NEBRASKA
Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

February 15, 2026

Mr. Brandon Metzler
Clerk of the Legislature
P.O. Box 94604
Lincoln, NE 68509

Subject: Family Home Visitation Act Annual Report

Dear Mr. Metzler:

In accordance with Neb. Rev. Stat. § 68-2309 the Department of Health and Human Services Division of Public Health submits the Family Home Visitation Act Report.

Sincerely,

Ashley Newmyer
Director, Division of Public Health

Attachment

Department of Health and Human Services
Report

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Division of Public Health

Family Home Visitation Act Annual Report

February 2026

Neb. Rev. Stat. § 68-2309

Federally and State Funded Home Visiting Programs

In Nebraska, there are currently two models of evidence-based home visiting that meet the legislative reporting criteria implemented by the Department of Health and Human Services (DHHS). Healthy Families America, administered by the Division of Public Health Nebraska-Maternal, Infant, and Early Childhood Home Visiting Program (N-MIECHV), and Parent as Teachers (PAT), administered by the Division of Children and Family Services (CFS) Family First Prevention Services Act (FFPSA) program. These programs meet the definition of a home visitation program described in Neb. Rev. Stat. § 68-2309. Specifically, "…a voluntary program carried out in relevant settings, primarily in the homes of families with one or more children, five years of age or younger, or pregnant persons."

Model Information

Description

N-MIECHV implements the Healthy Families America (HFA) model of evidence-based home visiting. HFA is strengths-based, family-centered, and offers support for pregnant or parenting families of children birth to age five who may struggle with significant life stressors such as poverty, exposure to violence or substance use, teen parenting, or military families with one or both parents in service. If a family chooses to participate in this voluntary program, they will receive visits from skilled, experienced home visitors (also called Family Support Specialists) who can assess the family's needs and risk factors. In addition to connecting families to other services and supports, home visitors conduct routine screening and assessment of parent–child interactions, child development, and maternal depression. In addition, many HFA sites offer parent support groups and services to promote social health and community connections. Local HFA sites offer weekly, hour-long home visits beginning prenatally or within the first three months after a child's birth. Visit frequency decreases over time based on family progress, and services are offered until children are between the ages of three and five.

The FFPSA program implements the PAT model of evidence-based home visiting to families involved in child welfare as a primary prevention strategy for out-of-home (foster) placement. PAT programs provide one-on-one home visits, monthly parent group connections, developmental screenings, and approaches to connect families to needed resources. Home visitors (referred to as parent educators) conduct personal visits using structured visit plans and guided planning tools. Local sites offer at least twelve hour-long home visits annually, with more offered to families with higher needs. PAT serves families for at least two years between pregnancy and kindergarten entry and is implemented by affiliate organizations.

Location of Services

Healthy Families America
Statewide needs assessments conducted by DHHS in 2010 and updated in 2020 identify 31 Nebraska counties as most at risk of poor lifespan health outcomes. To date, there are HFA programs in 30 of the 31 priority counties, and services are available in 78 of the 93 Nebraska counties. (https://dhhs.ne.gov/Pages/MIECHV-Programs.aspx)

Parents as Teachers
The Nebraska Children's Home Society, a local implementing agency, can provide PAT services in all 93 Nebraska counties, although primary offices are located in Douglas, Hall, Lancaster, Lincoln, and Madison counties. Another PAT local implementing agency provides services in Douglas and Lancaster County.

Training and Credentialing

HFA staff undergo extensive training specific to their role, implementing the model to fidelity and on critical support topics such as child development, maternal depression, substance use, parent-child interactions and relational health, intimate partner violence, safe sleep, home safety, child maltreatment, respect for family traditions and values, and continuous quality improvement. HFA staff complete, on average, 90 – 100 hours of professional development annually. Many HFA home visitors have advanced skills, including Certified Lactation Counselor, Child Passenger Safety Technician, infant massage, certified trainers or facilitators for Circle of Security, Mothers and Babies (support for maternal depression), and/or Mobility Mentoring (economic self-sufficiency).

New HFA programs must complete a Fidelity Assessment with the national office within the first three years of implementation, then complete accreditation with the national model every three years thereafter.

PAT staff also undergo extensive training specific to their role, implementing the model to fidelity and on critical support topics such as supporting families involved in child welfare, screenings and assessments, autism within families, prenatal and post-partum maternal health, and reflective practice. Similar to HFA, home visitors complete ongoing training throughout the year on relevant topics. The model developer provides continuous technical assistance to affiliates and staff as needed.

New PAT programs complete an "Affiliate Plan" that must be approved by the national office. There are 21 required performance standards, or "essential requirements," that the affiliate site must demonstrate a high percentage of compliance based on the minimum national model standards. This will allow them to achieve a "Quality Endorsement" and move on to the next steps of accreditation, or "Blue Ribbon Certification."

Eligibility Criteria and Target Population

HFA programs are administered by the N-MIECHV program, implementing the federal MIECHV grant requirements. The MIECHV grant requirements for eligibility are families that meet one or more of the following:

- Primary residence in priority communities as identified through the Needs Assessment process
- Low income (up to 300% of the Federal Poverty Level)
- Under 21 years of age
- Involved in the child welfare system (past or present)
- Exposure to substance use
- Exposure to family or community violence
- Exposure to tobacco/nicotine use in the home
- Low student achievement (for the parent)
- Children with identified developmental disabilities or delays
- Members of the Armed Forces with one or more parents with multiple deployments

The HFA model requires that at least 80% of all enrolled families are enrolled prenatally or within the first 90 days after birth.

PAT programs can choose their own criteria for eligibility based on the identified needs of the community. Eligibility starts prenatally and continues through kindergarten. The PAT model requires that families be offered services for a minimum of two years during that time, so children up to age 3 can be potentially enrolled.

The FFPSA funds families involved in child welfare in both HFA and PAT programs. The purpose of the federal FFPSA grant funds is to focus on strategies to prevent out-of-home placement for children. The target population is not only those families actively involved in child welfare, but also those families that have a greater risk of future or further involvement (recidivism) and pregnant or parenting mothers who are wards of the state themselves as a prevention strategy.

Wait Lists

HFA programs are not allowed to keep wait lists; they must provide timely resources for families in crisis. However, if a family is interested in participating, they may ask that the HFA staff contact them when an opening becomes available. PAT programs are allowed to carry a waitlist, but none of the programs currently have one.

Referral Sources

The referral network for both models consists of community partners such as hospital/clinic health systems; resource programs such as Women, Infants, and Children (WIC); Medicaid eligibility offices; public or parochial schools; other home visiting programs in the area; home visiting programs a family used prior to relocating to Nebraska; Education Service Units (ESUs); Early Development Network programs; early childhood education providers; community members; and self-referrals. For FFPSA-funded families involved in child welfare, the referrals must come from the family's case manager.

Program Goals

HFA is designed to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family well-being by reducing risk and building protective factors.

The goals of PAT are to increase parent knowledge of early childhood development and improve positive parenting practices; provide early detection of developmental delays and connection to services; improve parent, child, and family health and wellbeing; prevent child abuse and neglect; increase children's school readiness and success; improve family economic wellbeing; and strengthen community capacity and connectedness.

Outcomes

US Department of Health and Human Services Home Visiting Evidence of Effectiveness website (HomVEE) publishes validated outcomes for evidence-based home visiting models based on the six benchmarks for the federal MIECHV program: (1) maternal and newborn health; (2) child injuries, abuse, neglect and maltreatment, including emergency department visits; (3) school readiness and

achievement; (4) crime or domestic violence; (5) family economic self-sufficiency; and (6) coordination and referrals for other community resources and supports.

HFA demonstrates achieved outcomes in:

- Child development and school readiness;
- Child health;
- Family economic self-sufficiency;
- Linkages and referrals;
- Maternal health;
- Positive parenting practices;
- Reductions in child maltreatment; and
- Reductions in juvenile delinquency, family violence, and crime.

PAT demonstrates achieved outcomes in:

- Child development and school readiness;
- Positive parenting practices; and
- Family economic self-sufficiency.

Funds Expended

July 1, 2024, to June 30, 2025, funds expended on these models for direct home visiting services:

- DHHS Division of Public Health N-MIECHV Program for HFA $3,827,534
  - MIECHV federal grant funds..... $1,564,120
  - TANF federal grant funds $1,450,500
  - State General Funds $812,914
- DHHS Division of Children & Family Services FFPSA Program for HFA..... $1,489,792
- DHHS Division of Children & Family Services FFPSA Program for PAT $41,142

Nebraska Outcomes

As evidence-based programs, both programs track progress towards the stated goals to report to the national offices and to funding partners. The following data is a selection of measures tracked by these programs that demonstrate the target accomplishments listed in Neb. Rev. Stat. § 68-2309. In some cases, more than one target accomplishment can be demonstrated by the same measure, reducing data burden at the local level. Both the N-MIECHV and the FFPSA programs also report data to the federal funding partners. For the HFA program, the agreements and therefore the data are aligned with the federal fiscal year cycle (FFY 24). For PAT programs, data are reported following the state fiscal year cycle.

Improve Maternal, Infant, or Child Health Outcomes, including Reducing Preterm Births

For HFA programs reporting data across the state, there were 13 infants born preterm (before the 37th week of pregnancy) while a caregiver was enrolled in an HFA program. This represents 10.74% of the total 121 infants that were born while a caregiver was enrolled in an HFA program.

Pregnant caregivers are not eligible to be enrolled as prenatal clients under FFPSA funding, as CFS cases do not begin during pregnancy. This means no infants are born to FFPSA-eligible families enrolled in a PAT program.

Table 1. Percent of infants who were born preterm (before the 37th week of pregnancy) following program enrollment.

Programs	Infants Born Preterm	Total Infants Born	Percent
Healthy Families America	13	121	10.74%
Parents as Teachers	0	0	0%

Promote Positive Parenting Practices

Many activities carried out by home visitors promote positive parenting practices, including curriculum instruction, promotion of literacy activities, and discussion of developmental, behavioral, or learning concerns. For HFA, 12,197 home visits were completed for families with target children; this excludes home visits conducted with prenatal clients. Home visitors addressed parents' concerns about their child's development, behavior, or learning at 11,559 home visits or 94.77% of eligible visits. For PAT programs, all home visits for families funded by FFPSA are eligible for addressing these concerns. At 92.31% of visits for these families, caregivers discussed their concerns about their child's development, behavior, or learning (Table 2).

Table 2. Percent of home visits where primary caregivers were asked if they had any concerns regarding their child's development, behavior, or learning.

Programs	Home Visit with Concerns Discussed	Total Home Visits	Percent
Healthy Families America	11,559	12,197	94.77%
Parents as Teachers	--	--	92.31%

Build Healthy Parent and Child Relationships

As with the promotion of positive parenting, much of the home visitor activities work toward building healthy parent-child relationships. For HFA, progress towards this goal is primarily measured through regular assessment with the CHEERS Check-In tool (CCI). Developed by HFA, CHEERS is an acronym for Cues, Holding, Expression, Empathy, Rhythm/Reciprocity, and Smiles (Healthy Families America, 2017-2020). The data below represent caregivers who received at least one CCI assessment in each year of their child's life; 383 caregivers received a timely assessment of the 396 caregivers needing assessments. For PAT, 34.62% of FFPSA-funded families received timely assessments using Keys to Interactive Parenting Scale (KIPS) or Protective Factors Survey (PFS-2), both of which are validated tools (Table 3).

Table 3. Percent of primary caregivers who receive an observation of caregiver-child interaction (CCI) by the home visitor using a validated tool.

Programs	Caregivers with CCI	Total Caregivers	Percent
Healthy Families America	383	396	96.72%
Parents as Teachers	--	--	34.62%

Enhance Social and Emotional Development

The Ages and Stages Questionnaire, Third Edition (ASQ-3) and the Ages and Stages Questionnaire: Social-Emotional, Second Edition (ASQ:SE-2) are the most widely used, validated tools to measure child development. The ASQ-3 screens five major milestone domains, including communication, gross motor, fine motor, problem solving, and personal-social skills, while the ASQ:SE-2 focuses entirely on social and emotional development (Ages and Stages Questionnaires 2024). HFA programs complete both questionnaires under the recommended American Academy of Pediatrics (AAP) schedule. For the N-MIECHV programs, data collected focuses on the 9-month, 18-month, 24-month, and 30-month questionnaires tracked for completeness, timeliness, and resulting referrals. Of the 888 children due for a required screen, 784 children received their last required screen. For PAT, 92.31% of children due for an ASQ screen receive timely and complete one (Table 4).

Table 4. Percent of children with a timely screen for developmental delays. This should be based on the most recent screen according to the focus child's age.

Programs	Children with Timely Screen	Total Children	Percent
Healthy Families America	784	888	70.42%
Parents as Teachers	--	--	92.31%

Support Cognitive Development

For both HFA and PAT programs, cognitive development can be measured by the ASQ-3. See Table 4.

Improve the Health and Well-being of the Family

HFA programs document both well-child visits and immunizations, but only well-child visits are reported to DHHS. Home visitors encourage and support caregivers to follow the AAP-recommended schedule and work with them to overcome potential barriers to receiving care. Over the most critical time in early childhood (birth to age five), a child receives as many as 15 well-child visits (American Academy of Pediatrics 2025). Primary focus is not just on identification of potential areas of concern, but also education of the importance of connection to a family provider when the child is healthy to track appropriate development, answer developmental stage questions, and get recommended preventive immunizations. For HFA, 917 children were eligible for at least one well-child visit, and 450 were documented as having received it on time. Potential reasons for a result under 50% are families reporting major barriers with scheduling, transportation, and insurance. For families funded by FFPSA enrolled in a PAT program, 69.23% of children received their last AAP-recommended well-child visit (Table 5).

Table 5. Percent of children who received the last recommended well-child visit based on the AAP schedule.

Programs	Children with last well-child visit	Total Children	Percent
Healthy Families America	450	917	49.07%
Parents as Teachers	--	--	69.23%

Empower Families toward Economic Self-Sufficiency

The HFA program funded by N-MIECHV measures improvement in economic self-sufficiency by employment status. Data is collected on employment status by a self-reported type of employment (full-time, part-time, or unemployed). These data may not represent strict definitions of full-time and part-time employment, only what caregivers consider to be their employment type. There were 995 caregivers served in the federal fiscal year (FFY 2024); 227 caregivers reported full-time employment. This measure does not distinguish between unemployed caregivers seeking employment and unemployed caregivers not seeking employment (typically parents managing a home). For families funded by FFPSA enrolled in a PAT program, 81.25% of caregivers reported full-time employment or consistently working at least 30 hours per week (Table 6).

Table 6. Percent of caregivers employed full-time.

Programs	Caregivers Employed Full Time	Total Caregivers	Percent
Healthy Families America	227	995	22.81%
Parents as Teachers	--	--	81.25%

Reduce Child Maltreatment and Injury

N-MIECHV works closely with CFS to determine the number of children with an investigated case of maltreatment through a specific data-sharing agreement. Of the 917 target children enrolled in an HFA program, 101 were investigated for maltreatment through CFS. This only includes investigations that were active in the reporting period. Closed or ongoing cases investigated prior to the reporting period are not included in this measure. Of the target children enrolled in a PAT program eligible for FFPSA funding, 14.29% had an investigated case of child maltreatment.

Table 7. Percent of children with at least one (1) investigated case of maltreatment within the reporting period.

Programs	Children with Investigated Maltreatment	Total Children	Percent
Healthy Families America	101	917	11.01%
Parents as Teachers	--	--	14.29%

Increase School Readiness

Activities conducted by HFA programs that may lead to an increase in school readiness include encouraging and supporting daily literacy activities such as singing, reading, and storytelling.The ASQ-3 is used to measure school readiness for both HFA and PAT. See Table 4.

Families Served

Table 8. Families Served for each Program from July 1, 2024, to June 30, 2025

Healthy Families America	881 (995 FFY25)
Parents as Teachers	11

Demographic Data

Demographic data is collected for adult participants.

Income

For HFA programs in Nebraska, families are asked to report their estimated household income and household size. For HFA programs, 80% of all households enrolled must have an income equal to or less than 300% of the Federal Poverty Level (FPL). For HFA, 62.82% of families have an income at or below the federal poverty level. Of the families eligible for FFPSA funding enrolled in a PAT program, 81.25% have an income below the federal poverty level (Table 9).

Table 9. Household Income in Relation to the Federal Poverty Level				
Programs	0-100% FPL	101-300% FPL	>300% FPL	Unknown/Did Not Report
Healthy Families America	62.82%	18.48%	0.80%	17.89%
Parents as Teachers	81.25%*	--	--	--
*Does not include families with income equal to the federal poverty level (0-99.99% of FPL)				

Employment

Employment status is a self-report measure and may not reflect strict definitions of full-time and part-time employment. For HFA participants full-time employment is defined as regulalry scheduled and a minimum of 30 hours per week

Table 10. Employment Status				
Programs	Employed Full-Time	Employed Part-Time	Not Employed	Unknown/Did Not Report
Healthy Families America	22.81%	17.19%	57.49%	2.51%
Parents as Teachers	81.25%	--	18.75%	--

Race and Ethnicity

Table 11. Race						
Programs	American Indian/Alaska Native	Asian	Black or African American	White	More Than One Race	Unknown/ Did Not Report
Healthy Families America	3.62%	1.41%	6.43%	63.32%	10.35%	14.87%
Parents as Teachers	2.78%	--	5.56%	86.11%	--	5.55%

Table 12. Ethnicity			
Programs	Hispanic or Latino	Not Hispanic or Latino	Unknown/Did Not Report
Healthy Families America	40.10%	57.89%	2.01%
Parents as Teachers	22.86%	71.43%	5.71%

Insurance Status

Table 13. Type of Health Insurance Coverage			
Programs	No Insurance Coverage	Insured	Unknown/Did Not Report
Healthy Families America	19.70%	76.28	4.02%
Parents as Teachers	--	90.46%	--

References

Administration of Children and Families Home Visiting Evidence of Effectiveness (HomVEE)

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