New Jersey Needs Assessment
Preschool Development Grant Birth through 5 (PDG B-5)

New Jersey Department of Children and Families
in Collaboration with Johns Hopkins University

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New Jersey Needs Assessment
Preschool Development Grant Birth through 5 (PDG B-5): Executive Summary

High quality early experiences are critical to assuring that all children enter kindergarten ready to achieve their full potential and are on a trajectory for lifelong learning, health, development and well-being. The state of New Jersey recognizes the importance of investing in children birth to age five and has made considerable strides in providing high quality services to young children and their families. New Jersey is strongly committed to implementing a fully-integrated early childhood system of care that embraces a two-generational approach and advances equity.

The state's vision is for PDG to promote a comprehensive, coordinated early childhood system of care in addressing the physical, social-emotional, behavioral and cognitive aspects of child wellbeing and school readiness from prenatal through age five. This vision builds on a family centered approach that recognizes varied needs, priorities, and strengths. It also builds on the strategic plan for NJ's Race to the Top Early Learning Challenge Grant with a mission "to create an aligned system of early education and care with measurable impact for all NJ high needs children to age eight and pregnant women."[1] New Jersey's vision recognizes the need for a competent workforce, equitable access to affordable services for all children and families, adequate and sustainable financing, varied high-quality service delivery options, and a system for ongoing accountability including evaluation and continuous quality improvement.[2]

This needs assessment was conducted under the auspices of the Interdepartmental Planning Group (IPG). The IPG is comprised of representatives of five state departments – Department of Education (DOE - Division of Early Childhood Education, Offices of Special Education and Title I, Homeless and Migrant Education), Department of Human Services (DHS – Division of Family Development), Department of Health (DOH – Office of Early Intervention), Department of Labor and Workforce Development (DOL – Strategic Planning and Outreach), and Department of Children and Families (DCF – Offices of Licensing, Child Protection and Permanency, Family and Community Partnerships).

The purpose of this needs assessment is to analyze the current landscape of New Jersey's B-5 early childhood mixed delivery system to inform strategic planning. The needs assessment also identifies systems changes needed to maximize the availability of high-quality early childhood services for low-income and disadvantaged families across providers and partners, improve the quality of care, streamline administrative infrastructure, and improve state-level early childhood care and education (ECCE) funding efficiencies. In defining early childhood, New Jersey includes all aspects of maternal and child health: preconception, interconception, pregnancy, postpartum, and parenting (including fathers). New Jersey's early childhood system also includes family supports, especially in services and programs such as home visiting, Early Head Start, and Central Intake, New Jersey's statewide system that provides a single point of entry for families to access a wide array of services from prenatal to age five. For the needs assessment, over 50 state and local needs assessments and other reports were reviewed, and input was sought from key stakeholders including the New Jersey Child Care Advisory Group and the New Jersey Council for Young Children.

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[1] Race to the Top- Early Learning Challenge Final Report. 2019.

[2] National Academies of Sciences, Engineering, and Medicine. (2018). Transforming the Financing of Early Care and Education. Washington, DC: The National Academies Press. DOI: https://doi.org/10.17226/24984.

Who are the Children of New Jersey?

An estimated 626,249 children under the age of six live in New Jersey. Of these children:

- 107,244 (17.1%) **live in poverty**: Children growing up in poverty have less access to resources such as safe and affordable housing, access to education, public safety, available and affordable healthy foods, local health services, and environments free of toxins. They also experience worse health outcomes than their peers growing up in higher income households. [3]
- 247,157 (40.9%) have **one or more foreign-born parent**: A high percentage of foreign-born parents has implications for workforce development, family engagement, and culturally appropriate service delivery.[4]
- 268,080 (13.5%) live in **food insecure households** (all ages children): Children living in food insecure households are at higher risk of poor health outcomes.[5]
- 255,647 (48.5%) of children 0-5 are enrolled in **Medicaid or the Children's Health Insurance Program (CHIP)**[6]
- 13,644 (4.3%) of children 0-3 years have an **Individualized Family Service Plan (IFSP)**[7]
- 19,763 (8.2%) of children aged 3-5 years participated in **special education** through Part B of the Individuals with Disabilities Education Act (IDEA)[8]

The state is racially, ethnically and culturally diverse. In New Jersey, the percentages of children under six living in poverty vary notably by race/ethnicity; the percentages are highest for children who are black (31.7%) and Hispanic (28.2%). The percentages for white, not Hispanic and Asian children under age six who are living in poverty are 8.5% and 5.2%, respectively. Reducing disparities and promoting health equity are priorities across state agencies and in ongoing initiatives such as Healthy New Jersey 2020 and Project HOPE (Harnessing Opportunity for Positive, Equitable Early Childhood Development).

Defining Vulnerability in New Jersey

Children in New Jersey who are vulnerable or underserved include those with poverty/economic stressors, special educational needs, special medical/health needs, and those who otherwise have special circumstances.

- **Families living with poverty/economic stressors** include pregnant women, parents, and children in low-income families, including (but not limited to) those eligible for State-funded preschool, EHS/HS, CCDBG subsidized child care, HV, Title I services, GA, TANF, Medicaid, NJ FamilyCare (Child Health Insurance Program-CHIP), SNAP, or WIC.

[3] American Community Survey 2013-2017, B17020

[4] American Community Survey 2017, C05009

[5] Health Indicator Report of Food Insecurity, NJ SHAD, https://www-doh.state.nj.us/doh-shad/indicator/view/FoodInsecurity.CoChild.html

[6] Correspondence with Division of Family Development, New Jersey Department of Human Services, 2019.

[7] https://www.nj.gov/health/fhs/eis/documents/DOH%20Table%201%20Dec%201%202017.pdf

[8] Correspondence with the New Jersey Department of Education, 2019.

- **Families with special education needs** include children/families participating in IDEA Part C Early Intervention & Part B (619) Preschool Special Education.
- **Families with special medical or health needs** include medically compromised children or parents with special medical, behavioral (alcohol/substance abuse), mental health, and/or disability needs.
- **Families with child welfare and safety needs** include children/families referred to child protective services (CPS)--DCF Child Protection & Permanency (CP&P) or families impacted by domestic violence (DV)/interpersonal violence (IPV).
- **Families with special circumstances** include children in military families, children with an incarcerated parent, children/families with transportation barriers, families where English is a second language or with other communication barriers, children in migrant families, socially isolated children/families with limited family/community supports, children of teen parents, and homeless children.

New Jersey's Mixed Delivery System for Early Childhood Care and Education (ECCE) Services

New Jersey's has a mixed-delivery system for ECCE services which include home visiting, child care, preschool including Head Start, kindergarten and Grow NJ Kids.

- **Home Visiting:** New Jersey offers voluntary early home visiting at no cost to families. Local programs implement one or more of five of the models designated as evidence-based by the US Department of Health and Human Services (DHHS).
- **Child Care:** The state offers licensed and registered child care. Centers serving six or more children under the age of 13 are required by state law to be licensed. Family care providers may serve up to five children.
- **Preschool:** The State of New Jersey funded 50,684 preschool slots in 2017-2018 for 3 and 4-year olds. These slots included 12,368 through Federally funded Head Start and 12,784 in special education.[9]
- **Kindergarten:** Across the state, about 85% of 5-year olds are enrolled in kindergarten with about 90% enrolled in full-day programs. A majority of school districts (480/673) offer full day programs, while 40 offer half-day services.
- **Grow NJ Kids (GNJK):** GNJK is New Jersey's Quality Rating Improvement System (QRIS) to assess and improve the quality of early child care and education programs. A total of 1233 center-based programs and family child care providers are actively enrolled in Grow NJ Kids as of October 2019. Of these, 202 center-based programs and 32 family child programs completed the rating process with a three out of five stars.[10]

The Table presents the broader set of two-generational services offered by each of the five agencies of the New Jersey Interdepartmental Planning Group (IPG).

[9] National Institute for Early Education Research. The State of Preschool 2018. Rutgers Graduate School of Education. 2019

[10] Correspondence with New Jersey Division of Family Development, Department of Human Services. 10/24/19.

Table: Summary of NJ Interdepartmental Planning Group 2-Gen Services (B-5)

Education (DOE)	Human Services (DHS)	Children and Families (DCF)	Health (DOH)	Labor (DOL)
PDG Expansion grant State-Funded Pre-K Preschool Education Expansion Aid -- PEEA Early Head Start/Head Start Collaboration Office Teacher Credential & Licensing Preschool Special Education (IDEA Part B, Section 619) School Support Services--teen parents Federal Title I services for low-income families Other Federal Educ Programs & Services Region Achievement Centers (RAC) NJ Council for Young Children (NJCYC) NJ Enterprise Analysis for Early Learning (NJ-EASEL) integrated data system	Grow NJ Kids–QRIS CCDF Child Care Development Block Grant (CCDBG) Subsidized Child Care Wraparound Care NJ First Steps-Infant/ Toddler Program Family Child Care (FCC) Providers Child Care Resource & Referral Agencies (CCR&R) GNJK-TTA NJCCIS-Child Care Workforce Registry WorkFirst NJ-TANF, GA, SNAP Emergency Services Child Support Addiction & Mental Health Neonatal Abstinence Disability Services NJ Medicaid NJ FamilyCare-CHIP	Child Care Licensing FCC Registration NJ Home Visiting/CI ECCS/Help Me Grow SF Protective Factors County Councils for Young Children/CCYC Parent-Linking Program School-Based Services Project TEACH for Teen Parents Family Success Centers Division on Women-DV/IPV services Children's Trust Fund Federal CBCAP (Community-Based Child Abuse Prevention) Child Behavioral Health Services Child Developmental Disabilities Child Protection & Permanency Family First Prevention Act Project HOPE	Title V MCH Block Grant Healthy Women/ Healthy Families Black Infant Mortality Maternal Mortality Perinatal Risk Assessment (PRA) CHWs / CI Hubs Access to PN Care Home Visiting FQHCs/Primary Care WIC Services Breastfeeding SNAP Education Child Health/ Immunizations Healthy Homes Child Lead Poisoning Adolescent Health / Pregnancy Prevention Shaping NJ EI - IDEA Part C Special Child Health Peds Mental Health Access Program	WFNJ TANF/GA SNAP Smart Steps Career Advancement Voucher Program (CAVP) WFNJ-OJT YTTW-Youth Transition to Work Youth Corps Literacy-Title II Federal Bonding YouthBuild Temporary Disability Insurance (TDI) Family Leave Insurance (FLI) Unemployment Insurance (UI) Earned Sick Leave enforcement One-Stop Career Centers (OSCC) CHW apprenticeship w/ Rutgers

Quality and availability of services are not enough to assure that families receive needed and desired services. New Jersey invests in systems infrastructure at the state and local levels to support the development and quality of services. The state's Central Intake system, overseen by both DOH and DCF, demonstrates New Jersey's commitment to systems integration. In each county, Central Intake hubs provide a single point of entry for families to access a wide array of community services from prenatal to age five. Another strong example of New Jersey's commitment to systems integration is Grow New Jersey Kids. GNJK is a collaborative effort of DCF, DOE, DOH, and DHS. It supports workforce development and trainings across multiple early care and education programs led by DHS and DOE. The NJ Workforce Registry allows early care and education professionals to track their education and professional development activities. Lastly, the state participates in various efforts focused on systems integration such as the Early Childhood Comprehensive Systems Impact, Help Me Grow, and Project HOPE.

Key Findings and Recommendations

New Jersey has four gaps in availability data and research about the quality and availability of programming and supports for children birth through five, including: programming and supports for children with special circumstances; shared understanding of the definition of vulnerability and high quality ECCE programs; availability of mental health services for young children; and child care demand, affordability, locations and slots.

New Jersey is committed to supporting collaboration between programs and services maximizing parental choice. To achieve these goals, New Jersey intends to address four key needs.

- Identification, Programming and Supports for Children in Special Circumstances
- Unmet Need for Affordable Childcare and Preschool
- Continued Investment in Central Intake Infrastructure to Support Coordination
- Sustained Funding for NJ-EASEL

To monitor progress in achieving the PDG vision, New Jersey uses four sets of indicators in addition to a broad set of indicators related to health and well-being.

- School Performance
- Early Intervention and Special Education Performance
- Workforce Development
- Central Intake Screens

As indicated in the needs assessment, New Jersey has strong administrative code and regulations surrounding transition supports for children in preschool through third grade; however, findings also highlight that there is uneven implementation of best practices with regard to child care and teacher training, engaging parents, preschool to third grade transition plans in school districts, and connections across early care and education settings.

New Jersey has made remarkable progress in implementing high quality early childhood care and education services and supports. However, five barriers remain: the need for a communication strategy for a shared vision; insufficient funds; unintended consequences of diverse funding streams that are not aligned; and insufficient time to allocate funds and enroll families when funds newly become available.

Finally, New Jersey maintains a strong commitment to systems integration as a means to promote the delivery and enhancement of high quality, efficient and effective services to families with young children. This commitment is supported by interagency state -level entities, such as the Early Learning Commission, the Interdepartmental Planning Group, the New Jersey Council for Young Children. Their efforts are supported by 21 County Councils for Young Children with use a shared leadership approach that includes parents as active partner with service providers and community leader to identify the needs, concerns, aspirations and successes of collective efforts to positively impact the health, education and well-being of young children and families.

New Jersey currently is developing a comprehensive, multi-year strategic plan that incorporates findings from the needs assessment and input from stakeholders in order to support enhanced collaboration and coordination among existing early childhood services within New Jersey's mixed delivery system. It will incorporate the essential domains from the needs assessment and outline goals, action plans, and performance indicators for New Jersey's early childhood mixed delivery system. The strategic plan will also build on the many strengths of New Jersey's current early childhood system. The plan will focus on improving services in order to best support all children and their families, particularly those identified as low-income or vulnerable.

1. Introduction

This needs assessment has been conducted as part of New Jersey's Preschool Development Grant Birth through Five (PDG B-5) sponsored by the Administration for Children and Families (ACF), Office of Child Care. The needs assessment has been conducted by the Department of Children and Families and Johns Hopkins University under the auspices of the NJ Interdepartmental Planning Group (IPG). The IPG is comprised of representatives of five state departments –Department of Education (DOE - Division of Early Childhood Education, Offices of Special Education and Title I, Homeless and Migrant Education), Department of Human Services (DHS – Division of Family Development), Department of Health (DOH – Office of Early Intervention), Department of Labor and Workforce Development (DOL – Strategic Planning and Outreach), and Department of Children and Families (DCF – Offices of Licensing, Child Protection and Permanency, Family and Community Partnerships).

The needs assessment has been conducted in alignment with work of the NJ Council for Young Children (NJCYC), the Governor's state advisory council for early care and education. This report draws from more than 50 state and local needs assessments and other reports completed since the inception of NJCYC. As a group, prior assessments had a broad scope that spanned the accessibility, availability and quality of services across the State. The reports had a particular focus on vulnerable and underserved young children and their families.

Parent voices informed multiple prior needs assessments. For example, validation studies of New Jersey's Quality Rating Improvement System included surveys of 500 parents about their children's characteristics and home experiences.[11] In addition, the County Councils for Young Children, established in each of New Jersey's 21 counties, routinely seek parents' input regarding service needs and recommendations. For example, the Passaic County 2018 needs assessment highlighted parents' preferences for receiving information about community services via the internet, desire for parent trainings, and need for language/translation services for parents and caregivers.[12] More recently, parent focus groups conducted as part of Project Hope-- Harnessing Opportunity for Positive, Equitable Early Childhood Development-- serving Atlantic City and Bridgeton focused on needs related to to lack of economic opportunity, affordable housing, quality childcare, and reliable services (e.g., transportation, health, social services) for low income families.[13,14]

For this PDG needs assessment, additional input was sought from key stakeholders for several reasons – to identify the most relevant and useful data, to interpret available data from cross-sector perspectives, and to refine this report of findings. Meetings were held with the NJCYC (6/19/19, 6/27/19, 8/23/19), New Jersey Child Care Advisory Group (6/20/19) and the IPG (3/26/19, 5/28/19, 7/23/19) (Appendix B). The Child Care Advisory Group, convened by DHS/DFD in 2018, includes advocacy groups, parents, organizations representing child care providers and child care centers from across the state and government agency representatives from DOE, DOH, DCF, and the Department of Community Affairs. In addition to receiving stakeholder input during regularly scheduled meetings, staff from multiple New Jersey agencies provided feedback on draft materials.

The needs assessment is organized in alignment with guidance provided by ACF in

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[11] Race to the Top-NJ Report June 2018.

[12] Passaic County Council for Young Children Needs Assessment Final Report 2017.

[13] Project Hope Team. Themes from Project HOPE New Jersey Beneficiary Voice Site Visits in Atlantic City and Bridgeton. April 4-5, 2019.

[14] Project Hope Team. Executive Memo to Inter Departmental Planning Group. 7/14/19.

March 2019. The guidance emphasized the importance of a shared understanding of key terms and identification of children 0-5 who are vulnerable. The needs assessment highlights the availability and quality of an array of early care and education services, numbers of children awaiting services, gaps in programming and supports, indicators of progress, gaps in ECE facilities, barriers and opportunities for providing high quality early childhood services, and needs for transition supports between early childhood care and education programs and school entry. It also emphasizes the critical importance of systems integration and interagency collaboration in order to meet the needs of children and families.

Findings from this needs assessment are informing ongoing strategic planning regarding collaboration, coordination, and quality improvement activities among existing programs in the State, local educational agencies (LEAs) and early childhood providers. The strategic plan will identify facilitators and barriers for collaboration and coordination among existing programs and providers in the state in order to better serve children and families. It also will build on the *2012 New Jersey Plan* which was developed as part of New Jersey's successful Race to the Top-Early Learning Challenge application. As such it will provide recommendations for early care and education programs and incorporate new and revised Federal, State, and local requirements.

2. Summary of the State of New Jersey and Its Young Children

This section gives an overview of the demographic and health characteristics of the State's population and the rankings of its counties with regard to these. Of the 626, 249 children under age 6, about one in seven live in poverty and about three in seven have a foreign born parent. The state is racially, ethnically and culturally diverse, and reducing disparities is a priority across state agencies. Although several key perinatal and early childhood health outcomes in New Jersey are more favorable than those for the US as a whole, disparities by race and place persist for low birth weight, preterm birth, infant mortality, and child death.

a. Demographic Characteristics

More than 9 million people live in the 21 counties in New Jersey. The most populated counties are Bergen and Middlesex, while Salem and Cape May are among the least populated. New Jersey is the most densely populated state in the United States with considerable variability across counties. Hudson is the most densely populated while Salem is the least densely populated county (See Appendix C-1).

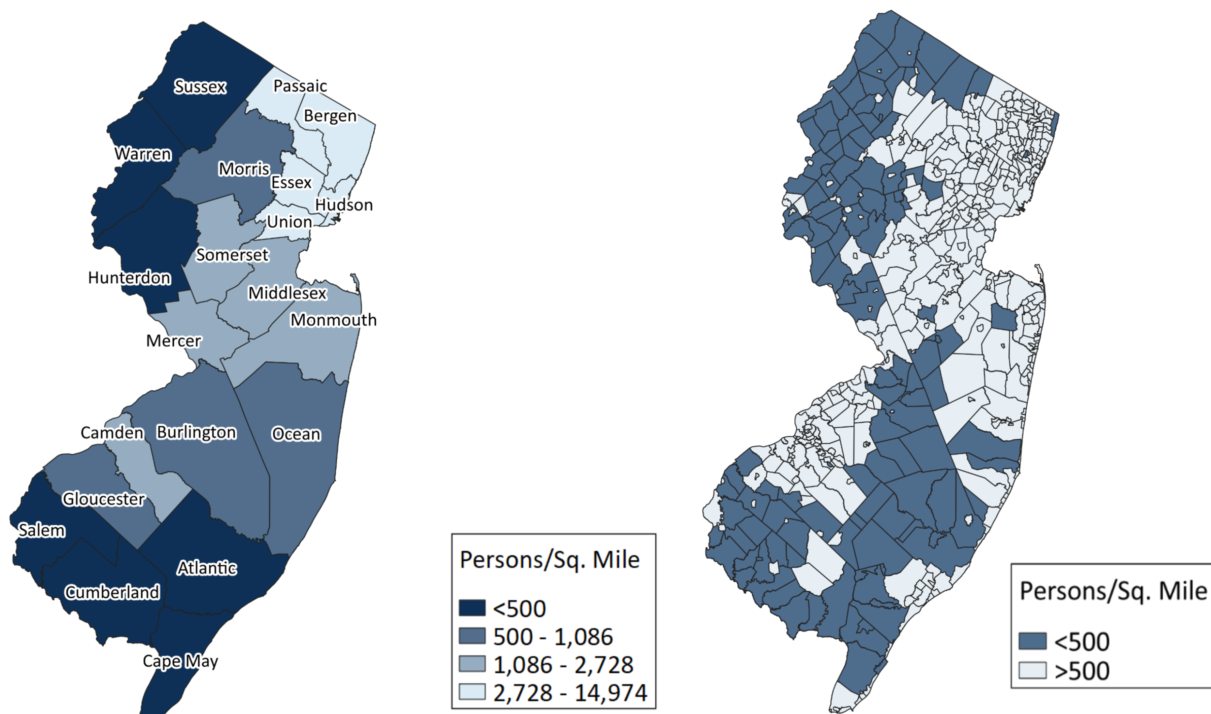
Although no communities in New Jersey meet the formal federal definition of a Rural Area, the state recognizes extreme pockets of need in rural parts of the state. The New Jersey State Office of Rural Health identifies rural counties and communities as those having a population density of fewer than 500 people per square mile. Seven counties and 123 municipalities are rural using this definition (Figure 1).[15]

New Jersey is a racially, ethnically and culturally diverse state. Approximately two-thirds (67.9%) of New Jerseyans are white, 13.5% black, 9.4% Asian, 0.2% American Indian/Alaska Native, 2.6% multiracial, and 6.4% Other. About one in five (19.7%) are Hispanic with nearly one third (31.0%) speaking a language other than English at home and 12.2% reporting

[15] Institute for Families, School of Social Work, Rutgers University. New Jersey Rural Health Needs Assessment Executive Summary, https://www.nj.gov/health/fhs/primarycare/documents/Rural%20Health-New%20Jersey%20Rural%20Health%20Needs%20Assessment-website.pdf

speaking English less than "very well." Across all ages, 22.1% of New Jerseyans are foreign born.[16]

Figure 1: New Jersey Population Density by County[17] and Municipality[18], 2017



Reducing disparities – which are rooted in social, economic and environmental disadvantage – is an overarching goal of many New Jersey initiatives. For example, New Jersey's Preschool Expansion Plan (2015-2018) expanded access to full-day preschool in 16 high-need communities through a mixed-delivery system of school-based, private provider and Head Start programs. Recognizing both un-served and under-served 4-year olds, the initiative expanded access for children in families earning < 200% of federal poverty level and required participating programs to offer comprehensive services and include children with disabilities. Supports for participating programs included assignment to an early childhood liaison, trainings, and professional development through Grow NJ Kids, the state's Quality Rating Improvement System.

Reducing disparities also is the central focus of Healthy New Jersey 2020. It is a focus as well of the 2018 Healthy Women, Healthy Families initiative in the Department of Health, and the recently completed LAUNCH initiative. It is a priority goal of New Jersey's Title V Maternal

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[16] Data in paragraph from: American FactFinder, 2013-2017 American Community Survey 5-Year Estimates. CP05, S0501, C16001

[17] New Jersey Department of Labor and Workforce Development, Population Density by County and Municipality, New Jersey, 2010 and 2017, https://nj.gov/health/fhs/primarycare/documents/Rural%20NJ%20density2015-revised%20municpalities.pdf

[18] Institute for Families, School of Social Work, Rutgers University. New Jersey Rural Health Needs Assessment Executive Summary, https://www.nj.gov/health/fhs/primarycare/documents/Rural%20Health-New%20Jersey%20Rural%20Health%20Needs%20Assessment-website.pdf

and Child Health Block Grant Program. Within DCF's Office of Early Childhood Services, Project HOPE (Harnessing Opportunity for Positive, Equitable Early Childhood Development) strives to optimize health and well-being for young children from prenatal to age five, prevent and mitigate early childhood adversities, and improve adverse social settings to reduce racial, ethnic, geographic, and economic inequities.

Efforts to promote equity inform local as well as statewide efforts. As noted in the Introduction (Section 1), Project Hope (Harnessing Opportunity for Positive, Equitable Early Childhood Development) focuses on two high need communities in Atlantic City and Bridgeton. These communities have among the least favorable health, welfare, economic, and educational outcomes in the state. The goal of Project HOPE is to promote optimal health and well-being for young children from perinatal to age five, prevent and mitigate early childhood adversities, and improve adverse social settings to reduce racial and ethnic, geographic, and economic inequities. It intends to achieve this goal by realigning systems of care and increasing access to opportunities. Project HOPE also strives to engage community members and create feedback loops to ensure ongoing comunication among state and local policy makers, practitioners, community leaders and families.

Of the 626,249 children under six years of age in NJ, 17% live in poverty.[19,20] Children growing up in poverty have less access to resources such as safe and affordable housing, access to education, public safety, available and affordable healthy foods, local health services, and environments free of toxins. They also experience worse health outcomes than their peers growing up in higher income households. While the overall percentage of New Jersey children in poverty is less than that for children under six across the US (22%), the percentages exceed the national average in seven NJ counties (Salem, Atlantic, Passaic, Essex, Cumberland, Ocean, and Hudson). The lowest percentages of children under six living in poverty are in Somerset, Morris and Hunterdon counties (See Appendix C-2).[21]

Figure 2 highlights variability across and within counties in the percentage of children under 6 living in poverty. Even among the counties with the highest percentages of children in poverty, there are pockets of concentrated need as well as areas with less extreme poverty. For example, the percentage of children living in poverty in Atlantic county includes municipalities categorized into all 4 poverty groups.

In New Jersey, the percentages of children under 6 living in poverty vary notably by race/ethnicity; the percentages are highest for children who are black (31.7%) and Hispanic (28.2%). The percentages for white, not Hispanic and Asian children under age six who are living in poverty are 8.5% and 5.2%, respectively.

Estimates of children under six living in poverty do not fully estimate households constrained by limited income. The 2018 ALICE report reviews economic status by households by focusing on households with income exceeding the FPL and employed. The report includes households with children of all ages.[22] An estimated 38.5% of all households in New Jersey could not afford basic needs such as housing, child care, food, transportation, health care, and technology. Of these households, 10.5 percent had earnings < FPL and 28.5% were ALICE

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[19] American Community Survey 2013-2017, B17020

[20] This translates to a family of three earning less than $20,420 in 2017 ($21,330 for family of three in 2019; Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services, 2019 Poverty Guidelines, https://aspe.hhs.gov/2019-poverty-guidelines.

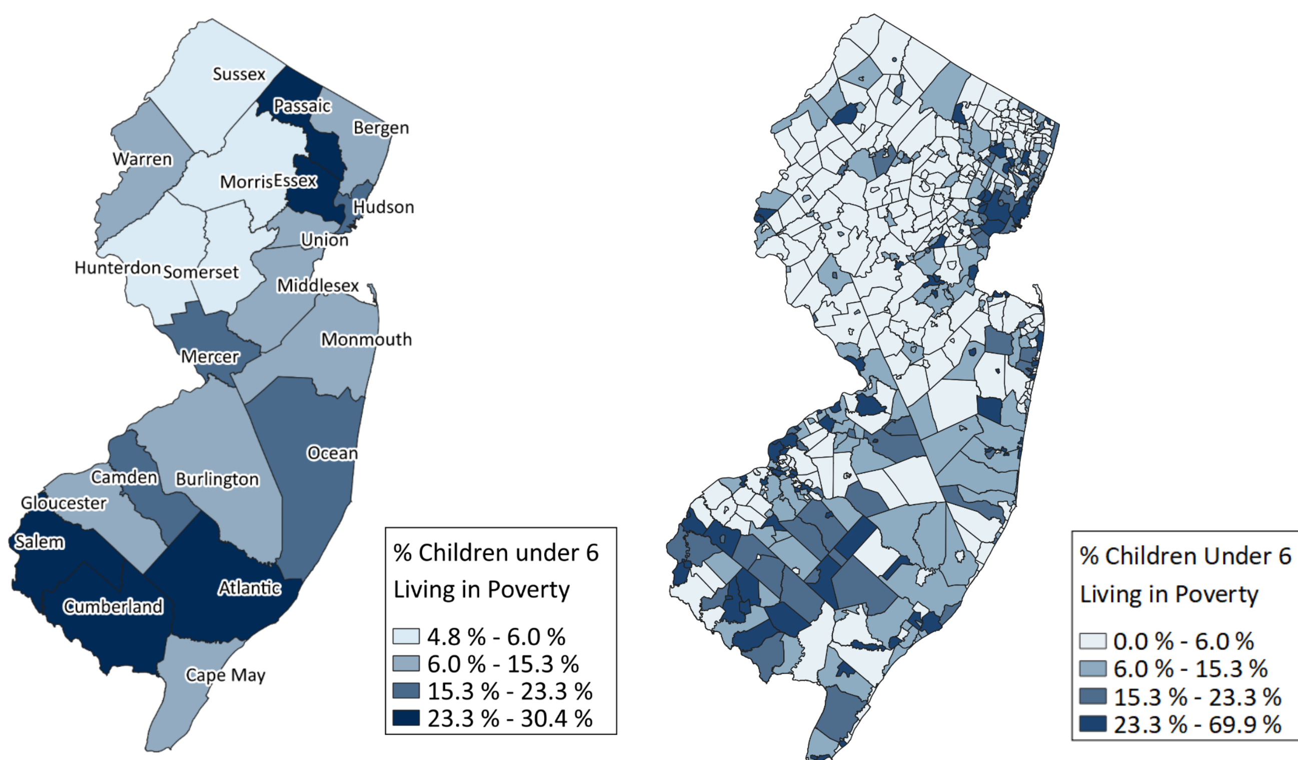
[21] American Community Survey 2013-2017, B17020

[22] United Way (2018). ALICE: A Study of Financial Hardship in New Jersey: 2018 Report.

households with earnings > FPL and employed. Variation in the percentage of ALICE households ranged from 27% in Hunterdon to 61% in Cumberland Counties.

Among New Jersey children under six years of age, 40.9% have one or more foreign-born parent, much higher than the national average (25.0%). The percentages vary considerably by county, ranging from 8.7% in Essex and Warren to 62.8% in Hudson. In addition to Hudson county, in four other counties more than half the children have one or more foreign born parents (51.4% in Union, 52.3% in Essex, 54.4% In Passaic, and 58.2% in Middlesex) (See Appendix C-3). These high percentages have implications for workforce development, family engagement, and culturally appropriate service delivery in addition to variability in service needs and values based, in part, on country of origin and prior experiences.

Figure 2: New Jersey Children Under 6 Living in Poverty by County (Left) and Municipality (Right), 2013-2017[23]



b. Health Characteristics: Birth Outcomes, Infant Mortality and Child Mortality

Health indicators for young children in New Jersey appear more favorable than those for children across the US with regard to low birth weight, preterm birth, infant mortality, and child death rates. (Table 1).

Racial disparities in birth outcomes in New Jersey parallel those for the country as a whole (Table 1). Black infants have the least favorable outcomes. While 8.0% of NJ infants are born low birth weight relative to 8.3% of US infants, the percentages for black (12.3%) and Asian infants (9.2%) are substantially higher than for white infants (6.4%). Breastfeeding disparities also persist despite recognized benefits for nutrition, immunity and SIDS prevention.

[23] American Community Survey 2013-2017, B17020

Smaller percentages of black infants (84.4%) relative to white (89.5%), Hispanic (93.0%) and Asian infants (97.7%) initiate breastfeeding. Disparities are even more pronounced for infant and child deaths. Infant mortality rates are nearly five times higher for black infants and child death rates are twice as high as those for white infants. In 2018, the state established the Healthy Women, Healthy Families Initiative to provide community-based programs with resources to increase the percentage of healthy births and reduce black infant mortality.

Table 1: New Jersey Birth and Death Outcomes by Race, 2017 for Births and Breastfeeding and 2016 for Deaths[24]

Outcome	New Jersey	United States	Race/Ethnicity (New Jersey)			
			White	Black	Hispanic	Asian
Low Birth Weight (live born infants < 2500 g)	8.0%	8.3%	6.4%	12.3%	7.7%	9.2%
Preterm Birth (born < 32 weeks)	9.5%	10.0%	8.3%	13.1%	8.7%	8.6%
Infant Mortality (deaths < 1 year per 1000 live births)	4.1	5.9	2.2	10.0	3.7	2.6
Child Deaths, Ages 1-4 Years (per 100,000 children)	18.8	25.3	16.6	34.1	16.5	--
Ever Breastfed	90.9%	--	89.5%	84.4%	93.0%	97.7%

New Jersey also experiences variability in birth outcomes by place of birth as demonstrated in review of outcomes by county for low birth weight, preterm birth and infant mortality (See Appendix C-4). Low birth weight rates range from a low of 5.9% in Morris and Sussex to a high of 10.4% in Cumberland. Percentages of infants born preterm range from 7.4% in Cape May to 12.8% in Cumberland and the infant mortality rate varies from 2.8 deaths per 1,000 live births in Morris to 7.6% in Camden.

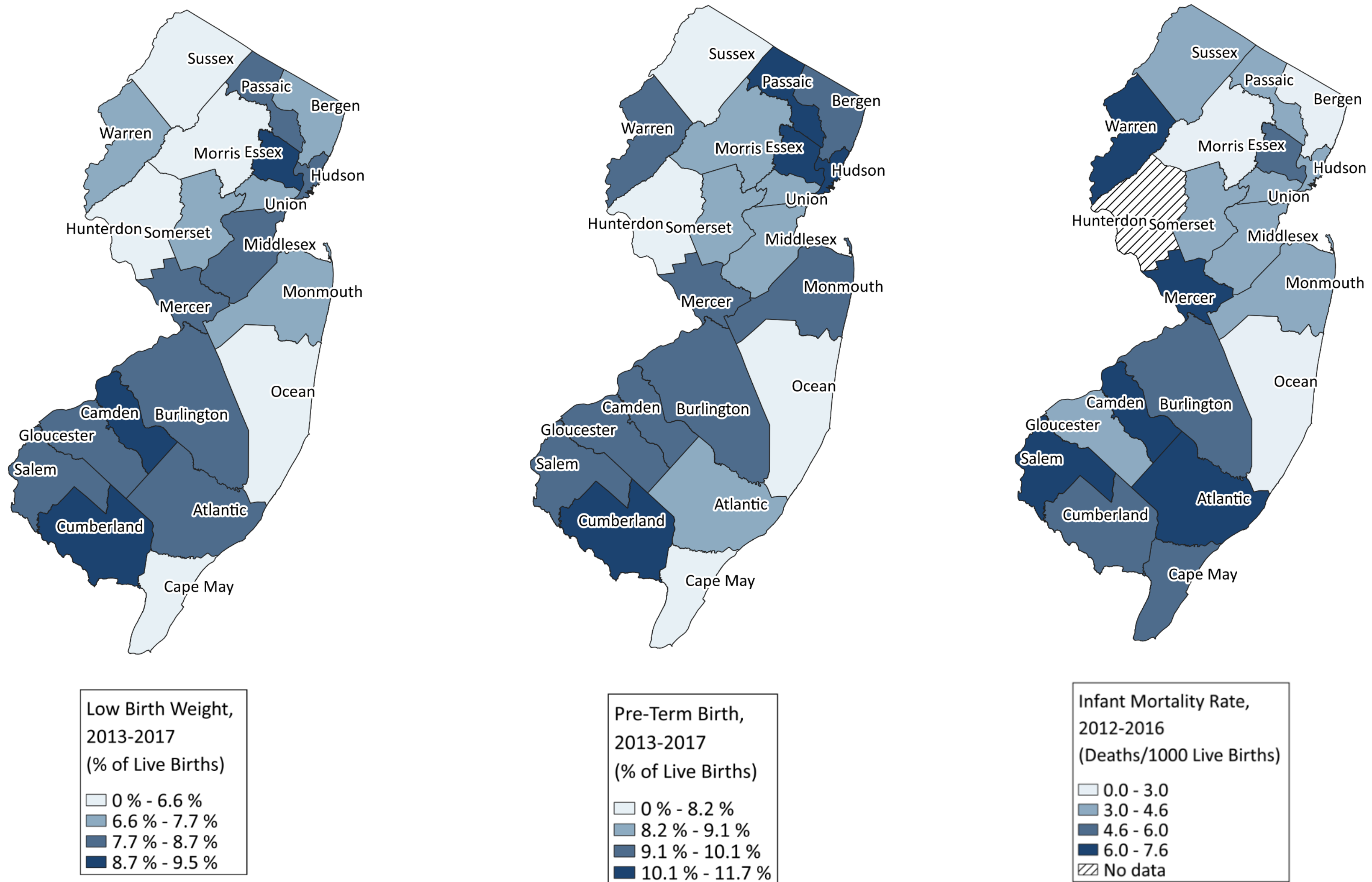
Figure 3 maps three of these health indicators by county over the past five years for which data are available. Ocean County consistently experiences health outcomes in the most favorable category (e.g., smallest % low birth weight). In contrast, Camden, Essex and Cumberland counties score in the least favorable categories for two or more outcomes.

Variability across counties also is noted in births to mothers who have less than a high school education (range: 4.0% in Warren to 25.1% in Cumberland), are foreign born (range: 8.9% in Gloucester to 58.6% in Cumberland), and who are insured by Medicaid (range: 9.8% in Hunterdon to 57.7% in Salem). The percentage of births to mothers < 20 years of age ranges from a low of 0.5% in Hunterdon to a high of 8.4% in Cumberland (See Appendix C-5).

For aligning service delivery with needs, municipality level data are critical. Figure 4 highlights variability in low birth weight and preterm birth by municipality and demonstrates how, within counties, there is variability by municipality for both outcomes. Selected initiatives in the state focus on municipalities with the least favorable outcomes. For example, the DOH Healthy Women, Healthy Families initiative, noted above, addresses high black infant mortality in eight areas (Figure 5, Appendix C-6). These areas with highest black infant mortality also experience other unfavorable birth characteristics (See Appendix C-7).

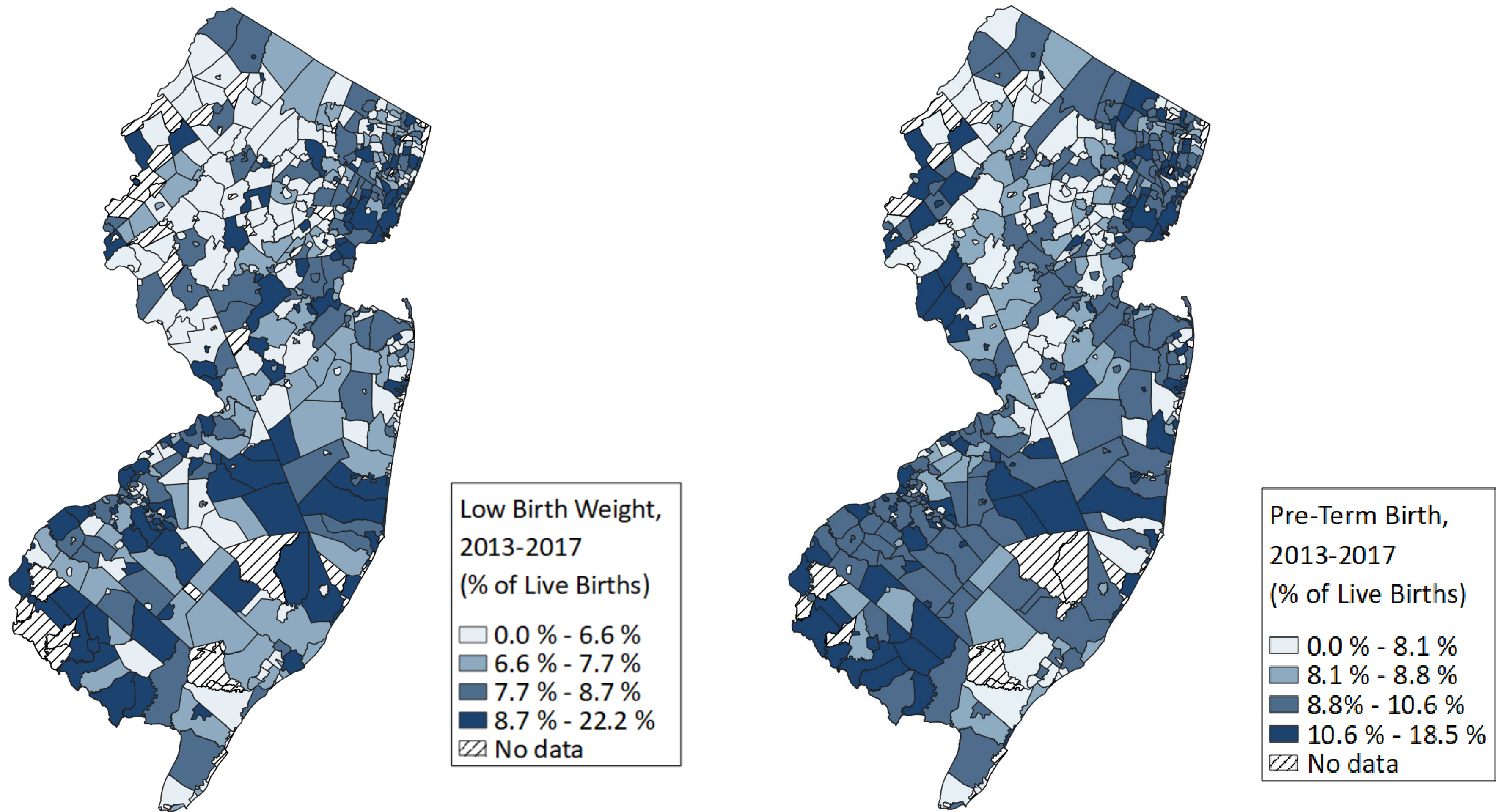
[24] New Jersey Department of Health, New Jersey State Health Assessment Data, 2016-2017, https://www-doh.state.nj.us/doh-shad/topic/Births.html

Figure 3: Health Characteristics by County[25]



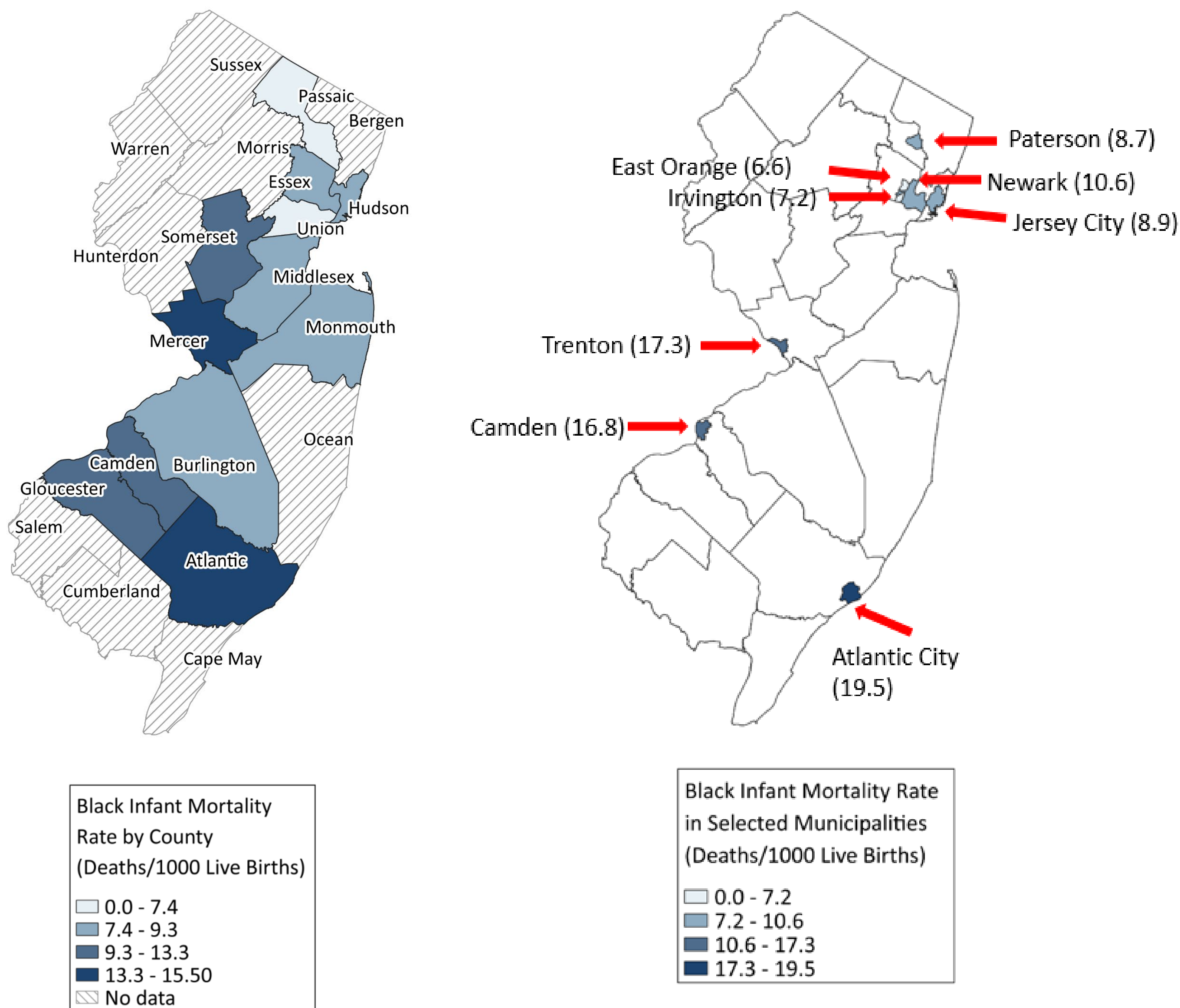
[25] New Jersey Department of Health, New Jersey State Health Assessment Data, https://www-doh.state.nj.us/doh-shad/topic/Births.html

Figure 4: Health Characteristics by Municipality, 2013-2017[26]



[26] New Jersey Department of Health, New Jersey State Health Assessment Data, 2016-2017, https://www-doh.state.nj.us/doh-shad/topic/Births.html

Figure 5: Black Infant Mortality Rate by County (Left) and in Municipalities Participating in Healthy Women, Healthy Families Initiative (Right), 2012-2016[27]



c. County Rankings

Advocates for Children of New Jersey (ACNJ) annually reviews the conditions for children living in each county and ranks the counties according to four domains: child and family economics, child health, safety and well-being, and education. Three indicators inform each domain for a total of 12. The table below summarizes 2018 rankings, with 1 indicating the most favorable and 21 the least favorable in each domain.

[27] New Jersey Department of Health, New Jersey State Health Assessment Data, 2016-2017, https://www-doh.state.nj.us/doh-shad/topic/Births.html

Table 2: New Jersey Kids Count 2018 County Rankings[28]

County	Child and Family Economics	Child Health	Safety and Well-Being	Education
Atlantic	20	12	17	17
Bergen	4	14	5	2
Burlington	5	8	13	10
Camden	14	18	17	17
Cape May	19	8	21	13
Cumberland	21	20	20	21
Essex	16	16	16	20
Gloucester	8	15	13	8
Hudson	12	17	9	17
Hunterdon	3	2	10	1
Mercer	11	5	12	14
Middlesex	5	8	4	8
Monmouth	9	6	6	5
Morris	1	3	2	3
Ocean	15	1	3	12
Passaic	18	13	15	15
Salem	17	6	19	16
Somerset	2	18	1	4
Sussex	7	3	6	6
Union	13	8	10	11
Warren	9	21	6	7

Indicators include: Child and Family Economics (% children living below poverty threshold, unemployment rate, % households spending more than 30% on rent); Child Health (% low birthweight infants, % children under age 18 without health insurance, % children under 6 tested for lead); Safety and Well-Being (% of reported children with substantiated findings of abuse/neglect, % teens ages 16-19 not working and not in school, juvenile arrests), and Education (% eligible children receiving free/reduced price school breakfast, % children chronically absent, high school graduate rates).

3. Definition of Key Terms

Table 3 below provides definitions of key terms for NJ's needs assessment process, along with a full description of NJ's vulnerable, high risk populations of infants, children, parents, and families. Note: No communities in NJ meet the formal federal definition of a Rural Area, nevertheless, needs assessment updates continue to show extreme pockets of need in rural parts of the state.

[28] Advocates for Children New Jersey, New Jersey Kids Count 2018 County Profiles, https://acnj.org/downloads/2018_08_21_new_jersey_kids_count_county_profiles_rankings_press_releases.pdf

Table 3: Key Terms

Early Childhood—Birth to Age Five (EC)	NJ includes all aspect of maternal and child health--pregnancy, postpartum, interconception, preconception, parenting (including fathers) and family supports--in its EC definition, especially in HV, EHS, Central Intake, CHWs, & other related community services
High Quality Early Childhood Care and Education (ECE)	-Provision of care in a safe and nurturing environment that optimizes early learning and leads to school readiness--regardless of the setting. -Caregiver/parent understand infant/toddler/child growth & development; promote physical, social-emotional (S-E) & cognitive development of young children. -Mixed delivery partners include--licensed CC centers (private, nonprofit, faith- based), EHS/HS, LEAs, school districts, approved private schools for the disabled, registered FCC & HV; and integration with IDEA Part C & Part B (619) -NJ partners offer resources to support quality for parents opting out of a formal EC setting, and other caregivers--Family/Friend/Neighbor (FFN)
Availability	EC programs and related supportive services have the infrastructure in place (staffing, management, fiscal, facility) to immediately screen, refer & enroll infants, young children, parents and/or families in need of services.
Vulnerable, Underserved, High Needs Populations *Families with young children Prenatal through Age 5 who experience any one, or more, of these factors*	**Poverty/Economic Stressors**: pregnant women, parents & children in low income families, including (but not limited to) those eligible for State-funded Preschool, EHS/HS, CCDBG subsidized child care, HV, Title I services, GA, TANF, Medicaid, NJ FamilyCare (Child Health Insurance Program-CHIP), SNAP, WIC **Special Educational Needs**: children/families participating in IDEA Part C Early Intervention & Part B (619) Preschool Special Education **Special Medical/Health Needs**: medically compromised children, parents w/ special medical, behavioral (alcohol/substance abuse), mental health, &/or disability needs **Child Welfare & Safety Needs:** children/families referred to child protective services (CPS)--DCF Child Protection & Permanency (CP&P); families impacted by domestic violence (DV)/interpersonal violence (IPV) **Special Circumstances**: children in military families, children with an incarcerated parent, children/families with transportation barriers, families where English is a second language or with other communication barriers; children in migrant families, socially isolated children/families w/ limited family/community supports, children of teen parents, homeless children
Children in Rural Areas	NJ has no geographic areas that meets the federal definition of a rural area. However, the southern and northwestern sections of NJ (e.g. farmland, pine barrens) have high needs families with challenges and barriers to access for infant/child care, health, behavioral health and other supportive services.

4. Children who are Vulnerable or Underserved and Children in Rural Areas

As described in Section 3, NJ children who are vulnerable or underserved include those with poverty/economic stressors, special educational needs, special medical/health needs, and those who otherwise have special circumstances. Each group is characterized below.

a. *Poverty/Economic Stressors*

The prevalence and distribution of New Jersey children from birth through five who experience poverty/economic stressors vary across and within counties. At the county level, we identify vulnerable children on the basis living below poverty (see Figure 2, Appendix C-2).

We also can identify vulnerable children on the basis of enrollment in public programs for which eligibility is determined, in part, on the basis of family income. Head Start and Early Head Start offer early learning, health and family support services for children in families at or below the federal poverty level. In 2018, 26 Head Start Programs had 12,069 slots for children ages 3-5 years, and 29 Early Head Start programs had slots for an additional 313 pregnant women and 2,960 young children, birth up to three years.[29] The vast majority of participants meet eligibility requirements on the basis of income, but some qualify on the basis of being in foster care, homeless, or receiving TANF or SSI. (See Section 5a for Early Head Start and 5c for Head Start.)

Additional programs for which eligibility is determined, in part, on the basis of family income include Temporary Assistance to Needy Families (TANF) as well as the Supplemental Nutrition Assistance Program (SNAP) and the Supplemental Nutrition Program for Women Infants and Children (WIC). Income eligibility for SNAP and WIC (up to 185% FPL) is far more generous than that for TANF (up to 26.2% FPL[30]). Variations in enrollment by county reflect eligibility requirements for each program, population size, and client accessibility to and interest in participating in each program (See Appendix C-8).

Figure 6 identifies how economic vulnerability varies across counties by highlighting the numbers of women and children enrolled in WIC; more than 13,000 are enrolled in Essex, Hudson, Ocean, and Passaic.[31] Passaic is also one of four counties in which more than one in five children live in households receiving SNAP (see Appendix C-8). Variability in economic need at the municipality level is shown by reviewing participation in SNAP and TANF. (Figure 7). While the highest need municipalities, shown in dark blue often appear comparable in the maps for SNAP and TANF, many fewer children live in households receiving TANF given more restrictive income eligibility.

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[29] Office of Head Start. New Jersey Program Information Report. Enrollment Statistics Report. 2018.

[30] Center on Budget and Policy Priorities, TANF Benefits Remain Low Despite Recent Increases in Some States, 2019, https://www.cbpp.org/sites/default/files/atoms/files/10-30-14tanf.pdf. Appendix Table 2.

[31] Data are not available specific to children in order to calculate percent enrolled by county.

Figure 6: WIC Participation by County (Number of Women, Infants and Children Receiving Benefits), 2017[32]

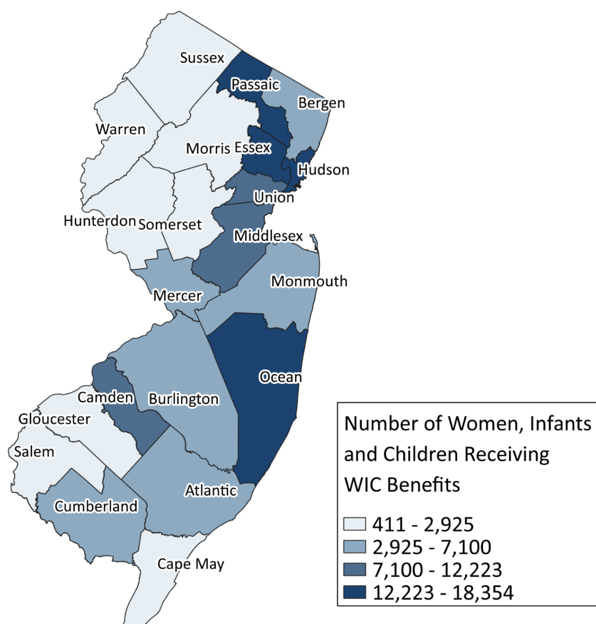
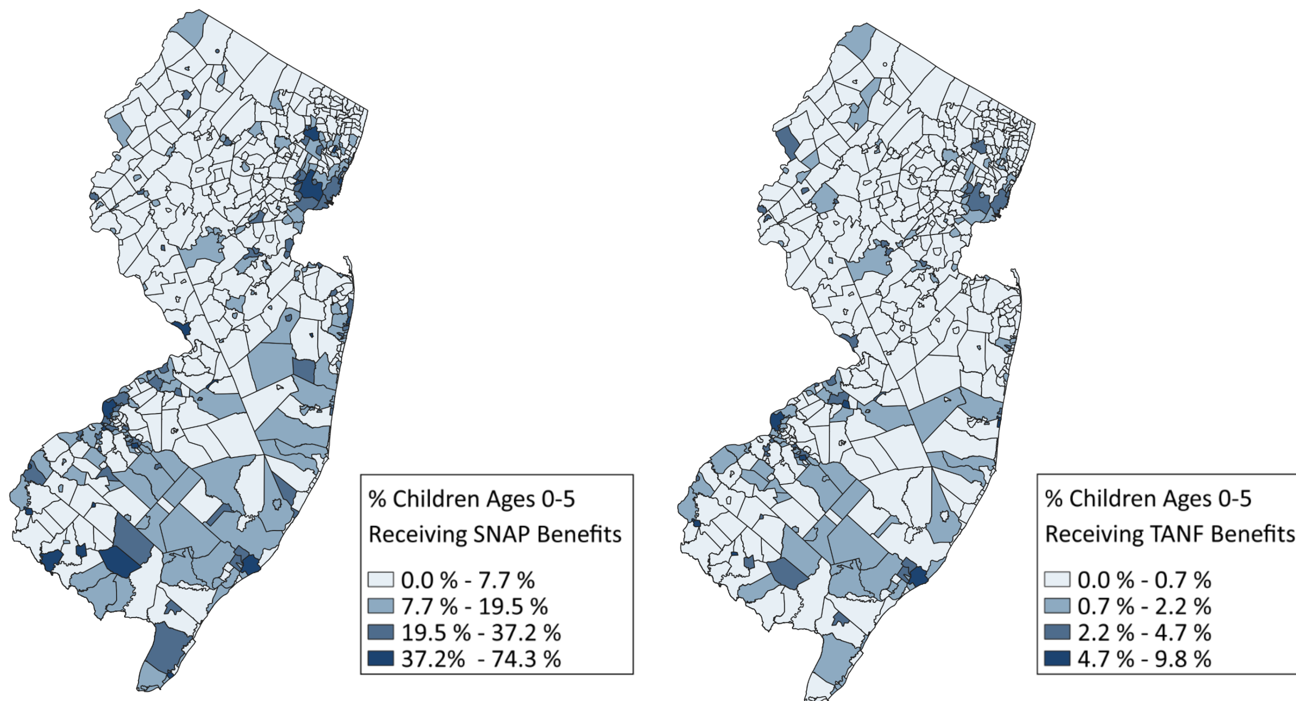


Figure 7: Children Ages 0-5, Enrolled in SNAP (Left) and TANF (Right), by Municipality, 2019[33]



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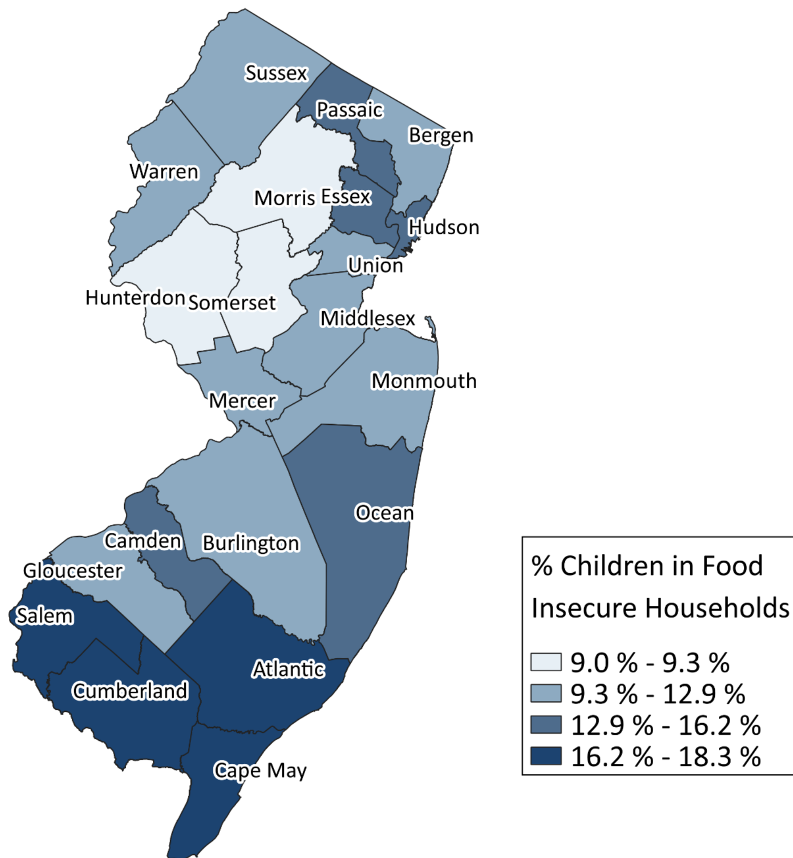
[32] NJ KIDS COUNT Data Center, 2017. Women, infants and children enrolled in the WIC nutritional program in New Jersey. https://datacenter.kidscount.org/data/tables/2111-women-infants-and-children-enrolled-in-wic-nutrition-program?loc=32&loct=5#detailed/5/4699-4720/false/871,870,573,869,36,868,867,133,38,35/any/4426

[33] 2019 County Labor Force Estimates; https://www.nj.gov/labor/lpa/employ/uirate/lfest_index.html

Other indicators of economic stress include qualifying for free- or reduced-price school meals and living in food insecure households. The largest percentages of children living in food insecure households reside in four southern counties – Salem, Cumberland, Atlantic, and Cape May (Figure 8; Appendix C-9). These four counties also experience the highest unemployment rates, as of April 2019 (Cape May 7.3%, Cumberland 4.6%, Atlantic 4.3%, and Salem 4.0).[34]

Figure 8: Food Insecure Children by County, All Ages of Children, 2016[35]



Economic insecurity also can be assessed by enrollment in public insurance. As of May 2019, statewide, 224,145 children 0-5 were enrolled in Medicaid and 31,502 in the Children's Health Insurance Program (CHIP). Overall, the percentage of children enrolled in Medicaid or CHIP ranges from 21.1% in Morris to 72.1% in Cumberland (Figure 9; Appendix C-10).

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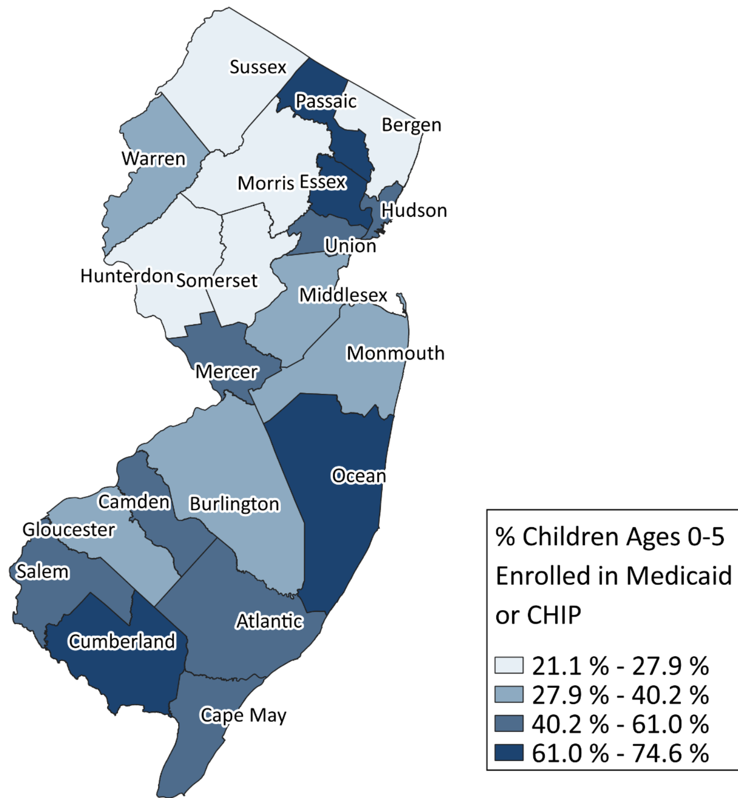
[35] Health Indicator Report of Food Insecurity, NJ SHAD, https://www-doh.state.nj.us/doh-shad/indicator/view/FoodInsecurity.CoChild.html

Figure 9: Children Ages 0-5 Enrolled in Medicaid or CHIP, May 2019[36]



b. *Special Educational Needs*

As part of the Individuals with Disabilities Education Act (IDEA), New Jersey provides both early intervention services for children from birth up to age three (Part C) as well as special education services for children three through five years (Part B, Section 619). Early intervention services intend to improved outcomes that are key to educational success; services identify and meet children's needs across five areas of development (physical, cognitive, communication, social or emotional, and adaptive).[37] For children three through five, New Jersey's efforts align with national efforts to provide integrated educational placements given links between inclusion and enhanced academic, social and emotional performance and positive effects on classmates without disabilities.[38,39] New Jersey's vision is for all general education classrooms to include and appropriately support children with disabilities. To achieve this vision, New Jersey has created a Multi Tiered Systems of Support that includes preschool, and is meant to increase

[36] Correspondence with Division of Family Development (DFD), New Jersey Department of Human Services (DHS), 6/4/19. Total Medicaid includes 112 not assigned to a county.

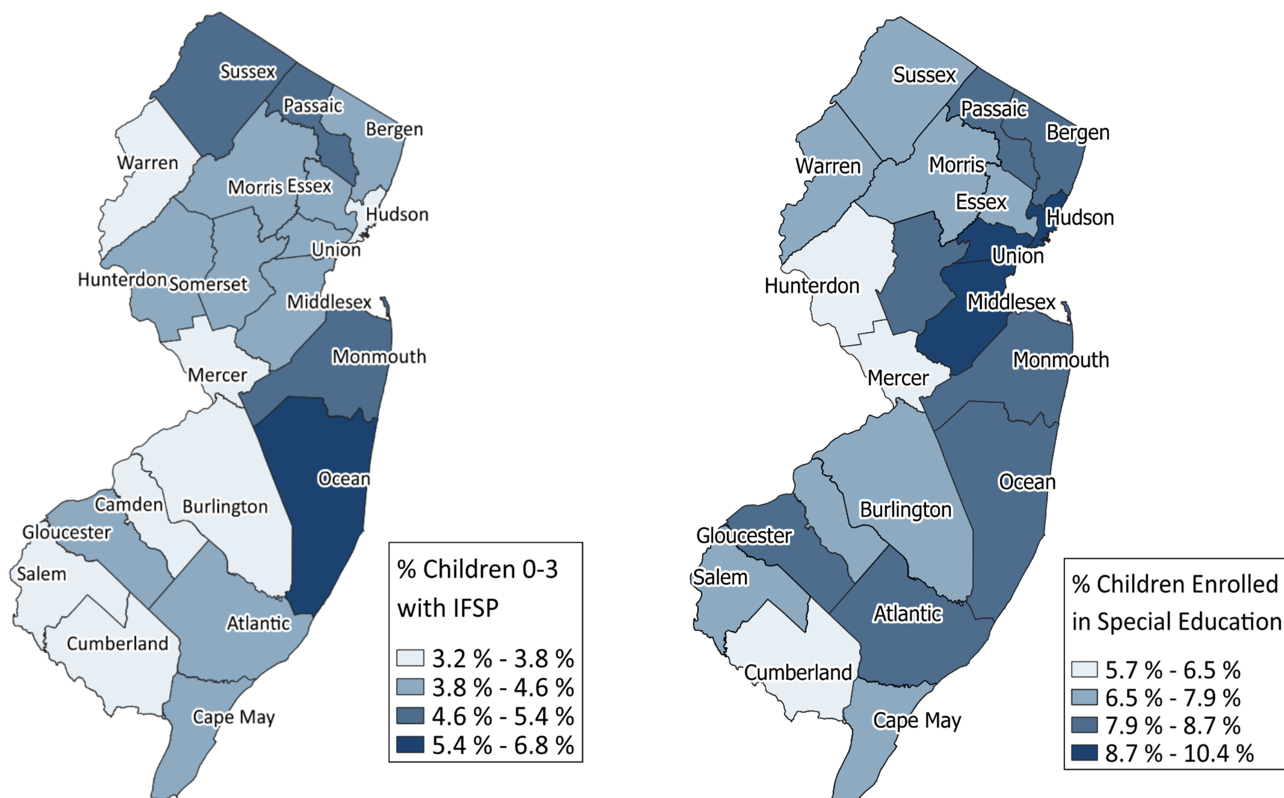
[37] U.S. Department of Education, 40th Annual Report to Congress on the Implementation of the *Individuals with Disabilities Education Act, 2018.* https://www2.ed.gov/about/reports/annual/osep/2018/parts-b-c/40th-arc-for-idea.pdf

[38] National Council on Disability, IDEA Series. https://ncd.gov/sites/default/files/NCD_Segregation-SWD_508.pdf

[39] U.S. Department of Health and Human Services, U.S. Department of Education, Policy Statement on Inclusion of Children with Disabilities in Early Childhood Programs. https://www2.ed.gov/policy/speced/guid/earlylearning/joint-statement-full-text.pdf

inclusion through the implementation of Positive Behavior Supports (Pyramid Model in Early Childhood) and academic interventions.[40]

Figure 10: Children 0-3 Years with Individualized Family Service Plan (IFSP) by County, 2017 (Left)[41] and Children 3-5 Years Enrolled in Special Education, 2016 (Right)[42]



The percentage of children zero up to three years participating in special education with individualized family service plans (IFSP) through Part C of IDEA ranges from 3.39% in Middlesex to a high of 6.76% in Ocean counties. The numbers in each county increase as children get older with a total of 793 infants < 12 months, 3818 infants greater than 12 and less than 24 months, and 9033 toddlers greater than 24 and less than 36 months. While the age differences are expected as children are more likely to be screened and referred for services as they get older, there also are differences by race/ethnicity. Among children with an IFSP, 41.7% are white not Hispanic, 36.6% Hispanic, 9.8% black, 7.5% Asian, and 4.3% multiracial (See

[40] NJ Department of Education, New Jersey Tiered System of Supports. https://www.nj.gov/education/njtss/
[41] New Jersey Department of Health, https://www.nj.gov/health/fhs/eis/documents/DOH%20Table%201%20Dec%201%202017.pdf
Percents reported for FY 2016-2017 in County Performance Reports, SPP Indicator 6 (% with IFSP) and Indicator 1 (% receiving all IFSP services in timely manner). Timely services are provided within 30 days from date parent(s) consents for services through the IFSP.
https://www.nj.gov/health/fhs/eis/documents/County_Performance_Report%202016-2017.pdf
For entire state, 4.38 % for FFY 2016 from https://www.nj.gov/health/fhs/eis/documents/APR-2016C-NJ.pdf
[42] Correspondence from New Jersey Department of Education, Office of Legal Affairs, 5/22/19

Appendix C-11; Figure 10). Overall, nearly 95% of children receive all services on the IFSP in a timely manner with two counties at less than 85% --Atlantic and Cumberland.[43]

As of 10/15/17, across the state, 19,763 children ages three through five participated in special education through Part B IDEA.[44] Of these, 45.9% receive the majority of services in a regular early childhood program, 14.2% receive the majority of services outside of the regular early children program, and 39.8% attend a special education program entirely.[45]

Geographic variability also is noted in the percentages of children enrolled in Part B; in 2016, enrollment varied from 5.7% in Cumberland to a high of 10.4 % in Middlesex. (See Figure 11). Overall percentages for children receiving services in Part B are higher than for those receiving Part C, in part, due to the increased likelihood of older children being enrolled in preschool programs and referred by their teachers. Younger children 0-3 are likely to be referred only if in child care settings and referred by the provider. Parents may not be familiar with early intervention services nor recognize behaviors or symptoms meriting referral.

c. *Special Medical/Health Needs*

Statewide, an estimated 10.4% of NJ children, ages 0-5 years, have special health care needs, comparable to what is reported for all children in the US.[46] Data are not available at county levels to identify children with special health care needs from the National Survey of Children's Health. However, county-level data are available specific to birth defects and autism.

The New Jersey Birth Defects Registry mandates reporting by health care facilities, providers, and medical examiners, the birth defects for children five years and younger. Across all categories, the rate of birth defects is 213/10,000 children with cardiovascular being the most common. Counties with the highest reported levels of birth defects include Sussex, Essex, Union and Morris, where rates exceed 260/10,000 (Figure 11; Appendix C-12).

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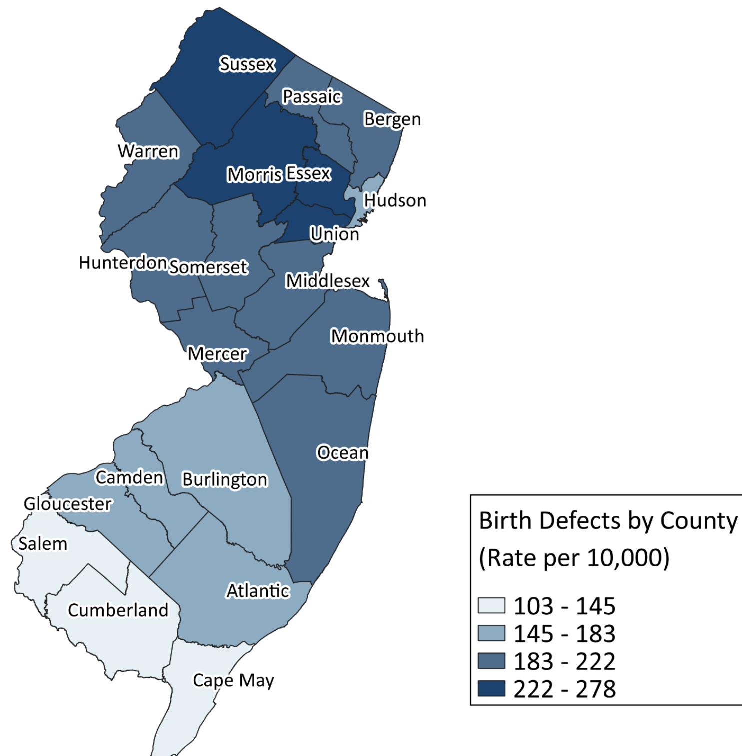
[43] New Jersey Department of Health, Division of Family Health Services, New Jersey Early Intervention System County Performance and Determination Report, FY 2017-2018, https://nj.gov/health/fhs/eis/documents/County_Performance_Report%20(002).pdf

[44] New Jersey Department of Education, Office of Special Education Programs, Children Receiving Free and Appropriate Education (Ages 3-5), 2017. https://nj.gov/education/specialed/data/2017/3_5_FAPE.pdf

[45] New Jersey Department of Education, Office of Special Education Programs, Children Participating in Separate Settings. 2017. https://nj.gov/education/specialed/data/2017/3-5_Placement.pdf

[46] Child and Adolescent Health Measurement Initiative. 2016-2017 National Survey of Children's Health (NSCH) data query.

Figure 11: Birth Defects/Congenital Anomalies by County[47]



New Jersey has the highest autism rates among states in the Autism and Developmental Disabilities Monitoring (ADDM) Network. ADDM is a surveillance system that provides 2014 estimates of the prevalence of ASD among eight year old children in 11 ADDM sites.[48] An estimated one in 34 eight year old children are diagnosed with autism in NJ relative to the ADDM average of one in 59 eight year old children.[49] The ADDM network also examined prevalence among children four years of age in seven of the original sites and, again, found NJ to have the highest rates (28.4/1000 children).[50] The high rates are attributed, in part, to excellent clinical and educational services and high rates of detection, researcher access to both educational and health records, and increases in perinatal risk factors associated with autism (e.g., multiple order births, advanced maternal age).[51] New Jersey's mandated autism registry tracks prevalence by county; Mercer and Ocean counties have higher rates than other

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[47] New Jersey Birth Defects Registry, https://www.nj.gov/health/fhs/bdr/

[48] Christensen DL, et al. Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years – Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2012. *MMWR Surveill Summ*, 65(13):1-23. 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6237390/ New Jersey data based on data from four counties (Union, Hudson, Essex, and Ocean)

[49] New Jersey Department of Health, New Jersey Autism Registry, https://nj.gov/health/fhs/autism/documents/NJAC_11_24C%20managed%20care.pdf

[50] Christensen DL, et al. Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 4 Years – Early Autism and Developmental Disabilities Monitoring Network, Seven Sites, United States, 2010, 2012, and 2014. *Surveillance Summaries,* 68(2): 1-19. 2019. https://www.cdc.gov/mmwr/volumes/68/ss/ss6802a1.htm?s_cid=ss6802a1_w

[51] New Jersey Department of Health, New Jersey Autism Registry, https://nj.gov/health/fhs/autism/documents/NJAC_11_24C%20managed%20care.pdf

counties, while Bergen has lower rates, perhaps due to deliveries, by some women from Bergen, outside the state in New York.[52]

Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) yields statewide estimates of the special needs of mothers who recently gave birth. Among PRAMS participants in 2017, in the three months prior to becoming pregnant, 50.7% had alcoholic drinks, 11.6% smoked, 8.3% had depression, and 14.9% experienced anxiety. In the last 12 months preceding pregnancy, 1.3% experienced intimate partner violence. During the last three months of pregnancy, 3.5% smoked and 10.6% drank; 1.3% reported IPV during pregnancy. Postpartum, a larger percentage of women reported smoking (7.0%), and 13.2% experienced post partum depression.[53]

Central Intake data also inform about the special needs of mothers. Central Intake reports economic, social and health risks using screens conducted by community health workers (community health screen or CHS) and medical providers (perinatal risk assessment or PRA). These screens are conducted both prenatally and postnatally making direct comparisons to PRAMS challenging. As reviewed at a 2018 NJ Continuous Quality Improvement Committee Meeting, 64% of mothers screened had at least one of the DCF prioritized risks for referral to home visiting. Among mothers who were screened with the CHS, 11% reported tobacco use, 4% alcohol, and 2% drug use with an overall 9% screening positive on the 4Ps Plus (depression, tobacco use, substance use, domestic violence). Percentages of mothers reporting domestic violence ranged from 1% among those screened with a PRA to 4% of those screened with a CHS. Using both screens, 3% reported perinatal depression. Among mothers enrolled in home visiting, 42% reported having inadequate social support.

d. *Child Welfare and Safety Needs*

Across the state, the rate of children 0 through 5 years referred to Child Protection and Permanency (CP & P) is 26.7/1000 with a range from a low of 11.3/1000 in Bergen to a high of 71.7/1000 in Cumberland (Figure 12, Appendix C-13).

A 2018 needs assessment conducted by the Department of Children and Families documented high levels of need among families who are involved with CP & P.[54] Commonly reported needs related to substance use, family poverty, and caregiver mental health with many families experiencing multiple needs. Surveyed staff indicated that for most services, such as substance use, services were well aligned with levels of family need. The report also identified that shortages of services related to housing and family poverty required broad, cross-system solutions in order for families to provide safe, stable homes for their children. The report also concluded that future efforts should examine how needs and services relate to child welfare outcomes, including child safety, permanency, and well-being.

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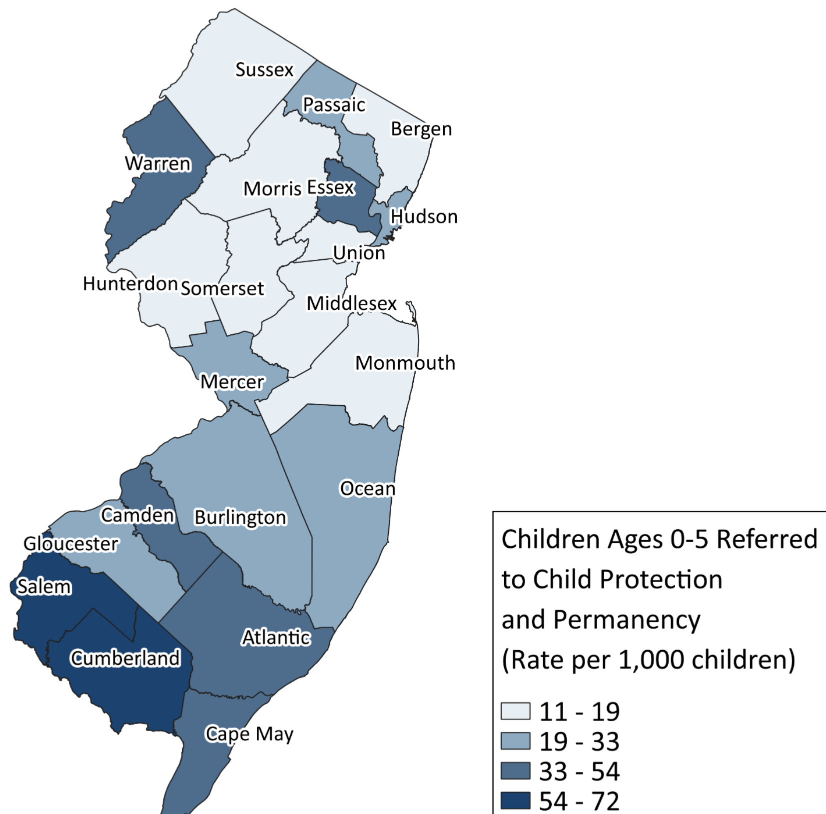
[52] The Birth Defects and Autism Reporting System (BDARS) is a tool for surveillance, needs assessment, service planning, research, and linking families to services. The BDARS refers children and families to the Special Child Health Services Case Management Units which are within the Family Centered Care Services Program.

[53] New Jersey PRAMS. https://www-doh.state.nj.us/doh-shad/query/selection/prams/PRAMSSelection.html

[54] NJ Department of Children and Families, DCF Needs Assessment 2018, Executive Summary: Phase IV Survey Findings and Synthesis. https://www.nj.gov/dcf/childdata/protection/DCF.Needs.Assessment.Phase.IV.Executive.Summary-March2018.pdf

Figure 12: Children Ages 0-5 Years Referred to Child Protection and Permanency (Rate per 1,000 Children), 2017[55]



e. *Other Special Circumstances*

Children also may be vulnerable on the basis of special circumstances such as living in military families[56] or living in households in which English is a second language or family members experience other communication barriers. In addition, children may be at high risk due to having an incarcerated parent or experiencing transportation barriers or social isolation with limited family/community supports. Limited data are available at the county level or specific to children ages 0-5 for these characteristics.

Another indicator of variability is the number of child support cases and average payment per case. These too vary by county, with the greatest number of cases in Essex county and the largest average payment per case in Bergen County (Appendix C-14).

5. Quality and Availability of Early Childhood Care and Education

The agencies which comprise the IPG play key roles in the delivery of 2-Gen services. This section focuses on early childhood care and education, though the full array of services extends beyond to include health, welfare, and other services (See Table 4).

[55] Child Welfare Referrals, NJ Child Welfare Data Hub, Rutgers School of Social Work, 2017. https://njchilddata.rutgers.edu/

[56] www.miltarybases.com identifies 1 air force, 3 army, 2 coast guard, and 2 navy bases in New Jersey.

Table 4: Summary of NJ Interdepartmental Planning Group 2-Gen Services (B-5)

Education (DOE)	Human Services (DHS)	Children and Families (DCF)	Health (DOH)	Labor (DOL)
PDG Expansion grant State-Funded Pre-K Preschool Education Expansion Aid -- PEEA Early Head Start/Head Start Collaboration Office Teacher Credential & Licensing Preschool Special Education (IDEA Part B, Section 619) School Support Services--teen parents Federal Title I services for low-income families Other Federal Education Programs & Services Region Achievement Centers (RAC) NJ Council for Young Children (NJCYC) NJ Enterprise Analysis for Early Learning (NJ-EASEL) integrated data system	Grow NJ Kids–QRIS CCDF Child Care Development Block Grant (CCDBG) Subsidized Child Care Wraparound Care NJ First Steps-Infant/ Toddler Program Family Child Care (FCC) Providers Child Care Resource & Referral Agencies (CCR&R) GNJK-TTA NJCCIS-Child Care Workforce Registry WorkFirst NJ-TANF, GA, SNAP Emergency Services Child Support Addiction & Mental Health Neonatal Abstinence Disability Services NJ Medicaid NJ FamilyCare-CHIP	Child Care Licensing FCC Registration NJ Home Visiting/CI ECCS/Help Me Grow SF Protective Factors County Councils for Young Children/CCYC Parent-Linking Program School-Based Services Project TEACH for Teen Parents Family Success Centers Division on Women-DV/IPV services Children's Trust Fund Federal CBCAP (Community-Based Child Abuse Prevention) Child Behavioral Health Services Child Developmental Disabilities Child Protection & Permanency Family First Prevention Act Project HOPE	Title V MCH Block Grant Healthy Women/ Healthy Families Black Infant Mortality Maternal Mortality Perinatal Risk Assessment (PRA) CHWs / CI Hubs Access to PN Care Home Visiting FQHCs/Primary Care WIC Services Breastfeeding SNAP Education Child Health/ Immunizations Healthy Homes Child Lead Poisoning Adolescent Health / Pregnancy Prevention Shaping NJ EI - IDEA Part C Special Child Health Peds Mental Health Access Program	WFNJ TANF/GA SNAP Smart Steps Career Advancement Voucher Program (CAVP) WFNJ-OJT YTTW-Youth Transition to Work Youth Corps Literacy-Title II Federal Bonding YouthBuild Temporary Disability Insurance (TDI) Family Leave Insurance (FLI) Unemployment Insurance (UI) Earned Sick Leave enforcement One-Stop Career Centers (OSCC) CHW apprenticeship w/ Rutgers

The remainder of this section has five parts, each part focused on a particular aspect of NJ's system of early childhood care and education: home visiting; child care, Head Start and Grow NJ Kids; preschool; kindergarten; and systems infrastructure to support high quality services. Data are available at the county level with regard to availability of home visiting, child care, preschool, and kindergarten services.

a. Home Visiting

New Jersey offers voluntary early home visiting at no cost to families via local programs implementing one or more of five of the models designated as evidence-based by DHHS. The most predominant models are Healthy Families, Nurse Family Partnership, and Parents as Teachers. As shown in Table 5, each county offers each of these three models.

Local programs implementing these models receive funding from multiple sources, mainly state funding and funding from the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, with funding administered by DCF. The models differ on eligibility requirements though generally serve low income, at-risk pregnant women and families. All three models are comprehensive and long-term.

Together, these programs provide a total of 4801 slots. Local programs served 5700 unique children in FY2018. DCF also funds an additional 50 slots in Bergen County for Home Instruction to Parents of Preschool Youngsters (HIPPY).

Early Head Start-Home Visiting (EHS-HV) is federally funded and provides an additional 658 slots serving young children in 12 counties. Data are not available for the number of unique children served in EHS-HV in a given year.

Table 5: Home Visiting Slots[57,58] and Number of Unique Children Served by Home Visiting in FY18,[59] by County and Model

County	Total # Home Visiting Slots - HFA	# Unique Children Served - HFA	Total # Home Visiting Slots - NFP	# Unique Children Served - NFP	Total # Home Visiting Slots - PAT	# Unique Children Served - PAT	Total # of EHS-HV Slots
Atlantic	95	121	50	44	70	77	See Cape May[60]
Bergen	78	122	50	54	20	21	98
Burlington	76	88	50	55	60	95	31
Camden	143	213	150	142	80	92	0
Cape May	113	149	50	45	60	83	166
Cumberland	100	127	100	85	88	114	See Cape May
Essex	224	352	150	148	60	77	0
Gloucester	80	101	50	50	50	68	See Cape May
Hudson	95	143	65	63	60	73	36
Hunterdon	30	101	10	17	10	14	161
Mercer	103	102	125	117	60	51	100
Middlesex	132	215	153	157	60	67	0
Monmouth	145	233	112	128	60	67	0
Morris	66	72	50	76	40	52	0
Ocean	70	72	50	52	40	49	60
Passaic	203	245	150	144	60	65	0
Salem	80	93	25	10	60	35	See Cape May
Somerset	17	See Middlesex[61]	10	15	60	66	See Hudson[62]
Sussex	69	116	50	33	40	65	0
Union	139	153	65	60	60	89	0
Warren	40	See Hunterdon[63]	40	31	50	36	0
New Jersey	**2098**	**2818**	**1555**	**1526**	**1148**	**1356**	**658**

b. Child Care, Head Start, and Grow NJ Kids

New Jersey offers licensed and registered child care providers within its mixed delivery early childcare and education (ECCE) system. Centers serving six or more children under the

[57] Home Visiting Program Quarterly Reports, July 1, 2017 – June 30, 2018
[58] Correspondence from NJ Head Start Collaboration Office, 6/5/19.
[59] Home Visiting MISs
[60] This agency operates EHS-HV in Cape May, Cumberland, Gloucester, Atlantic and Salem counties and data are combined as a single program site.
[61] This agency operates HF in both Middlesex and Somerset counties and data are combined in the MIS as a single program site.
[62] This agency operates EHS-HV in Hudson and Somerset counties and data are combined as a single program site.
[63] This agency operates HF in both Hunterdon and Warren counties and data are combined in the MIS as a single program site. Note: The MIS does not capture all counties.

age of 13 are required by New Jersey State law to be licensed.[64] Family Child Care (FCC) homes (also known as family day care homes) provide care for five or fewer children under the age of 13 in the provider's private residence. FCC providers may choose to become voluntarily registered through the Child Care Resounrces and Referral Centers under contract with the Department of Human Services.[65] New Jersey serves 386,582 children in licensed child care centers and an additional 1,482 children with registered family care providers (Table 6). The licensing process identifies ages for which providers are approved to offer services, but does not track children's ages for slots actually provided.

As discussed in Section 4a, Head Start and Early Head Start offer early learning, health and family support services for children in families at or below the federal poverty level. In 2018, 26 Head Start Programs had 12,069 slots for children ages 3-5 years, and 29 Early Head Start programs had slots for an additional 313 pregnant women and 2,960 young children, birth up to three years.[66]

Grow NJ Kids (GNJK) is New Jersey's Quality Rating Improvement System (QRIS) to assess and improve the quality of early child care and education programs. QRIS rates five aspects of quality: 1) Safe, healthy learning environments; 2) Curriculum and learning environment; 3) Family and community engagement; 4) Workforce/professional development; 5) Administration and management.[67] To receive 3-, 4-, or 5-star ratings, programs must meet certain requirements in classroom observation scores, curriculum training, and environment documentation.

GNJK enrolls licensed centers and school-based programs, Head Start programs, preschools, and registered family child care providers.[68] As of October 9, 2019, a total of 1233 center-based programs and family child care providers are actively enrolled in Grow NJ Kids. Of these, 202 center-based programs and 32 family child programs completed the rating process with a 3 out of 5 stars (See Appendix C-15). [69] Grow NJ Kids provides training and incentives to improve the quality of child care and early learning programs and communicates levels of quality to the public.

In 2018, GNJK implemented a tiered reimbursement system for center-based programs that receive higher level ratings on the Star Level Rating Scale.[70] Depending on the Star Level Rating, programs receive a 4-24% increase in their reimbursement rate when providing care to children receiving a childcare subsidy.[71]

From a family's perspective, accessibility of child care relates not only to geographic location and transportation, but also to cultural relevance and affordability. Subsidies are available to offset child care costs for New Jersey residents who qualify based on income

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[64] New Jersey Department of Children and Families, Office of Licensing. https://www.nj.gov/dcf/about/divisions/ol/.

[65] Ibid.

[66] Office of Head Start. New Jersey Program Information Report. Enrollment Statistics Report. 2018.

[67] New Jersey Center for Quality Ratings, William Paterson University. *Documentation Review Protocol.* http://www.grownjkids.gov/getattachment/700f874d-18ae-4278-b68c-d7293af46d17/Documentation-Review-Protocol-All-Programs.aspx.

[68] Grow NJ Kids, http://www.grownjkids.gov/About.

[69] Correspondence with New Jersey Division of Family Development, Department of Human Services. 10/24/19.

[70] Race to the Top Final Performance Report. New Jersey. 2019.

[71] Kim J & Joo M, School of Social Work, Rutgers University, 2017 New Jersey Child Care Market Price Study, http://www.childcarenj.gov/getattachment/Resources/Reports-and-Statistics/2017-New-Jersey-Child-Care-Market-Price-Study-pdf.pdf.aspx?lang=en-US

requirements (< 200% FPL), and engagement in work (30 hours/week or more), school (12 credits or more), or job training (at least 20 hours/week). Maximum monthly child care payment rates vary based on child's age, part- or full-time care, and Grow NJ Kids ratings (See Appendix C-16). Copays are based on family size, gross annual income, hours of care needed and number of children in care; copays are required only for the first two children.

Table 6: Licensed Child Care Centers and Registered Family Care Providers in New Jersey, April 2019[72]

County	Number of Centers	Capacity of Centers	Registered Family Care Providers
Atlantic	107	8,290	49
Bergen	438	40,958	49
Burlington	146	14,263	73
Camden	235	22,075	129
Cape May	32	2,143	7
Cumberland	68	7,644	37
Essex	473	45,783	180
Gloucester	130	10,429	21
Hudson	391	34,291	188
Hunterdon	67	6,398	7
Mercer	209	20,159	33
Middlesex	351	33,995	114
Monmouth	268	25,255	61
Morris	270	25,313	47
Ocean	159	14,124	39
Passaic	234	23,900	286
Salem	24	1,636	24
Somerset	173	19,389	15
Sussex	64	3,669	16
Union	278	25,333	56
Warren	49	3,085	51
New Jersey	4,166	386,582	1,482

A 2018 New Jersey child care market rate study prepared in compliance with the Child Care Development Block Grant Reauthorization Act of 2014 found that the 75% percentile monthly price for full-time care at licensed child care centers was $1,300 for infants, $1,195 for toddlers, and $1,055 for preschoolers.[73]

There have been three rate increases over the past two years, with a special focus on infant care, and an approximate 30% increase from 2017. In addition, a special rate has been implemented since 2017 and provides a higher subsidy rate. However, the rate does not cover the full cost of care. The 2017 prices for children without special needs exceeded the 2019 monthly subsidies for full time care for the 5-star rated providers for whom higher subsidies are provided ($1116 for infants, $898 for toddlers, $775 for preschoolers). The 2017 prices approximated 2019 subsidies for the same providers when caring for children with special

[72] Correspondence with Office of Licensing, New Jersey Department of Children and Families (DCF), 5/31/19.
[73] Kim J, Joo M. 2017 New Jersey Child Care Market Price Study. Rutgers School of Social Work. http://www.childcarenj.gov/getattachment/Resources/Reports-and-Statistics/2017-New-Jersey-Child-Care-Market-Price-Study-pdf.pdf.aspx?lang=en-US

needs whose care is recognized to be more expensive ($1340, $1078, $984, respectively) (See Appendix C-16).

The child care market rate study also noted an imbalance between child care slots for older and younger children. The centers included in the study had nearly five times more licensed child care slots for preschoolers than for infants.

Two New Jersey reports, the above child care study and a report by Advocates for Children of New Jersey, examine the availability of child care relative to demand for services though arrive at different conclusions regarding levels of unmet need. These studies demonstrate how estimates vary based on assumptions about numbers of families needing child care, availability of relatives who care for children, and hours of employment relative to available child care.

The market study report analyzed child care capacity by school districts and concluded that most districts did not have shortages. The study included licensed centers, registered family providers, public free child care providers and Head Start/Early Head Start programs. The report noted that 82% of school districts did not have a shortage of slots when considering *any* type of child care provider. However, 35 school districts in 14 counties that were less populous and/or characterized by low income were identified as having shortages. The report estimated that only 27% of children under age six are regularly cared for by licensed child care or family care providers. The report assumed that the observed 27% of children in child care equated with demand for child care, rather than considering that some parents may not enter the labor force due to lack of affordable child care or might choose care settings (e.g., friend or relative) not captured in the report.

A 2017 report, by Advocates for Children of New Jersey, entitled *No Room for Babies*, focused specifically on availability of child care for infants and toddlers.[74] Similar to the above report, this publication reviewed both licensed child care centers and family day care providers. In contrast to the above report, it assumed that infants and toddlers with all parents in the labor force all needed child care. It noted a shortage of 150,000 licensed child care slots given the capacity to serve 55,565 infants and toddlers. Report authors highlighted that child care centers served only 27% of those needing care, and that registered family care centers served an additional 9500 children of all ages. The report also found that about 40% of municipalities lacked child care for infants.

Given different methodologies and assumptions about the number of families needing child care, the two reports on availability of child care are difficult to compare. However, there is general agreement that there is insufficient supply of affordable, high quality child care for infants and toddlers. The needs assessment addresses lack of reliable data regarding demand for child care and related factors in Section 7 which highlights gaps in available data.

c. Preschool

The State of New Jersey funds three preschool programs with a total of 50,684 slots available in 2017-2018 for 3 and 4-year olds. These slots included 12,368 through Federally funded Head Start and 12,784 in special education.[75] Preschool is provided in three categories of programs:

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[74] Advocates for Children of New Jersey. No Room for Babies: Center-Based Infant-Toddler Child Care in Short Supply, 2017. https://acnj.org/downloads/2017_05_30_no_more_room_for_babies.pdf

[75] National Institute for Early Education Research. The State of Preschool 2018. Rutgers Graduate School of Education. 2019

- former Abbott districts (35 low income school districts, for all 3 and 4-year olds who choose to enroll, 42,266 children),
- Early Childhood Program Aid or ECPA (99 districts in which 20-40% of children qualify for free or reduced-price lunch, 7676 children), and
- Early Launch to Learn Initiative or ELLI (24 districts including 9 also part of the ECPA program, 742 four-year olds).

New Jersey also has one Migrant Head Start Program with 85 slots in Cumberland County (29 enrolled in Early Head Start, 33 enrolled in Head Start).[76] Preschool Development Grant funding supported 12 of 99 ECPA districts (1489 children) and 1 of 24 ELLI districts (114 children) as well as three additional districts, outside of the state-funded programs (320 four-year old children). Ongoing efforts for preschool expansion in non-Abbott districts continue.

Increases in 2018 funding in the Child Care and Development Block Grant have supported increases in infant child care access and quality through small grants focused on: Health and Safety to address safety violations and provide workforce training; Program and Classroom Quality Enhancement; and expanding access for infants (licensed centers only) by adding $100 monthly to the infant subsidy rate for a one-year period.

The NJ Department of Education tracks 39,696 students enrolled in state-funded preschool by county (Table 7). These data exclude children enrolled in Head Start and private preschools.

[76] Office of Head Start Program Information Report. Enrollment Statistics Report for New Jersey. 2018.

Table 7: Students Enrolled in State-Funded Preschool, 2017-2018[77]

County	Preschool Half-day	Preschool Full-day	Total	% Children Enrolled in State-Funded Preschool
Atlantic	493	1,362	1,855	23.5
Bergen	1,302	1,299	2,601	6.3
Burlington	697	1,119	1,816	11.6
Camden	934	1,997	2,931	26.6
Cape May	341	370	711	21.8
Cumberland	-	1,554	1,554	78.7
Essex	473	3,770	4,243	46.5
Gloucester	1,050	297	1,347	10.5
Hudson	1,011	3,437	4,448	50.3
Hunterdon	213	183	396	0.7
Mercer	311	216	527	24.4
Middlesex	786	1,751	2,537	15.6
Monmouth	863	2,395	3,258	16.7
Morris	734	349	1,083	1.8
Ocean	382	874	1,256	4.3
Passaic	368	2,291	2,659	37.6
Salem	216	332	548	28.4
Somerset	430	389	819	7.2
Sussex	292	53	345	0.0
Union	776	3,485	4,261	37.4
Warren	213	288	501	14.7
New Jersey	11,885	27,811	39,696	23.7

d. Kindergarten

Across the state, about 85% of 5-year olds are enrolled in kindergarten with about 90% of these children enrolled in full-day programs (Table 8). A majority of school districts (480) offer full day programs, while 40 offer half-day services. DOE recently surveyed these forty school districts about their plans for full day kindergarten.[78] Forty three percent of respondents indicated they intended to move forward with full day programs beginning as early as 2019 and extending until 2023. Reasons for not moving forward included insufficient funding, lack of space to add extra classrooms and bathrooms, a shortage of staff and transportation, over-crowded classrooms, and reductions in state aid. Respondents indicated that additional funds would be used for classrooms, teachers, supplies, and professional development. They further suggested offering money to districts for full day kindergarten as has been done for Pre-K.

[77] NJ Department of Education, 2017-2018 Enrollment District Reported Data, https://www.nj.gov/education/data/enr/enr18/county.htm
[78] Personal Communication. Beth Wharton. NJ DOE. 7/19/19

Table 8: Students Enrolled in Kindergarten, 2017-2018[79]

County	Kindergarten Half-day	Kindergarten Full-day	Total	% Children Enrolled in Kindergarten
Atlantic	421	2,305	2,726	95.9
Bergen	168	8,758	8,926	77.3
Burlington	929	3,318	4,247	82.5
Camden	1,199	3,931	5,130	74.0
Cape May	-	866	866	108.7
Cumberland	-	1,785	1,785	90.7
Essex	150	7,816	7,966	75.1
Gloucester	725	2,568	3,293	93.8
Hudson	-	5,980	5,980	76.8
Hunterdon	-	1,055	1,055	126.8
Mercer	524	3,192	3,716	87.0
Middlesex	2,166	5,734	7,900	83.6
Monmouth	317	5,343	5,660	78.6
Morris	708	3,973	4,681	86.2
Ocean	-	4,338	4,338	59.4
Passaic	377	4,856	5,233	73.5
Salem	-	737	737	95.3
Somerset	997	1,986	2,983	81.9
Sussex	-	1,216	1,216	68.2
Union	730	5,212	5,942	81.1
Warren	102	874	976	86.5
New Jersey	9,513	81,315	90,828	84.6

e. Systems Infrastructure to Support High Quality Services

Quality and availability of services are not enough to assure that families receive needed and desired services. Early Childhood Comprehensive Systems (ECCS)/Help Me Grow (HMG) is an initiative working with public and private partners to facilitate linkages across programs, disciplines and sectors. The goal of NJ ECCS is to implement and maintain an accessible, comprehensive and culturally competent early childhood health, development and early learning communication system that informs and empowers families and caregivers while supporting the needs of each child.

New Jersey's system of Central Intake facilitates enrollment of high-risk children and families into perinatal services. Established in 2001 in seven counties, by 2015, all 21 counties had a Central Intake hub that provides a single point of entry for families to access a wide array of community services from prenatal to age five. These services include prenatal care, infant/child health, family planning, nutrition/WIC, home visiting (Healthy Families, Parents As Teachers, Nurse-Family Partnership), Head Start/Early Head Start, child care services,

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[79] NJ Department of Education, 2017-2018 Enrollment District Reported Data, https://www.nj.gov/education/data/enr/enr18/county.htm Percentages may exceed 100 (Cape May, Hunterdon) due to assignment of children to different counties and overlapping but different periods of data collection for the two data sources (2016-2017 DOE enrollment vs. 2013-2017 American Community Survey).

preschool programs, Family Success Centers, early intervention, special child health services, behavioral health, domestic violence support, financial needs/public assistance services, substance use/addiction treatment and others. The Central Intake hubs use standardized screening and referral forms (Perinatal Risk Assessment, Community Health Screen), a shared data system to foster coordination and systems integration, and community advisory boards to inform decision-making.[80] Community Health Workers were established in 13 counties in 2013 and their use had been expanded to all 21 counties by 2018.

Stakeholder engagement also informs systems infrastructure through state, county and local level efforts. At the state level, the Child Care Advisory Group along with the New Jersey Council for Young Children supports stakeholder engagement. Commissioners, or their designees, from the NJ Departments of Education, Health, Human Services, Department of Children and Families and Labor and Workforce Development, serve as ex-officio members. The statewide Council also includes representatives from a local education agency, institutions of higher education, early childhood local providers, Head Start, State 619 Coordinator, President of the NJ Head Start Association and the SPAN Parent Advocacy Network. The Council, governed by the Early Learning Commission (ELC) and the Interdepartmental Planning Group (IPG), focuses on enhancing the coordination and quality of early childhood systems from pregnancy through age eight.

New Jersey also supports 21 County Councils for Young Children (CCYCs). The local CCYCs complement statewide efforts by strengthening local collaboration among parents, families and local community stakeholders and other service providers in the early childhood system. CCYC participants apply a Strengthening Families Protective Factors Framework to develop mutually-established goals and recommend creative strategies that respect the views and priorities of diverse families in the community. The local CCYCs also work closely with Central Intake to strengthen local program coordination and integration.

At the local level, two examples of stakeholder engagement include the Head Start Policy Councils and the engagement activities required by the Every Students Succeeds Act (ESSA). Both efforts recognize that stakeholder engagement is essential for student success. Head Start supports Head Start Policy Councils for each of the 26 programs. These councils include parents and community members who are elected at the center level to engage in decision and policy making. Under ESSA, consultation with diverse stakeholders, including parents, staff, and community members, is required when local education agencies receive federal funding. DOE encourages engagement as part of each district's school-level planning process.[81]

6. Number of Children Awaiting Service in Such Programs

Some data are available about the numbers of children awaiting services in early care and education programs. Each program uses different approaches to identify families with unmet need. There are no child care subsidy wait lists. However, Early Head Start has a wait list of 1526 infants and toddlers reflecting a shortage of affordable early care learning

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[80] Zero to Three, Cross-System Collaboration to Better Support Babies in New Jersey: Providing Families with a Single Point of Entry for Accessing Services, 2019. https://www.zerotothree.org/resources/2598-cross-system-collaboration-to-better-support-babies-in-new-jersey-providing-families-with-a-single-point-of-entry-for-accessing-services

[81] NJ DOE. Local Stakeholder Engagement Under the Every Student Succeeds Act (ESSA): A Guide for Districts and School Leaders, 2017. https://www.state.nj.us/education/ESSA/guidance/njdoe/StakeholderGuidance.pdf

opportunities for the youngest children.[82] For home visiting, while there are no counts of children awaiting services, across all 65 MIECHV funded home visiting programs, 55% were at capacity ($\geq$ 85% of contracted slots filled) in FY18Q4 (April 2018- June 2018).[83] Of course multiple factors may contribute to why programs may not be at capacity including inadequate volume of referrals of eligible families, staff turnover and vacancies, time needed for new home visiting staff to be sufficiently trained in order to serve families, the mismatch between available slots for English speaking families and demand for services by Spanish-speaking families, and challenges with family retention.

7. Gaps in Data or Research About the Quality and Availability of Programming and Supports for Children Birth through 5, Considering the Needs of Working Families, as Well as Those Who Are Seeking Employment in Job Training

As shown above, New Jersey is rich in available data on the availability and quality of care and education programs for children birth through five. A strong culture of quality improvement reinforces use of these data for decision-making. The needs assessment identifies 4 gaps in data and research:

a. Programming and Supports for Children with Special Circumstances

The needs assessment identified gaps in available data for children in special circumstances including those in military families, with incarcerated parents, living in migrant families, experiencing homelessness, or families experiencing communication and transportation barriers.

The NJ Enterprise Analysis System for Early Learning (NJ-EASEL), the state's Early Childhood Integrated Data System, may ultimately address these data gaps. NJ-EASEL's purpose is to provide critical data to inform business, fiscal and policy decision-making to improve service availability and quality. NJ-EASEL includes information on homelessness, domestic violence, households with limited English proficiency and children in military families. NJ-EASEL also will collect and integrate early childhood data regarding child, family, classroom, program and workforce characteristics. These data will address key questions about early care and education programs and services and their impact.

While much progress has been made, NJ-EASEL is not fully operational. NJ-EASEL planning began in 2014 and production began November 2018 with integration of data from DOE (NJ Student Data from NJ SMART, County/District/School Reference Data) and DHS (Child Care Subsidies Data). Currently, three additional data systems are being added with data from DCF (home visiting data for HFA and PAT) and DOH (birth records).

When fully operational, NJ-EASEL will provide additional counts of vulnerable children. It also will provide longitudinal data to assess the effectiveness of early care and education services. NJ-EASEL will draw on data provided by NJ DOE, DHS, DCF, and DOH and will pull data from 15 data systems (See Appendix C-17). A recent Data Gap Analysis reviews progress to date (See Appendix C-18). At the current time, no data are available to inform this needs assessment.

[82] Personal communication, Suzanne Burnette, NJ Head Start Collaboration Office, 7/16/19.
[83] HV MIS.

b. Shared Understanding of Definition of Vulnerability and High Quality ECCE Programs

Although different programs and services will continue to have different missions and priorities, a greater shared understanding of vulnerability could enhance the efficiency and effectiveness of cross sector collaborations and better meet the needs of children and families. NJ-EASEL will help stakeholders achieve a shared understanding of vulnerability as the process of creating an integrated data system fosters deeper relationships, sharing of information, and sense of trust. The process also enhances shared vocabulary and understanding of vulnerability and service use from the perspective of multiple agencies and programs.

NJ-EASEL and its focus on monitoring the effectiveness of programs and outcomes over time will contribute to a shared understanding of quality across stakeholder groups. This focus will address the need identified by NJ CCYC to create a shared sense of the importance of the quality of early care and education programs among families and policy makers through educational campaigns. Moreover, the focus on quality will be enhanced as Grow NJ Kids revises and disseminates its standards with 30% fewer standards overall and a more user friendly format.

c. Availability of Mental Health Services for Young Children

There is a general agreement about New Jersey's insufficient supply of mental health services for young children, especially infants. New Jersey prohibits the suspension or expulsion of students enrolled in preschool in a district or charter school (Public Law, 2016, *Chapter 45;* 18A:37-2c), yet early learning centers lack sufficient resources to support children with behavioral health needs. Similarly, New Jersey Head Start Performance Standards prohibit expulsion due to a child's behavior. The Department of Human Services, Division of Family Development also requires that providers receiving funds through the Child Care Subsidy Program establish policies to prevent suspension, expulsion and denial services due to children's behavior.[84]

Ongoing survey efforts will characterize the availability and geographic distribution of mental health services for young children by assessing the availability of psychologists serving children 0-5 years. This information, to be released Fall 2019, will be viewed in the context of a recently fielded survey of 368 private preschool programs regarding expulsions and the degree to which they relate to behavioral health needs. These efforts are being led by Kean University in collaboration with the Center for Autism and Early Childhood Mental Health, Montclair State, and the New Jersey Association for Infant Mental Health and the YCS Institute for Infant and Preschool Mental Health.

Within the state, there has been ongoing investment in training early child health professionals in Keeping Babies and Children in Mind (KBCM) and the Pyramid Model for Supporting Social/Emotional Competency in Infants and Young Children. The KBCM series includes seven three-hour workshops that promote the importance of social and emotional development of young children, reflective caregiving towards building resilience, and the centrality of forming relations and social connections in practice. The Pyramid Model emphasizes universal promotion for all children, secondary prevention to address needs for children at risk for social emotional delays and tertiary interventions for children with persistent challenges. The model uses systems-thinking and implementation science to promote evidence-based practices in homes and classrooms to build skills to support nurturing and responsive caregiving, create learning environments, provide targeted social-emotional skills,

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[84] http://www.childcarenj.gov/getattachment/Resources/Reports/DHS-DFD-Policy-Statement-Prevention-of-Suspension-and-Expulsion.pdf?lang=en-US

and support children with challenging behaviors. The trainings have been implemented in selected, publicly funded DOE preschools, Early Head Start and Head Start programs, Early Intervention, and privately funded child care programs.

d. *Child Care Demand, Affordability, Locations and Slots*

Reports assessing affordability of child care make varied assumptions about the percentage of parents in the labor force seeking care from licensed child care or registered family care providers. It is unclear the extent to which parents do not seek care due to lack of options in their community, affordability, lack of transportation or other factors. As noted in the market price study, accurate child care price data are needed from all providers on a regular basis to assess affordability. In addition, centralized data for locations and slots of public and free child care programs for child care are needed to inform future supply shortage analyses.

8. Gaps in Data or Research Most Important for State to Fill to Meet the Goals of Supporting Collaboration between Programs and Services and Maximizing Parental Choice

This needs assessment identifies four gaps that are essential to fill to support collaboration between programs and services and maximize parental choice.

a. *Identification, Programming and Supports for Children in Special Circumstances*

As noted in Section 7, NJ-EASEL promises to provide additional information about children in selected special circumstances (e.g., children in military families) as well as provide longitudinal data to assess outcomes and the effectiveness of 0-5 programming and services. However, not all special circumstances will be addressed in NJ-EASEL.

Ongoing efforts are focusing on children and young families who, for example, have experienced violence (both domestic and neighborhood) and other adverse experiences in order to provide trauma-informed services. New efforts to address childhood adversity, supported by three New Jersey foundations (Nicholson Foundation, Burke Foundation, Turrell Fund) in partnership with New Jersey public agencies and other stakeholders will further inform strategies to build resilience, prevent adverse childhood experiences, mitigate their sequelae and promote healing.

One of the gaps most important to fill in the current context is assuring an accurate count of young children in the upcoming US Census. It is widely recognized that the Census historically undercounts children who are: not the biological or adopted children of the householder (e.g., grandchild, other relative, not related); Hispanic or racial minorities; members of complex households (non-nuclear) and single-person households; living in renter-occupied housing and multiunit structures; and very young infants.[85] Given the large proportion of New Jersey children, 0-5, with foreign born parents and the dependence of early childhood funding allocations on population counts, it remains critical to accurately count New Jersey children.

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[85] https://www.census.gov/programs-surveys/decennial-census/2020-census/planning-management/final-analysis/2020-report-2010-undercount-children-summary-recent-research.html

b. Unmet Need for Affordable Childcare and Preschool

Another gap critical to fill is understanding the unmet need for affordable childcare and preschool. Current reports apply different estimates for the numbers of families seeking services though generally agree on limited availability of high quality, affordable child care for infants and toddlers. As the state strives to achieve universal preschool, using data to enhance shared understanding of the implications of expanded numbers of children in preschool on the business model for early child care is essential. As more three and four year olds enter preschool, the relative proportion of infants and toddlers in child care increases, thus increasing the overall costs of delivering services in child care settings given higher per child costs for younger ages.

While no gaps in data or research, per se, the next two gaps relate to the sustained **commitment to infrastructure** to support coordinated service delivery. Central Intake is critical to assuring that families can access desired, high quality services and NJ-EASEL is essential to identifying vulnerable families and assessing the effectiveness of service delivery.

c. Central Intake Infrastructure to Support Coordination

New Jersey's statewide Central Intake system has achieved national recognition and is frequently highlighted at national conferences, in peer-reviewed publications, and by the state's selection as a peer leader in national quality improvement efforts (e.g., Project Launch, HV CoIIN). The promise of Central Intake, however, requires renewed investments with dedicated staff and funding to support coordination as well as investments to support ongoing quality improvement efforts within and across the 21 hubs.

d. Sustained Funding for NJ-EASEL

Efforts to implement NJ-EASEL are underway and require sustained commitment by multiple state agencies. However, these collaborative efforts require additional funding to realize the potential of NJ-EASEL. New funding sources that rely on competitive funds through public and private grants and contracts are risky in that funding is not assured and the investments to date may not be realized through full implementation. Considerations for new, long term funding sources might include public private partnerships and allocations as a line item in the state budget. Such an approach also may apply to Central Intake. This funding strategy also would speak to the primacy of investment in early childhood and in assuring the effectiveness and efficiency of service delivery and refinement in those services, when needed.

9. Current Measurable Indicators of Progress that Align with the State's Vision and Desired Outcomes

The state's vision is for PDG to promote a comprehensive, coordinated early childhood system of care in addressing the physical, social-emotional, behavioral and cognitive aspects of child wellbeing and school readiness from prenatal through age five. This vision builds on a family centered approach that recognizes varied needs, priorities, and strengths. It also builds on the strategic plan for NJ's Race to the Top Early Learning Challenge Grant with a mission "to create an aligned system of early education and care with measurable impact for all NJ high needs children to age eight and pregnant women."[86] Consistent with the 2018 National Academies of Sciences report on the financing of early care and education, New Jersey's vision

[86] Race to the Top- Early Learning Challenge Final Report. 2019.

recognizes the need for a competent workforce, equitable access to affordable services for all children and families, adequate and sustainable financing, varied high-quality service delivery options, and a system for ongoing accountability including evaluation and continuous quality improvement.[87]

As such, currently measurable Indicators of progress relate to health and well-being, school performance, early intervention and special education workforce development, and Central Intake screens. Indicators related to health and wellbeing as well as vulnerability are described in Section 2 and 3. The remainder are highlighted below.

a. School Performance

School performance data currently are available at the 4th grade level using the Partnership for Assessment of Readiness for College and Careers (PARCC). Across the state, a high percentage (50%) of children did not meet or exceed grade 4 math test scores, with variability across communities (Figure 13). More favorable scores are reported in higher income communities. For example, over 90% of 4th graders in higher resourced Upper Saddle River (Bergen County) and Milburn (Essex County) had test scores that met or exceeded expectations.

New Jersey is currently implementing a kindergarten entry assessment. As of Dec 31, 2018, DOE has trained 1259 teachers and 434 district level administrators across 114 programs in Teaching Strategies GOLD, a performance based assessment instrument as part of the KEA. Ultimately, the KEA scores will be tracked in NJ-EASEL to support assessments of how service delivery and supports influence kindergarten readiness.

b. Early Intervention and Special Education Performance

In accordance with Part C of the Individuals with Disabilities Act (IDEA), New Jersey annually reports state and county performance on required early intervention indicators. Similarly, New Jersey reports state and county performance data for Part C 618.[88] These reports are publicly available. (See Section 4b).

The inclusion of children with disabilities in general education classrooms is a key indicator of progress and is supported not only through the implementation of IDEA, but also by various professional organizations including the Division for Early Childhood (DEC) and the National Association for the Education of Young Children (NAEYC).[89] New Jersey strives to assure that children with disabilities, including those in public or private educational settings, are educated with their typically developing peers to the maximum extent appropriate. The state also works hard to assure that special classes, separate, schooling or other removal of children from the regular educational setting occurs only when the nature of the child's disability is such that the use of supplementary aids and services cannot support the child in the general education environment. Progress towards the inclusion of young children with disabilities is currently measured through data indicating the percentage of children who receive the majority of their special education and related services in regular early childhood programs and is collected annually.[90]

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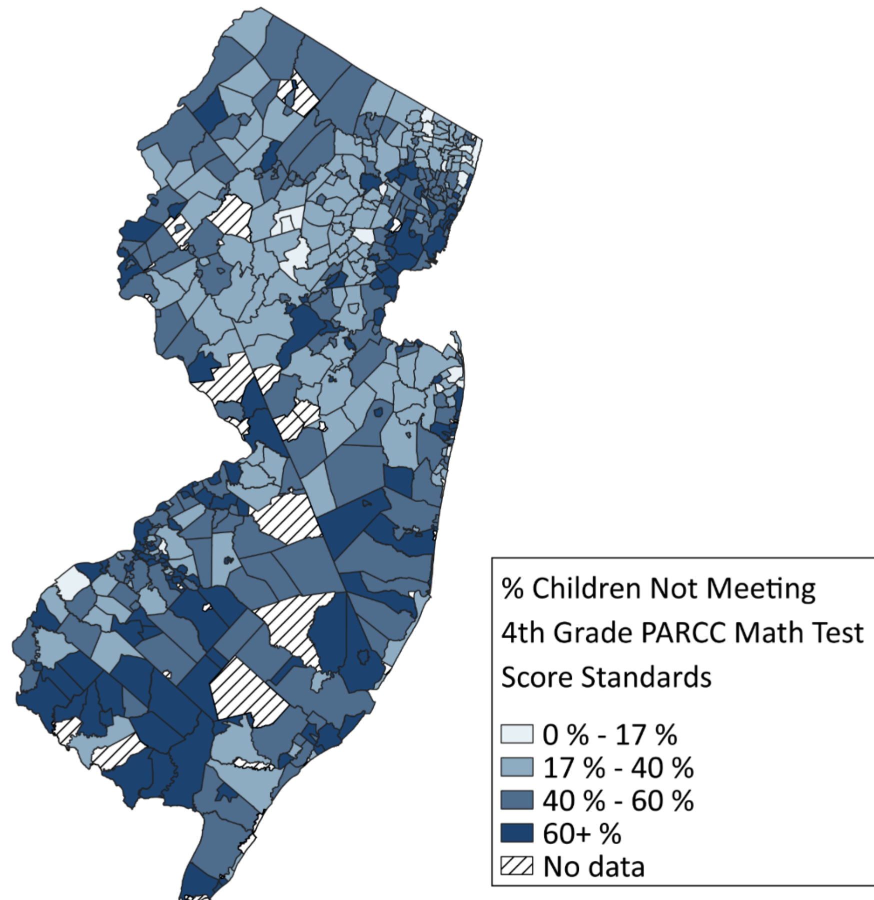
[87] National Academies of Sciences, Engineering, and Medicine. (2018). Transforming the Financing of Early Care and Education. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/24984.
[88] https://www.nj.gov/health/fhs/eis/public-reporting/
[89] https://elc.grads360.org/services/PDCService.svc/GetPDCDocumentFile?fileId=9652
[90] https://nj.gov/education/specialed/data/2017/3-5_Placement.pdf

Figure 13: Percentage of Children Not Meeting/Exceeding Grade 4 Math Test Score Expectations, 2017-2018[91]



c. Workforce Development

Indicators of progress regarding workforce development include the number of persons completing various early childhood education programs in New Jersey (Appendix C-19), certificates of eligibility (Appendix C-20), professional development activities sponsored by Grow NJ Kids (Appendix C-21), and various trainings offered by the Early Childhood Training Institute. The Workforce Registry, coordinates tracking for individuals in the early childhood workforce, provides training academy postings of statewide professional development and training opportunities, and provides DHS with data and information on workforce and training needs. DHS requires all contract agencies to post training via the Workforce Registry system.

New Jersey maintains an integrated child care information system for providers (www.njccis.com). It includes information related to licensed child care centers, registered family child care providers, the NJ Workforce Registry and Grow NJ Kids.

[91] New Jersey Data Book. Rutgers Center for Government Services, New Brunswick, NJ. njdatabook.rutgers.edu.

Even prior to the Workforce Registry, New Jersey tracked completion of preschool certificates of eligibility. As reviewed in the Ready, Set, Go 2018 report produced by the National Institute for Early Education Research (NIEER), there have been fewer individuals earning P-3 certificates in recent years (Appendix C-20).[92] In addition, those who complete the certificate, an alternate route to licensure for those who have met basic requirements, may be employed in K-3 classrooms and therefore may not contribute to the early care and education workforce for children ages 0-5.

A new indicator of success will be completion of the statewide Infant and Toddler Instructional Certificates which will address a gap in workforce development by focusing on infants and toddlers. Both NJCYC and NIEER recognized this gap. The Certificates will be available to those with Associates or Bachelors degrees and will require 18 hours of coursework. New Jersey will track completion in the Workforce Registry. Six community colleges had expressed interest in offering the certificates.[93] The Certificate also will provide a career ladder for practitioners by offering professional learning, higher education opportunities, and credentials. It also aligns with the Head Start Act 645A, Head Start Performance Standards, and national trends.

Grow NJ Kids offers a series of trainings to assure that professionals have the knowledge and skills to promote optimal development.[94] The Statewide Training Academy, GNJK Training Services, is a collaboration between DHS and the Institute for Families at Rutgers School of Social Work. GNJK Training Services provides all professional development including dual modalities- online and in person training - in English and Spanish. Completion of statewide trainings provides another current indicator of success; more than 3200 providers participated in trainings from 7/1-12/31/18 (Appendix C-21). In addition to classroom courses and web-based trainings for providers, training days prepare facilitators to deliver GNJK courses using the established evidence-based learning objectives for the course. They reflect a commitment to collaborative facilitation, staff development, and continuous quality improvement.

In addition, the Early Childhood Training Institute at Montclair State University offers: statewide training coordination for school district, Head Start, center-based, and family child care in both English and Spanish; statewide training on the Pyramid Model and Keeping Babies and Children in Mind; cross-department coordination of Train the Trainer for Developmental Screening Tools, Strengthening Families, and the Pyramid Model; online modules on topics such as physical activity, Birth to Three Standards, Dual Language Learners, and Cultural Competency; and Technical assistance supports for training and social-emotional development of children in child care/preschool settings.[95] Since trainings began, 3500 participants have attended at least one workshop for Keeping Babies and Children in Mind (May, 2014 – June, 2019; 450 workshops) and 1800 participants have attended either Preschool or Infant/Toddler modules for the Pyramid Model Module 1 trainings (July, 2016 – June 2019; 120 workshops).[96]

New Jersey professionals also have the opportunity to seek Infant and Early Childhood Mental Health Endorsements to recognize their expertise in social emotional development of

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[92] The National Institute for Early Education Research (NIEER) (2018). Ready, Set, Go! Assessing Capacity for Pre-K Expansion in New Jersey. URL: http://nieer.org/wp-content/uploads/2018/10/Ready-Set-Go_2018.pdf.

[93] Personal Correspondence. Suzanne Burnette, NJ Head Start Collaboration Office. 7/18/19.

[94] Grow NJ Kids Training Services: July-December 2018 Half-Year and Year End Report. Rutgers School of Social Work.

[95] RTT Final Report

[96] Personal Correspondence, Kailtin Mulcahy, Center for Autism and Early Childhood Mental Health, Montclair State University. 7/26/19.

infants and young children; a total of 157 have been endorsed.[97] However, only 20 endorsed professionals in the state are prepared to provide infant/toddler/parent/family clinical services. This underscores the need to increase the competency and capacity of licensed mental health professionals to engage in this work.

d. Central Intake Screens

Given New Jersey's focus on coordination in the early childhood system, New Jersey tracks the number of screens into Central Intake as a proxy for the number of families for whom linkages to services are being made. The number of screens also reflects the system capacity to screen and refer families to needed and desired services. Figures 14 and 15 summarize screens from both PRAs and CHS both before and after the announcement of the Healthy Women, Healthy Families initiative; the RFP was released in April 2018. From July-December 2017 to July 2018 - March 2019, the average number of screens per quarter decreased 28% among hubs funded by DCF and 46% among hubs funded by DOH.

The Healthy Women, Healthy Families initiative implemented several key strategies to address high rates of black infant mortality. These efforts have increased outreach, support, and services for women of color. In addition, there have been many benefits of the initiative, including increased access to family planning methods, an increase in outreach workers (e,g., doulas and community health workers), and expanded commitment to use medications shown to reduce preterm birth among high risk women.[98] However, the Central Intake data above also suggest that the initiative may have had unintended consequences; these data also highlight the need for a a renewed focus on systems coordination.

[97] https://easy.mi-aimh.org/njaimh and Personal Correspondence, Kaitlin Mulcahy (see above).

[98] NJ Department of Health, *Nurture NJ Increases Services to Address Black Infant Mortality: 6 Month Accomplishments of the Healthy Women Healthy Families Program,* https://www.state.nj.us/health/news/2019/approved/20190304a.shtml

Figure 14: Number of Screens into Central Intake by DCF Counties and Quarter – July 2017-March 2019[99]

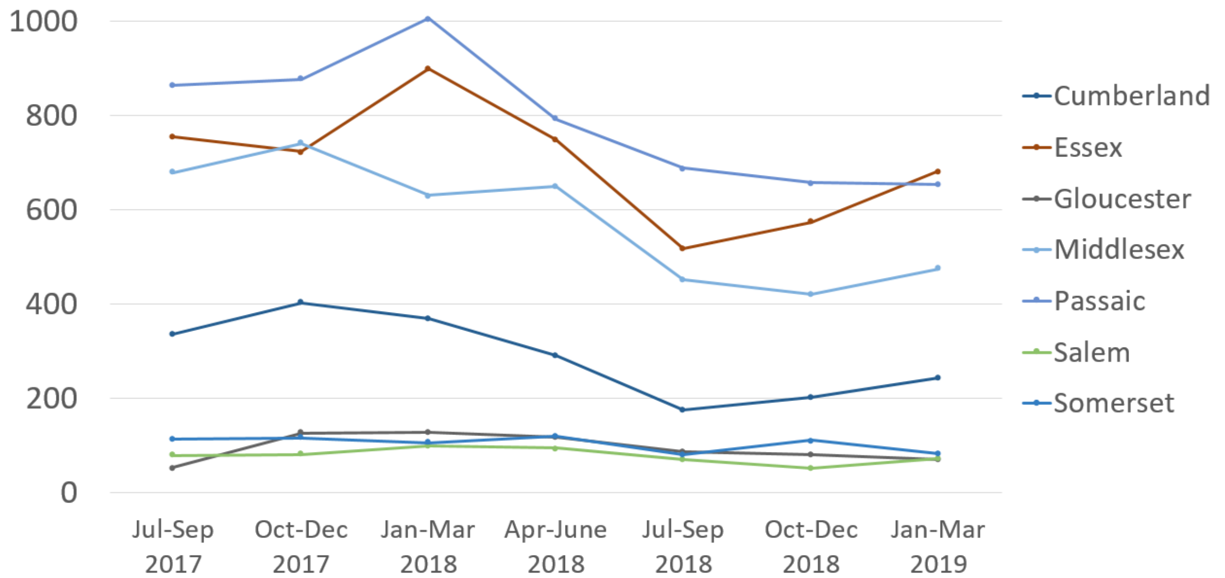
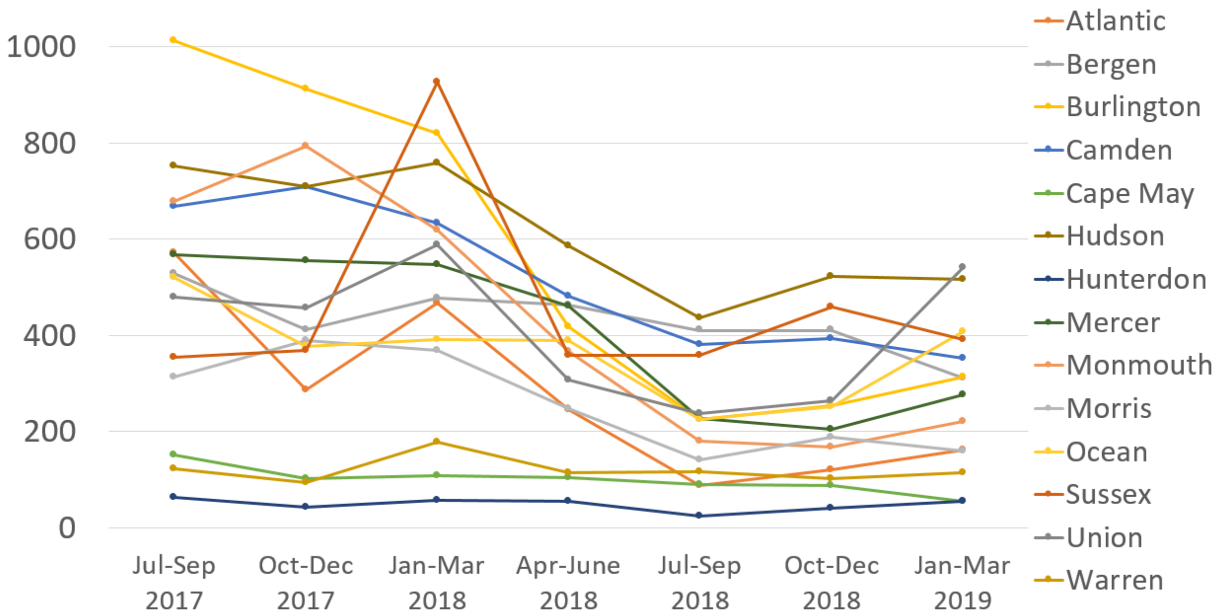


Figure 15: Number of Screens into Central Intake by DOH Counties and Quarter – July 2017-March 2019[100]



[99] New Jersey Central Intake System, 2017-2019.
[100] New Jersey Central Intake System, 2017-2019.

10. Describe Key Concerns or Issues Related to ECCE Facilities

There is scant information on the quality of existing ECCE buildings and physical infrastructure. Although the initial RFP included a NJ Strategic Plan Facilities Assessment, reduced funding levels relative to the requested amount precluded such activities as part of this needs assessment.

A recognized challenge for DOE funded preschools is that New Jersey administrative code establishes a minimum of 950 net square feet of classroom space for each classroom, including in-district buildings, charter schools, licensed community provider sites, and Head Start (N.J.A.C. 6A:26). Of the 950 square feet, 750 must be useable space and excludes storage, major equipment, and built in furnishings. Although required for DOE funded preschools, this allotment is not achievable in many areas with a shortage of rentable space.

According to the 2018 Ready, Set, Go Study Report based on assessments in 30 districts likely to benefit from preschool expansion funds, preschool classrooms do not have adequate capacity and quality to serve all children eligible for services.[101] The report recommends that preschool expansion efforts focus initially on facilities planning. Ready, Set, Go further recommends that the state authorize additional funding for facilities projects in expansion districts with low capacity and/or facilities not meeting standards. Additionally, the report encourages the state foster public-private partnerships with organizations and donors focused on community development in order to establish a revolving loan fund for Head Start and child care center buildings in districts needing more centers.

State guidelines and licensing requirements as well as federal standards establish requirements for facilities. The New Jersey *Guidelines for Preschool Facilities* outline the design and construction of facilities to provide a safe and healthy environment for preschool children.[102] Licensed facilities also must adhere to the regulations outlined in the *Manual of Requirements for Child Care Centers.*[103] Furthermore, any center receiving payment through the Child Care Subsidy Program must comply with the Child Care Development Block Grant (CCDGB) Reauthorization Act of 2014.[104] This law authorizes the Child Care Development Fund (CCDF), offers grants to States to administer the Child Care Subsidy Program, and provides health and safety standards for child care providers.[105]

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[101] *Ready, Set, Go! Assessing Capacity for Pre-K Expansion in New Jersey, Study Report.* July 31, 2018.
[102] NJ Department of Education, Division of Early Childhood Education. *Preschool Guidance and Materials.* https://www.nj.gov/education/ece/psguide/facilities.htm.
[103] New Jersey Department of Children and Families, Office of Licensing, *Manual of Requirements for Child Care Centers,* 2017. https://www.nj.gov/dcf/providers/licensing/laws/CCCmanual.pdf.
[104] New Jersey Department of Human Services, Division of Family Development. Child Care Subsidy Program Requirements and CCDBG. http://www.childcarenj.gov/Providers/Child-Care-Subsidy-Program-Requirements-and-CCDBG.aspx.
[105] Ibid.

11. Barriers to the Funding and Provision of High-Quality Early Childhood Care and Education Services and Supports, and Identify Opportunities for More Efficient Use of Resources

New Jersey has made remarkable progress in implementing high-quality early childhood care and education services and supports as previously described. However, five key barriers were identified in this needs assessment: the need for a communication strategy for the shared vision, insufficient funds, unintended consequences of diverse funding streams that are not aligned, insufficient time to allocate funds and enroll families when funds newly become available (e.g., Preschool Expansion Aid difficult to spend with short turnaround), and the need to stimulate consumer demand (e.g., marketing campaign)

a. Communication Strategy for NJ Shared Vision

A shared vision is fundamental to inform strategic planning to strengthen service availability and quality. As articulated by PDG and RTT-ELC, New Jersey's shared vision aligns well with recommendations from a National Academies of Sciences 2018 report (see Section 9). Moreover, New Jersey agencies have been successful in securing public and private funding for multiple initiatives serving the B-5 population and they engage in many related activities within a mixed delivery system. Despite these successes, stakeholders identified a need to develop a communication strategy that enables all stakeholders to reinforce the shared vision and explicitly recognize how varied initiatives align and support this vision.

A successful communication strategy will create feedback loops and provide guidance regarding the exchange of information among the County Councils for Young Children, the NJ CYC, the IPG, and the ELC. Such a strategy will facilitate increased collaboration, enhance the sense of shared accountability, and contribute to greater impact. Although there is overlapping membership among some of the NJ organizations and agencies working to promote the well-being of the birth to five population, greater communication could increase the efficient use of local, state and federal resources. Enhanced communication also would recognize that various agencies and organizations have complementary, and at times overlapping missions, activities, and priorities. In addition, such a communication strategy can increase shared appreciation for the requirements of varied public and private funding streams and agency regulations which, in turn, influence how resources are allocated and activities conducted. In addition, enhanced communication could support greater understand of varied, constituencies, eligibility requirements, and quality standards.

b. Insufficient Funds

The NJCYC ICHC recognizes that there is limited funding for early childhood care and education services and infrastructure, which forces restrictions and requirements.[106] One of New Jersey's strategic planning priorities is to provide sustained funding to further develop the NJ-EASEL Early Childhood Integrated Data System. Insufficient funds also threaten the robust Central Intake system with hubs in each of the 21 counties.

Funding uncertainties also relate to the increased New Jersey minimum wage, which increased from $8.85 to $10.00/hour. New Jersey has a goal of increasing the minimum wage to $15.00/hour by 2024. The increase impacts the costs of providing child care without immediate plans to increase the child care subsidies. Child care providers have few options given their commitment to high quality services, the need to maintain staff/child ratios, and the inability of most parents to pay more for child care. In addition, the increase in minimum wage may reduce

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[106] Ibid.

the number of families eligible for Head Start with its income requirement to enroll children in families with incomes at or below the federal poverty level.

c. Diverse Funding Streams

Additionally, diverse funding streams with differing goals and priorities can lead to a lack of coordination and inefficiencies. The Infant-Child Health Committee (ICHC) of the New Jersey Council for Young Children (NJCYC) identifies the lack of collaboration and communication across programs with different restrictions and funding as a barrier to early childhood care and education funding. The Committee recommends increasing knowledge and awareness of the different programs and opportunities in order to promote communication.[107]

d. Timing of Allocating Funds

When state funding for early child care and education services becomes available, time is needed to allocate funding and enroll children or families in the services. Insufficient time can lead to funding not being expended in time. For example, Governor Murphy campaigned on fully funding preschool expansion. The legislature allocated $25 million for the 2017-2018 school year and an additional $50 million for preschool expansion for the 2018-2019 school year through the Preschool Education Expansion Aid program (PEEA).[108] However, more than $5 million of the available funding was not expended in FY2018.[109] Multiple factors may have contributed to lack of spending including the timing in proximity of an election year and the uncertainty of future funding.

e. Need to Increase Consumer Awareness

There is a need to stimulate consumer awareness in order to increase service usage and promote awareness and coordination across services. However, the NJCYC identifies limited funding for marketing. The Committee recommends providing more links to resources on local and state websites in order to increase knowledge of early childhood care and education services. Such an approach should be aligned with the communication strategy for the shared vision and include a bidirectional flow of information with the general public (Section 11a). Also, NJ's new partnership with Vital Villages will include a focus on increasing consumer awareness about available services and supports. Vital Villages is an organization that provides TA regarding cultivating stronger connections between community residents and community agencies in order to improve community systems and support social change with a focus on enhancing family and community protective factors.

12. Transition Supports and Gaps that Affect How Children Move between Early Childhood Care and Education Programs and School Entry

As reviewed in a 2015 ACNJ policy brief, New Jersey's Department of Education broadly defines early learning transitions as "an organized system of actions and transactions that takes into account the relationships among home, school and community as the child moves from preschool to kindergarten, through grade three."[110]

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[107] Ibid.

[108] *Ready, Set, Go: Assessing Capacity for Pre-K Expansion in New Jersey, Study Report.* July 31, 2018.

[109] Ibid.

[110] Shore V, Rice C. Right from the Start: Guiding Young Children's Transitions in the Early Years. Advocates for Children of New Jersey. 2015.

The state administrative code (6A:13A-6.1) highlights elements of transition initiatives including the processes for: collaborating with other preschool through grade 3 administrators in the district; communicating information about individual children to their new teachers including results of performance-based assessments, identifying and communicating the curriculum with other programs, providing information to parents about the kindergarten program and the transition plan from preschool through grade three.[111] This approach is supported by multiple standards including the Birth-to-Three Early Learning Standards, Preschool Implementation Guidelines, the Preschool Teaching and Learning Standards and Head Start Program Performance Standards. While administrative code and regulations are strong, the policy brief highlights uneven implementation of best practices with regard to child care and teacher training, engaging parents, preschool to third grade transition plans in school districts (previously only required in districts with state funded preschools), and connections across early care and education settings.

13. Systems Integration and Interagency Collaboration

New Jersey leadership maintains a strong commitment to systems integration as a means to promote the delivery of high quality, efficient and effective services to families with young children. This commitment is supported by interagency state- and county-level entities and is further highlighted by many ongoing initiatives. Several examples are highlighted below to illustrate New Jersey's intentional approach to systems integration. Many more examples of systems integration efforts are designed to support effective service delivery for children and families across the state.

a. Entities that Facilitate Interagency Collaboration at the State- and County Levels

As part of the Race to the Top Early Learning Challenge initiative, New Jersey established both the Early Learning Commission (ELC) and the Interdepartmental Planning Group (IPG). The ELC includes commissioners from the following agencies: Department of Education (DOE), the Department of Children and Families (DCF), the Department of Health (DOH), the Department of Human Services (DHS) and the Chairperson from the New Jersey Council for Young Children (NJCYC). With the current administration, the Department of Labor (DOL) joined the commission.

The **Interdepartmental Planning Group** (IPG), comprised of leadership from DOE, DCF, DOH, DHS, DOL, and NJCYC, is the primary implementation arm for programs and policies affecting young children in the state. The group reviews the feasibility of program and policy recommendations (e.g., from NJCYC), develops plans for implementation, and ultimately carries out the plans while working in collaboration with other relevant state agencies and organizations.

The IPG has facilitated implementation of multiple successful initiatives such as Race to the Top – Early Learning Challenge (RTT-ELC), for which the Administrator sat in DOE's Division of Early Childhood Education. The IPG now has oversight for implementation of **NJ-EASEL**, the state's early childhood integrated data system which was initiated with RTT-ELC support. NJ-EASEL is highlighted in section 7a (Programming and Supports for Children with

[111] New Jersey Department of Education, N.J.A.C. 6A: 13A, Elements of High Quality Preschool Programs, https://www.state.nj.us/education/code/current/title6a/chap13a.pdf

Special Circumstances), section 7b (Shared Understanding of Definition of Vulnerability and High Quality ECCE Programs), section 8d (Sustained Funding for NJ-EASEL), section 11b (Insufficient Funds) and in Appendices C-17 and C-18.

The **New Jersey Council for Young Children (NJCYC)**, a governor-appointed advisory council for early care and education, further supports interagency collaboration. Members include leaders from DHS, DOE, DOH, DOL, DCF as well public members representing a local education agency, institution of higher education, local service provider, Head Start, Title I, the State Homeless Education Coordination, and other groups relevant to the Council's work. NJCYC is charged with enhancing the coordination and quality of early childhood systems from pregnancy through age eight and ensuring a seamless system of communication between internal and external stakeholders.

All 21 counties have a **County Council for Young Children (CCYC)** to strengthen collaboration among parents, families, and local community stakeholders with health, early care and education, family support, and other service providers. This shared leadership approach includes parents as active partners with service providers and community leaders helping to identify the needs, concerns, aspirations and successes of collective efforts to positively impact the health, education and well-being of children from pregnancy/birth to age 8.

b. Examples of Initiatives that Support of Systems Integration

The state's Central Intake system, overseen by both DOH and DCF, demonstrates New Jersey's commitment to systems integration. In each county, Central Intake hubs provide a single point of entry for families to access a wide array of community services from prenatal to age five. The hubs meet regularly to share expertise and engage in continuous quality improvement activities. Issues pertinent to Central Intake are highlighted in section 5e (Systems Infrastructure to Support High Quality Services), section 8c (Central Intake Infrastructure and Systems Coordination), 9c (Systems Coordination), and 11b (Insufficient Funds).

Another strong example of New Jersey's commitment to systems integration is Grow New Jersey Kids. GNJK is a collaborative effort of DCF, DOE, DOH, and DHS. It supports workforce development and trainings across multiple early care and education programs led by DHS and DOE. The GNJK standards also inform work across multiple agencies; standards relate to developmental screening (DHS, DCF, DOH Early Intervention), health and safety and family engagement (DHS, DCF Office of Licensing and Early Childhood, DOE), Head Start (DOE, DHS), preschool expansion and the Office of Special Education (DOE, DHS).

DCF and DHS also jointly coordinate Strengthening Families, an initiative to prevent child abuse and neglect by strengthening families through the state's early care and education network. Strengthening Families uses the Protective Factors Framework to promote the healthy development and well-being of children and families. Within each county, the Child Care Resource Referral Agencies train child care and family child care staff to incorporate protective factors and key related program strategies in their daily activities.

DOH and DHS jointly oversee SNAP ED, a USDA/FNS funded nutrition and physical activity program aimed at teaching NJ residents how to make healthy, budget-friendly food choices and lead more active lives. Through the initiative, community-based agencies and schools provide education aimed at reducing hunger and preventing obesity.

Thus, New Jersey focuses on systems integration and interagency collaboration both at state and local levels in an effort to promote service coordination and assure that families get services they need and prioritize. The state has benefitted from participation in several initiatives focused on systems integrations to promote the health and well-being of expectant families and families with young children. These efforts include Race to the Top Early Learning Challenge, the Early Childhood Comprehensive Systems Impact, Help Me Grow, Project LAUNCH, Project HOPE, the National Governors Association 2-Gen Parents and Children Thriving Together, and Healthy Women Healthy Families. Each of these initiatives has supported a culture of quality improvement and contributed to workforce development. Lessons learned from these efforts and this PDG needs assessment are informing ongoing statewide strategic planning and updates of the B-5 New Jersey Plan.

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   - C-16. Maximum Monthly Child Care Payment Rates, 2019
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Appendix A: Abbreviations

ACF	Administration for Children and Families, US Department of Health and Human Services
ACNJ	Advocates for Children of New Jersey
CC	Child care
CCDBG	Child Care Development Block Grant
CCDF	Child Care Development Fund
CCYC	County Council for Young Children, New Jersey
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CI	Central Intake
CP&P	Child Protection and Permanency, Department of Children and Families, NJ
CPS	Children's Protective Services
CQI	Continuous Quality Improvement
DCF	Department of Children and Families, New Jersey
DHS	Department of Human Services, New Jersey
DHS-DFD	Department of Human Services, Division of Family Development, New Jersey
DOE	Department of Education, New Jersey
DOH	Department of Health, New Jersey
DOL	Department of Labor and Workforce Development, New Jersey
EC	Early childhood
ECCE	Early Childhood Care and Education
ECCS	Early Childhood Comprehensive System
ECIDS	Early Childhood Integrated Data System
EI	Early intervention
EHS/HS	Early Head Start/Head Start
ELC	Early Learning Commission, New Jersey (DOE, DHS, DCF, DOH, DHL, NJCYC)
ESSA	Every Student Succeeds Act, Department of Education, US
FCC	Family Child Care
FFN	Family/Friend/Neighbor
GNJK	Grow NJ Kids
HFA	Healthy Families America
HMG	Help Me Grow, Department of Children and Families
HOPE	Project HOPE: Harnessing Opportunity for Positive, Equitable EC Development
HV	Home visiting

ICHC	Infant/Child Health Committee, New Jersey Council for Young Children
IECMH	Infant and Early Childhood Mental Health
IDEA	Individuals with Disabilities Education Act
IDEIA, IDEA-B,	Individuals with Disabilities Education Improvement Act of 2004 (reauthorization Or IDEA Part B of IDEA)
IPG	Interdepartmental Planning Group, New Jersey (DOE, DHS, DCF, DOH, DHL, NJCYC)
LAUNCH	Linking Actions for Unmet Needs in Children's Health, New Jersey
LEA	Local education authority
MIECHV	Maternal, Infant & Early Childhood Home Visiting
NFP	Nurse-Family Partnership
NIEER	National Institute for Early Education Research
NJCYC	New Jersey Council for Young Children
NJ-EASEL	New Jersey Enterprise Analysis System for Early Learning (state-level ECIDS)
NJ-SHAD	New Jersey State Health Assessment Data
OECS	Office of Early Childhood Services, Department of Children and Families, NJ
OOL	Office of Licensing, Department of Children and Families
PAT	Parents as Teachers
PDG	Preschool Development Grant
PDG B-5	Preschool Development Grant Birth through Five
QRIS	Quality Rating and Improvement System, HHS
RTT-ELC	Race to the Top Early Learning Challenge
SNAP	Special Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
2-Gen	Two-generational

Appendix B: New Jersey Committee Rosters

B-1: New Jersey Council for Young Children Roster

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Appendix C: Tables

Table C-1: Population[1] and Population Density[2] in New Jersey, by County, 2017

County	Population	Persons/Square Mile
New Jersey	9,005,644	1,224.6
Atlantic	269,918	485.7
Bergen	948,406	4,070.3
Burlington	448,596	561.7
Camden	510,719	2,308.2
Cape May	93,553	372.1
Cumberland	152,538	315.4
Essex	808,285	6,404.2
Gloucester	292,206	907.5
Hudson	691,643	14,973.5
Hunterdon	125,059	292.3
Mercer	374,733	1,668.8
Middlesex	842,798	2,728.3
Monmouth	626,351	1,336.1
Morris	499,693	1,085.9
Ocean	597,943	951.0
Passaic	512,607	2,777.0
Salem	62,792	189.2
Somerset	335,432	1,111.4
Sussex	141,682	273.0
Union	563,892	5,482.4
Warren	106,798	299.2

[1] American Community Survey-1 year estimates, 2017
[2] https://nj.gov/health/fhs/primarycare/documents/Rural%20NJ%20density2015-revised%20municpalities.pdf

Table C-2: Children Under 6 Years Living in Poverty in New Jersey, by County, 2013-2017[3]

County	Percent in Poverty	Number of Children in Poverty	Total Children < 6 Years
Atlantic	29.5%	5,357	18,158
Bergen	8.9%	5,388	60,568
Burlington	10.2%	2,854	28,003
Camden	22.0%	8,393	38,072
Cape May	12.5%	628	5,033
Cumberland	26.1%	3,079	11,791
Essex	26.5%	16,542	62,466
Gloucester	10.2%	1,962	19,198
Hudson	23.3%	12,742	54,636
Hunterdon	5.2%	297	5,722
Mercer	18.8%	4,707	25,075
Middlesex	12.0%	6,972	58,117
Monmouth	11.2%	4,314	38,587
Morris	5.1%	1,552	30,238
Ocean	22.8%	10,738	47,186
Passaic	28.5%	11,826	41,561
Salem	30.4%	1,294	4,256
Somerset	4.8%	1,023	21,167
Sussex	6.0%	498	8,261
Union	15.3%	6,247	42,064
Warren	10.7%	651	6,090
New Jersey	17.1%	107,244	626,249

[3] American Community Survey 2013-2017, B17020

Table C-3: Children Ages 0-6 with One or More Foreign-Born Parent by County, 2017[4]

County	Percent Children <6 Years with One or More Foreign-Born Parent	Number of Children <6 Years with One or More Foreign-Born Parent	Total Children < 6 Years
Atlantic	34.4	5,485	15,938
Bergen	49.7	28,988	58,359
Burlington	18.0	4,730	26,315
Camden	18.6	6,278	33,779
Cape May	10.8	539	5,007
Cumberland	30.1	3,703	12,313
Essex	52.3	31,602	60,367
Gloucester	8.7	1,481	17,006
Hudson	62.8	33,326	53,059
Hunterdon	23.3	1,369	5,872
Mercer	45.2	10,889	24,112
Middlesex	58.2	32,523	55,873
Monmouth	30.1	11,426	37,926
Morris	39.4	11,583	29,381
Ocean	16.0	7,850	49,121
Passaic	54.4	22,000	40,468
Salem	9.9	350	3,538
Somerset	48.2	9,895	20,524
Sussex	18.2	1,402	7,716
Union	51.4	21,240	41,283
Warren	8.7	498	5,694
New Jersey	40.9	247,157	603,651

[4] American Community Survey 2017, C05009

Table C-4: New Jersey Selected Birth and Death Outcomes, by County[5]

County	**Low Birth Weight, 2013-2017** (% live born infants <2500 g)	**Preterm Birth, 2013-2017** (% infants born <37 weeks)	**Infant Mortality Rate, 2012-2016** (Deaths per 1,000 Live Births)
Atlantic	8.0	8.7	7.3
Bergen	7.7	9.7	2.9
Burlington	8.1	9.5	5.4
Camden	9.0	10.1	7.6
Cape May	6.6	7.8	5.2
Cumberland	9.4	11.7	5.8
Essex	9.5	11.0	6.0
Gloucester	8.4	10.1	4.6
Hudson	8.7	10.6	3.4
Hunterdon	6.4	8.2	**
Mercer	8.5	9.4	6.6
Middlesex	8.0	8.9	3.6
Monmouth	7.4	9.5	3.6
Morris	6.5	8.4	2.8
Ocean	6.0	7.6	3.0
Passaic	8.6	11.0	4.1
Salem	7.9	9.7	6.6
Somerset	7.6	9.0	3.9
Sussex	6.1	7.7	3.5
Union	7.7	9.1	4.5
Warren	7.2	9.5	7.3
New Jersey	8.0	9.6	4.4
United States	8.0		5.9

** Number of deaths too small to calculate a reliable rate.

[5] https://www-doh.state.nj.us/doh-shad/topic/Births.html

Table C-5: Maternal Education, Foreign Born, Medicaid Status, and Age < 20 Years for New Jersey Births, by County, 2017[6]

County	Mothers with < HS Education (%)	Mothers Foreign Born (%)	Mothers Insured by Medicaid (%)	Mothers < 20 Years of Age (%)
Atlantic	12.7%	28.5%	40.0%	3.5%
Bergen	5.8%	46.5%	17.1%	1.2%
Burlington	5.6%	18.2%	24.0%	2.3%
Camden	12.5%	19.4%	41.2%	4.0%
Cape May	10.1%	12.0%	40.9%	3.7%
Cumberland	25.1%	24.2%	52.4%	8.4%
Essex	14.5%	43.6%	44.4%	3.8%
Gloucester	5.3%	8.9%	28.5%	2.6%
Hudson	11.5%	58.6%	39.6%	2.8%
Hunterdon	5.5%	19.5%	9.8%	0.5%
Mercer	16.4%	41.1%	35.6%	3.7%
Middlesex	9.7%	56.8%	25.2%	2.3%
Monmouth	8.5%	24.9%	21.2%	2.2%
Morris	4.7%	33.6%	12.0%	1.2%
Ocean	9.4%	15.4%	41.4%	1.4%
Passaic	17.4%	50.2%	45.0%	5.0%
Salem	12.9%	9.7%	57.7%	4.2%
Somerset	7.6%	45.4%	15.4%	2.1%
Sussex	3.8%	10.5%	18.2%	1.8%
Union	16.0%	49.8%	26.5%	3.1%
Warren	4.0%	17.5%	22.1%	2.3%
New Jersey	10.9%	37.7%	31.8%	2.8%

[6] NJ SHAD 2017. https://www-doh.state.nj.us/doh-shad/query/builder/birth/BirthBirthCnty/Count.html

Table C-6: Black and White Infant Mortality Rate, by County, 2012-2016[7]

County	Black IMR (Deaths/1000 Live Births)	White IMR (Deaths/1000 Live Births)	Overall IMR (Deaths/1000 Live Births)
Atlantic	14.5	4.6	7.3
Bergen	-	2.1	2.9
Burlington	9.3	3	5.4
Camden	13.3	4.2	7.6
Cape May	-	-	5.2
Cumberland	-	-	5.8
Essex	8.5	2.2	6.0
Gloucester	11.8	2.5	4.6
Hudson	8.1	2.1	3.4
Hunterdon	-	-	-
Mercer	15.5	-	6.6
Middlesex	8.4	2.8	3.6
Monmouth	7.8	2.8	3.6
Morris	-	2.1	2.8
Ocean	-	2.5	3.0
Passaic	7.4	2.3	4.1
Salem	-	-	6.6
Somerset	12.4	-	3.9
Sussex	-	-	3.5
Union	6.8	2.7	4.5
Warren	-	-	7.3
New Jersey	8.8	2.7	4.4

[7] NJ SHAD 2012-2016. https://www-doh.state.nj.us/doh-shad/query/builder/birth/BirthBirthCnty/Count.html

Table C-7: Key Indicators* in Births to Black Mothers in Selected Municipalities, 2017 (Healthy Women, Healthy Families RFP)[8]

	New Jersey	Atlantic	Camden	Newark	Irvington	East Orange	Jersey City	Trenton	Paterson
Black (non-Hispanic) births (n)	13,068	202	492	1,873	686	652	753	549	489
Teen births (%)	5.6	5.9	7.9	6.8	5.7	5.1	7.6	7.3	9.4
Medicaid (%)	53.2	68.8	86.2	67.4	60.6	60.6	64.0	65.6	63.6
Late/No PNC (%)	10.9	9.9	10.0	15.5	15.3	13.2	12.1	14.2	10.4
Smoked during pregnancy (%)	6.0	24.8	10.8	5.7	2.2	4.0	6.9	10.4	6.5
Preterm birth (%)	13.1	15.3	12.8	14.8	15.2	16.0	15.1	11.5	13.7
Low birth weight (%)	12.3	13.4	15.2	13.1	10.5	12.3	13.9	12.2	12.7
Exclusive BF at discharge (%)	22.8	24.8	23.8	15.6	11.8	17.5	14.7	30.2	13.5

* Data not available for Black mothers in selected municipalities for the following indicators: Gestational diabetes (%); Gestational HBP (%); Obesity (%); Income below Poverty Line (%); Median household income ($); Females (25+ years old) with No High School Diploma (%); Households led by women (%)

[8] NJ SHAD, 2017. https://www-doh.state.nj.us/doh-shad/query/builder/birth/BirthBirthCnty/Count.html.

Table C-8: Participation in TANF and SNAP, 2019[10]; and WIC, 2017[11], by County

County	Children 0-5 Living in Families Receiving TANF	% Children 0-5 Receiving TANF	Children 0-5 Receiving SNAP	% Children 0-5 Receiving SNAP	Women, Infants and Children Enrolled in WIC	Women, Infants and Children Receiving WIC Benefits	Total Children <6 Years[9]
Atlantic	337	1.9%	3,454	19.0%	5,863	5,178	15,767
Bergen	142	0.2%	2,517	4.2%	6,840	6,147	49,660
Burlington	209	0.7%	2,234	8.0%	4,450	3,952	23,276
Camden	769	2.0%	7,076	18.6%	11,104	9,976	31,687
Cape May	50	1.0%	869	17.3%	1,445	1,289	4,483
Cumberland	200	1.7%	3,275	27.8%	5,287	4,646	10,232
Essex	1,125	1.8%	12,951	20.7%	20,792	18,311	52,804
Gloucester	131	0.7%	1,806	9.4%	3,274	2,925	15,904
Hudson	703	1.3%	9,840	18.0%	20,129	18,354	47,441
Hunterdon	15	0.3%	258	4.5%	439	411	4,992
Mercer	347	1.4%	3,756	15.0%	7,990	7,100	21,113
Middlesex	236	0.4%	5,244	9.0%	13,361	12,223	49,144
Monmouth	109	0.3%	3,078	8.0%	6,900	6,338	31,705
Morris	40	0.1%	1,089	3.6%	2,654	2,339	24,949
Ocean	165	0.3%	7,638	16.2%	18,528	16,372	40,591
Passaic	632	1.5%	11,178	26.9%	16,712	15,180	34,842
Salem	62	1.5%	963	22.6%	1,001	829	3,531
Somerset	99	0.5%	874	4.1%	3,023	2,725	17,653
Sussex	20	0.2%	357	4.3%	789	701	6,605
Union	218	0.5%	5,062	12.0%	11,582	10,385	35,278
Warren	80	1.3%	671	11.0%	1,142	1,035	5,059
New Jersey	5,689	0.9%	84,190	13.4%	163,305	146,416	526,716

[9] American Community Survey 2013-2017, B17020

[10] Correspondence with Division of Family Development, New Jersey Department of Human Services, 2019.

[11] NJ KIDS COUNT Data Center, 2017. Women, infants and children enrolled in the WIC nutritional program in New Jersey. https://datacenter.kidscount.org/data/tables/2111-women-infants-and-children-enrolled-in-wic-nutrition-program?loc=32&loct=5#detailed/5/4699-4720/false/871,870,573,869,36,868,867,133,38,35/any/4426

Table C-9: Food Insecure Children, All Ages Children, by County, 2016[12]

County	Percent in Food Insecure Households	Number of Children in Food Insecure Households	Total Children <18 Years
Atlantic	18.3%	11,120	60,765
Bergen	10.6%	21,420	202,075
Burlington	11.4%	11,160	97,895
Camden	14.9%	17,790	119,396
Cape May	18.1%	3,100	17,127
Cumberland	17.9%	6,630	37,039
Essex	16.2%	30,900	190,741
Gloucester	12.3%	8,260	67,155
Hudson	15.6%	21,450	137,500
Hunterdon	9.3%	2,450	26,344
Mercer	12.3%	9,900	80,488
Middlesex	11.5%	21,170	184,087
Monmouth	11.2%	15,680	140,000
Morris	9.0%	9,980	110,889
Ocean	15.9%	21,880	137,610
Passaic	16.2%	19,990	123,395
Salem	17.7%	2,540	14,350
Somerset	9.2%	7,100	77,174
Sussex	11.5%	3,570	31,043
Union	12.8%	16,820	131,406
Warren	12.9%	2,960	22,946
New Jersey	13.5%	268,080	1,985,778

[12] Health Indicator Report of Food Insecurity, NJ SHAD, https://www-doh.state.nj.us/doh-shad/indicator/view/FoodInsecurity.CoChild.html

Table C-10: Children, Ages 0-5, Enrolled in Medicaid and the Children's Health Insurance Program (CHIP), by County, May 2019[13]

County	Medicaid	CHIP	Total	% Medicaid or CHIP
Atlantic	8,441	1,011	9,452	59.9%
Bergen	11,268	2,588	13,856	27.9%
Burlington	7,058	1,097	8,155	35.0%
Camden	17,982	1,335	19,317	61.0%
Cape May	2,088	313	2,401	53.6%
Cumberland	6,653	728	7,381	72.1%
Essex	32,290	2,090	34,380	65.1%
Gloucester	5,108	661	5,769	36.3%
Hudson	22,696	2,363	25,059	52.8%
Hunterdon	895	219	1,114	22.3%
Mercer	10,091	1,245	11,336	53.7%
Middlesex	15,687	3,226	18,913	38.5%
Monmouth	9,528	1,435	10,963	34.6%
Morris	4,289	985	5,274	21.1%
Ocean	24,481	5,794	30,275	74.6%
Passaic	20,896	2,553	23,449	67.3%
Salem	1,874	194	2,068	58.6%
Somerset	3,763	782	4,545	25.7%
Sussex	1,351	309	1,660	25.1%
Union	15,832	2,303	18,135	51.4%
Warren	1,762	271	2,033	40.2%
New Jersey	224,145	31,502	255,647	48.5%

[13] Correspondence with Division of Family Development, New Jersey Department of Human Services, 2019. Totals include 112 enrolled in Medicaid and not assigned to a county.

Table C-11: Children 0-3 Years with IFSP[14] and Children 3-5 Years with Special Education Needs, by County, 2017[15]

County	< 12 mos	>12 and < 24 mos	>24 and <36 mos	Total	Children 0-3 with IFSP (%)[16]	Children Received All Services on IFSP in Timely Manner (%)	Children 3-5 with Special Education Needs (%)
Atlantic	14	109	217	340	4.21	78.95	8.43
Bergen	47	386	905	1,338	4.44	96.25	8.68
Burlington	38	149	317	504	3.66	88.00	7.86
Camden	53	185	412	650	3.30	91.18	7.29
Cape May	4	23	83	110	4.04	100.00	7.54
Cumberland	13	57	137	207	3.49	80.00	5.68
Essex	107	414	973	1,494	4.56	98.63	7.34
Gloucester	16	82	267	365	4.15	100.00	8.57
Hudson	55	258	740	1,053	3.23	89.80	9.90
Hunterdon	8	28	80	116	4.02	100.00	6.03
Mercer	31	147	283	461	3.39	100.00	6.54
Middlesex	61	347	861	1,269	4.26	85.45	10.41
Monmouth	67	239	601	907	5.17	97.50	8.32
Morris	19	174	451	644	4.47	97.06	7.44
Ocean	106	507	880	1,493	6.76	90.63	8.45
Passaic	60	270	773	1,103	5.39	95.92	8.28
Salem	6	18	45	69	3.66	90.00	7.31
Somerset	16	102	264	382	3.85	100.00	8.14
Sussex	10	49	123	182	5.17	100.00	7.61
Union	47	242	567	856	4.00	97.06	10.03
Warren	15	32	54	101	3.75	100.00	7.47
New Jersey	793	3,818	9033	13,644	4.38	94.61	8.17

[14] https://www.nj.gov/health/fhs/eis/documents/DOH%20Table%201%20Dec%201%202017.pdf
[15] Data obtained from NJ Department of Education
[16] According to FFY 2016 Part C State Performance Plan/Annual Performance Report, the target for FFY2016 is 3.43%. https://www.nj.gov/health/fhs/eis/documents/APR-2016C-NJ.pdf. Data reported as of 12/1/17

Table C-12: Birth Defects and Congenital Anomalies, by County (Rate per 10,000), 2011-2015[17]

County	Orofacial	Musculo-skeletal	Genito-urinary	Gastro-intestinal	Eye	Ear	Chromo-somal	Cardio-vascular	CNS	Total
Atlantic	14.4	23.9	41.4	8.8	0.6	4.4	15.7	65.3	8.2	182.7
Bergen	11.1	19.5	46.6	8.5	1.3	3.3	9.1	107.1	5	211.5
Burlington	9.9	15.3	56.6	9.4	1.8	0.4	12.6	69.6	2.7	178.3
Camden	17.2	19.8	43.7	4.8	1.6	1.9	14.3	53.2	6.4	162.9
Cape May	17.6	19.8	37.4	8.8	0	0	6.6	44	11	145.2
Cumberland	17.6	18.6	18.6	3.9	1	2	14.6	46.9	5.9	129.1
Essex	9.3	29.4	38.7	9.3	2	3	14.3	164.6	7.6	278.2
Gloucester	14.7	15.3	48.6	6.7	2	0	12	58.6	5.3	163.2
Hudson	8.6	17	47.4	6.2	2	2	11.9	73.8	5.1	174.0
Hunterdon	8.9	24.4	62.1	6.7	2	2	20	57.7	11.1	194.9
Mercer	12	17.8	35.6	8.2	2	3	19.7	87.5	7.7	193.5
Middlesex	9.3	24.5	43.2	7.7	2	2	12	96.4	9.1	206.2
Monmouth	12	21.4	42.1	13	3	2	14	85.9	8.7	202.1
Morris	11.6	28.4	80.4	7.7	2	1	13.3	111.7	6.4	262.5
Ocean	14.4	18.1	42.7	9	2	2	14.9	83.5	5.9	192.5
Passaic	13.2	25.3	41.7	8.1	3	2	17	93.3	6.6	210.2
Salem	8.8	8.8	29.4	5.9	3	0	8.8	35.3	2.9	102.9
Somerset	14.2	28.3	50.2	8.3	4	4	18.3	92.1	3	222.4
Sussex	16.2	32.4	85.9	8.1	3	0	13	111.8	3.2	273.6
Union	13.3	29.2	49.9	9.4	2	3	15	142.5	9.4	273.7
Warren	8.4	25.3	48.6	8.4	0	6	21.1	86.6	8.4	212.8
New Jersey	12.3	22.8	46.8	8.4	2.2	2.5	14.1	97.0	6.9	213.0

[17] New Jersey Department of Health Birth Defects Registry, 2011-2015. https://www.nj.gov/health/fhs/bdr/

Table C-13: Children, Ages 0-5 Years, Served by Child Protection and Permanency (CP&P), by County, 2017[18]

County	Ages 0-2	Ages 3-5	Total	Total Children <6 Years	Rate of Children < 6 Years Referred to CP&P (per 1000 children)
Atlantic	447	395	842	18,158	46.4
Bergen	350	335	685	60,568	11.3
Burlington	360	346	706	28,003	25.2
Camden	968	871	1839	38,072	48.3
Cape May	143	128	271	5,033	53.8
Cumberland	441	405	846	11,791	71.7
Essex	1,174	1,147	2321	62,466	37.2
Gloucester	329	311	640	19,198	33.3
Hudson	597	606	1203	54,636	22.0
Hunterdon	47	42	89	5,722	15.6
Mercer	366	316	682	25,075	27.2
Middlesex	520	541	1061	58,117	18.3
Monmouth	368	356	724	38,587	18.8
Morris	174	185	359	30,238	11.9
Ocean	560	522	1082	47,186	22.9
Passaic	554	503	1057	41,561	25.4
Salem	157	138	295	4,256	69.3
Somerset	149	147	296	21,167	14.0
Sussex	79	70	149	8,261	18.0
Union	420	388	808	42,064	19.2
Warren	112	121	233	6,090	38.3
Other	206	346	552	0	--
New Jersey	8,521	8,219	16,740	626,249	26.7

[18] New Jersey Child Welfare Data Hub; 2013-2017 American Community Survey 2013-2017, B17020

Table C-14: Child Support Case Counts and Payments, by County, 2019[19]

County	Case Count	Payments	Average Payment per Case
Atlantic	577	$ 2,061,601.90	$ 3572.97
Bergen	656	$ 3,957,022.54	$ 6032.05
Burlington	681	$ 2,934,553.61	$ 4309.18
Camden	1,256	$ 4,432,976.95	$ 3529.44
Cape May	177	$ 689,042.73	$ 3892.90
Cumberland	659	$ 2,252,690.33	$ 3418.35
Essex	1,475	$ 5,622,697.31	$ 3812.00
Gloucester	646	$ 2,641,820.88	$ 4089.51
Hudson	959	$ 4,451,565.25	$ 4641.88
Hunterdon	74	$ 392,272.49	$ 5300.98
Mercer	620	$ 2,337,768.14	$ 3770.59
Middlesex	867	$ 4,207,710.35	$ 4853.18
Monmouth	575	$ 3,090,756.76	$ 5375.23
Morris	312	$ 1,837,743.84	$ 5890.20
Ocean	713	$ 3,337,314.35	$ 4680.67
Passaic	817	$ 3,428,623.49	$ 4196.60
Salem	214	$ 696,299.55	$ 3253.74
Somerset	263	$ 1,320,183.06	$ 5019.71
Sussex	157	$ 937,099.16	$ 5968.78
Union	831	$ 3,753,163.87	$ 4516.44
Warren	132	$ 657,797.11	$ 4983.31
New Jersey	12,661	$ 55,040,703.67	$ 4347.26

[19] Correspondence with Division of Family Development (DFD), New Jersey Department of Human Services (DHS), 2019.

Table C-15: New Jersey Early Learning and Development Program Participation in Grow NJ Kids, 2018[20]

Program	# Programs	# in Grow NJ Kids (%)
State-Funded Preschool	597	206 (34.5%)
Early Head Start and Head Start	150	123 (82.0%)
Programs Funded by IDEA, Part C	n/a	n/a
Programs Funded by IDEA, Part B	350	23 (6.6%)
Programs funded under Title I of ESEA	n/a	n/a
Programs Receiving CCDF Funds	2,441	312 (12.8%)
Other DOE-funded Preschool Programs	198	11 (5.6%)
Family Child Care Centers Receiving CCDF	1,637	192 (11.7%)
Other Licensed Center and Family Child Care Sites	2,258	207 (9.2%)

[20] New Jersey Race to the Top – Early Learning Challenge Final Performance Report, 2019.

Table C-16: Maximum Monthly Child Care Payment Rates, 2019[21]

Age Group		Licensed Child Care Centers	Accredited Child Care Centers	Grow NJ Kids 3-Star Rated Providers	Grow NJ Kids 4-Star Rated Providers	Grow NJ Kids 5-Star Rated Providers
Infants (Birth to 17 mos.)	Full time care (6+ hrs.)	$ 904.02	$949.22	$1,012.50	$1,063.13	$1,116.28
	Part time care (2-3 hrs.)	$ 452.01	$474.61	$506.25	$531.57	$558.14
Infants with special needs (Birth to 17 mos.)	Full time care (6+ hrs.)	$1,084.82	$1,139.06	$1,215.00	$1,275.75	$1,339.54
	Part time care (2-3 hrs.)	$542.41	$569.53	$607.50	$637.88	$669.77
Toddlers (18-29 mos.)	Full time care (6+ hrs.)	$761.46	$799.53	$814.77	$855.50	$898.28
	Part time care (2-3 hrs.)	$380.73	$399.77	$407.39	$427.75	$449.14
Toddlers with Special Needs (18-29 mos.)	Full time care (6+ hrs.)	$913.76	$959.45	$977.72	$1,026.60	$1,077.93
	Part time care (2-3 hrs.)	$456.88	$479.72	$488.86	$513.30	$538.97
Preschool (30 mos. – 5 years)	Full time care (6+ hrs.)	$644.96	$677.21	$703.01	$738.16	$775.07
	Part time care (2-3 hrs.)	$322.48	$338.60	$351.51	$369.08	$387.54
Preschool with Special Needs (30 mos. – 5 years)	Full time care (6+ hrs.)	$819.10	$860.06	$892.82	$937.46	$984.34
	Part time care (2-3 hrs.)	$409.55	$430.03	$446.41	$468.73	$492.17

[21] New Jersey Department of Human Services, Maximum Child Care Payment Rates, 2019. http://www.childcarenj.gov/getattachment/Resources/Reports/Maximum-Child-Care-Payment-Rates-effective-1-19.pdf?lang=en-US.

Table C-17: NJ-EASEL Source Systems Descriptions

Agency	Source System	Description
NJ DOE	NJ SMART	NJ Standards Measurement and Resource for Teaching (NJ SMART) is a comprehensive statewide longitudinal data system solution.
	CDS	The County District School (CDS) Information System collects and tracks data about educational entities in the state of New Jersey.
	Title 1	Title 1 Single Accountability System ensures that all children obtain a high quality education and achieve, at a minimum, proficiency on the challenging Common Core State Standards as measured by state assessments.
NJ DHS	CARES	The Childcare Automated Resources and Eligibility System (CARES) supports the Child Care subsidies program. Low- and moderate-income working parents can receive state subsidies for child care, including preschool instruction, after-school programs for children up to age 13, and care for children and teens with special needs.
	FAMIS	The Family Assistance Management Information System (FAMIS) provides cash and food stamp assistance to needy families by automating the processing and issuance of benefits from the Work First New Jersey (WFNJ) Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance to Needy Families (TANF) Programs.
	OMEGA	The Online Management of Economic Goal Achievement (OMEGA) system, formerly known as Realizing Economic Achievement (REACH), serves children receiving transitional payments from the state's welfare reform program Work First NJ (WFNJ) and provides post TANF benefits such as transportation, Child Care and training to qualified FAMIS clients as they move from welfare to work.
	Grow NJ Kids	Grow NJ Kids is New Jersey's Quality Rating and Improvement System (QRIS). It is a system designed to create universal standards of quality for all early care and education programs (Head Start, Child Care, Preschool, etc.) throughout New Jersey.
	Workforce Registry	The Workforce Registry is a statewide system that guides, tracks and recognizes the professional growth and development of individuals working in early care and education, afterschool and primary education. It keeps track of professional development achievements by maintaining confidential records for each individual who participates in the system. Participants will be approved at one of the ten levels of the NJ Registry Career Lattice, based on their education and experience.
NJ DCF	PatSys	As one of the Home Visitation models, the Parents as Teachers (PATSys) program is an early childhood parent education, family support and school readiness program serving families throughout pregnancy until their child enters kindergarten through the PAT System (PATSys).
	FamSys	As one of the Home Visitation models, the Healthy Families (HF) program provides education and supportive services to new and expectant parents through the FAM System (FAMSys).
	NFP	As one of the Home Visitation models, the Nurse-Family Partnership (NFP) program provides low-income, first-time moms with nurse home visits every other week early in their pregnancy until the child is 2. The National Service Organization (NSO) was formed to provide support to the NFP program model implementing agencies. The NFP goals include improving pregnancy outcomes, child health and development and mom's clarity and goals of aspiration.
	LIS	The Licensing Information System (LIS) provides licensing information for child care centers serving six or more children under the age of 13, which must be licensed by DCF.
	NJS	The New Jersey Statewide Protective Investigation, Reporting and Information Tool (NJ SPIRIT) system is a comprehensive, automated case management tool that integrates various aspects of case practice in a single statewide system, including intake, investigation, case planning, case recording, resource management, service delivery tracking, and financial management.
NJ DOH	EIS	The Early Intervention System (EIS) supports New Jersey's statewide system of services for infants and toddlers, birth to age three, with developmental delays or disabilities, and their families.
	BR	The Birth Record (BR) data system includes all birth record information from EBC (Electronic Birth Certificate) and VIP (Vital Information Platform), as well as additional data, such as geocoded fields and out of state (PA and NY) births.

Appendix C-18: NJ-EASEL Conditions Data Gap Analysis

Ref #	Q/Obj	Vulnerable Conditions		Phase 1 (Live)		Phase 2 (In Progress)				Future (Planned)					
				NJ DOE	NJ DHS	NJ DOE	NJ DOH	NJ DCF		NJ DOE	NJ DHS		NJ DCF		NJ DOH
		Types of Condition	Measurable Indicators	NJ SMART	CARES	NJ SMART	BR	FAMSys	PATSys	Title 1	FAMIS	OMEGA	Licensing information system	NJ Spirit	EIS
1	1a	Health-Related Conditions	Exposure to substance abuse				X	X	X						
2			Low birth weight				X	X	X						
3			Exposure to lead				X								
4			Chronic medical conditions				X								
5			**Preterm birth**	**No source system data identified to date**											
6			Smoking during pregnancy				X	X	X						
7			Vision deficits											X	
8			Hearing deficit											X	
9			Family member with depression					X	X						
10			**Obesity**	**No source system data identified to date**											
11			**Asthma**	**No source system data identified to date**											
12			Inadequate prenatal care				X								
13	1b	Social-Emotional and Situational Conditions	**Parental Unemployment (Underemployed, In school)**	**No source system data identified to date**											
14			Teen parenthood								X			X	
15			Homelessness	X			X	X	X						X
16			Foster care												
17			Domestic violence				X	X	X						
18			**Poverty**	**No source system data identified to date**											
19			**Child maltreatment**	**No source system data identified to date**											
20			Out-of-home care (family foster cares, kinship care, treatment foster care, residential & group care)		X						X			X	
21			Low parent educational level				X								
22a			Limited English proficiency (LEP)	X											
22b			English Language Learner (ELL)			X									
23			**Illiteracy**	**No source system data identified to date**											
24			**Incarcerated parent/sibling**	**No source system data identified to date**											
25			Military family			X									
26			**Refugee family**	**No source system data identified to date**											
27			First generation immigrant/migrant	X							X				X
28			Grandparent as primary care giver					X	X						X

Disclaimer:
1. The remaining NJ-EASEL source systems which are not listed in the table above include: CDS (reference data). NFP (not available), Grow NJ Kids (program assesment data) and Workforce Registry (Workforce data).
2. The table above is based on the NJ-EASEL requirements gathered to date.

Table C-19: Number of Completers by Award Level in Early Childhood Education Programs in New Jersey, by County, 2015-2017[22]

	North									Central		South	Total
Program Area and Award Level	Bergen	Essex	Hudson	Morris	Passaic	Somerset	Sussex	Union	Warren	Mercer	Ocean	Camden	
13.1015 Education/Teaching of Individuals in Early Childhood Special Education Programs		**10**	**97**										**107**
Master's degree		10	97										107
13.1209 Kindergarten/Preschool Education and Teaching		**1**	**33**	**76**		**176**	**9**	**98**	**20**	**47**			**460**
Award of less than 1 academic year		1											1
Award of at least 1 but less than 2 academic years						11			2				13
Associate degree				76		165	9		18				268
Bachelor's degree			12					83		41			136
Master's degree			21					15					36
Postbaccalaureate certificate										6			6
13.1210 Early Childhood Education and Teaching	**32**				**211**	**3**				**38**		**36**	**320**
Award of less than 1 academic year						3							3
Award of at least 1 but less than 2 academic years					7								7
Associate degree	19				15							36	70
Bachelor's degree	10				189					25			224
Postbaccalaureate certificate	3									13			16
19.0709 Child Care Provider/Assistant			**3**	**9**	**95**		**7**				**11**		**125**
Award of at least 1 but less than 2 academic years				9			7				11		27
Associate degree			3		95								98
Total	**32**	**11**	**133**	**85**	**306**	**179**	**16**	**98**	**20**	**85**	**11**	**36**	**1,012**

[22] New Jersey Department of Labor and Workforce Development. 2019.

Table C-20: Preschool Certificate of Eligibility (CE) or Certificate of Eligibility with Advanced Standing (CEAS) Issued in New Jersey, by Year[23]

	2014-2015	2015-2016	2016-2017	Total
CE	482	302	242	1,026
CEAS	844	767	653	2,264
Total Issued	1,326	1,069	895	3,290

[23] Infant-Child Health Committee (ICHC) of the NJ Council for Young Children (NJCYC), *Strategic Plan dev. December 2014, Working Document,* updated April 2018.

Table C-21: Grow NJ Kids Professional Development Activities and Trainings (7/1/18 – 12/31/18)

Activity and Training	Number
Total Number of Course Titles	39
Instructor-Led Classroom Courses	160
Instructor-Led Classroom Training Days	277
Web-Based Trainings	97
Total Number of Provider Participants	3,235