]

The reader will also note more provider dots in individual small towns in map 4 than in map 3, as detail is lost in the statewide maps. We have provided multiple maps to ensure that all necessary data are available in the report, even though this imposes somewhat more burden on the reader to compare maps to one another instead of dot locations on a single map.

Map 5, which repeats map 3, adds in the background shades of green indicating relative levels of poverty. Secondary roads have been deleted from this and subsequent maps to make them easier to read.

Map 5 shows multiple areas of individual or contiguous census block groups that are shaded medium green (i.e., 40 to 50 percent of the population with incomes less than 185 percent of the FPL), and many of them had very few or no family day care home providers at the start of the pilot.[47] There are also many dark green areas with few or no providers, suggesting that the poorer sections of rural Nebraska may not have been well served by family day care homes participating in the CACFP prior to the pilot.[48] In contrast, most of the dots in map 5 fall in census block groups where less than 40 percent of the population has an income below 185 percent of the FPL.

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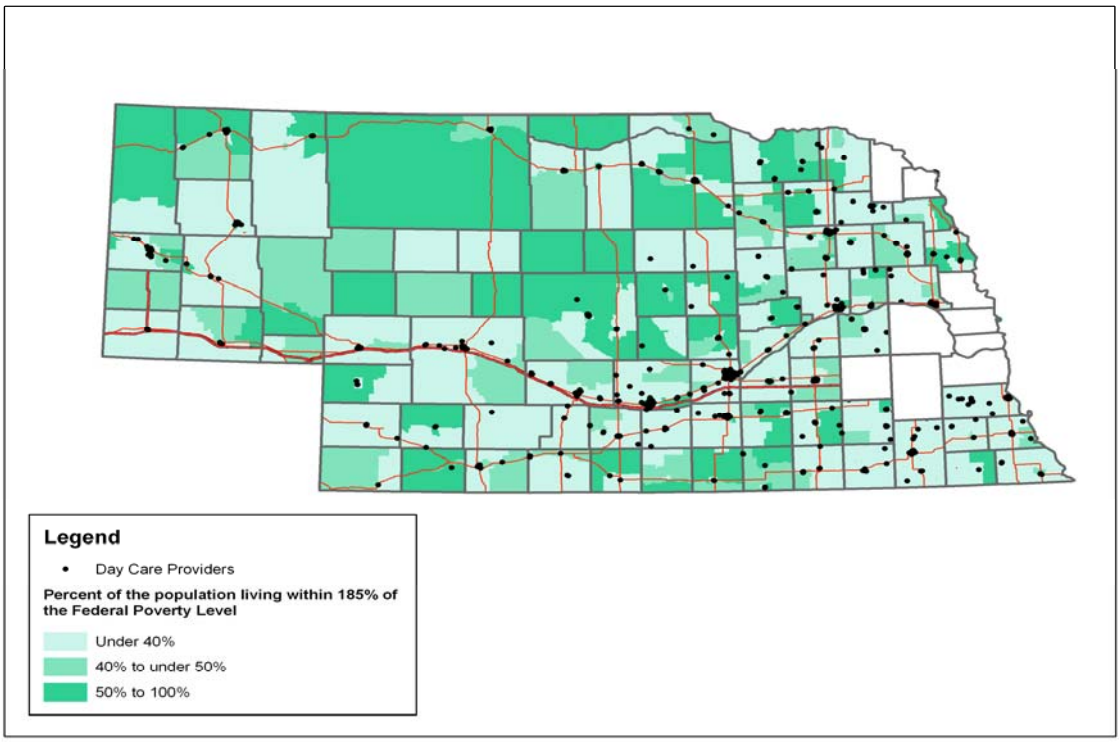
existing." There was no way to ensure that providers starting in 2005 were correctly assigned to "pre-existing" and "new" categories because the pilot started three-quarters of the way through the calendar year. To minimize any errors in classification, all providers starting in 2005 are treated as "pre-existing." Thus, approximately one-quarter of the 2005 starters are likely misclassified as "pre-existing" rather than "new." Because the number of new 40% providers was low in the initial months of the pilot (as noted in graph 2), it is unlikely that this approach has affected the maps presented herein in a substantive way. It is important to note that the other analysis in this chapter are based on dates that include both month and year, so they encountered no problems in identifying new providers after the start of the pilot.

[46] It also suggests that the pilot might have increased the number of 40% providers further had census-based area-eligibility thresholds been used as well as the school-based threshold.

[47] Recall, however, that approximately 480 providers that were active just prior to the start of the pilot quit the CACFP before August 2007 and, therefore, are not included in the map. An unknown number of these missing providers may have been located in areas not served by the providers that are shown on map 5.

[48] Data are not available to measure the demand for family day care services relative to the supply of such services in areas with few or no providers.

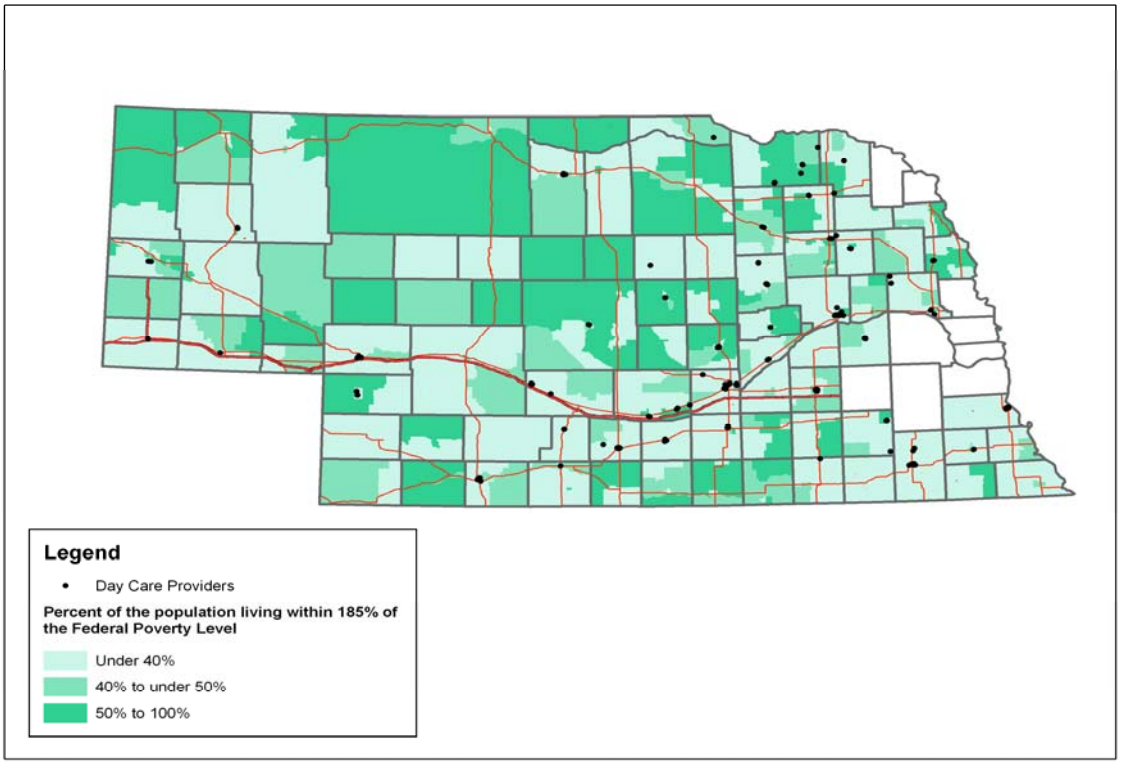
Map 5: All Rural Providers Prior to the Start of the NeRAED Pilot



Note: Locations on the map with black dots represent 1,181family day care home providers; some dots represent more than one provider.

Map 6 shows the location of the 213 pre-existing providers who became 40% providers at the start of the pilot, although only about 55-65 individual dots can be identified on the map at this scale and resolution. The remaining providers are located close enough to other providers that their locations cannot be uniquely mapped. About 11 of the provider dots in map 6 are located in or very near the highest poverty census block groups, and another ten or so are located in or very near the medium-shaded areas depicting 40-50 percent of the population below 185 percent of the FPL. Thus, most of the pre-existing 40% providers (i.e., the remaining 40 or so dots) are located in areas of lowest poverty on the maps. Nevertheless, many are located away from the larger population centers in rural Nebraska and therefore served some of the least densely populated areas of the State—a key objective of the pilot.

Map 6: Locations of Pre-existing 40% Providers



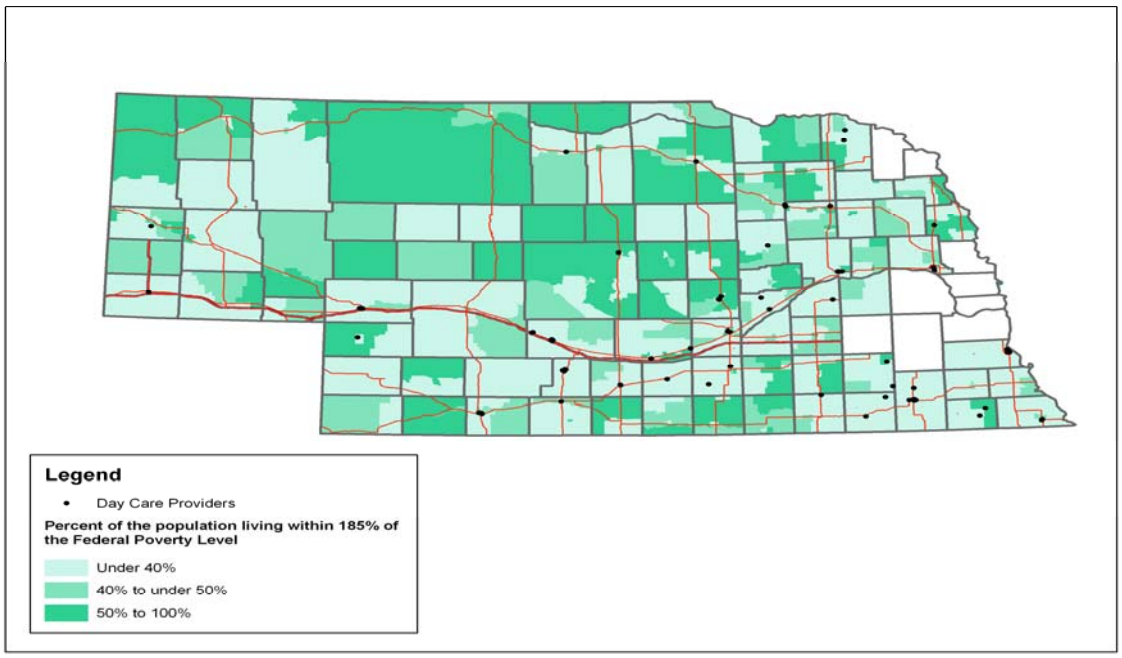
Note: Locations on the map with black dots represent 213 family day care home providers; some dots represent more than one provider.

Map 7 shows the locations of the 122 providers in 40-percent areas who joined the CACFP at or after the start of the pilot. Approximately 50 individual dots may be seen on the map, indicating that many of the dots represent two or more providers. Most of the newly added providers are located close to where the pre-existing providers resided, although there are about 10 provider dots on map 7 that have no corresponding pre-pilot dots on map 6. Of course, even in areas that had CACFP providers prior to the pilot, the addition of more program providers in the same or nearby areas would be of value if demand for day care services in these areas exceeded the supply.[49]

Finally, map 8 completes this section by showing the locations of all new providers during the pilot who were not in 40-percent areas (i.e., the combination of non-40% providers and not-tier I providers). There were about 450 such providers by August 2007, but only 140-145 individual dots can be seen on the map. About 15 of the provider dots in map 8 are in areas not served by pre-existing providers in map 5.

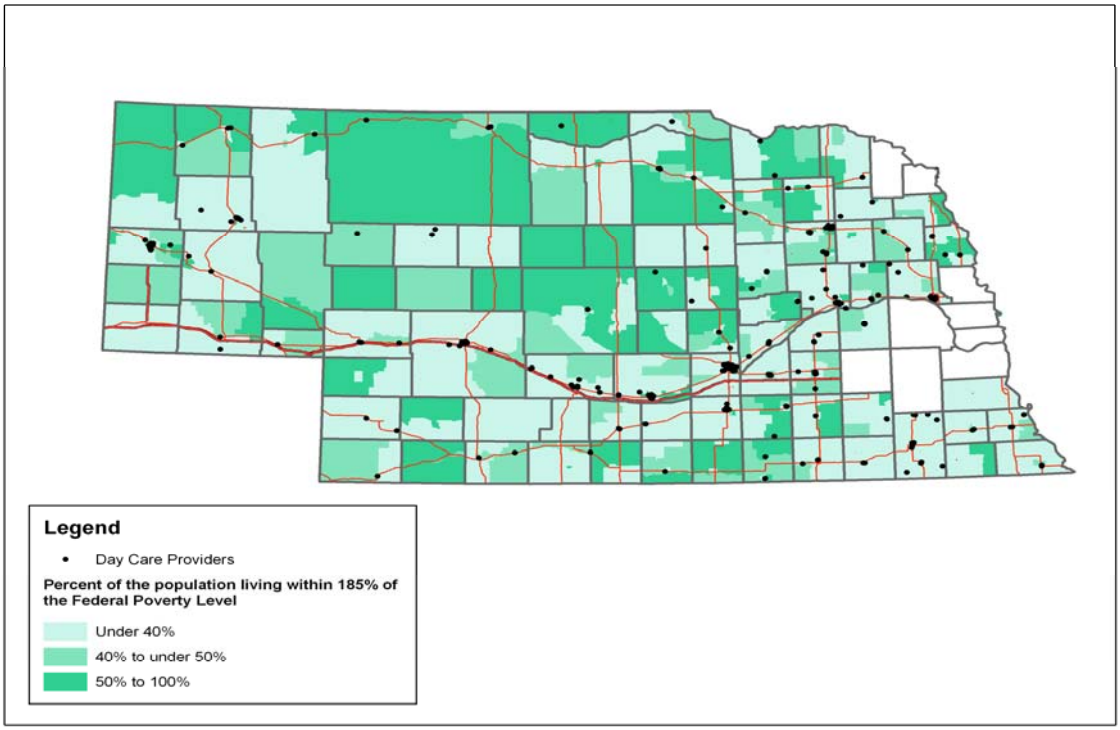
[49] Chapter 5 will present survey evidence that over 51 percent of all 40% providers near the end of the pilot had waiting lists, demonstrating the demand for day care services in these areas of rural Nebraska.

Map 7: Locations of 40% Providers Who Joined the CACFP During the Pilot



Note: Locations on the map with black dots represent 122 family day care home providers; some dots represent more than one provider.

Map 8: Locations of All Other Providers Who Joined the CACFP During the Pilot



Note: Locations on the map with black dots represent approximately 450 family day care home providers; some dots represent more than one provider.

4.3 Impacts of the Pilot on the Number of Rural Providers

The previous two sections of the chapter have shown that:

- The number of FDCH providers in rural Nebraska increased by 123 during the 24 months of the pilot—an increase of 10.5 percent compared to the 1,171 rural providers active in October 2005. During the same time period, the number of urban providers fell by 45, or 2.9 percent.

- Changes in the numbers of rural and urban providers in Nebraska have been similar to each other for most of the five years of monthly data examined for this evaluation. It was not until September 2006—about halfway through the two-year pilot—that the patterns of month-to-month change in provider counts diverged substantially for the urban and rural providers.

- In the first month of the pilot, sponsors identified 220 providers as eligible for tier I status on the basis of being located in a 40-percent FRP threshold area. Forty percent of these providers had previously qualified for tier I status based on income standards (either their own or that of their children's families), and 57 percent switched to tier I from tier II or mixed-tier status as a direct result of the pilot. Seven of the 220 providers (three percent of the total) were new to the CACFP as of October 2005.

- During the subsequent 23 months of the pilot, 115 additional providers qualified for tier I status because they resided in a 40-percent area.[50] Most of these new providers were located in or near geographic areas already being served by CACFP providers.

The question for the evaluation was whether the increase in rural providers was attributable to the pilot, or did other factors not related to the pilot cause the increase? As detailed below, it appears that the NeRAED Pilot was responsible for much of the increase in rural providers during the pilot, but for an unexpected reason. Specifically:

> *The evidence suggests that the pilot did not cause more providers to **join** the CACFP than would otherwise have been expected. Rather, the pilot appears to have induced existing providers in 40-percent areas to **remain** in the CACFP longer than they otherwise might have.*

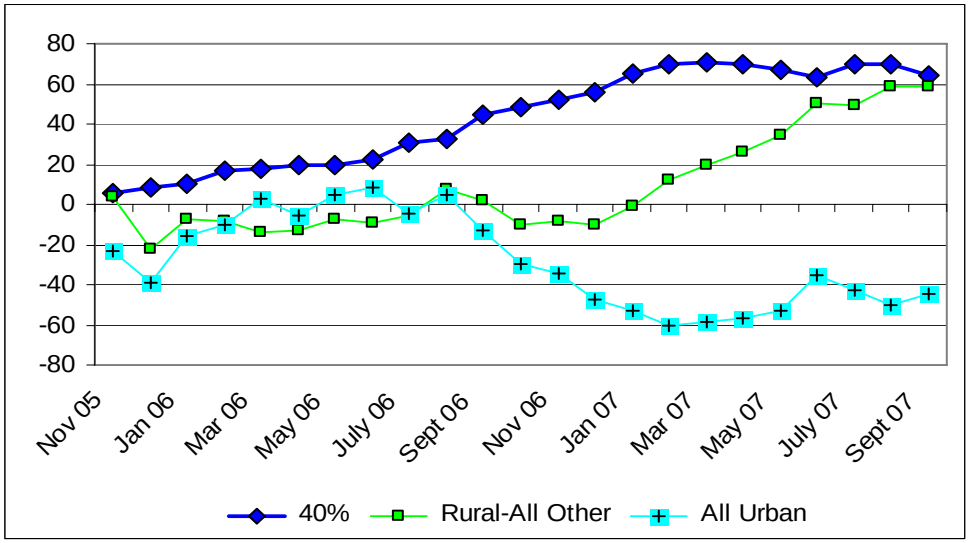
Changes in Number of Providers During the Pilot

Graph 6 shows the cumulative ***change*** in the number of rural and urban providers during the 24 months of the pilot; rural providers are separated into those residing in 40-percent areas and all others. The number of 40% providers rises almost continually until March 2007, when the graph peaks at 71 more providers than the 220 starting in October 2005; it ends at a positive value of 64. The cumulative change in urban providers drops to a value of negative 60 by February 2007, but then rebounds and ends at a negative 45. Interestingly, although the number of all other rural providers (i.e., all the rural providers except the 40% providers)

[50] Some of these 115 additional providers may have been able to qualify for tier I status on the basis of their own income, but the evaluation has no information to identify how many.

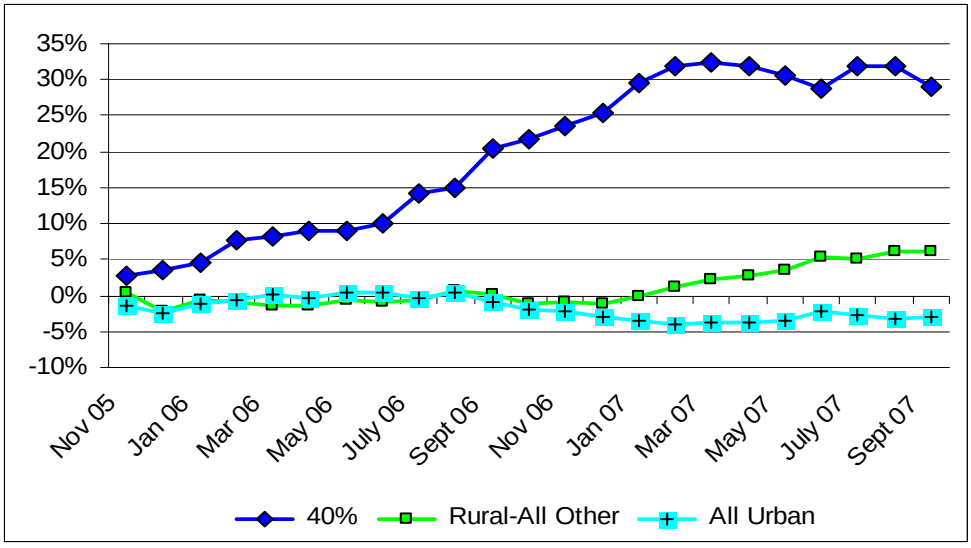
changed very little from October 2005 through December 2006, the number began to rise quickly beginning in January 2007, ending at a positive value of 59 at the end of the pilot. Thus, the ***number*** of 40% providers increased only slightly more (64) during the two-year period than did the number of all other rural providers (59). When presented on a percentage basis, however (graph 7), it is clear that the 40% providers experienced the greatest growth ***rate*** during the pilot: 29.1 percent, versus 6.2 percent for all other rural providers and a

Graph 6: Cumulative *Numerical Change* in Number of Providers after October 2005



Source: NDE Administrative data 2005-2007.

Graph 7: Cumulative *Percentage Change* in Number of Providers after October 2005



Source: NDE Administrative data 2005-2007.

negative 2.9 percent for urban providers. This is reasonably strong evidence that it was the pilot that acted to increase the number of rural FDCH providers during the Nebraska pilot.

Entrances into the CACFP

By lowering the percent-FRP threshold for tier I eligibility in rural areas, the evaluation hypothesized that the NeRAED Pilot would encourage more providers to join the CACFP through two mechanisms. First, by offering higher reimbursement levels for providers, the pilot was expected to increase provider demand for joining the CACFP. Second, by encouraging more providers to join in areas with dispersed providers, the pilot was expected to increase the willingness of sponsoring organizations to sponsor new rural providers. That is, with more providers located in a given geographic radius, multiple providers could be visited during a single monitoring trip to the area, thereby lowering the sponsor's administrative costs on a per-provider basis.

Table 10 presents the percentages of providers, by group, who were new to the CACFP during the pilot period. For example, there were 220 40% providers active in October 2005, and another 115 providers in 40-percent areas joined the CACFP thereafter. The 115 new providers during the pilot represent 52.3 percent of the base of 220 providers active at the start.[51] This percentage is lower than the 60.8-percent rate for non-40% tier I providers in

Table 10: Percentage of Providers Who Were New During the Pilot

Area of State and Provider Base	Number of Providers in October 2005 (Base)	Number of New Providers During Pilot	New Providers as a Percentage of the Base
Rural			
40%	220	115	52.3%
Non-40% Tier I	607	369	60.8%
Not Tier I	344	142	41.3%
All Rural Providers	1171	626	53.5%
Urban			
Tier I	837	448	53.5%
Not Tier I	704	226	32.1%
All Urban Providers	1541	674	43.7%

Note: Number of new providers excludes providers who joined the CACFP in October 2005—the first month of the pilot. This measure also ignores multiple openings by the same provider during the period.

Source: NDE Administrative data 2005-2007.

[51] The seven 40% providers who were new to the CACFP in October 2005 are treated as part of the base and not counted as "new" providers in this analysis. The same treatment is used for all provider groups in the table.

rural areas, and it is similar to the 53.5-percent rate for tier I providers in urban areas. From the data in this table, it is difficult to conclude that the pilot encouraged new providers into the CACFP. If it had, one would expect to have seen a higher percentage for new providers within the 40-percent areas.

Departures from the CACFP

Table 11 shows the numbers and rates of providers departing the CACFP during the pilot, by provider group.[52] The 40% provider group is notable in the table for its low rate of departures (23.6 percent) relative to all other groups in the table. For instance, other rural, tier I providers (i.e., the "Non-40% Tier I" group) had a departure rate of 53.5 percent, and tier II and mixed-tier providers (i.e., the "Not Tier I" group) had a departure rate of 44.8 percent. Overall, rural and urban providers had similar departure rates over the two years—about 46 to 47 percent.[53]

Table 11: Percentage of Providers Who Left the CACFP During the Pilot

Area of State and Provider Status	Number of Providers in October 2005 (Base)	Number of Providers That Left	Departing Providers as a Percentage of the Base
Rural			
40%	220	52	23.6%
Non-40% Tier I	607	308	53.5%
Not Tier I	344	146	44.8%
All Rural	1171	506	46.4%
Urban			
Tier I	837	467	55.8%
Not Tier I	704	254	36.1%
All Urban	1541	721	46.8%

Note: Excludes closures in October 2007.

Source: NDE Administrative data 2005-2007.

While it is not possible to conclude from the findings that that the NeRAED Pilot ***caused*** providers in 40-percent areas to remain in the CACFP longer, given the design of the

[52] The evaluation has no information on the number of providers who left the CACFP but continued to provide child care versus those that left the day care business altogether.

[53] Note that these departure rates are for those providers active in October 2005. If a provider joined the CACFP in, say, May 2006 and then left the Program in the fall of the same year, he or she would not be counted in either the base or the departures in table 11.

Nebraska pilot[54], the rates in table 11, suggest that providers in the 40-percent areas of rural Nebraska were less likely to depart the CACFP than they would have been had the pilot not been implemented.

There is a plausible logic linking these two findings. There are obstacles to overcome if someone wants to start a family day care home or to enroll an existing home in the CACFP. For the former, appropriate space for taking care of children needs to be created, a state license often has to be obtained, procedures and policies have to be developed, and children need to be recruited. For the latter, an existing provider has to learn about the CACFP, find a sponsor, learn about program rules governing eligibility and menu planning, accept monitors into the home periodically, and maintain proper paperwork. Tier I reimbursement rates are more of an economic incentive to join the CACFP than are tier II rates, but even the tier I rates may not be enough of an economic inducement for some providers to join the CACFP.

For providers already in the CACFP, however, the "cost" of staying in the program is relatively low. For example, although program providers need to continue planning and serving nutritious meals and snacks and maintaining their daily CACFP paperwork, these are tasks that providers already have learned. Furthermore, even though staying in the program means that a provider still has to accept unannounced visits from the sponsor, existing providers have learned how to deal with these monitoring visits, and many may have established good working relationships with their sponsors. *In this environment, postponing a decision to leave the CACFP may be more strongly influenced by increased reimbursements than the decision to enter the Program.*

This hypothesis is consistent with the decisions made by 40% providers in Nebraska under the pilot. Table 12 displays, for providers active in October 2005, the average number of months they were active during the 24-month pilot and the percentage of providers within selected groups who were active throughout the entire pilot. The 40% providers were the most likely group to remain active throughout the entire pilot (86.8 percent), and they had the highest average number of active months during the pilot (22.8).

Other Potential Factors Affecting the Number of 40% Providers

Chapter 3 identified two factors other than the pilot that could have caused an increase in the number of 40% providers during the pilot: (1) the general recruiting effort supported by the Appleseed Center for Law and Justice; and (2) a list of license-exempt providers whose release date coincided closely with the start of the pilot. For reasons described below, neither of these factors appeared to have a noticeable impact on the total number of providers in 40-percent areas in Nebraska.

[54] If all providers in 40-percent areas had been randomly assigned to either a tier I or a tier II status, then one could better attribute any differences in their behaviors as a result on the pilot.

Table 12: Length of Time that Providers Remained in the CACFP During the Pilot

Area of State and Provider Status	Number of Providers in October 2005	Average Number of Active Months During Pilot	Percentage Active for Entire 24 Months
Rural			
40%	220	22.8	86.8%
Not 40%	951	19.7	69.7%
All Rural	1,171	20.0	72.9%
Urban			
Tier I	837	18.8	61.3%
Not Tier I	704	20.5	73.9%
All Urban	1,541	20.3	67.0%

Source: NDE Administrative data 2005-2007.

As described in chapter 3, several recruiting efforts occurred during the two-year period of the pilot:

- When the pilot was first announced, sponsoring organizations advertised the pilot by sending flyers to about 70 towns affected by the pilot (i.e., towns having schools with from 40 to 49.9 percent of students certified for FRP meals). Information about the pilot also was published in local newspapers and sponsor letters.

- In March 2006, the NDE continued its campaign to encourage greater participation in the CACFP by issuing a news release about the pilot.

- In January 2007, the Nebraska Sponsors Expansion Consortium, with assistance from the Appleseed Center for Law in the Public Interest, initiated a campaign to publicize the CACFP and the NeRAED Pilot in rural communities. The publicity campaign included radio and television spots, newspaper articles, and mailings to school principals and non-CACFP home day care providers.

- A final round of marketing, with advertisements and public service announcements, began in April 2007.

Graph 8 below repeats graph 6, but it adds in vertical bars indicating the months in which major recruiting events occurred or began. There is no clear association between changes in the number of 40% providers and the occurrence of recruiting events. For instance, rather

than seeing a sharp increase in 40% providers immediately after a recruiting event followed by a diminishing effect, the graph shows a gradual increase over time for the first 18 months of the pilot.[55] The sharp increase in the number of non-40% providers that begins in December 2006 and continues until August 2007, however, may have been related to the media campaigns in January and April 2007. These two media campaigns for the CACFP were general in nature and not focused on the pilot or 40-percent areas.

As was also described in chapter 3, the Nebraska Department of Health and Human Services (NDHHS) is responsible for the licensing of family day care homes in the State, and it maintains information on smaller, license-exempt providers who seek incentive payments from the State for completing certain workshops and training events. In early January 2006, the NDHHS provided NDE with a list of 2,100 day care providers in the State who were exempt from State licensing requirements. The NDE passed this information on to its seven CACFP sponsors, who were allowed to use the list to try to recruit new providers into the CACFP program.

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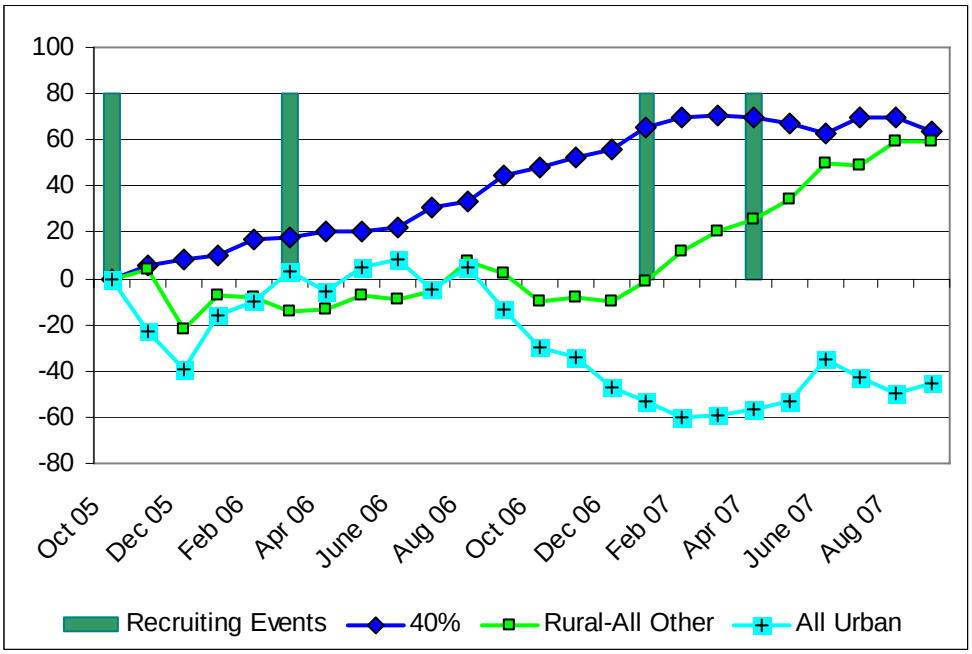
Graph 8: Cumulative Numerical Change in Number of Providers after October 2005 and Recruiting Events

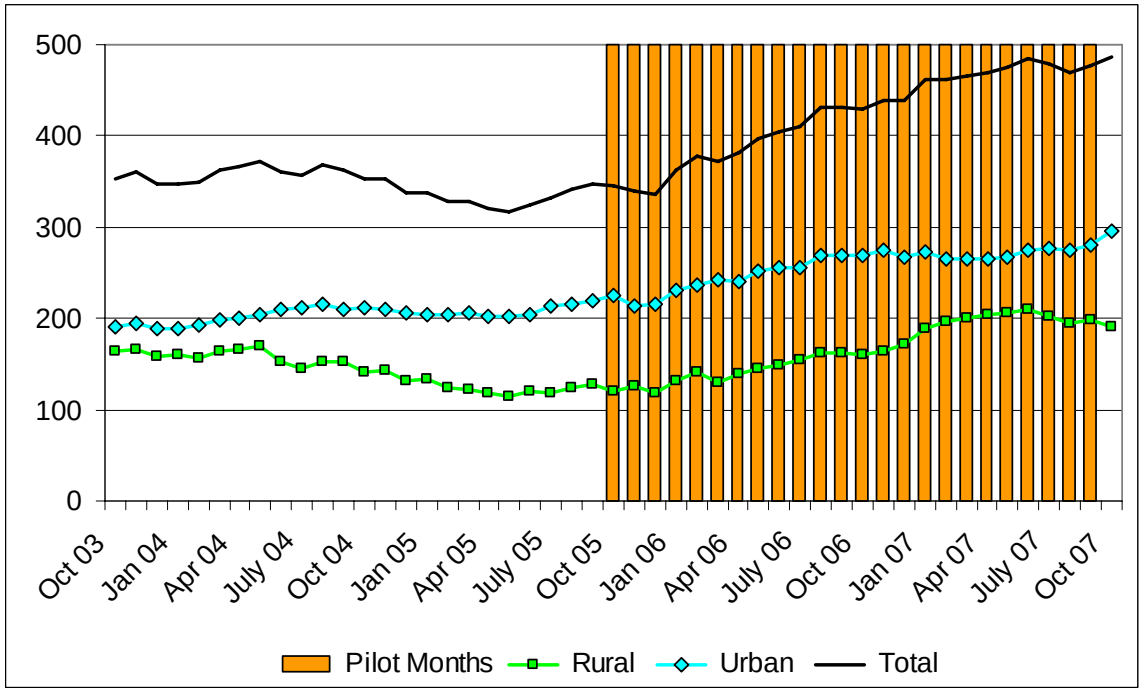


Source: NDE Administrative data 2005-2007.

[55] It is possible that the first two recruiting efforts directed at the 40-percent areas were effective, but that a delayed response to the recruiting efforts caused the pattern of change displayed in graph 8. There is no evidence to either support or refute such a hypothesis.

Graph 9 displays the number of urban and rural, license-exempt providers in the CACFP from October 2003 through October 2007. There is a clear and sharp upward trend beginning in January 2006. Using October 2005—the first month of the pilot—as a base, the number of CACFP, license-exempt providers in urban areas increased 24.4 percent (from 225 to 280), and the number of rural CACFP, license-exempt providers increased 63.6 percent (from 121 to 198). These percentage increases are much greater than those seen for all urban providers (a negative 2.9 percent) and all rural providers (10.5 percent) over the same time period

Graph 9: Number of License-Exempt Providers in the CACFP in Nebraska



Source: NDE Administrative data 2005-2007.

Throughout the 24 months of the pilot, 60 license-exempt providers participated in the CACFP as 40% providers. At the start of the pilot, 6.4 percent of the 220 40% providers were license-exempt. This percentage dropped to 6.1 percent in January 2006 and then climbed steadily until reaching a maximum of 14.8 percent in April 2007. Thereafter, it fell to 13.0 percent at the end of the pilot. Of the 115 new 40% providers added during the pilot, 46 (40.0 percent) were license-exempt. Among all other rural providers, however, an even larger percentage (58.2 percent) of new providers during the pilot period was license-exempt. Thus, the release in January 2006 by NDHHS of a large list of license-exempt providers certainly appears to have played a major role in the 10.5-percent growth in all rural providers. Although the impact was less in the 40-percent areas, nearly 38 percent of all newly added providers in these areas were license-exempt.

Recall, however, that most of the increase of 40% providers during the pilot resulted from pre-pilot providers remaining within the CACFP for longer periods of time and not from the addition of new providers. Pulling all of the information from this chapter together, we have the following, more complete understanding of the impact of the NeRAED Pilot on the number of CACFP providers in rural Nebraska:

- In October 2005, at the start of the pilot, sponsors listed 220 providers as 40% providers. Seven of these 220 providers (3 percent) were new to the program that month; the pilot may or may not have encouraged them to join at this early date before much recruiting had begun. Of the other 213 providers, 87 (41 percent) were already being reimbursed at tier I levels, but the remaining 126 providers (59 percent) were tier II or mixed-tier. The pilot increased the CACFP's meal reimbursements for these 126 providers.

- Providers in 40-percent areas were more likely to remain in the CACFP than other, rural providers. Of the 220 40% providers who were active at the beginning of the pilot, 191 (86.8 percent) remained in the CACFP for the full 24 months of the pilot. For all other rural providers that were active at the beginning of the pilot, only 69.7 percent remained in the CACFP for the full 24 months.

- Within the group of 40% providers at the start of the pilot, those who experienced an increase in reimbursement rates as a result of the pilot were most likely to remain in the CACFP for the full 24 months. Broken out by their tiering status in September 2005:

    - The number of tier I providers dropped from 87 to 72 (-17.2 percent);
    - The number of tier II providers dropped from 46 to 40 (-13.0 percent); and
    - The number of mixed-tier providers dropped from 80 to 76 (-5.0 percent).

    The pilot did not increase reimbursement rates for providers already at tier I, so it introduced no additional inducement for these providers to remain in the program. This is consistent with the explanation that the main effect of the pilot was to retain existing providers rather than recruit new ones.[56]

- Throughout the 24 months of the pilot, sponsors listed a total of 335 different providers as 40%. Thus, subtracting out the original 213, there were 122 providers in the 40% group that were new to the program during the pilot. At any one time, however, the maximum number of new providers was 98 (in August 2007) because some of the new providers left the CACFP before the end of the pilot. The months with the most new 40% providers were July 2006 (9), September 2006 (12), January

[56] Because the pilot had the potential to increase reimbursement rates more for tier II providers than for mixed-tier providers, one also would expect to see greater percentage declines among mixed-tier providers than tier II providers. The numbers do not support this expectation, perhaps because it was not possible to control for number of children in care. As an example of the importance of this factor, a mixed-tier provider with lots of children in care could have received a larger increase in reimbursements under the pilot than a tier II provider with only one or two children under care. In this situation, the mixed-tier provider would have more of an economic incentive than the tier II provider to remain in the Program during the pilot.

2007 (10), and August 2007 (9). These months do not match up well with or immediately following major recruiting efforts, lending further evidence that the existence of the pilot did not bring a lot of new providers into the program.

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CHAPTER 5: CHARACTERISTICS OF FAMILY DAY CARE HOME PROVIDERS IN NEBRASKA

Two of the research objectives for the evaluation are:

> *Determine the numbers, types (i.e., tiering status), and sizes of family day care homes offering meals through the CACFP in Nebraska…. Compare family day care homes selected under the 40-percent eligibility criterion with corresponding entities under the 50-percent criterion.*
>
> *Describe the types of services provided for children at tier I family day care homes. Compare services provided at family day care homes under the 40-percent and 50-percent thresholds.*

Chapter 4 addressed part of the first research objective above, but the evaluation's Provider Survey offers an opportunity to describe the characteristics of family day care providers in Nebraska in greater detail and to use these data to compare the services provided by day care homes of different tiering status. This chapter examines the following factors:

- Provider size, in terms of children under care;
- Provider reasons for becoming a day care provider and for joining the CACFP;
- Provider experience, licensure, and training;
- Provider operations, including meal and transportation services; and
- Changes in provider operations since the start of the pilot.

As in earlier chapters, providers are categorized as follows:

- "***40% providers***" – family day care providers residing in rural areas served by schools serving elementary school children in which the percentage of students certified for FRP meals is less than 50 percent but equal to or greater than 40 percent—all 40% providers are tier I providers;
- "***non-40% providers***" – family day care home providers with tier I status that are not 40% providers (i.e., providers in 50-percent areas plus providers who are income-eligible for tier I status regardless of location); and
- ***"not-tier I providers"*** – family day care home providers with either tier II or mixed-tier status.

It is not possible to separately identify 50% providers from other tier I providers, so the comparisons in this chapter and the next are among the three provider types: 40%, non-40%, and not-tier I.

Readers are reminded that the response rate to the Provider Survey was about 53 percent, and that younger and less experienced providers were less likely to respond to the survey than were older, more experienced providers. In addition, 40% providers were more likely to

respond than were non-40% providers. Given the low response rate, the analyses based on results from the Provider Survey do not concentrate on tests of whether differences between two groups of providers are statistically different from zero, but chi-square probability values are provided when the probability that the responses from all three provider groups came from the same population is less than 5 percent.

All percentages presented in graphs and tables are conditional percentages based on respondents who answered the associated question(s) in the survey. Missing responses, including "don't knows" and "refusals," are not included in the totals for conditional percentages.

5.1 Size of Family Day Care Homes

The NDE administrative records do not maintain information on the number of children for whom meals are being claimed by each provider. Rather, it is the responsibility of sponsoring organizations to maintain information on how many meals (and for which children) each of their providers is claiming. The data processing systems of the sponsors in Nebraska, however, were not set up to easily provide information on the number of children enrolled in each family day care home. The evaluation's data on size of family day care homes is drawn therefore from the Provider Survey.

Average Size of a Family Day Care Home

Graph 10 compares the average number of children under care by providers in each of the three provider groups. The averages are similar. Overall, providers in Nebraska had an estimated average of 8.1 children in care at the time of the survey. With averages of 8.6 and 8.5, respectively, providers in the 40% and non-40% tier I groups may be a little larger than day care homes in the not-tier I group (i.e., the combination of tier II and mixed-tier providers), which averaged 7.5 children in care. However, based on a one-way analysis of variance among the provider groups, the average sizes are not statistically different from one another.

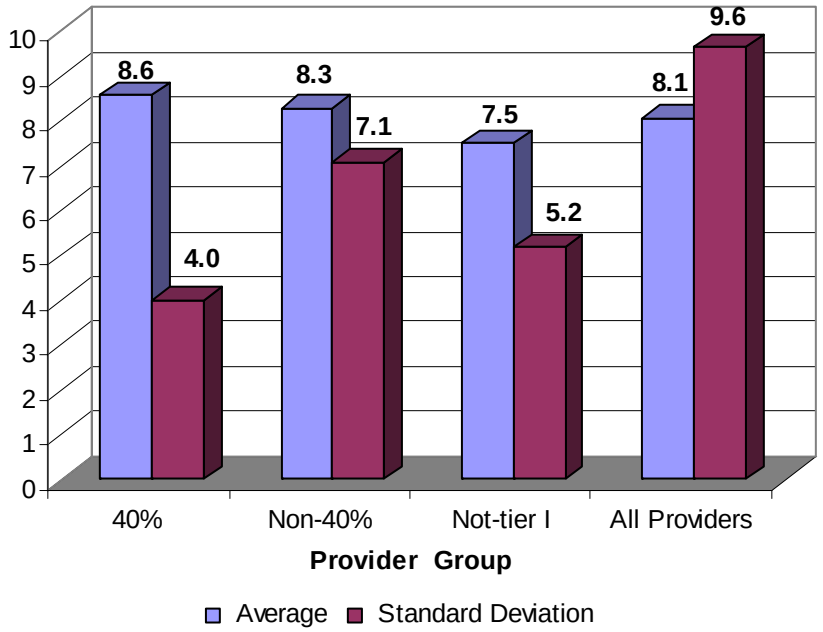
The number of children being cared for by a provider can vary from a single child up to the maximum capacity specified in the provider's license, and it can "exceed" the apparent maximum capacity if children come in shifts (i.e., the maximum capacity limits the number of children in care at the same time). From the standard deviations shown in graph 10, this variability becomes apparent. For instance, on average, the 40% providers in rural Nebraska take care of nearly the same number of children (8.6) as non-40% providers throughout the State (8.3). Among the 40% providers, about 78 percent reported that they cared for 5 to ten children. Only 66 percent of the non-40% providers cared for this many children. Compared to the 40% providers, the non-40% providers were more likely to care for fewer than 5 ***and*** more than 10 children

Total Number of Children in Care

Based on the survey estimates of the average numbers of children in care per provider and counts of providers within each group, the CACFP in Nebraska was serving an estimated

20,959 children daily throughout the State late in 2007. Table 13 shows the estimated numbers and percentages of children participating in CACFP, by provider group. Just over 11 percent of all the children under care were in the homes of 40% providers.

Graph 10: Average Number of Children in Care



Note: Average numbers of children are not statistically different from one another.
40 records (6.8 percent of total sample) had missing values and are not included in the analysis for this graph.
Source: NeRAED Provider Survey, 2007, question 16.

Table 13: Estimated Total Number of Children Receiving CACFP Meals throughout Nebraska (Late 2007)

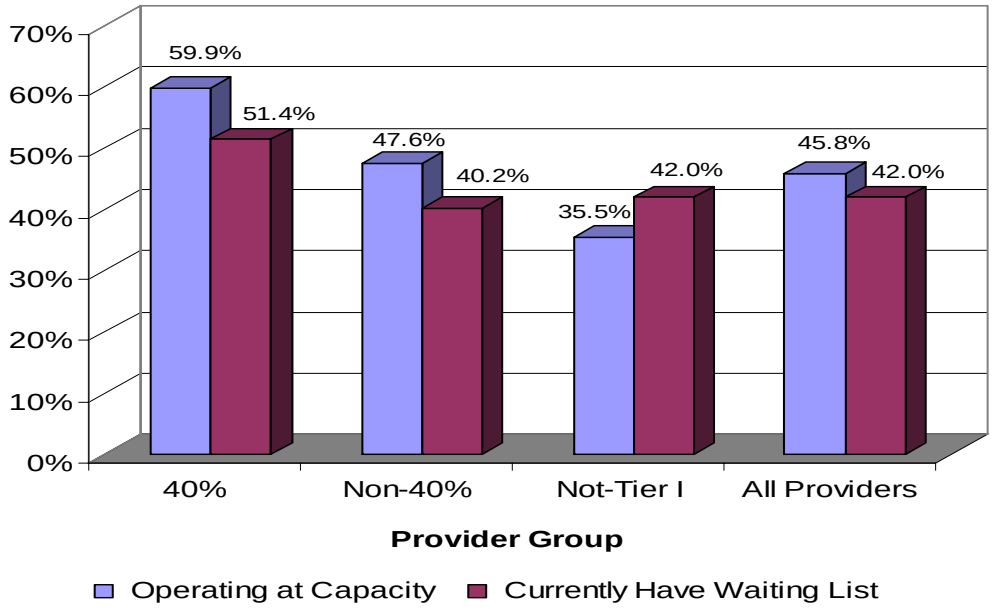
Total Children in CACFP	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Total Number of Participating Children	2,340	12,497	6,122	20,959
Percentage of Participating Children	11.2%	59.6%	29.2%	100.0%
Number Don't Know/Missing/Refused	*9*	*25*	*6*	*40*
Percent Don't Know/Missing/Refused	*5.8%*	*8.5%*	*4.4%*	*6.8%*

Source: NeRAED Provider Survey, 2007, question 16.

Presence of Waiting Lists

At the time of the survey in late 2007, 45.8 percent of all family day care home providers in Nebraska were operating at full capacity given their license status (graph 11). Providers in the 40% group were most likely to be operating at capacity (59.9 percent) and providers in the not-tier I group were least likely (35.5 percent) (chi-square $p<0.0001$).

Graph 11: Percentages of Providers Operating at Capacity, Having Waiting Lists



Notes: Chi-square p<0.0001 for "Operating at Capacity"
Chi-square p<0.0001 for "Currently Have Waiting List"
16 records (2.7 percent of total sample) had missing values for capacity and 38 records (6.5 percent) had missing values for waiting lists. These records are not included in the analyses for this graph.

Source: NeRAED Provider Survey, 2007, questions 17 and 18.

With so many providers operating at full capacity, one might expect the presence of unmet demand for child care services. Although some providers may not maintain waiting lists even if they are not at capacity (i.e., choosing to care for fewer children than their license allows), graph 11 shows that 42 percent of all providers had children on a waiting list at the time of the survey. Differences across groups were statistically significant (chi-square $p<0.0001$), with 40% providers being more likely to have waiting lists than other providers.

Taken together, the above results indicate that providers in the 40% group were both more likely than other providers to be at capacity and to have waiting lists, suggesting higher levels of unmet demand for child care services within the 40-percentareas than elsewhere (even near the end of the pilot when the number of 40% providers was at its greatest). Another question on the survey confirms this finding, but it also indicates that finding day care services may not have been particularly difficult for parents. The survey asked providers to

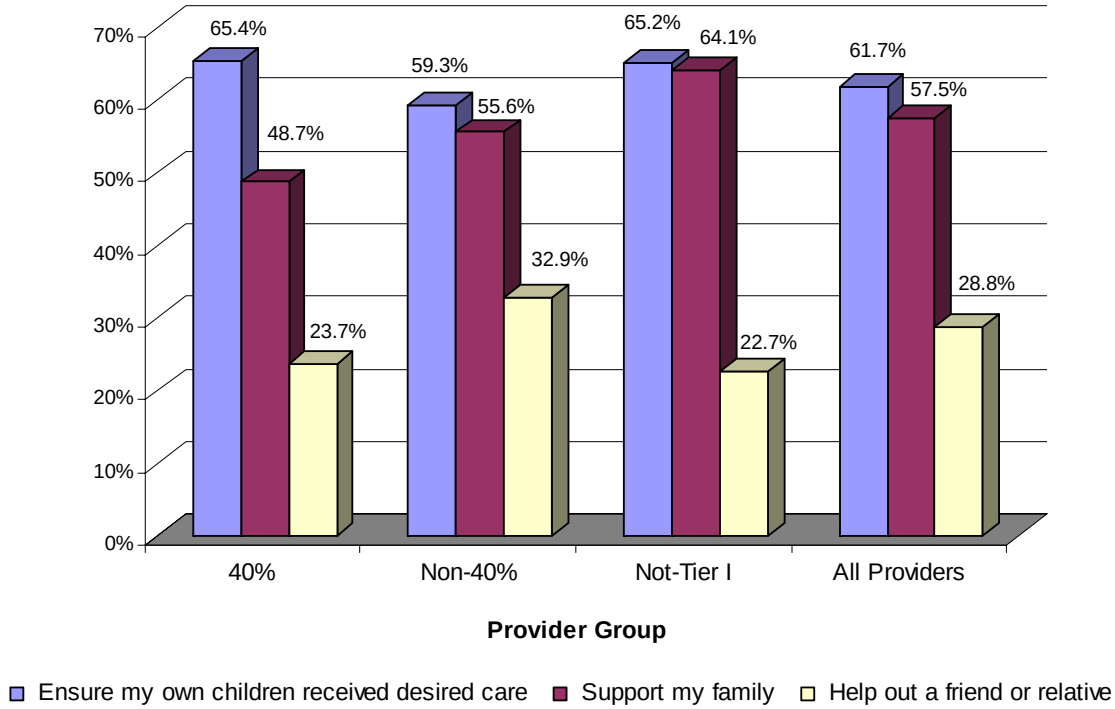
list the three most important reasons they thought that families selected their day care program. Two of the possible reasons that were listed on the survey were: (a) there are no other family day care providers nearby; and (b) there are no day care centers nearby. Both responses would be additional indicators of unmet need for day care services. Although providers in the 40% group were more likely than other providers to list at least one of these reasons, a total of only four did so.

5.2 Reasons for Becoming a CACFP Day Care Provider

The NeRAED Pilot was designed to increase the number of providers in rural areas, so the Provider Survey asked respondents why they became day care providers and what they saw as the main advantages and disadvantages of participating in the CACFP. Multiple reasons were allowed to both questions.

Respondents' most frequently cited reason for providing day care was to ensure that their own children received the care they wanted for them. Overall, 61.7 percent of respondents gave this reason. There is no statistically different variation among the provider groups (chi-square *p*=0.1372) (graph 12).

Graph 12: Percentages of Providers Giving Selected Reasons for Providing Child Care



Notes: Chi-square p=0.1372 for "Be sure my own children received desired care."
Chi-square p=0.0005 for "Support my family."
Chi- square p<0.0001 for "Help out a friend or relative."
No records with missing values.
Source: NeRAED Provider Survey, 2007, question 3.

The second most frequent reason given was to financially support their family. Overall, 57.5 percent of respondents cited financial support as a reason, and the chi-square value is statistically significant (chi-square p=0.0005). Tier II and mixed-tier providers were more likely to cite financial support (64.1 percent) than either 40% providers (48.7 percent) or non-40% providers (55.6 percent), even though their meal reimbursements were at a lower level.[57]

Finally, the third most frequently cited reason was to help out a friend or relative who needed day care for his or her kids, with non-40% providers being more likely to indicate this reason (32.9 percent) than other providers (chi-square p<.0001).

The Provider Survey gave respondents a list of possible advantages for participating in the CACFP and asked them to identify the most important advantages to them (up to a maximum of three). Table 14 displays the percentage of providers selecting each reason as their ***main***

Table 14: Percentage of Providers Citing Main Advantages for Participating in the CACFP, by Provider Group

Advantages	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Positive relations with sponsor agency	8.4	8.7	12.6	9.2
Positive relations with consultant	6.5	6.6	5.5	6.0
Useful feedback/evaluations	5.8	3.8	3.3	3.7
Ability to provide more food	11.6	11.5	5.7	9.4
Ability to provide better food	25.2	31.6	21.2	26.7
Informative newsletters/information	3.9	1.4	1.7	1.7
Sponsor and provider groups	0.6	0.3	0.9	0.5
Financial reimbursements	38.1	34.0	55.0	40.9
Help finding parents who need day care for their children	0	1.4	0.9	1.1
Training	0	0.3	0.9	0.4
Other	0	0.3	0.9	0.4
Total	100.0	100.0	100.0	100.0
Number Don't Know/Missing/Refused	*1*	*14*	2	*17*
Percent Don't Know/Missing/Refused	*0.6%*	*2.4%*	*1.5%*	*1.7%*

Note: Row stubs are listed in the same order as presented in the survey question.
Chi-square test not performed due to low expected counts in many cells.
Source: NeRAED Provider Survey, 2007, question 10.

[57] The survey did not collect other information that would help explain this counterintuitive result.

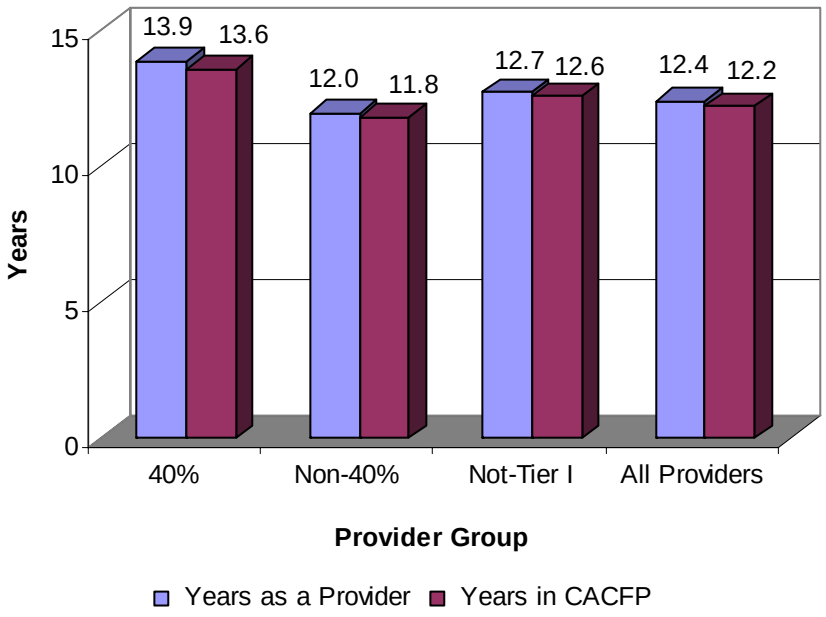
reason. Financial reimbursements and the ability to provide better food for children in their care were the main advantages providers identified for participating in the CACFP. Providers in all three areas selected these two reasons most often, but the not-tier I providers were especially likely to select financial reimbursements as the main advantage of participating in the CACFP.

5.3 Provider Experience, Licensing, and Training

Years of Experience

Respondents to the Provider Survey indicated: (a) the date they started providing family home day care; (b) whether there had been any interruptions in their service and, if so, for how long; and (c) when they started participating in the CACFP. There had been few interruptions in service, and only 4.4 percent of survey respondents indicated that they had participated in the CACFP for less time than their experience as a day care provider. Graph 13 displays respondents' average number of years as a family day care provider and average number of years in the CACFP. The two averages within each provider group in the graph are quite similar. Over the entire sample, providers had an average of 12.4 years of experience as a day care provider and 12.2 years of experience in the CACFP. Of the 25 providers in the sample who said they had fewer years of CACFP participation than their years of day care experience, the difference was usually just one or two years. Over 95 percent of all providers in the sample joined the CACFP when they started their day care operations or within a few months thereafter.

Graph 13: Average Years of Experience and CACFP Participation



Note: 68 records (11.6 percent of total sample) with missing values for both years of experience and years of CACFP participation.
Source: NeRAED Provider Survey, 2007, questions 1 and 8.

Comparing groups, providers in the 40% group, on average, may have the most years of day care experience (13.9) and of CACFP participation (13.6), followed by not-tier I providers (12.7 and 12.6 years, respectively) and non-40% providers (12.0 and 11.8 years, respectively). One-way analysis of variance tests, however, indicate that the differences among provider groups are not statistically significant.

Averages often may mask underlying variation, but this time they do not. As shown in graph 14, there is little variation among provider groups in the distribution of years of CACFP participation (chi-square p=.385). Among all providers in Nebraska, 18 percent had been CACFP participants for less than 1 year—that is, they joined the CACFP on or after October 1, 2006 (the start of the second year of the pilot). Another 9 percent had been CACFP participants for one to two years, joining on or after October 1, 2005 but before October 1, 2006. Thus, 27 percent of survey respondents had less than two complete years of CACFP participation. The remainder of the respondents split nearly evenly across the remaining categories of starting 1 to 5 years before the pilot, 6 to 10 years before, or 11 or more years before the pilot. The Statewide mean of 12.2 years of experience is as high as it is because many providers in the "11 or More Years" category had been with the program for many years.

The distribution of years of CACFP participation for the 40% providers in graph 14 is similar to the other provider groups. In particular, the percentage of 40% providers who had joined the CACFP since the start of the pilot (29 percent—the sum of the bottom two categories) is only slightly higher than the corresponding percentages for non-40% providers (27 percent) and not-tier I providers (26 percent). This result is consistent with the finding in chapter 4 that the pilot's main effect on provider participation was to ***retain*** existing providers rather than to encourage additional providers to ***join*** the program. Recall, however, that younger, less experienced providers were less likely to respond to the survey than older, more experienced providers, so the results of both graph 13 and 14 are likely to be skewed toward more years of participation than in the overall population of family day care home providers.

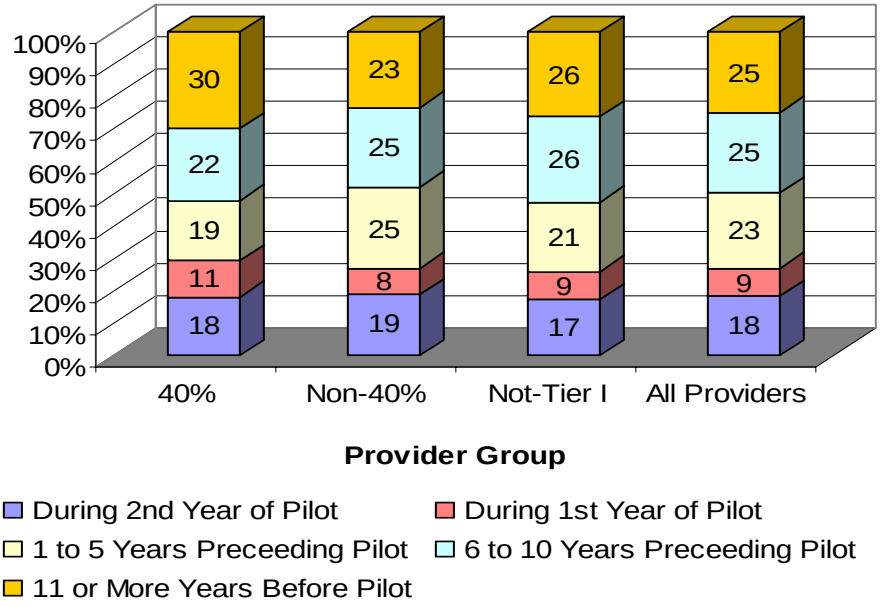
State Licensing as a Family Day Care Home Provider

The vast majority (90.9 percent) of day care providers responding to the survey said that they were licensed by the Nebraska Department of Health and Human Services (NDHHS), with the remainder exempt from licensure requirements. Table 15 shows the percentage of providers in each group that were licensed by the State versus license-exempt. Providers in the non-40% group were least likely to be licensed (88.3 percent), whereas 94.8 percent of the 40% providers reported that they were licensed by the State. Just under 95 percent of not-tier I providers indicated that they were licensed, and the hypothesis that all provider groups are equally likely to be licensed cannot be rejected (chi-square p=0.234); there are no statistically significant differences among the groups in terms of being licensed.

Asked how many children they could accommodate given their license status, most licensed providers responded they could care for 10 children, and most exempt providers reported they could care for 3 children – responses that are consonant with the State regulations.

Unfortunately, the reliability of the reporting on licensure status is suspect. Based on administrative data from the time of the survey, about 17 percent of all providers in the State were license-exempt, compared to 9.1 percent of survey respondents. Respondents may have been reluctant to report that they were not licensed, or licensed providers may have had higher survey response rates than license-exempt providers.

Graph 14: Percentage Distribution of When Providers Started CACFP Participation, by Provider Group



Note: 54 records (9.2 percent of total sample) had missing values and are not included in the analysis for this graph.
Source: NeRAED Provider Survey, 2007, question 8.

Table 15: Percentage of Providers Who Are Licensed

Licensing Status	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Licensed	94.8%	88.3%	94.5%	90.9%
License Exempt	5.2	11.7	5.5	9.1
Total	100.0	100.0	100.0	100.0
Number Don't Know/Missing/Refused	*3*	*2*	*1*	*6*
Percent Don't Know/Missing/Refused	*1.9 %*	*0.7 %*	*0.7 %*	*1.0 %*

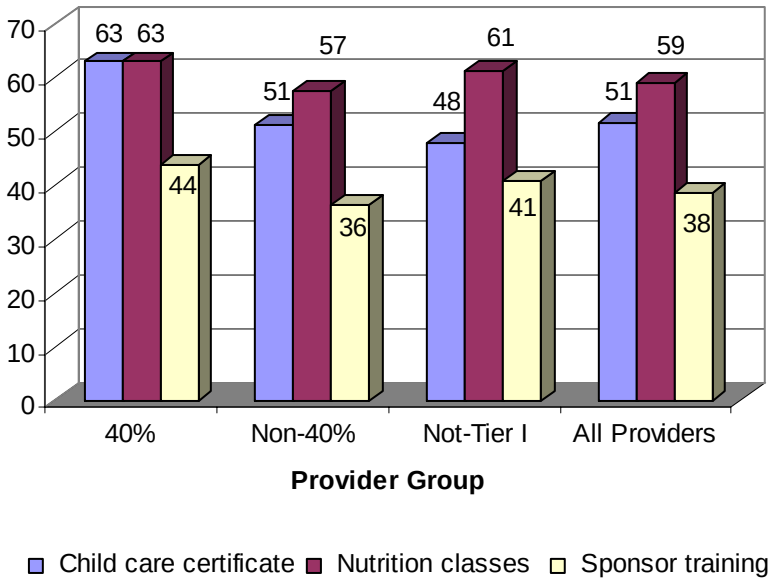
Note: Chi-square p=0.234
Source: NeRAED Provider Survey, 2007, question 5.

Provider Training

Most providers had received some type of training related to child care, and many had received training at multiple levels or from multiple sources. As shown in graph 15, 51 percent of all respondents reported that they had their child care certificate, 59 percent had attended nutrition classes, and 38 percent had received sponsor training (either in their homes from the sponsor's "food consultant" or at conferences). About 20 percent of all providers said that they had taken college courses, about 13 percent had a college or associates' degree, and 20 percent reported "other" training (not shown in the graph).

Providers in the 40% group were more likely to have their child care certificate (63 percent) than were non-40% providers (51 percent) or not-tier I providers (48 percent) (chi-square p=0.0084). Chi-square values for the distributions for nutrition classes and sponsor training were not statistically significant at the 0.05 level.

Graph 15: Percentage of Providers with Child Care Certificate, Nutrition Classes or Training



Notes: Chi-square p=0.0084 for "Child care certificate."
Chi-square p=0.3402 for "Nutrition classes."
Chi-square p=0.0704 for "Sponsor training."
No records with missing values.

Source: NeRAED Provider Survey, 2007, question 7.

5.4 Provider Operations

Activities

On average, the family day care homes were open approximately 12 hours a day during the school year, with no significant differences across the three provider groups. The survey

asked respondents to indicate which day care activities they did on a typical day. With one exception (watching TV), there were no statistically significant differences in the distributions of responses across provider groups (chi-square p=0.024). Overall, 82.8 percent of respondents included TV watching as an activity on a typical day. Providers in the not-tier I group were most likely to report watching TV (87.9 percent), followed by 40% providers (82.1 percent) and non-40% providers (79.1 percent).

Special Populations

Providers were asked specifically if they cared for any children from special populations. For purposes of this evaluation, special populations included children with special needs, migrant children, and bilingual children. These categories were identified during the interviews with sponsors and NDE staff at the onset of the project.

Results of the survey are shown in table 16. Nearly 18 percent of providers reported that they cared for special populations, with non-40% providers being more likely (22.7 percent) to care for children from special populations than either 40% providers (12.6 percent) or not-tier I providers (10.2 percent). Most of the providers taking care of children from special populations were taking care of special-needs children (11.1 percent of all providers), followed by bilingual children (4.4 percent) and migrant children (0.8 percent); 3.6 percent of the providers did not specify the type(s) of children in care.

Table 16: Percentage of Providers Taking Care of Special Populations

Special Population Type	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Any Special Population Children	12.6%	22.7%	10.2%	17.8%
Special-Needs Children	9.3	14.2	5.7	11.1
Migrant Children	1.3	1.1	0.0	0.8
Bilingual Children	4.0	6.7	0.0	4.4
Unspecified	0.7	3.5	4.5	3.6
Number Don't Know/Missing/Refused	*5*	*13*	*5*	*23*
Percent Don't Know/Missing/Refused	*3.2 %*	*4.4 %*	*3.6 %*	*3.9 %*

Note: Chi-square p<0.0001 for "Any Special Population Children."
Chi-square p<0.0001 for "Special-Needs Children."
Chi-square p=0.0096 for "Migrant Children."
Chi-square p<0.0001 for "Bi-lingual Children."
Source: NeRAED Provider Survey, 2007, question 15.

There are differences in the percentages of providers within each group that were caring for special-needs, migrant, and bilingual children (chi-square p <0.01 for all tested groups). Tier I providers who were not in 40-percent areas (i.e., the non-40% providers) were the most likely to be taking care of special-needs children (14.2 percent) and bilingual children (6.7

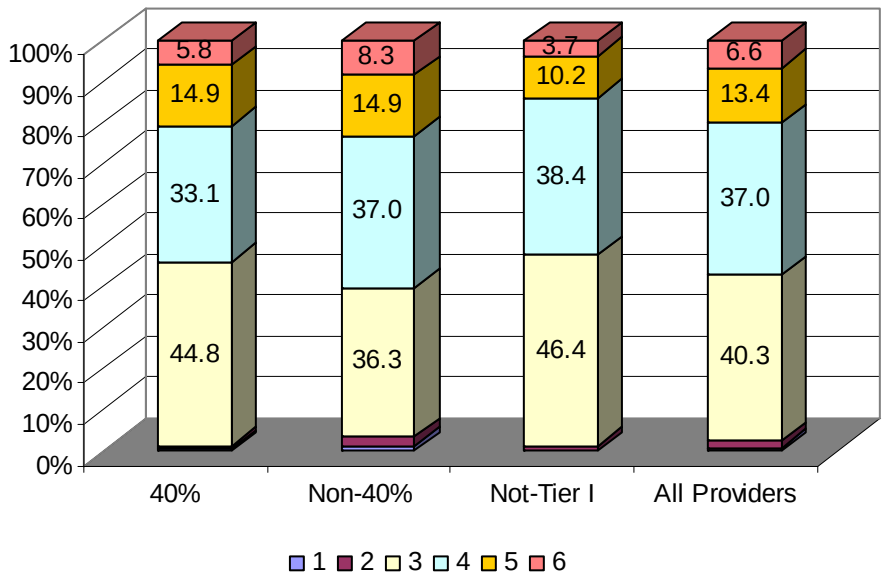
percent), whereas 40% providers were the most likely to be caring for migrant children (1.3 percent). These comparisons among provider groups are complicated, however, by the relatively large numbers of providers in the non-40% and not-tier I groups who said they were caring for children in special populations, but then did not specify who these children were.

Meals Served

The CACFP provides subsidies to family day care providers for up to three meal services per day per eligible child. The three meal services may include two meals and one snack or two snacks and one meal, and they do not have to be the same meals and snacks for each child. In addition, providers may serve additional meals, but they will not be reimbursed beyond the three meals per eligible child.

Very few providers reported serving just one or two meals services per day (0.9 percent and 1.7 percent, respectively). Most providers reported providing three (40.3 percent) or four (37.0 percent) meals a day, with a few offering five meals (13.4 percent) or six meals (6.6 percent). As shown in graph 16, 40% providers were more likely than others to offer just three meals per day.

Graph 16: Percentage of Providers Serving Specified Number of Meals per Day

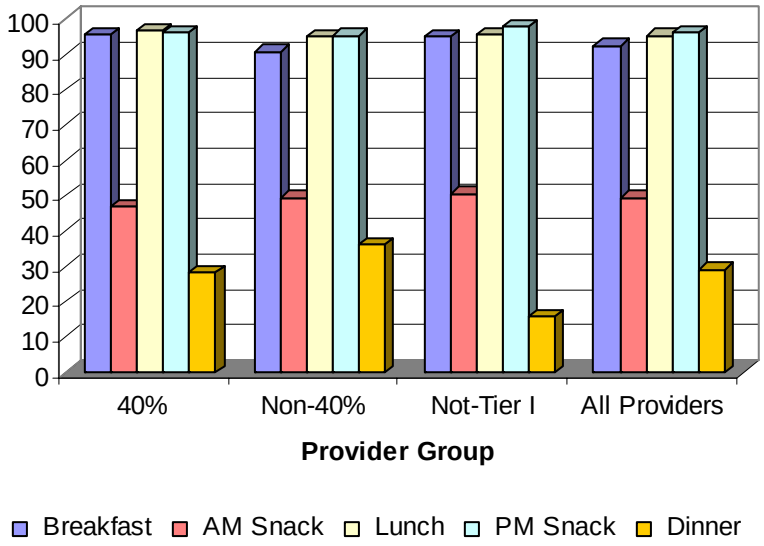


Notes: Chi-square p=0.0193
10 records (1.7 percent) had missing values and are not included in the analysis for this graph.
Source: NeRAED Provider Survey, 2007, question 26.

Looking at graph 17, breakfast, lunch, and afternoon snacks are clearly the most commonly served meals, with at least 91 percent of providers in each tier serving these meals. Dinner was the least commonly served meal (29.1 percent overall) and the only meal service being

offered by statistically different proportions of providers in each group (chi-square $p<0.0001$).[58]

Graph 17: Percentage of Providers Serving Meals and Snacks



Notes: Chi-square $p=0.5266$ for "Breakfast"
Chi-square p=0.7387 for "AM Snack"
Chi-square p=0.9502 for "Lunch"
Chi-square p=0.8350 for "PM Snack"
Chi-square $p<0.0001$ for "Dinner"
10 records (1.7 percent) had missing values and are not included in the analysis for this graph.
Source: NeRAED Provider Survey, 2007, question 26.

Transportation

About one-third (31.8 percent) of all family day care home providers in Nebraska provided some form of transportation for the children in their care at the time of the survey, including 28.9 percent of 40% providers, 34.3 percent of non-40% providers, and 28.0 percent of not-tier I providers (table 17). The most common services were dropping children off at school in the morning (20.3 percent overall) and picking them up afterwards (23.1 percent overall). Non-40% providers were most likely to provide these particular transportation services (chi-square $p<0.0001$ for each) as well as any transportation service (chi-square $p<0.05$).

[58] The Provider Survey did not ask respondents whether they served evening snacks.

Table 17: Percentage of Providers Providing Transportation Services

Transport Services	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Any service	28.9%	34.3%	28.0%	31.8%
Pick up in the morning	2.6	7.7	1.5	5.3
Drop off at school	15.8	21.7	19.1	20.3
Pick up at school	18.4	24.5	22.0	23.1
Drop off in the evening	1.3	7.3	3.1	5.4
Other	9.2	5.9	6.8	6.5
Number Don't Know/Missing/Refused	*4*	*9*	*2*	*15*
Percent Don't Know/Missing/Refused	*2.6%*	*3.1%*	*1.5%*	*2.6%*

Notes: Chi-square p=0.0218 for "Any service"
Chi-square p<0.0001 for "Pick up in morning"
Chi-square p=0.0835 for "Drop off at school"
Chi-square p=0.1086 for "Pick up at school"
Chi-square p<0.0001 for "Drop off in the evening"
Chi-square p=0.1346 for "Other"
Source: NeRAED Provider Survey, 2007, question 22.

5.5 Changes in the Operation of Family Day Care Homes

Providers were asked whether they had made any changes in several areas of their day care operations (food, activities provided, and hours of operation) since the beginning of the CACFP pilot in 2005. Table 18 shows that just over one-fifth (21.1 percent) reported they had made an operational change.[59] These changes were more common among 40% providers (28.2 percent) than among non-40% providers (17.8 percent) or not-tier I providers (25.2 percent). For all provider groups, changes in food operations were more common than other changes, and particularly so within the 40% group.

[59] Providers who had been operating for fewer than 3 months are excluded from the calculations.

Table 18: Percentage of Providers with Changes in Day Care Operations since the Onset of the Pilot

Operational Changes	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Any change	28.2	17.8	25.2	21.1
Food operation changes	29.6	17.4	21.6	20.0
Activities stopped	9.2	5.8	6.9	6.5
New activities started	14.8	13.1	11.8	12.9
Hours changed	9.9	10.8	17.7	12.8
Number operating for fewer than 3 months	*4*	*5*	*6*	*15*
Number Don't Know/Missing/Refused	*10*	*31*	*12*	*53*
Percent Don't Know/Missing/Refused	*6.4 %*	*10.5 %*	*8.9 %*	*9.0 %*

Notes: Chi-square $p<0.0001$ for "No change"
Chi-square $p=0.0001$ for "Food operations changes"
Chi-square $p=0.1231$ for "Activities stopped"
Chi-square $p=0.4767$ for "New activities started"
Chi-square $p<0.0001$ for "Hours changed"
Source: NeRAED Provider Survey, 2007, question 27.

When the providers who reported that their food operation had changed were asked to describe what had occurred, 45 percent gave responses related to ***higher quality food*** and 24 percent indicated ***greater quantities of food***. Among the 40% providers, however, the respective numbers were higher at 71 percent and 31 percent.[60] It is clear from their responses that many 40% providers believed the increased CACFP reimbursements from the pilot enabled them to offer higher quality food in larger quantities. Examples include:

- "Better food – more money to buy more fresh food; better types of food; not so much pasta and fatty filler foods"
- "Better quality. I always get good quality but it was easier because I got a better reimbursement. It helped a lot."
- "Can buy more fruits and more variety of them…"
- "During the pilot I offered less processed foods like hot dogs and chicken nuggets."
- "With being on tier I [i.e., in the pilot], I have been serving fresh fruits and vegetables for snacks and lunch and breakfast. Now I will be getting tier II [because the pilot was about to end]. I will not be able to feed them as well."

[60] Information for all provider groups is included in the final table of this chapter.

- "The full reimbursements help me so much…I always serve good, nutritious meals whether I get reimbursed or not. But without the reimbursement it is more difficult to do."

Although many comments from other providers also said that they were offering better food and larger portions, a substantial number of their comments indicated that they were cutting quality or portion sizes because of increasing food prices.

5.6 Summary

The purpose of this chapter has been to describe characteristics of family day care home providers in Nebraska and to compare the characteristics of 40% providers to other providers. The bullets below and table 19 summarize the comparative findings.

- Providers in the 40-percent areas defined by the pilot were slightly larger than providers in other parts of the State, but the differences were not statistically significant. 40% providers were more likely than other providers to both be operating at capacity and to have waiting lists, and these differences were statistically significant.

- Like other providers, the main reason 40% providers are operating family day care homes is to ensure that their own children receive desired care. Providers in the 40% group were less likely than other providers to cite financial reasons as a main reason, and they (together with not-tier I providers) were less likely to cite helping out a friend or relative as a main reason.

- On average, 40% providers had slightly more years of day care experience (13.9) and CACFP participation (13.6) than did providers in the other groups, but the differences were not statistically significant.

- Together, 40% providers and not-tier I providers were more likely to be licensed than non-40% providers. Also, 40% providers were more likely to have their child care certificate, to have taken nutrition classes, and to report receiving sponsor training.

- The 40% providers and not-tier I providers were less likely to be taking care of children in special populations (i.e., special-needs, migrant, bilingual) than non-40% providers.

- The 40% providers and not-tier I providers were less likely to be providing transportation services for their children than non-40% providers.

- Finally, 40% providers were more likely to have changed their day care operations during the pilot than other providers, especially in the area of food operations. The 40% providers were more likely than other providers to report providing higher quality food or greater quantities of food since the start of the pilot.

Table 19: Summary of Characteristics of Family Day Care Homes in Nebraska, by Provider Group

Characteristic	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Average number of children in care	8.6	8.3	7.5	8.1
Percent at capacity*	60%	48%	36%	46%
Percent with waiting lists*	51%	40%	42%	42%
Percent citing financial support as a main reason for providing day care*	49%	56%	64%	58%
Percent citing helping a friend or relative as a main reason for providing day care*	24%	33%	23%	29%
Average years of CACFP participation	13.6	11.8	12.6	12.2
Percent licensed as day care provider	95%	88%	96%	91%
Percent with child care certificate*	63%	51%	48%	51%
Percent taking care of special populations*	13%	23%	10%	18%
Percent providing transportation services*	29%	34%	28%	32%
Percent making changes to food operations during pilot*	29%	17%	21%	19%
Of those making changes to food operations, percent offering higher quality food	71%	51%	23%	45%
Of those making changes to food operations, percent offering greater quantities of food	31%	16%	33%	24%

Note: Characteristics marked with an asterisk have statistically significant differences in value among the three provider groups.
Source: NeRAED Provider Survey, 2007.

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CHAPTER 6: CHARACTERISTICS OF CHILDREN SERVED

The last remaining research objective of the study was to:

> *Determine the numbers and characteristics of children served, by age, gender, and other factors. Compare the types of children served under the 40-percent and 50-percent thresholds, and assess the types of new children attracted to the CACFP under the 40-percent criterion.*

This chapter describes the characteristics of children enrolled in family day care homes participating in the CACFP. As in previous chapters, information is provided for three provider groups (40%, non-40%, and not-tier I) and the statewide average. Topics covered in the chapter include:

- Number and gender of children,
- Age of children, and
- Residential location relative to day care home

One part of the above research objective that is not examined here or elsewhere in the report is the "types of new children attracted to the CACFP under the 40-percent criterion." As discussed in chapter 4, the increase in the number of family day care providers in rural Nebraska that coincided with the pilot was the result primarily of extant providers in 40% areas remaining in the program longer and, secondarily, to the enrollment of license-exempt providers. The latter reason was not the result of the pilot, and the retention of existing providers did not lead to "new" children being attracted to the CACFP.

6.1 Number and Gender of Children

One of the characteristics of providers presented in chapter 5 was their size—as measured by the number of children in care. The number of children in care was measured as of the date of the survey, and the averages by provider group were:[61]

- 8.6 for 40% providers,
- 8.3 for non-40% providers,
- 7.5 for not-tier I providers, and
- 8.1 overall.

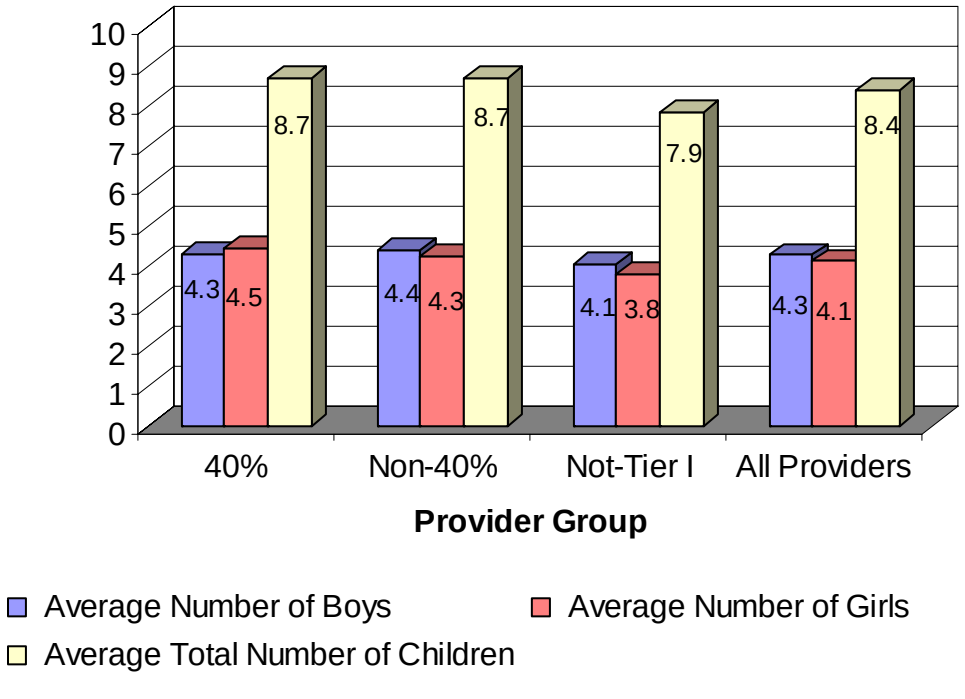
The survey question that provided the above findings did not ask respondents to provide separate counts of boys and girls. Another survey question, however, did ask for separate counts of boys and girls for the month of October in each of the three previous years, 2004-2006. Graph 18 presents the average numbers of boys and girls in care, by provider group,

[61] See graph 10 in chapter 5. The average sizes are not statistically different from one another.

for October 2006, about one year prior to the survey.[62] Statewide, family day care home providers in Nebraska were caring for averages of 4.3 boys and 4.1 girls in October 2006. There are no statistically significant differences in average numbers of boys or girls under care in graph 18. The averages in the graph for ***total children*** in care are slightly larger than those presented in chapter 5 and the bullets above, but they reference an earlier period and may be affected by the high rate of non-response (25.0 percent) for this question.

Chapter 5 noted that providers cared for an estimated 20,959 children in the State at the time of the survey in late 2007. If one applies the gender breakout from graph 18 to this statewide count, an estimated 10,233 of the children (50.8 percent) were boys and 10,726 (49.2 percent) were girls.

Graph 18: Average Number of Children, by Gender and Provider Group (October 2006)



Notes: There are no statistically significant differences in average numbers of boys or girls across provider groups.
147 records (25.0 percent of total sample) had missing values and are not included in the analysis for this graph.
Source: NeRAED Provider Survey, 2007, question 13.

[62] Figures for previous years are not presented due to high rates of non-response. For October 2006, the non-response rate was 25 percent.

6.2 Age of Children

As was evident in the sponsor and State interviews at the onset of the evaluation, providers cared for children of all ages, with older children, especially teenagers, being the least likely to use day care.

Table 20 presents the estimated percentages of providers, by group, taking care of children in different age categories. Providers in Nebraska were most likely to be taking care of 3- to 5-year olds (87 percent) or toddlers (83 percent). Sixty-seven percent of providers were taking care of infants, and 60 percent were caring for 6- to 12-year olds. Only 4 percent of providers were taking care of teenagers in October 2006.

There are no statistically significant differences among provider groups in their likelihoods of caring for infants, toddlers, or 3- to 5-year olds. Respondents in the not-tier I group were less likely than other providers to care for 6- to 12-year olds in October 2006 (chi-square p=0.0363), and non-40% providers were more likely than others to take care of teenagers (chi-square p=0.0006).

The above patterns were similar for each of the three years of data that were collected. There were about seven percent fewer children in child care in summer, but the same age group proportions generally held for both summer and school-year periods.

Table 20: Percentage of Providers Taking Care of Children of Different Age Groups

Age Grouping	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Infants (< 1 year)	77%	66%	64%	67%
Toddlers (1 – 2 years)	86	81	87	83
3 – 5 years	90	85	88	87
6 – 12 years	63	63	54	60
Teenagers	3	5	2	4
Number Don't Know/Missing/Refused	*41*	*79*	*25*	*145*
Percent Don't Know/Missing/Refused	*26.3%*	*26.8%*	*18.2%*	*24.7%*

Notes: Chi-square p=0.1483 for "Infants"
Chi-square p=0.2714 for "Toddlers"
Chi-square p=0.7050 for "3 – 5 years"
Chi-square p=0.0363 for "6 – 12 years"
Chi-square p=0.0006 for "Teenagers"
Source: NeRAED Provider Survey, 2007, question 14 (October 2006).

Table 21 focuses on the average ***number*** of children in care, by age category, rather than on the percentage of providers who take care of children within each category. The averages in

table 21 are based on all providers within a group regardless of whether or not they had children of that specific age category in care. The averages also have been proportionally adjusted so that the totals at the bottom of table 21 match the averages presented in graph 10 of chapter 5.[63]

The distributions within each provider group in table 21 are not statistically different from one another. The largest group of children in care was 3- to 5-year olds, with an average of 3.1 children per provider. The remaining groups, in order of descending size, were toddlers (an average of 2.2 toddlers per provider), 6- to 12-year olds (1.6), infants (1.2), and teenagers (0.1).

Table 21: Average Number of Children in Care, by Provider and Age Groups

Age Grouping	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Infants (< 1 year)	1.2	1.2	1.2	1.2
Toddlers (1 – 2 years)	2.4	2.2	2.2	2.2
3 – 5 years	3.3	3.1	2.9	3.1
6 – 12 years	1.7	1.8	1.2	1.6
Teenagers	0.0	0.1	0.0	0.1
Total	8.6	8.3	7.5	8.1
Number Don't Know/Missing/Refused	*41*	*79*	*25*	*145*
Percent Don't Know/Missing/Refused	*26.3%*	*26.8%*	*18.2%*	*24.7%*

Note: Providers taking care of no children within a group are included when estimating averages. Cell averages have been adjusted to match total averages in graph 10, which is based on current numbers of children (at the time of the survey) instead of October 2006.
Source: NeRAED Provider Survey, 2007, question 14.

Table 22 presents estimates of the percentages of all children in each age grouping, by provider group. Overall, 37.8 percent of all children in care in October 2006 were 3- to 5-year olds, followed by toddlers (27.5 percent), 6- to 12-year olds (19.6 percent), infants (14.4

[63] The survey asked for information about number of children in care at several different points, and this adjustment compensates for the large number of survey respondents (24.7 percent) who could not remember the number of children in their care in October 2006 or were not operating in October 2006. It also adjusts for the possibility that some of the respondents may have overestimated the number of children in care at a single point of time. (For example, providers counting all the children in care throughout the month rather than at any single time during the month.)

percent), and teenagers (0.7 percent). The distribution of children of different ages within the group of 40% providers is statistically no different than for the other provider groups.

Table 22: Percentage of Children in Care, by Provider Group and Age Group

Age Grouping	Provider Group			
	40%	Non-40%	Not-Tier I	All Providers
Infants (< 1 year)	14.0%	13.9%	15.5%	14.4%
Toddlers (1 – 2 years)	28.2	26.5	29.3	27.5
3 – 5 years	37.9	37.3	39.0	37.8
6 – 12 years	19.5	21.4	15.9	19.6
Teenagers	0.4	0.9	0.3	0.7
Total	100.0	100.0	100.0	100.0
Number Don't Know/Missing/Refused	*41*	*79*	*25*	*145*
Percent Don't Know/Missing/Refused	*26.3%*	*26.8%*	*18.2%*	*24.7%*

Note: The age distributions of children in care are not statistically different from one another across provider groups.
Source: NeRAED Provider Survey, 2007, question 14 (October 2006).

6.3 Distance from Day Care

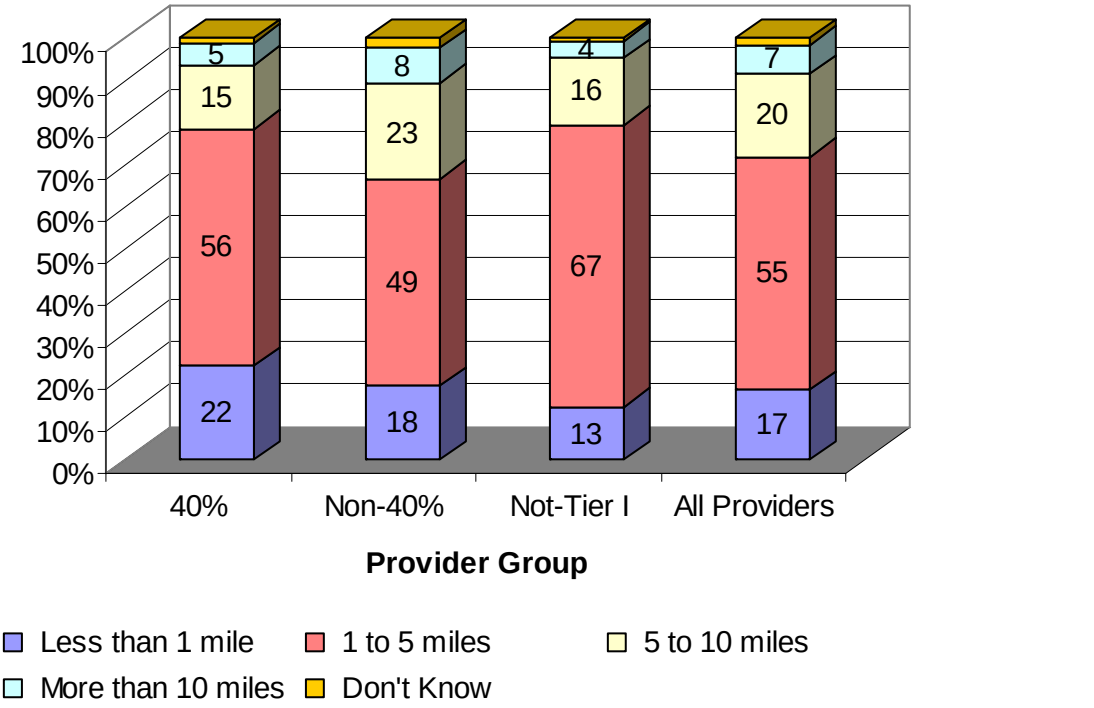
The Provider Survey asked respondents to estimate the average distance the children in their care had to travel to get there. Pre-coded responses were: (a) less than 1 mile; (b) 1 – 5 miles; (c) 5 – 10 miles; (d) more than 10 miles; and (e) don't know. Graph 20 displays the providers' responses. Statewide, 55 percent of the respondents to the survey estimated the children in their care travel, on average, 1 to 5 miles to come to day care. Another 20 percent of providers estimated the average distance as 5 to 10 miles, and 7 percent estimated a distance of 10 miles or more. Seventeen percent of all providers estimated that the average distance was less then one mile.

The results for the individual provider groups are somewhat surprising. Remember that, except for the providers in the 40% group, the other groups represent a mix of urban and rural providers. If children attending ***rural*** day care homes need to travel farther, on average, than children in urban areas, the children in 40-percent areas should have the farthest to travel. In contrast, 40% providers estimated ***shorter*** distances for their children than did other providers. For instance, 22 percent of providers in the 40% group estimated that the children in their care lived, on average, within one mile; the corresponding percentages for non-40% and not-tier I providers were 18 and 13 percent, respectively. Furthermore, 56 percent of 40% providers estimated their children traveled an average of 1 to file miles to get to their family day care home, compared to 49 percent for non-40% providers. The

statistically significant chi-square statistic indicates a very small probability that these different results were drawn from the same population.

The explanation for the above results may lie in the differential nature of residential communities in urban and rural areas. Whereas rural areas are less densely populated than urban areas, the maps in chapter 4 showed that many of the 40% providers were relatively clustered in small rural cities and towns. These communities are smaller than their urban counterparts. If the majority of children at 40% providers are drawn from the local communities rather than the dispersed farmsteads, it is not unreasonable to find shorter average home-to-day care distances in rural areas compared to urban areas.

Graph 19: Percentages of Providers Estimating Different Average Distances that Children in Their Care Travel to Day Care



Notes: Chi-square $p<.0001$ for overall distribution.
10 records (1.7 percent) had missing values and are not included in the analysis for this graph.
Source: NeRAED Provider Survey, 2007, question 20.

6.4 Summary

The purpose of this final chapter has been to describe characteristics of children in family day care homes in Nebraska and to compare the characteristics of children attending 40% providers to children of other providers. The bullets below summarize the comparative findings.

- Boys and girls attend family day care in Nebraska in nearly equal proportions, with boys representing an estimated 50.8 percent of all children in care. The gender split for children at 40% providers (48.8 to 51.2 percent) was statistically no different than for non-40% providers (50.6 to 49.4 percent) or for not-tier I providers (52.0 to 48.0 percent).

- The age distribution of children at 40% providers is statistically no different than the distributions at other providers. Statewide, about 38 percent of all children in care are 3- to 5-year olds and 27 percent are toddlers. Six- to 12-year olds represent 20 percent of all children, followed by infants (14 percent). Less than one percent of all children in family day care are teenagers.

- Despite the exclusively rural environment of the 40% providers, these providers estimated shorter average distances for their children to travel to day care than did non-40% providers and not-tier I providers. About 22 percent of 40% providers said the children in their care lived within one mile of them, compared to 18 percent for non-40% providers and 13 percent for not-tier I providers.

The findings that the age distribution and gender of children attending 40% providers are no different than for children in other parts of Nebraska should come as little surprise given earlier findings about the pilot. The main effect of the pilot was to encourage existing providers in 40-percent areas to remain in the CACFP longer that they would have otherwise. Thus, except for the normal turnover in day care homes as older children left and new ones arrived, and the normal addition of new homes to the program for reasons unrelated to the pilot, there were few or no "new" children as a result of the pilot. Instead, family day care home providers in Nebraska continued to take care of the same types of children they had before the pilot.

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LIST OF ACRONYMS

40% providers	Family day care providers residing in rural areas served by schools serving elementary school children in which the percentage of students certified for FRP meals is less than 50 percent but equal to or greater than 40 percent—all 40% providers are tier I providers
AFB	Air Force Base
BLS	Bureau of Labor Statistics
CACFP	Child and Adult Care Food Program
CDP	Census Designated Place
CFR	Code of Federal Regulations
FDCH	Family day care home
FNS	Food and Nutrition Service
FRAC	Food Research and Action Center
FRP	The acronym stands for "free and reduced-price" meals in the National School Lunch Program.
FY	Fiscal Year
GIS	Geographic Information System
ITO	Indian Tribal Organization
MSA	Metropolitan Statistical Area
NDE	The Nebraska Department of Education, whose Nutrition Services Division is responsible for administering the CACFP in Nebraska
NDHHS	Nebraska Department of Health and Human Services
Mixed-tier providers	All family day care home providers with some, but not all, of their children under care income-eligible for tier I reimbursement
NeRAED Pilot	The official name for this project is the Nebraska Rural Area Eligibility Determination for Day Care Homes Pilot, which has been shortened to NeRAED Pilot (or "pilot")
Non-40% providers	All family day care home providers with tier I status that are not 40% providers
Not-tier I providers	All family day care home providers with either tier II or mixed-tier status.
NSLA	National School Lunch Act

NSLP	National School Lunch Program
OMB	Office of Management and Budget
SY	School Year
Tier II providers	All family day care home providers with tier II status
UA	Urban Area
USDA	United States Department of Agriculture
WIC	Women, Infants, and Children (full program name is Special Supplemental Nutrition Program for Women, Infants, and Children)

APPENDIX A: RESULTS FROM MEETINGS WITH PROVIDERS

Interviews and focus groups were conducted with family day care home providers in October 2006, as described in Chapter 2. The providers had been providing day care for a range of 3 to 35 years. Our interest was in providers that gained tier I status *because of the pilot*; therefore, all had formerly been tier II CACFP providers.

The interviews and focus groups sought input from providers in seven broad areas germane to the NeRAED Pilot:

1. Reasons for becoming a family day care provider.
2. Recruitment of families.
3. A typical day in the home day care environment.
4. Meals provided.
5. Thoughts about and interactions with the CACFP.
6. The State's role in increasing provider participation and child enrollment.
7. Plans when the pilot ends.

The following sections contain summaries of the information obtained from providers during these interviews and focus groups.

1. Reasons for Becoming a Family Day Care Provider

Focus group participants became home day care providers primarily because of their love for children and their desire to stay home and care for their own children or grandchildren. The opportunity to receive an income in the process contributed to these decisions. The providers believed that home day care improves children's social skills and serves as an advantage for their own older children – affording them an opportunity to socialize and care for younger and special-needs children. Support from providers' families was seen as a key factor in the success of their day care businesses. Sponsoring organizations were chosen by providers based on the benefits of the sponsor organization and recommendations from peers.

All of the focus group members believed that there was a "tremendous" amount of paperwork related to participation in the CACFP, which made it "hardly worth the effort" and rendered very little financial benefit as a tier II provider.

2. Recruitment of Families

All providers participating in the three focus group sessions agreed that 'word of mouth' was the most effective method for recruiting clients for their day care homes, with many obtaining referrals from schools, parents, and other day care providers in the community. They also noted that the State of Nebraska has a listing of licensed providers that it makes available to interested families. Several providers also utilize a calling-tree method for recruitment – contacting other providers when they have vacancies, when they are aware of families seeking a day care home in another area, or when their homes are at capacity. All

providers in attendance discounted any form of advertising as an accepted recruitment method, citing the belief that most people they know either would never see the ads or would not find them to be a credible or reliable source for day care information. The providers included themselves among those who would not trust advertising as a source of information on care for their children.

Providers believed that parents chose day care based on the following factors (not necessarily in order of importance): location; transportation; the appearance of the home; the experience of the provider; whether the provider offered preschool instruction; and parental assessment of the provider as one who offered a safe, clean, and healthy environment. The providers emphasized the importance of the provider being "nice" and making the parents feel comfortable leaving their child (ren) in the provider's care. They believed that parents continually reassess these factors based on the emotional and physical appearance of the child in the evening.

Some providers said that the food they served was not a particularly important issue for parents, and that most parents do not even inquire about meals. Other providers believed that parents are interested in whether good meals are being served. A few providers stated that the meal/food issue was more important to them wanting to serve better food than it was for the parents.

3. A Typical Day in the Home Day Care Environment

Typical days in providers' homes varied, though all agreed upon the necessity of maintaining a schedule. Some homes are available 24 hours, while others operate on a daily schedule ranging from 5:30 a.m. to approximately 6:00 p.m. Generally, the day care schedule includes breakfast, free play, organized activities, lunch, quiet time/naps, educational TV, learning games and toys, preschool activities, library time, story time, coloring, dancing, singing, and snacks served throughout the day. Some providers provide dinners for those children remaining into the evening. Field trips and activities away from the home pose challenges unless volunteer parents or friends can assist and monitor.

4. Meals Provided

All providers participating in the focus groups agreed the meals they serve have improved with tier I status along with the ability to purchase better quality and more abundant food. Although not having received any complaints about their meals from clients prior to the pilot, providers cited offering superior cuts of meat; more fresh fruits and vegetables rather than canned; more milk and juice; and more brand-name products with the onset of the pilot. They were also able to purchase items such as disposable bibs and toys with the increased reimbursements.

Providers realized the importance of providing nutritious meals to their charges, as the food the children receive in day care may be the only or most important meal of their day. The providers reported that they prepare all their meals according to the guidelines and menus provided by the CACFP.

5. Thoughts About and Interactions with the CACFP

A perceived overabundance of paperwork in the CACFP was the major topic and cause of frustration for the providers in the focus groups. Some providers voiced frustration regarding the online version of forms, but others did not find this issue particularly difficult. It was felt, generally, that the program involved too much unnecessary work and bother for providers, including issues such as being 'docked' for not having cited a holiday on their logs when, in fact, the provider did not close for the holiday.

With the exception of one provider who had changed sponsors due to her displeasure in how sponsor staff treated her, most providers agreed that interactions with the sponsoring organization were pleasant. They particularly liked and appreciated the "consultant" with whom they dealt directly.[64] Providers believed that the information presented by their sponsors was useful and promoted growth both for themselves and the organization, and that the newsletters and sponsor groups were informational and helpful. No provider reported having difficulty finding a sponsor. There was some frustration noted by a couple of providers around the inability to change sponsors except on anniversary dates; other providers were unaware that there was more than one sponsor available in their area and that options existed in choosing one.

Overall, attendees felt the pilot to be an incentive for rural FDCHs, and most providers knew of others in their communities who became involved in order to participate in the NeRAED Pilot. Participants did not understand why more providers in rural areas were not enrolling.

6. The State's Role in Increasing Provider Participation and Child Enrollment

All providers, including those who participated in the focus groups, had been sent letters from their sponsors apprising them of the increase in reimbursement rates, yet some who attended the focus groups were not aware that they were a part of the NeRAED Pilot Program. They felt that the State should be doing a better job of informing providers about this and other projects that ultimately affect them. Other provider concerns dealt with the limitations on the number of children for whom they could care, the amount of paperwork, and other requirements that can render the running of FDCHs expensive, making the profession less viable as a means to earn a living in the region.

Comments and suggestions included the following:

- Maintaining tier I rates after the pilot ends;
- Allowing providers access to Government commodities such as milk and cheese;
- Allowing providers' children to be covered within the program;[65]
- Improving the overall communication flow;

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[64] Providers in the focus groups referred to visiting sponsor staff as "consultants" or "food ladies." These are the staff responsible for monitoring provider adherence to CACFP rules and for providing technical assistance and training, as needed or required by program regulations.

[65] Providers are allowed in include their own children in CACFP, although restrictions exist. It is unclear whether this comment reflects a desire for fewer restrictions or ignorance of the program regulations. Of course, providers rely on their sponsors for guidance about program regulations.

- Increasing awareness about the program;
- Publicizing grant information for those interested in starting an FDCH;
- Keeping pace with the actual cost of day care to providers and parents; State regulations make it impossible for many families to afford the day care services they need;
- Having more unannounced monitoring visits; and
- Decreasing the amount of time it takes (2–3 months) to obtain State licensure.

There was agreement that, overall; the State was performing as well as possible under the current regulations.

7. Plans When the Pilot Ends

Focus group attendees, representative of the tier I FDCH pilot providers, expressed a love for the work that they do and the children and families they serve. Generally very satisfied with their current chosen career paths, they appeared to be a committed group, with great concern about their client populations. None of the providers started in day care as a result of the pilot. As cited above, they were all satisfied with their sponsoring organizations and particularly appreciative of the consultant whom they referred to as "the food lady." Providers reported they were able to serve a better quality of meals and snacks to their clients as a result of the pilot.

Despite providers' generally positive assessments, focus group attendees were unsure about their continued participation in the CACFP following the cessation of the pilot and the resultant reduction of their reimbursements to their previous tier II levels. The benefits described above were seen as being outweighed by the disadvantages, including the amount of paperwork involved. All expressed great frustration with this aspect of the program and said that lesser reimbursements as tier II providers would not make the requirements worth it. Most providers reported that they would seriously consider leaving the CACFP at the end of the pilot due to this factor and the difficulties they would face in attempting to provide meals that comply with the guidelines of the program with less financial assistance.

There were some differences among the three focus groups:

- Group 1: Most of the providers in this group stated their intention to discontinue the food program and increase their rates for care. Another stated her plan to return to the less nutritious meals that she served prior to the pilot. None of the participants in that group expressed a desire to leave day care due to the termination of the pilot.
- Group 2: Most of the participants were considering the possibility of leaving the day care business to seek new challenges and lines of work. They all agreed that the food program in and of itself was not worth the effort to remain as a day care provider.
- Group 3: All participants in this group agreed that, even if they continued in day care, they would seriously consider not participating in the CACFP any longer because complying with the nutritional guidelines would be too difficult with a lower reimbursement. Many stated having considered leaving the program prior to the

pilot, as the tier II reimbursement had been too minimal to comply with the guidelines. Raising their prices for day care was not viewed as a viable option because the parents could not afford an increase in rates.

Despite the concern about continued participation raised in the focus groups, sponsors reported that very few providers had left the CACFP when they were asked about this early in January 2008 (about three months after the end of the pilot).

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APPENDIX B: SPONSORING ORGANIZATIONS

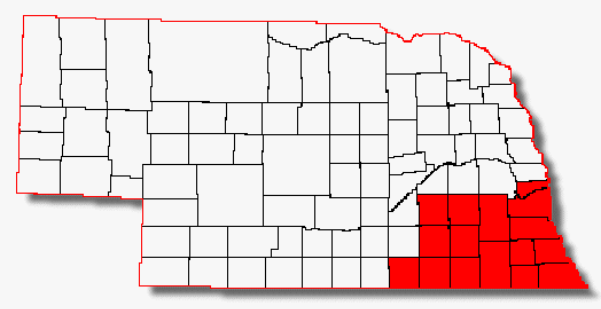
Below is a brief description of the seven sponsoring organizations that provided CACFP services in Nebraska prior to and during the NeRAED Pilot. Further information about the sponsors can be accessed at the Nebraska Department of Education's website, www.nde.state.ne.us/NS/sponsors/index.htm.

Child Nutrition Services

241 N. 12th, Suite D
Tecumseh, NE 68450-2199

Child Nutrition Services has been assisting family day care providers in southeast Nebraska since 1987. The agency's primary function is administering food program benefits to providers. In March 2006 (approximately 6 months after the start of the pilot), Child Nutrition Services was sponsoring 171 FDCH providers, of which 118 (69 percent) operated in rural areas.

Map B.1: Service Area for Child Nutrition Services



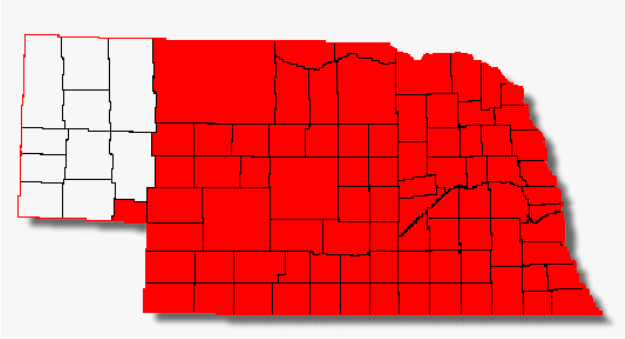
Counties served: Cass, Fillmore. Gage, Jefferson, Johnson, Lancaster, Nemaha, Nuckolls, Otoe, Pawnee, Richardson, Saline, Sarpy, Seward, Thayer, and York

Family Service

501 S. 7th
Lincoln, NE 68508

The Family Service agency has been in existence for more than 110 years, providing charity care and administering other community programs that cater primarily to the needs of children and their families. These programs include behavioral health, CACFP, Early Childhood and Youth Development, and WIC. In March 2006, Family Services was sponsoring 1,193 FDCH providers, of which 866 (73 percent) operated in rural areas.

Map B.2: Service Area for Family Service



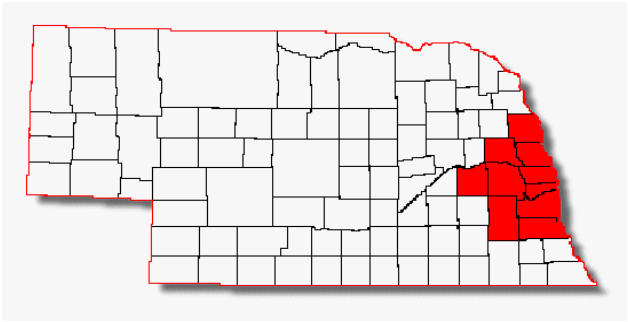
Counties served: Adams, Antelope, Arthur, Blaine, Boone, Boyd, Brown, Buffalo, Burt, Butler, Cass, Cedar, Chase, Cherry, Clay, Colfax, Cuming, Custer, Dakota, Dawson, Deuel, Dixon, Dodge, Douglas, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Knox, Lancaster, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Sarpy, Saunders, Seward, Sherman, Stanton, Thayer, Thomas, Thurston, Valley, Washington, Wayne, Webster, Wheeler, and York

Heartland Family Service

6720 N. 30th St
Omaha, NE 68112

Heartland Family Service has been serving families in eastern Nebraska and southwest Iowa since 1875. The agency has a central focus of strengthening families. In addition to administering the CACFP, Heartland provides counseling, education, and support services. In March 2006, Heartland Family Service was sponsoring 264 FDCH providers in Nebraska, of which 5 (2 percent) operated in rural areas.

Map B.3: Service Area for Heartland Family Service



Counties served: Burt, Butler, Cass, Dodge, Douglas, Lancaster, Otoe, Sarpy, Saunders,

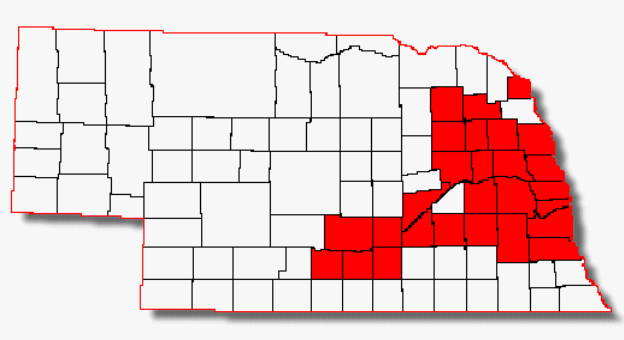
and Washington

Midwest Child Care Association

7701 Pacific
Omaha, NE 68114

Midwest Child Care Association was founded in 1980. The primary function of the association is to provide education and support services to working parents and early child care providers. Midwest provides an online database for child care referral and provider resource information. In March 2006, Midwest Child Care Association was sponsoring 752 FDCH providers, of which 107 operated in rural areas.

Map B.4: Service Area for Midwest Child Care Association



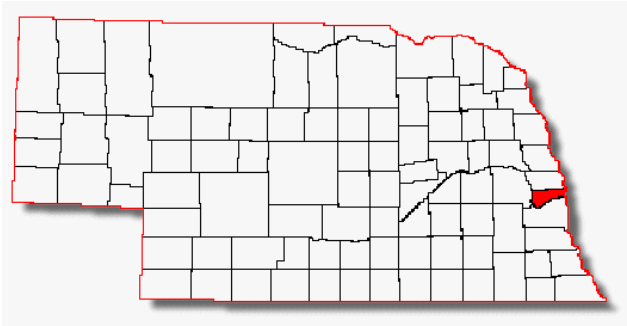
Counties served: Adams, Buffalo, Burt, Butler, Cass, Colfax, Cuming, Dakota, Dodge, Douglas, Hall, Hamilton, Kearney, Lancaster, Madison, Merrick, Otoe, Phelps, Pierce, Platte, Sarpy, Saunders, Seward, Stanton, Washington, Wayne, and York

Offutt AFB Child Development Center

55 SVS/SVYC MBB 2084
109 Grant Circle Ste 101
Offutt AFB, NE 68113

The Offutt Child Development Center has been operating for 15 years and provides child care services for families in the Air Force and other military services. In March 2006, the Offutt Child Development Center was sponsoring 32 FDCH providers, none of which operated in rural areas.

Map B.5: Service Area for Offutt AFB Child Development Center



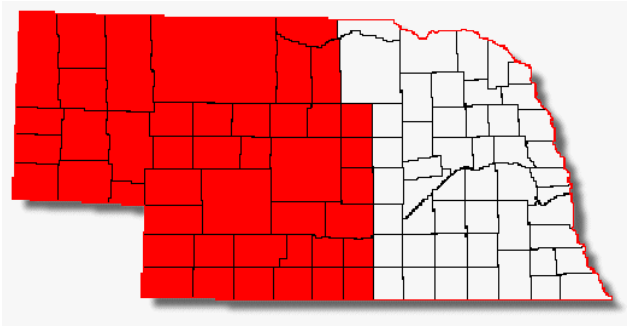
County served: Sarpy

Panhandle Family Day Care Center

89a Woodley Park Road
Gering NE 69341
P.O. Box 69
Scottsbluff, NE 69363

Founded in 1980, Panhandle serves counties located in the western section of the State. Principal responsibilities for the agency include administering, monitoring, and providing nutrition education training for the CACFP. In March 2006, Panhandle Family Day Care Center was sponsoring 144 FDCH providers, all of which operated in rural areas.

Map B.6: Service Area for Panhandle Family Day Care Center



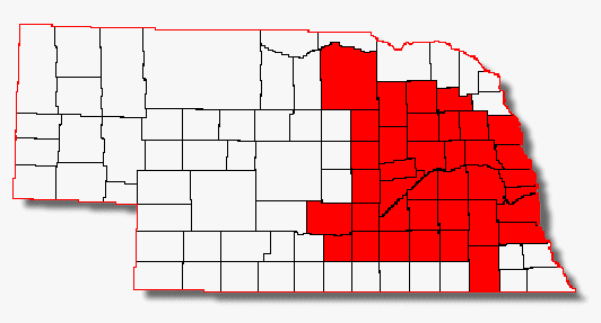
Counties served: Arthur, Banner, Blaine, Box Butte, Brown, Buffalo, Chase, Cherry, Cheyenne, Custer, Dawes, Dawson, Deuel, Dundy, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Harlan, Hayes, Hitchcock, Hooker, Kearney, Keith, Keya Paha, Kimball, Lincoln, Logan, Loup, McPherson, Morrill, Perkins, Phelps, Red Willow, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Thomas, and Valley

Provider's Network, Inc.

5645 O St., Suite C
Lincoln, NE 68510

Provider's Network, Inc. was founded in 1993. The primary focus of the agency is building a comprehensive resource center for family day care providers. Provider's Network services include the CACFP administration, interactive training, and a complete resource library. Provider's Network also has received special funding to assist non- English-speaking individuals in obtaining their license. In March 2006, Provider's Network was sponsoring 372 FDCH providers, of which 103 operated in rural areas.

Map B.7: Service Area for Provider's Network, Inc.



Counties served: Adams, Antelope, Boone, Buffalo, Burt, Butler, Cass, Clay, Colfax, Cuming, Dodge, Douglas, Fillmore, Gage, Greeley, Hall, Hamilton, Holt, Howard, Kearney, Lancaster, Madison, Merrick, Nance, Otoe, Pierce, Platte, Polk, Saline, Sarpy, Saunders, Seward, Stanton, Washington, Wayne, Wheeler, and York

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APPENDIX C: NEBRASKA SPONSOR'S EXPANSION CONSORTIUM

October 1, 2006 to September 30, 2007

Family Service Association of Lincoln
Midwest Child Care Association
Panhandle Family Child Care
Child Nutrition Services
Provider's Network, Inc

The above Nebraska Sponsoring Organizations have agreed to collaborate and pool their expansion funds in an attempt to increase awareness of the CACFP and participation in the 40-percent pilot project areas.

As a participant in the Nebraska Sponsor's Expansion Consortium I agree on behalf of my agency to the following:

1. To submit a joint application for expansion funds.
2. To deposit any expansion funds into a joint checking account for the purpose of paying any expenses that relate to the expansion project.
3. Provider's Network will act as the fiscal agent for grant funds as well as preparing fiscal reporting documents to NDE.
4. NDE will provide payment for all grant funds to Provider's Network as fiscal agent. Provider's Network will then transfer grant funds to the joint checking account established for the project.
5. Provider's Network will provide copies of all documents, bills, correspondence, etc. with members of the consortium.
6. The remaining consortium members will each designate an individual to be responsible to approve expenditures and sign checks.
7. All materials (print/audio/visual) created by expansion funds may only be used to benefit the CACFP statewide and not modified for any individual sponsor's use even after the end of grant period.
8. To follow the expansion grant application and participate fully in its outlined plan and timetable.
9. Any additions, deletions or deviations from the grant application will be made based upon consensus of the consortium members.

Name: _____

Sponsoring Organization: _____

Date: _____

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APPENDIX D: SAMPLE LETTER TO SCHOOL PRINCIPALS

January 25, 2007

Dear:

We are a group of nonprofit child advocate organizations writing to request your aid in spreading the word about eligibility for a child nutrition program. The name of the program is the Nebraska Child and Adult Care Food Program. Because of a new Federal pilot applying only in Nebraska, many home day care providers in Merna are now eligible to receive reimbursements at a higher rate than before for providing nutritious meals to the children they look after.

Research has shown that children who eat healthy, nutritious meals from a young age develop good eating habits, experience less behavioral problems, and enter school "ready to learn." On the other hand, children with inadequate access to healthy foods experience hindered development and are more vulnerable to illness.

We are writing to request your aid in getting the word out about this very important program. We would like to send flyers to your school in February to be distributed to your parents. The flyers could be distributed through a newsletter, a weekly folder, or in some other way – whatever avenue works best for communicating with your parents.

Please see the attached flyer for an example.

We will follow up with a phone call to you in a few days. In the meantime, if you have any questions, please feel free to contact any of us.

Sincerely,

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APPENDIX E: OVERVIEW OF THE CACFP

The Child Care Food Program was established in 1968 in response to the need to provide adequate nutrition to a growing number of children in day care. In 1988, eligible adults were included in the program which is now called the Child and Adult Care Food Program.

Good nutrition, the development of desirable eating habits and learning about food choices are vital building blocks for young children. Provisions must be made to ensure that these building blocks are in place in order to promote good health throughout life.

The goal of the Child and Adult Care Food Program is to see that well balanced meals are served and that good eating habits are taught in child care settings. The CACFP provides nutritious meals and snacks served to eligible children in child care centers, family day care homes, and outside-school-hours centers, as well as to eligible adults in adult care centers.

The CACFP is administered by the Nebraska Department of Education. Funding for the program is provided by the U.S. Department of Agriculture. All Program funds come from tax dollars, which is why all recipients must be accountable for how these funds are used.

The Program Serves:

- children through age 12
- children of migrant workers, through age 15
- physically and mentally disabled persons receiving care in a center where most children are 18 years old and under
- adults in nonresidential day care settings
- children ages 13 to 18 in educational enrichment programs in area eligible facilities (after school snack program)
- children age 18 and younger residing in homeless shelters

Eligibility Requirements:

- All institutions must be licensed by a federal, state or local licensing authority.
- Institutions must:
  1) have tax-exempt status from the Internal Revenue Service
  OR
  2) receive Title XX benefits from the Nebraska Health and Human Services System (NHHSS) for at least 25% of the eligible enrolled participants or 25% of licensed capacity, whichever is less, or, if a child care center, 25% of participants qualify for free or reduced price meals.
- Child care centers, adult care centers and outside-school-hours centers may participate in the program either with a sponsor or as independent centers. Family day care home providers who participate in the CACFP must be affiliated with a sponsoring organization.

Some Services of the Nebraska Department of Education:

- To provide reimbursement for meals served. The reimbursement is determined by the number of eligible enrolled participants who are served creditable meals, and the existing rates set by the U.S. Department of Agriculture.
- To provide technical assistance and training on nutrition, food service operations, program management and recordkeeping.
- To review and monitor program services to ensure good nutrition for all eligible enrolled participants.

Some Responsibilities of the Day Care Center:

- To serve meals meeting program requirements.
- To keep daily records of participants in attendance, number of meals served and quantities of food served and prepared.
- To collect household size and income information on Income Eligibility Forms.
- To comply with all regulations and instructions relating to the CACFP

Reimbursement Rates
July 1, 2006 - June 30, 2007

Child and Adult Care Centers

Breakfast	Free	$1.31
	Reduced	$1.01
	Paid	$0.24
Lunch/Supper	Free	$2.40
	Reduced	$2.00
	Paid	$0.23
Snacks	Free	$0.65
	Reduced	$0.32
	Paid	$0.06
Cash-in-lieu		$0.1675

Family Day Care Homes

	Tier I	Tier II
Breakfast	$1.06	$0.39
Lunch/Supper	$1.97	$1.19
Snacks	$0.58	$0.16

Family Day Care Home Sponsoring Organization Administration

Initial 50 day care homes	$95.00
Next 150 day care homes	$72.00
Next 800 day care homes	$56.00
Additional day care homes	$50.00

FOOD CHART

Meal Pattern Requirements

Age:	1-2	3-5	6-12	Adults
BREAKFAST				
Fluid milk	1/2 cup	3/4 cup	1 cup	1 cup
Juice or fruit or vegetable	1/4 cup	1/2 cup	1/2 cup	1/2 cup
Grains/bread or cold dry cereal or cooked cereal	1/2 slice (or 1/2 serving) 1/4 cup r 1/3 oz.) cup	1/2 slice (or 1/2 serving) 1/3 cup (or 1/2 oz.) 1/4 cup	1 slice (or 1 serving) 3/4 cup (or 1 oz.) 1/2 cup	2 servings (or 2 slices) 1 1/2 cup (or 2 oz.) 1 cup
SNACK	Select two of the following four components Juice or yogurt may not be served when milk is served as the only other component.			
Fluid milk	1/2 cup	1/2 cup	1 cup	1 cup
Juice or fruit or vegetable	1/2 cup	1/2 cup	3/4 cup	1/2 cup
Meat or meat alternate or yogurt	1/2 oz. 2 oz. (or 1/4 cup)	1/2 oz. 2 oz. (or 1/4 cup)	1 oz. 4 oz. (or 1/2 cup)	1 oz. 1 oz. (or 1/2 cup)
Grains/bread	1/2 slice (or 1/2 serving)	1/2 slice (or 1/2 serving)	1 slice (or 1 serving)	1 slice (or 1 serving)
LUNCH/SUPPER				
Fluid milk	1/2 cup	3/4 cup	1 cup	1 cup (Lunch only)
Meat or poultry or fish or cheese or meat alternate	1 oz.	1 1/2 oz.	2 oz.	2 oz.
Vegetables and/or fruit (2 or more different foods)	1/4 cup (Total)	1/2 cup (Total)	3/4 cup (Total)	1 cup (Total)
Grains/bread	1/2 slice (or 1/2 serving)	1/2 slice (or 1/2 serving)	1 slice (or 1 serving)	2 slices (or 2 servings)

For more information contact:
Nutrition Services
Nebraska Department of Education
301 Centennial Mall South
P.O. Box 94987
Lincoln, NE 68509
In Lincoln: (402) 471-2488
Toll Free: (800) 731-2233
http://www.nde.state.ne.us/NS/

Rev. 7/2006

APPENDIX F: CACFP BUILDING FOR THE FUTURE

CACFP
Building for the Future

Did you know that there is a program that helps children in day care get nutritious meals?

It is called the "Child and Adult Care Food Program" (CACFP). It provides cash assistance to day care providers for serving nutritious meals and snacks to children in their care.

This flier will help you learn about the program. It explains how you can participate and gives answers to frequently asked questions.

What is the CACFP? The CACFP is a Federal nutrition assistance program. It is operated in most States by the State education agency or State health department. The U.S. Department of Agriculture (USDA) is responsible for the program nationwide.

I take care of children in my home—am I eligible? Yes, you are eligible to participate in CACFP if you are a "day care provider" and licensed or approved to provide non-residential child care for children in your home. Your license or approval must come from the State, or from a local agency.

How do I participate in the program? Day care providers must sign an agreement with a *"sponsoring organization"* that operates the program. Parents must also complete forms to enroll each child in the program.

What kinds of meals do I have to serve? Meals must meet nutritional guidelines established by USDA. To do this, you must supply and serve portions from different food groups at each meal. Please see the chart below. This "meal pattern" is slightly different for breakfast, lunch and snacks.

Breakfast: *One serving from each group*	**Lunch or Supper**	**Snacks:** *One serving from two of the four groups:*
Milk Fruit or Vegetable Grains or Bread	Milk—*one serving* Meat or meat alternate--*one serving* Grains or bread--*one serving* *Two different servings* of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable
For example: Milk, banana, and cereal	For example: Milk, cheese sandwich, carrots, and grapes	For example: Bagel and apple juice

How do I get paid? Providers must keep accurate daily records of the meals served and children present, and submit these records to the sponsoring organization each month. The records will be checked for accuracy by the sponsoring organization and then the provider is sent a check for each meal and snack which meets the meal pattern and is served to an enrolled child.

How many meals can I be paid for? You may be paid for the actual number of meals you serve to enrolled children—up to two meals and one snack, or two snacks and one meal per day for each child enrolled.

How much will I be paid? Rates vary depending on location of the home, the income of the provider or the children in care. Your sponsor will explain the system to you.

I also take care of my own children—can I be paid for the meals I serve to them? Under certain circumstances you may receive payment for meals you serve to your own children in care. Check with the contact listed at the bottom of this page to see if you qualify.

Is there an age limit for children to participate? Yes, in day care homes only children 12 and under are eligible to have meals through CACFP.

Are there other requirements? Yes. Your sponsoring organization will provide training to help you better understand the rules of the program and give you the forms you need.

How do I get started? Contact the State agency or organization listed below for more information:

English Version

APPENDIX G: PROVIDER SURVEY

Nebraska Rural Area Eligibility Determination (NeRAED) Project

Provider Survey

"According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0584-0543. The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, search existing data resources, gather and maintain the data needed, and complete and review the collection of information. This collection of information expires 09/30/2010."

Hello, and thank you for your participation in this research study about the State of Nebraska's Child and Adult Care Food Program (CACFP), the program in which your sponsoring organization provides reimbursements to you each month for many of the meals and snacks you provide to children in your day care setting.

McFarland and Associates has been selected to study the impacts of a special program in the CACFP called the "Nebraska Rural Area Eligibility Determination Pilot", which increases the number of rural areas in Nebraska where family day care providers are eligible for higher (tier I) reimbursement rates for meals and snacks served to participating children. An important part of the study is to better understand day care providers' participation in the CACFP.

This is a research study and not an audit or review of your day care home, your CACFP sponsor, or the CACFP itself. The only information that will be reported is grouped information combined from many different providers, and these grouped data will be used to describe the characteristics of family day care providers in Nebraska and to evaluate the impacts of the Rural Area Eligibility Determination pilot, as mandated by the U.S. Congress (P.L. 108-265 §119). Per the Privacy Act of 1974, as amended, all information that we collect will be confidential, and no individual names or other identifying information will be reported. Results from individual surveys will not be reported to your sponsor, the State of Nebraska, the Federal government, or anybody else.

Your answers to the questions below are very important to the success of the pilot and the study, and we ask your cooperation in answering the following questions. Your contribution to this study is very important and will allow us to learn more about the effectiveness of the pilot."

Thank you, again, for your participation.

If you have any questions, contact us at: [xxxx]

1. In what month and year did you <u>first</u> start providing day care services in your home? _____/_____

(If you cannot remember the date, in what year did you start?) _____

2. After you started as a home day care provider, was there ever a time that you left this line of work to do something other than day care?

___No. I have been providing day care regularly since I started. [Go to Question 3]

___Yes.

Number of months I did something other than day care: ___

Number of years I did something other than day care: ___

3. Why did you become a day care provider? (Check all that apply.)

___ a. My own children were young and needed day care.
___ b. To ensure that my children received the type of day care I wanted for them.
___ c. To support my family.
___ d. To earn extra money.
___ e. To help out a friend or relative who needed day care for his or her kids.
___ f. Other (Please specify.) _____

4. What are your hours of operation? (Please use HH:MM format, like 7:30 a.m. If you have different hours throughout the week, please complete for your most common schedule.)

During the School Year:	During the Summer:
Open: ___:__ a.m./p.m.	Open: __:__ a.m./p.m.
Close: ___:__ a.m./p.m.	Close: ___:__ a.m./p.m.
___ Open 24 hours	___Open 24 hours

5. Are you a licensed or license-exempt provider? ___Licensed ___Exempt

6. With the type of license or exemption that you have, what is the maximum number of children you are allowed to care for at the same time? ___

7. Please check your education, training, or certification relevant to early childhood care: (Check all that apply.)

___ a. Child care certificate
___ b. Sponsor training
___ c. Nutrition classes
___ d. College courses
___ e. Associate or Bachelor's degree
___ f. Post-graduate degree

___ g. Other (Please specify.) _____

8. When did you start participating in the CACFP and working with your sponsor? _____ (Provide month, year.)

9. After you initially started participating in the CACFP, was there ever a time that you did NOT participate in the CACFP even though you were still providing day care?

___ No. I have participated in the CACFP since I started with it. [Go to Question 10]

___ Yes. Number of months or years I did NOT participate in the CACFP. (Please indicate) ____ months _____ years

Why did you stop participating in the CACFP for a period of time? (Check all that apply.)

___a. Too much paperwork.
___b. Did not get along with my sponsor.
___c. Wanted more flexibility in the foods and snacks I was serving to the children.
___d. Too many errors in my monthly reimbursement amount.
___e. Other (Please specify.) _____

10. What do you see as the main <u>advantages</u> of participating in the CACFP? (Indicate the 3 most important advantages with a 1, 2, and 3.)

___a. Positive relations with sponsor agency
___b. Positive relations with consultant
___c. Useful feedback/evaluations
___d. Ability to provide more food to my kids at meals and snacks
___e. Ability to provide better food to my kids at meals and snacks
___f. Informative newsletters and information
___g. Sponsor and provider groups
___h. Financial reimbursement
___i. Help finding parents who need day care for their children
___j. Training
___k. Other (Please specify.)_____

11. What are the main <u>disadvantages</u> of participating in the CACFP? (Indicate the 3 most important disadvantages with a 1, 2, and 3.)

___a. Challenging relations with sponsor agency
___b. Challenging relations with consultant
___c. Lack of communication with agency or consultant
___d. Difficulty making contact with agency or consultant
___e. Not enough feedback/constructive help
___f. Too much feedback/criticism
___g. Too much paperwork
___h. Too many regulations and requirements

___i. Other (Please specify.)_____

12. Have you had any contact with the State of Nebraska's CACFP office or staff in the past 2 years?

___ No [Go to Question 13]

___ Yes (Circle all that apply.)

a. Site visits
b. Training
c. Advice
d. Informational phone calls or e-mails
e. Other (Please specify.)_____

13. How many children did you take care of in October of the past 3 years?

	# of boys	# of girls
October 2004		
October 2005		
October 2006		

14. How many children of each age range did you take care of during the following time frames?

	During the School Year				
	Infants Birth through 11 months	Toddlers 1 year through 2 years	3 years through 5 years	School-age children 6 years through 12 years	Teenagers 13 years and older
October 2004					
October 2005					
October 2006					

	During the Summer				
	Infants Birth through 11 months	Toddlers 1 year through 2 years	3 years through 5 years	School-age children 6 years through 12 years	Teenagers 13 years and older
2004					
2005					
2006					

15. Do any special-needs, migrant, or bilingual children currently attend your day care home?

___ No [Go to Question 16]

___ Yes

If yes, insert number in each category. (If any children can fit into more than one category, please count those children in each box.)

# Special Needs	# Migrant	# Bilingual

16. I am currently caring for _____ (insert #) children.
    a. I would like to care for _____ children.

17. Are you currently operating at your full licensing capacity (caring for the maximum number of children)?
    ___ Yes
    ___ No

18. Did you have a waiting list of parents seeking day care for their infants or children at any time during the past 3 years?
    ___ No [Go to Question 19]
    ___Yes

    a. At any time during the past year?
        ___ No [Go to Question 19]
        ___ Yes

        If yes, do you have a waiting list now?
            ___ No
            ___Yes – How many infants are waiting? ____
                How many children are waiting? ____

19. What do you think are the 3 most important reasons that families select your day care program? (Number 1, 2 and 3 for the most important reasons.)

    ___ a. They don't want their children going to a large day care center.
    ___ b. Most of the parents are personal friends.
    ___ c. Most of my families live nearby.
    ___ d. Referrals from other families.
    ___ e. The safe, healthy environment I provide.
    ___ f. The activities I provide.
    ___ g. The meals I provide.
    ___ h. The hours I am open.
    ___ i. I provide transportation.
    ___ j. They like that I stress educational activities.
    ___ k. There are no other family day care providers nearby.
    ___ l. There are no day care centers nearby.
    ___ m. My costs are reasonable.
    ___ n. Other (Please specify.)_____

20. What is the average distance the children attending your family day care home travel to get there?

___a. Less than 1 mile
___b. 1 – 5 miles
___c. 5 – 10 miles
___d. More than 10 miles
___e. Don't know

21. How far out of their normal commute do parents travel to bring their children to your family day care home?

___a. Less than 1 mile
___b. 1 – 5 miles
___c. 5 – 10 miles
___d. More than 10 miles
___e. Don't know

22. Do you provide transportation services for any of your kids?

___ No [Go to Question 23]
___Yes, I: (Check all that apply.)
___a. Pick up in the morning.
___b. Drop off at school.
___c. Pick up at school.
___d. Drop off in the evening.
___e. Other (Please specify.)_____

23. Please check your day care activities on a typical day, by time of day as indicated in the table below. (Check all that apply.)

Activity	Before Breakfast	After Breakfast	After Lunch	After Dinner	At Any Time
1 Greet and settle children in					
2 Song/prayer					
3 Snack					
4 Nap					
5 Quiet time					
6 Story telling					
7 Read to children					
8 Watch TV					
9 Games and toys					
10 Free play indoors					
11 Free play outdoors					
12 Other outdoor play					
13 Planned activity					
14 Other					

24. Please check any special activities or events that you offered in the past 3 years.

Calendar Year	2004	2005	2006
Birthday Parties			
Christmas Celebration			
Easter Celebration			
Halloween Party			
Hanukah Celebration			
Thanksgiving Celebration			
Other			

25. Did you take any field trips in the past 3 years (for example: to the zoo, the library, the park)?
___No ___Yes

If yes, about how many in:
2004 ___
2005 ___
2006 ___

26. Which meals do you serve at this time of year? (Check all that apply.)
___a. Breakfast
___b. Morning Snack
___c. Lunch
___d. Afternoon Snack
___e. Dinner
___f. Other (Please specify.) _____

27. Please indicate whether you have made any of the operating changes noted below since the beginning of the pilot in October 2005**.** (Complete all that apply.)

___a. No, my day care has not changed since October 2005. [Go to Question 28]
___b. Mark here ___ and go to Question 28 if you have been operating your day care for fewer than 3 months.
___c. Yes, there are changes:

A. Food:
The amounts or types of food I served changed. How?
_____
_____

B. Activities:
I have added or stopped doing the following activities.
I started doing: _____
I stopped doing: _____
_____

C. Hours of Operation or Costs:

I changed my hours of operation.

From:

To:

I changed the number of staff.

____Yes

____ No

If yes, _____ I added staff

_____ I decreased staff

D. Monitoring and Reporting Activities

Since October 2005, I spent about the same amount of time running my day care and doing paperwork:

___Yes [Go to Question E]

___ No

If no, I spent

___ less time running my day care and doing paperwork.

___ more time running my day care and doing paperwork.

E. Please write in any other operating changes you have made since October 2005.

_____

_____

_____

28. Do you know of day care providers who could not find a CACFP sponsor to work with them?

___ No [Go to Question 29]

___ Yes

If yes, in what town or county were they located _____ and when did this occur?_____

If you know, please indicate why they could not find a sponsor. _____

29. Are you aware of the new eligibility criteria for the CACFP pilot that were implemented in October 2005 and will end on October 1, 2007?

___ No [Go to Question 32]

___ If "yes, I am aware that the pilot increases the number of rural areas where providers can qualify for higher (tier I) reimbursements for meals and snacks," how did you learn about these new eligibility criteria for the CACFP pilot? (Please check all that apply)

___a. From my sponsor

___b. From the State

___c. I wasn't aware of these new eligibility criteria. I was thinking of something else.

___d. Other (Please specify.) _____

30. What information did you receive? (Check all that apply.)
___a. The meal reimbursement levels would change.
___b. There was a change in the status of the schools.
___c. There was new information about menu requirements.
___d. There were other changes in regulations.
___e. There were other changes. (Please specify.) _____

31. How was this information provided? (Check all that apply.)
___a. Call from sponsor informing me about the pilot
___b. Letter or e-mail from sponsor
___c. Letter from State Department of Education
___d. Sponsor newsletter
___e. Local newspaper article
___f. Provider group
___g. Sponsor group
___h. Other (Please specify.) _____

32. Do you know if you are in an area that qualifies for the higher or tier I rates?
___a. No, I don't know.
___b. Yes, I know that I am.
___c. Yes, I know that I am not.

33. Did you receive training about the CACFP pilot?
___ No [Go to Question 34]
___ Yes
If yes, what kind of training did you receive? _____

_____

34. Do you have suggestions for better informing providers about the pilot?
___ No [Go to Question 35]
___ Yes (Check all that apply.)
___a. Send out mailings to inform all providers.
___b. Telephone all providers.
___c. Visit all providers.
___d. Other (Please specify.) _____

35. In your opinion, what can the State do to increase the *number of family day care homes* participating in the CACFP in your area? (Circle all that apply.)
___a. Send out information to all potentially eligible households.
___b. Advertise in local media.
___c. Recruit via sponsors.
___d. Recruit via schools/churches/community groups.
___e. Nothing. There are enough family day care homes in my area already.
___f. Other (Please specify.)_____

36. In your opinion, what can **sponsors** do to increase the *number of family day care homes* participating in the CACFP in your area? (Circle all that apply.)

___a. Send out information to all potentially eligible households.
___b. Advertise in local media.
___c. Recruit via providers.
___d. Recruit via schools/churches/community groups.
___e. Increase the number of children that day care providers are allowed to care for.
___f. Other _____

37. After the pilot ends at the beginning of October 2007, reimbursements for some providers are likely to be reduced to their levels before the pilot. If your CACFP reimbursements are lowered beginning this fall, do you plan to continue offering day care services to children?

___a. Yes [Go to Question 38]
___b. Don't know [Go to Question 38]
___c. No

If no, why not? (Circle all that apply then skip to **Ending**.)

___a. Plan to retire.
___b. Going into other type of work.
___c. Participant children aging out.
___d. I no longer want to do the administrative work necessary.
___e. I cannot increase my rates without losing my parents.
___f. I would be losing money.
___g. Other (Please specify.)_____

38. If you do continue to provide day care, will you continue to participate in the CACFP as well?

___a. Yes
___b. Don't know
___c. No

If no or don't know, why? (Circle all that apply.)

___a. I no longer want to do the administrative work necessary.
___b. I cannot increase my rates without losing my parents.
___c. I would be losing money.
___d. Other (Please specify.)_____

Ending: *Thank you, again, for your time and consideration.*