A Comprehensive Fiscal Analysis of the Prenatal to Five System in the Adirondack Region of New York State

A tool to promote understanding of essential services for young children and their true costs

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May 2024

P▸5 Fiscal Strategies

About Prenatal to Five Fiscal Strategies

Prenatal to Five Fiscal Strategies is a national initiative, founded by Jeanna Capito and Simon Workman, that seeks to address the broken fiscal and governance structures within the prenatal to five system with a comprehensive, cross-agency, cross-service approach. The initiative is founded on a set of shared principles that center on the needs of children, families, providers, and the workforce. This approach fundamentally rethinks the current system to better tackle issues of equity in funding and access. For more information about P5 Fiscal Strategies, visit: www.prenatal5fiscal.org

About Adirondack Foundation

Founded in 1997, Adirondack Foundation is a nonprofit community foundation serving the Adirondack region, a vast rural expanse of protected forests, small communities, and micropolitan cities. The Foundation inspires donors, builds partnerships, and mobilizes resources to strengthen the region by actively seeking opportunities where grants, convening, and leadership can better the lives of people who live in the Adirondack region. The Foundation also leads initiatives, including the Birth to Three Alliance which was formed to identify issues and drive solutions so that all young children are healthy, learning, and thriving in families are supported by a full complement of services and resources. The coalition has 200+ members, including child care providers, child care resource and referral directors, county administrators, home visitors and program directors, parent educators, pediatricians, and parents in Clinton, Essex, Franklin, Warren, and Hamilton counties, and the St. Regis Mohawk Territory.

Acknowledgments

The authors wish to thank the multiple constituents across the Adirondack region who engaged in this comprehensive fiscal analysis, giving their time and expertise to inform the analysis and recommendations. Specific thanks to the members of the Adirondack Birth to Three Alliance and the steering committee, as well as child care and home visiting ad-hoc groups who guided the work, and all other constituents who provided data for this report.

The authors also acknowledge the contributions of Prenatal to Five Fiscal Strategies team members who supported this comprehensive fiscal analysis and the provider data collection and outreach, including Heather Adams, Casey Amayun, Jenna-Marie Nelson, and Karen Rhinehardt.

Report design by Barbara Dufford.

Suggested Citation

Jeanna Capito and Simon Workman, A comprehensive fiscal analysis of the prenatal to five system in the Adirondack Region of New York State, Prenatal to Five Fiscal Strategies, 2024.

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Executive Summary

The first five years of a child's life are some of the most critical in their development, but the programs and systems that serve young children face persistent under-investment. The complexity of multiple funding streams with separate requirements results in an uncoordinated system that is difficult for families and programs to navigate. These challenges are felt most acutely by children and families farthest from opportunity, perpetuating existing inequities. Layered with the complexity of delivering services in a rural area, the under-investment presents an even further broken system.

To better understand and address the uncoordinated and insufficient finances of the prenatal to five system within the North Country, the Adirondack Birth to Three Alliance (BT3) engaged in a comprehensive fiscal analysis (CFA). This CFA focused on multiple services and elements of financing the prenatal to five system, including understanding available service capacity, current funding, the true cost of services and infrastructure, and the revenue needed to achieve the shared vision established for the Adirondack region's young children and their families.

The comprehensive fiscal analysis was conducted in partnership with Prenatal to Five Fiscal Strategies (P5FS), a national non-profit that supports states and communities to address the broken systems and persistent underfunding that impact this sector. The CFA process developed by P5FS comprises a fiscal mapping analysis and the development of cost models for direct services and infrastructure costs. These activities help better understand the current investments supporting young children and their families in the Adirondack region and estimate the true costs of services that meet the needs of children and families. These analyses inform a set of comprehensive recommendations designed to strengthen the prenatal to five systems and advance sustainable change.

Mapping Current Investments

To understand the Adirondack region's current investments, the CFA team conducted interviews and reviewed budget, grant, and contractual documents to create a fiscal map. Several state programs serve the health, educational, and social-emotional needs of young children in the region, including home visiting, early intervention, subsidized child care, public pre-K and Head Start, and other programs such as those funded through the Maternal and Child Health Block Grant. The fiscal analysis focused on programs specifically designed for children from prenatal period to five years of age.

This analysis found close to $36.7 million in public funding is invested annually in early learning, early intervention, and family support/home visiting programs, and other services for the Adirondack region's young children and their families. The largest early learning programs are the Preschool Special Education program, Head Start, and the child care assistance program. Over 4,800 children or families are served across the programs included in this analysis.

Nonetheless, significant numbers of children and families who need support are unserved. Currently, home visiting and parenting education services reach about 550 children in the region, out of more than 4,800 who could benefit.[1] Across the North Country, there are between five and 14 young children for every child care slot, making the entire region a child care desert.[2] The region has lost 20-25 percent of regulated child care capacity in the last two years, going from nearly 5,000 slots down to 4,100. There are over 22,000 children birth to age 12 vying for these 4,100 slots.[3]

Meanwhile, child care providers in the Adirondack region earn an average salary of $35,000 a year, or about $16 per hour, which is just a bit more than minimum wage in New York, despite many providers' experiences and qualifications in the field. This is well below the estimated living wage for the North Country of $22 per hour.[4]

Home visiting staff face similar low pay and minimal benefits and throughout the CFA process, programs across the sector identified the challenges of recruiting, hiring, and retaining qualified staff and paying competitive salaries and benefits. Even when able to offer better salaries and benefits, programs report that their rural location adds additional challenges to recruiting the professionals needed to carry out these services. Programs consistently listed recruiting qualified staff as their most pressing barrier to providing programming.

Understanding the True Cost of Services

An integral component of the Adirondack Region Comprehensive Fiscal Analysis was the development of cost models for child care and home visiting. The CFA team developed these cost models to help better understand the cost of providing prenatal to five services across the Adirondack region, how this varies by program type, location, and type of service, and the extent to which current revenues are sufficient to cover the estimated costs of providing services.

Cost models are dynamic tools that estimate the true cost of services and the variations in that cost based on different program characteristics, quality or intensity levels, and compensation decisions. The need for cost models stems from the broken market for child care and other early childhood services, where the private tuition that parents can afford to pay, or the grant or contract amount a program can receive, rarely covers the actual costs of providing care or delivering a high-quality service. Cost models estimate the true costs incurred by programs to meet required program standards or higher quality standards and can demonstrate the impact of increased compensation on the cost of care.

The cost models were developed for the Adirondack region, incorporating local data where available and integrating the voices of local child care providers and home visiting programs. Given the importance of compensation in this labor-intensive sector, the models include the ability to estimate the true cost using current salaries, based on U.S. Bureau of Labor Statistics (BLS) data for the region, or with higher salaries, at a living wage, based on the MIT Living Wage calculator.

Results from the cost models find the true cost of child care is above what most parents can afford and above what child care subsidy will reimburse. The gaps are even more pronounced when paying a living wage to the child care workforce. Key results from the child care cost model analysis include:

- The annual cost of care for an infant in a child care center that meets state licensing standards, using current salary data, is $25,584, which is $9,588 more than the annual subsidy rate for an infant.
- The annual cost of care for a child under five in a family child care home that meets state licensing standards, using current salary data is $19,044, which is $5,328 more than the subsidy rate for an infant or toddler and $6,540 more than the subsidy rate for a three- or four-year-old.
- The annual cost of care for an infant in a child care center that meets state licensing standards, and pays staff a living wage, is $31,296, which is $12,270 more than the annual subsidy rate for an infant.

- The annual cost of care for a four-year-old in a child care center that meets state licensing standards, and pays staff a living wage, is $19,524, which is $5,772 more than the annual subsidy rate for a four-year-old.
- The annual cost of care for a child under five in a family child care home that meets state licensing standards, and pays staff a living wage is $25,140, which is $11,390 more than the subsidy rate for an infant or toddler and $12,639 more than the subsidy rate for a three- or four-year-old.

These disparities illustrate the difficulty providers face when trying to increase employee compensation. The gaps grow even larger when quality enhancements, such as smaller ratios and group sizes and release time for planning and professional development, are included.

Similarly, data from the home visiting cost model find that current public funding is insufficient to cover program costs at the standard caseload and current salary levels. Key results from the home visiting cost model analysis include:

- The average annual cost per slot for a home visiting program in the Adirondack region is $5,000. The current payment amounts range from $500 to $4,000 per slot.
- For a program paying a living wage to the workforce, the average cost per slot increases to $5,700 per year.
- Despite an eight percent increase in families receiving services since 2015, only 550 families currently receive comprehensive home visiting in the region. There are an estimated 1,100 children birth to five living in poverty in the Adirondack region who could qualify.

Beyond the direct service cost modeling, this CFA also includes an estimate of the systemwide cost to achieve the region's vision for the prenatal to five system. The system-level modeling presented in the CFA identifies the total investments needed to build a system that truly meets the needs of children and families in the Adirondack region. Key findings include:

- To increase compensation to pay a living wage and maintain current service capacity across child care, home visiting and parent education is estimated to cost $11.2 million per year.
- To implement universal child care, and to expand home visiting and parent education to meet the needs of children and families is estimated to cost just under $217 million per year.

Recommendations

As a result of the comprehensive fiscal analysis activities, a series of recommendations were developed. These recommendations are intended to provide a roadmap for constituents in the region to drive the change necessary to strengthen, sustain, and expand a robust prenatal to five system that meets the needs of children, families, and the community. The six recommendations are:

1. **Establish a comprehensive coordinated early childhood system that removes barriers for families, minimizes the burden on early care and education providers, and maximizes the use of available funding streams.** Services for young children are spread across many agencies and programs, leading to challenges with coordination and navigation. Fostering collaboration between local agencies, organizations, local service providers and partners within the Adirondack region and across the prenatal to five system, will help ensure that families can benefit from an aligned early childhood system. By coordinating the system, leaders can maximize existing funding sources and

explore new financing strategies to improve quality and access to programs and services. Through this process, barriers for families such as overburdensome application and enrollment processes will be simplified and streamlined.

2. **Implement a cost-based approach to rate setting and contracting for child care, home visiting, and parenting education.** The most important initial step in expanding quality services for young children is to address the longstanding gap between the importance of early care and education providers' work and their low compensation. The region's leaders should work with state leaders to ensure public funding rates are set with consideration for the true cost of services, including moving to a standard of incorporating the cost of paying living wages and benefits across the early childhood field.

3. **Strengthen and expand access to prenatal to five services.** For a community to rally around increased, sustained funding, the community must understand the critical role of the service. A messaging and communication campaign for the region should be developed to support this effort. In addition, although increased funding is crucial, it is not the only strategy. For example, the region can implement supply-building strategies for all services, reflecting the local context. Additionally, local leaders can work with state leaders to analyze regulations and program and policy changes that could be adjusted to allow for more viable business models for the region's service providers.

4. **Develop a systematic approach to recruitment, workforce development, training, and support of qualified staff for all early childhood education and care programs in the Adirondack region.** Across the constituent engagement conducted for this CFA there was uniform agreement that recruiting and retaining qualified staff is the biggest barrier to providing services to children and families. A multi-pronged approach is needed to address this challenge, including developing a pipeline of qualified staff in the region by working closely with professionals who not only deliver services but also manage programs and deliver two- and four-year degree programs. In addition, reimbursement rates must be sufficient to cover the cost of paying livable wages, and messaging and communication campaigns can educate the broader community about the lack of qualified staff and the need for supports and investment to recruit and retain this critical workforce.

5. **Ensure access to early intervention services for all eligible children.** Delivering early intervention services in a rural, mountainous region adds a layer of complications that many other regions do not have to endure. Winding roads and unstable weather patterns can turn a 30-minute speech therapy session into a four-hour trip; however, the reimbursement rate does not reflect the entire service. An early intervention cost model should be developed to better capture the true cost of this service in the region. In addition, leaders should work with statewide funders to analyze policies that inhibit and support the delivery of early intervention services.

6. **Work to ensure all children and families have access to high-quality comprehensive services.** Locally, constituents can work together to ensure processes and services work for families, that eligible families and children can access care, and these services

meet their unique needs and are culturally responsive. To meet this goal, leaders should consider strategic priorities for the growth of the system with a shared leadership approach which can help mitigate the challenges inherent when services are spread across many agencies and programs. At the community level, leaders can invest in providing equitable and sufficient funding to local systems coordination organizations and investing in systems such as coordinated enrollment and community information hubs to help ensure families and children can access services for which they are eligible.

I. Introduction

The first five years of a child's life are some of the most critical in their development but the programs and systems that serve young children face persistent under-investment. However, many families of young children struggle to afford the cost of accessing the services that meet their children's needs.

The complexity of multiple funding streams with separate requirements results in an uncoordinated system that is difficult for families and programs to navigate. These challenges are felt most acutely by the children and families farthest from opportunity, perpetuating existing inequities.

To better understand and address the broken finances of the prenatal to five system within the rural Adirondack region, the Adirondacks Birth to Three Alliance engaged Prenatal to Five Fiscal Strategies (P5FS) to lead a comprehensive fiscal analysis (CFA) focusing on multiple services and elements of financing the prenatal to five system. This work included developing a fiscal map detailing the current funding streams supporting prenatal to five programs and systems to address the following questions:

- What funding currently supports prenatal to five services in the Adirondack region?
- How are these funds being used, and can they be more fully leveraged?
- What opportunities exist to better coordinate, streamline, and maximize existing funds?

Adirondack Region: By the Numbers

10,000 children birth to five live in Clinton, Essex, Franklin, Hamilton, and Warren counties.

2,000 babies are born annually across these five counties, on average.

33% of children live in families with incomes at or below 185 percent of the federal poverty level (FPL)

19% of children live in poverty (at or below 100% of the FPL)

10% of the region's children live in deep poverty (at or below 50% of FPL)

Over 50% of births in the region are Medicaid-funded. [5]

The comprehensive fiscal analysis also included the development of cost models to estimate the true cost of quality services for child care and home visiting, including increased workforce compensation. These cost models estimate a per-child or per-family cost of services at various levels of quality and intensity, as well as system-level supports. The information gathered through this comprehensive fiscal analysis informs recommendations and action steps for system change.

The P5FS analysis was conducted by a team of early childhood system, program, and financing experts with experience working in multiple states and communities. The P5FS team partnered with a workgroup of Adirondack region stakeholders to articulate a vision, guiding principles, and key elements to be considered in the comprehensive fiscal analysis and cost models. The project followed a framework developed by P5FS which includes fiscal mapping, cost modeling, and systems analysis, informed by constituent engagement, all driving toward recommendations for fiscal and systems change. Adirondack Birth to Three Alliance led this work, as a part of the prenatal-to-three efforts funded by the Pritzker Children's Initiative. BT3's goals include maximizing investments in prenatal to age three services, removing barriers to access for families, paying providers fairly, developing a cross-sector strategy to improve compensation for the early childhood workforce, and improving equity for children across the region.[6]

The Adirondack Birth to Three Alliance is committed to focusing on young children, prenatal through three. For the overarching Steering Committee guiding this work, the agreement was that young children are defined as prenatal through age eight. There are places where prenatal to five years is the focus due to the nature of the funding or the areas of impact the Alliance has direct influence on.

The members of the Adirondack Birth to Three Alliance have a compelling interest in the development of the region's youngest citizens. Infants and toddlers represent the future of the Adirondack region and research and practice show a strong link between healthy development during the early years of childhood and success later in life.[7] The Adirondack Birth to Three Alliance recognizes the importance of the first 1,000 days of life and was established to facilitate greater region-wide collaboration to improve childhood outcomes. BT3 is working to bring the resources of all programs and services for young children and their families together in helping to fulfill the promise of today's children to become healthy, thriving, and contributing members of the Adirondack community.

BT3 focuses on three goal areas: Healthy Children, Strong Families, and High-Quality Early Learning. In each area, the Alliance pursues strategies to strengthen and expand services to meet the needs of young children and their families. The strengths of BT3 are rooted in the following goals and assumptions:

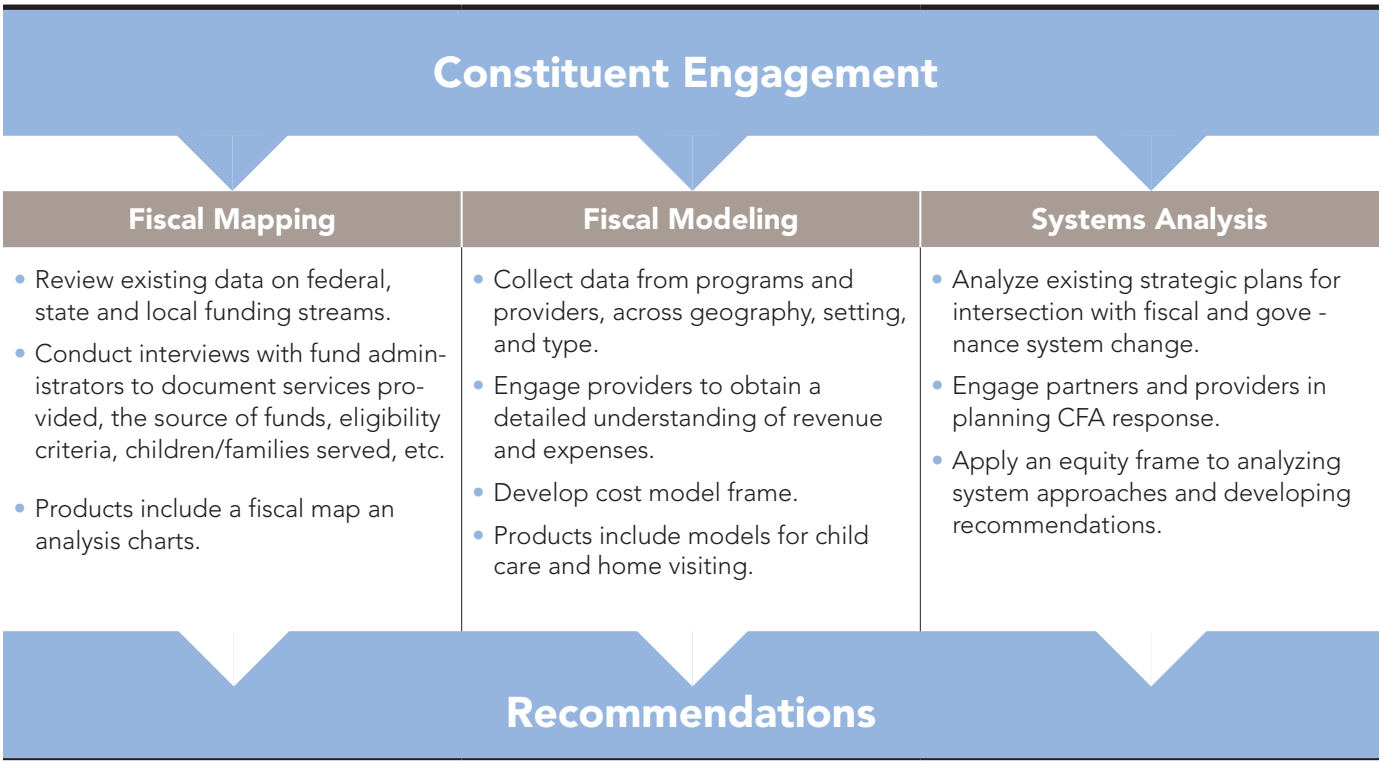
- Greater collaboration across counties and programs will reach more children and families across the large, rural area.
- Greater reach ensures that diverse populations are being served.
- Improved connections and resources are needed to effectively meet the sometimes-multiple needs of children and families.
- Better connections between supports and services are more effective and more efficient.

The need for a comprehensive fiscal analysis

To build an infrastructure that supports and sustains comprehensive and cross-sector prenatal to five systems work, an understanding of the fiscal context is imperative. One of the most complex challenges raised in the National Academies of Sciences, Engineering, and Medicine 2018 report *Transforming the Financing of Early Care and Education* is the patchwork of funding sources and financing mechanisms, which reinforces how issues of isolated impact and siloed approaches stem in large part from how programming and systems are funded.[8] The National Academies report under-scores the issues that result from an uncoordinated, patchwork, or non-functioning system, including inequities in access, quality, affordability, cultural responsiveness, and accountability, critical issues that are felt most acutely by the children and families these programs are designed to serve. Funding sources and mechanisms vary in their implementation requirements and contract approach, based on the funding entity, and have their own standards and reporting requirements. These variances and the lack of collective understanding of them across the prenatal to five system creates a disadvantage when attempting to craft policies, develop funding mechanisms, and implement systemic changes that will result in efficiencies and economies to benefit family access and program quality.

A comprehensive fiscal analysis, or CFA, promotes system-wide thinking and cross-systems analysis to recognize shared challenges and understand how programs and services across the prenatal to five system interact. The process for funding the services and programs in the prenatal to five period represents a fragmented and broken model of funding that has never met the reality of the cost of the services. The CFA process developed by P5FS begins with fiscal mapping to understand the scope of current investments. The fiscal map also explores limitations on current funding and opportunities to leverage current funding sources more fully. The CFA then draws on provider and constituent input to create fiscal models that allow users to estimate the future costs of expanding programs and services, both based on a cost per child and at the system level. This allows for a complete systems analysis and development of recommendations that advance the shared vision and principles for the prenatal to five system. This process is illustrated in Figure 1.

Figure 1: The P5FS Comprehensive Fiscal Analysis Process



Understanding the true cost of services

The current understanding of the cost of services in the prenatal to five period is typically more representative of the price of the service (what a family can afford to pay) or the amount reimbursed for the service (what a contract pays for the service). In both instances, these are not the cost of delivering the service but instead what a consumer or public funding source pays a provider for a service. Staff in programs have been forced into practices that will allow them to deliver services with revenues that do not cover cost. Programs and staff have made accommodations (e.g., use of personal funds for materials, working nights and week-ends, management staff working in classrooms to maintain coverage, etc.) to maintain the work and attempt to meet family needs. Many of the programs across the prenatal to five system, includ-ing child care, home visiting, parent support, and early intervention, rely on these accommodations, making it extremely difficult to sustain the system and provide fair compensation for the workforce and the quality programming families and young children need. These accommodations include:

- Low wages, especially in child care, which are close to the poverty level in the Adirondack region, and limited benefits for staff.
- Reliance on women living in poverty, those who are undervalued for their role in child rearing and domestic efforts; and
- Staffing patterns that reflect that staff work far more hours than they are paid for.

Identifying the true cost of providing programming for young children and families is critical to addressing the underfunding of the system. Revenue and expense models, or cost models, are tools used to understand costs and the relationship between the expense of delivering services, or costs, and the available revenues.[9] Models should be in-

formed by program engagement and primary and secondary data collection, customized for the community in which they will be used. Cost models are dynamic tools that estimate the true cost of services on a per-program and per-child basis. Models can estimate the changes in cost for programs with different characteristics, such as varying compensation, or services of different intensity. They can also show the gap between costs and revenue sources. Importantly, cost models provide transparency into the financial reality faced by programs offering prenatal to five services. Cost models demonstrate the true cost of services in this labor-intensive sector, highlighting the interrelated nature of workforce compensation and the cost of service, and why the true costs are so much higher than current funding levels or what families can afford. This disparity is even further exacerbated within a rural community such as the Adirondack region.

The need for cost models stems from the broken market for child care and other early childhood services. High-quality early care and education costs more than families can afford, which depresses the market demand for quality services. Providers must compete on price and set tuition prices at levels families can afford to pay, which disincentivizes investment in more expensive, higher-quality programming.[10] Many providers rely on in-kind support, unpaid overtime, or artificially low wages for themselves and their staff to effectively subsidize the difference between what families can pay and the cost of care.

In child care, most states set subsidy rates based on a market rate survey, which reflects tuition charged to families by programs, or the price that families are paying for child care.[11] Providers in low-income areas face even greater pressure to lower prices, and they are then paid a lower subsidy rate because of the lower market price in their area. For states using a market price study to set subsidy rates, the U.S. Department of Health and Human Services recommends setting subsidies at the 75th percentile of the market rate, however many states fail to meet this benchmark.[12] In New York, the FY22-23 Enacted Budget increased funding to move rates up to the 80th percentile of the market rate.[13] Since the 2014 reauthorization of the Child Care Development Fund, states have had the option to use cost modeling to inform rates, rather than a market price survey. This approach can ensure subsidy rates do not exacerbate the inequities within the private pay market.[14] As of 2023, only two states, New Mexico, and Virginia, along with the District of Columbia, set subsidy rates based on cost rather than a market rate survey.

The disconnect between the cost of services and the available revenues exists for other prenatal to five programs also. In programs such as home visiting, parent education, and early intervention, a contract, grant, or set fee-for-service approach dictates how much revenue is available to a program, irrespective of the cost of delivering the service. These programs rely on rates paid out by contracts. True costs of services are not driving these contract decisions. In addition, costs increase year after year often without an increase in the payment rate. Therefore, the payment rate does not cover the cost of the service. As noted above, program staff make accommodations to deliver their services to families. Home visitors are professionals who take on enormous stress as they work with many families with varying needs. However, they are not compensated anywhere near the level they should be for the amount and type of work they do for the families of young children. Early intervention programs are faced with heavy caseloads and staffing shortages due to low compensation and high workloads. In addition, it is hard for a rural area like the Adirondack region to recruit qualified staff. In addition to high caseloads, in both home

visiting and early intervention, staff work far more than the hours they are reimbursed for each week, to meet the program requirements (both administrative and family service requirements). As in child care, the true cost of providing quality services does not dictate the amount that providers are paid, leading to a structural funding gap.

Overview of the CFA report

This report details the results of the comprehensive fiscal analysis, including the identification of recommendations for advancing the prenatal to five system in the Adirondack region. Section II describes the leadership of the project and how Adirondack region constituents were engaged at all stages. Section III presents the fiscal vision and principles that guide this analysis. Section IV presents a fiscal map of existing funding that supports programs and systems for children under five and their families in the Adirondack region, including narrative and table summaries. Section V presents a cost analysis for child care, home visiting, and early intervention, including cost estimates of the true cost of services from the child care and home visiting direct service cost models. Finally, Section VI presents findings and recommendations drawn from constituent input and analysis of the prenatal to five system.

II. Adirondack Region Leadership and Constituent Engagement

To guide this project, the Adirondack Birth to Three Alliance utilized an existing Steering Committee.

The Steering Committee members were drawn from across the region and represent different sectors of the prenatal to five system. A full roster of members is available in Appendix 1. Steering Committee meetings from September 2022 through December 2023 were used to guide decision-making for the comprehensive fiscal analysis and the cost models, and to support the development of the recommendations and initial action plan. P5FS also met routinely with the full Adirondack Birth to Three Alliance to gather additional input and inform the analysis and recommendations.

Engagement with the Prenatal to Five Field

Across all aspects of the CFA, opportunities were sought to gather input from service providers and other key constituents across the region. Constituents were convened to develop a 'north star' vision for the prenatal to five system, building on the strategic planning already underway at the state and regional level. This vision and accompanying principles helped guide the work of the CFA. To inform the fiscal mapping and analysis the P5FS team conducted a review of key documents, such as budgets, legislative reports, contracts, and grant reporting, and interviewed key program managers and providers. The Adirondack region CFA also benefited from a similar project that P5FS led for New York State.

Additional interviews were held within the region ensuring that this analysis was customized for the Adirondack region. A full list of those interviewed can be found in the Appendix of this report.

The CFA also engaged in data collection directly with early childhood providers and home visiting system components and programs in the region. Provider data informed the cost estimation models which were used to understand the expenses and revenues for different program types and to estimate the cost per child or family with variations for program type, location, and age of child served.

Child care, home visiting, parent education, and early intervention programs in the field also had several opportunities to share cost data and give qualitative input on the challenges they are facing, and the costs associated with those challenges. In partnership with the Adirondack Birth to Three Alliance, P5FS facilitated four virtual input sessions, met with home visiting program leads, and hosted an early intervention-focused subgroup. These partnerships allowed for the incorporation of data from more providers across the region while minimizing the burden on providers to gather and share cost information. Across all these opportunities for engagement, over 50 individuals across the region participated in interviews, surveys, or input sessions representing the five counties that make up the Adirondack region for this study.

III. Fiscal Vision and Guiding Principles for the Adirondack Region Prenatal to Five System

Among the Steering Committee's first activities was the development of a fiscal vision and guiding principles for the early childhood system in the Adirondack region.

To address the complexity of the needs of children and families and the non-system in which those needs exist, communities must hold a vision for how to increase investments, better align current investments, and develop funding and governance structures that maximize efficiency and minimize burden. A fiscal vision, combined with guiding principles, establishes a 'north star' for future work. P5FS facilitated discussion among the members of the Steering Committee to develop the fiscal vision and principles within the context of existing, broader visions for young children, across the health, education, and family support fields. Building a shared agreement across this group for the future of prenatal to five services in the Adirondack region was a key first step to ensure that decisions related to the fiscal analysis were grounded in this vision and aligned with these principles. The full Birth to Three Alliance was also engaged in developing and finalizing the vision and principles.

Vision

A community effort that **meets the needs of every child and family from the prenatal period to eight years of age and** is enhanced by **sufficient and stable funding** streams that provide maximum **flexibility** for families and programs with **efficient** funding administration and **minimum burden** for program providers.

This fiscal vision is supported by a set of guiding principles which specify what a system that meets this vision will do. The principles drive the important work of a cohesive, equitable, and effective prenatal to eight system to best support families and young children. The vision was established with prenatal to eight as the intentional framing and definition for the early childhood period. This is an important distinction given the importance of the prenatal to three period in setting children and families up for continued success in parenting and child development and that successful transition to elementary school and through the early years of formal public education is critical to children's lifelong success. The Steering Committee acknowledged that supporting the healthy development of young children requires collaborative partnerships across the many different entities that impact these critical years of a child's life, to ensure access to the highest quality services for all young children and their families.

Principles

A community that…

- works for all children and families ensuring that programming reaches and positively impacts those children and families farthest from opportunity, including the unique needs of rural communities.
- is fair to providers and comprehensively supports their individual and collective capacity for quality implementation.
- uses public resources wisely and efficiently, augmenting private resources from those families who can afford services.
- acknowledges embedded societal inequities and implements changes to remediate inequity.
- includes compensation that meets a living wage standard and addresses the qualifications and expectations of the workforce.
- supports the entirety of a child's and family's experiences, addressing the developmental trajectory of young children and the need for transitions across sectors and programs.
- is driven by constituent voices with parents, families, and communities as equal partners with the public and private entities who work in the system.
- addresses the financing of the full infrastructure, from programming to workforce and quality supports to capital, facility, and organizational capacities.

The fiscal vision and principles were used to support the development of recommendations, informed by the fiscal mapping analysis and cost modeling results, ensuring that the recommendations were aligned with the shared vision and goals for the region's prenatal to eight system.

IV. Fiscal Mapping and Analysis

A prenatal to five fiscal map presents the current funding streams supporting programs and systems that serve children under five and their families, organized by funding source, administrator, and population served.

To create a fiscal map for the Adirondack region the P5FS team began by reviewing key documents, such as budgets, legislative reports, contracts, and grant reports. The team then conducted 19 interviews with key informants across the region who administer programs and systems serving children under age five and their families. Input and feedback from the Steering Committee identified further areas for exploration.

Several programs serve the health, educational, and social-emotional needs of young children in the Adirondack region; home visiting, early intervention, the child care assistance program, and Head Start make up the largest state investments in young children. This fiscal analysis focused on programs specifically designed for young children, including early learning, early intervention, and family support/home visiting programs. The following tables summarize the results of the fiscal mapping analysis. Table 1 details the current direct service funding to the region, by program, with amounts. Table 2 lists the programs and their funding sources. Finally, Table 3 details direct services and children/families served.

Table 1: Direct Service Funding, by Program FY 2022

Program	Federal Funding	State Funding	Local Funding	Total
Child Care Subsidies	$2,927,866[I]		$167,075 [II]	**$3,094,941**
Child Care Quality Improvement	$764,399			**$764,399**
Food & Nutrition Services	$85,200			**$85,200**
Universal Preschool	$1,385,605	$8,610,149		**$9,995,754**
Head Start	$10,253,305			**$10,253,305**
American Indian/Alaska Native Head Start	$794,919			**$794,919**
Preschool Special Education		$5,648,262	$3,844,615	**$9,492,877**
Early Intervention		$732,187	$423,448	**$1,155,635**
Maternal & Child Health Block Grant	$141,604			**$141,604**
Healthy Families New York		$624,029		**$624,029**
Family Resource Centers & Parenting Education		$300,000		**$300,000**
TOTAL	**$16,352,898**	**$15,914,627**	**$4,435,138**	**$36,702,663**

As shown in Table 1, over $36.7 million in public funding is invested annually in early learning, early intervention, and family support/home visiting programs and services in the Adirondack region. The largest investments in early learning programs are for Head Start/Early Head Start, Preschool Special Education, Universal Preschool, and Child Care Subsidies. As shown in Table 3, the Adirondack region serves over 600 young children through Head Start; over 1,200 children through Preschool Special Education programs, services, and evaluations; over 1,300 three- and four-year-old children through the Universal Preschool Program; and over 460 children birth through age five through child care subsidies.

Despite this funding, significant gaps remain, with children and families going unserved across child care, Head Start, home visiting, and early intervention. In the Adirondack region, there are between five and 14 young children for every child care slot[15], making the entire region a child care desert. The region has lost 20–25 percent of regulated child care capacity in the last two years, going from nearly 5,000 slots down to 4,100. There are over 22,000 children, birth to age 12, vying for these 4,100 slots. In addition, home visiting services reach about 550 children, out of more than 4,800 who could benefit.

[I] County level data for child care subsidy funding is not broken out by federal and state sources.

[II] Local funding, by county: Clinton, $99,395; Essex, $16,498; Franklin, $26,381; Hamilton, $2,738; Warren, $22,063.

Table 2: Program and Funding Source(s)

Program	Funding Sources
Child Care Subsidies	Primarily Child Care Development Fund (federal), TANF (federal), and state general fund, local maintenance of effort.
Child Care Quality Improvement	Child Care Development Fund (federal)
Head Start / Early Head Start	Head Start (federal) with 20 percent non-federal match
Universal Pre-K	Primarily state general fund: limited federal sources are expiring after 23–24 school year
Early Intervention	IDEA Part C (federal) with state and local match; Medicaid and private insurance
Preschool Special Education	State and local funding for services; federal IDEA Section 619 preschool funding for systems and administration
Healthy Families New York	State general fund; Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant (federal); local and private funding
Family Resource Centers & Parenting Education	Child and Family Trust Fund (state)
Child and Adult Dependent Care Food Program	Child and Adult Dependent Care Food Program (federal)
Maternal and Child Health Services	Title V Maternal and Child Health Services Block Grant (federal)

Table 3: Number of children/families funded by each direct service program, FY2022

Program	Children/Families served
Child Care Subsidies	468
Universal Preschool	1,333
Head Start/Early Head Start	145 (EHS) 482 (HS)
American Indian/Alaska Native Head Start	64
Preschool Special Education	1,224
Early Intervention	190
Healthy Families New York	119
Family Resource Centers & Parenting Education	781

V. Cost Modeling and Analysis

To fully understand the cost of providing services that align with the vision and principles and meet the needs of children and families, the CFA includes the development of cost estimation models. These models are informed by analysis of program standards, primary and secondary data collection, and input from key constituents, as detailed below. This section of the report details the methodology and assumptions embedded in the child care and home visiting cost models and presents a sample of results, along with an analysis of these results.

Child Care

Child care cost models can provide transparency into the fiscal realities of operating early education and care programs. Models can provide a comprehensive understanding of the true cost of meeting program standards and the impact of different programmatic and policy decisions on the financial stability of child care providers.

Input from Child Care Providers

To ensure the cost model reflects the realities faced by providers in the region, the P5FS team partnered with the Adirondack Birth to Three Alliance to gather input from

child care providers in the region. P5FS held four provider input sessions in April and May of 2023. Although there was limited participation (seven participants), the attendees were diverse, representing child care centers, school-age programs, family homes, and child care resource and referral agencies. Clinton, Warren, and Franklin counties were all represented during the input sessions.

Participants discussed barriers and challenges they encounter, and the overwhelming consensus was that finding qualified staff and the inability to pay competitive salaries and benefits are the most challenging problems they face. They are unable to find reliable staff to work, family child care homes have no access to group health benefits and cannot afford them on their own, and rural programs are not taking waiting lists because they know they will not be able to serve those families due to a lack of staffing.

Participants also discussed the rising costs of food and supplies and the inability to cover these costs through tuition or child care subsidies. Parents cannot afford the recent market rate for tuition, so providers charge less to accommodate these families but then are prevented from accessing the full subsidy payment rate from the state.

One family home provider participant noted, "I love what I do, and I will continue doing it even though I only make about $6 an hour after all of the expenses. I just wish I had a retirement or pension to look forward to like all of my friends who do similar work in the school or for the county."

Participants noted that their top desire is to provide and/or receive higher pay with affordable benefits to attract and retain staff. They are very interested in a benefit group plan for all providers to access, collectively. They also noted that if the state allowed more school-age children in home-based care it would help not only generate income but serve more children in need.

Providers most often wanted help with administrative tasks and daily preparations such as cooking, cleaning, and shopping. Also, many made requests for incentive pay for providers who complete more than the required training hours each year, and most attend training courses on their own time, without compensation. They also noted that access to a substitute pool would allow for better staffing options for illnesses.

A family home provider noted, "We lose teachers to the public school system every year because they pay more and receive benefits. Birth to five are the most important years of children's lives but there is no public recognition or benefits to stay in the child care field if you have a degree. Professional recognition would help ease the pain for all of the extra hours we put in."

The providers were also asked how they define high-quality early care and learning environments, and most noted were strong relationships between staff and children; experienced, qualified staff; and a nurturing, family environment.

One school-age provider noted, "We try to be an extension to each family and support their needs. We work to get homework done so that it isn't a stressor for the family each night."

Modeling the Cost of Child Care

The child care cost model includes center-based care and family child care settings and is informed by financial and qualitative data collected from providers across the region, as well as other public sources. The child care cost model allows users to model a full-day, full-year program serving children from birth to school age, with variations based on different-sized programs as well as care during non-traditional hours. To estimate available revenue streams, the model also includes the ability to modify the number of children receiving state child care subsidies versus private-pay

families.

The model accounts for all expenses related to a legally operating child care program, meeting either licensing or license-exempt requirements, as well as all federal and state requirements related to running a business, such as employee and employer taxes and required breaks.

Personnel expenses, which account for the largest cost in a provider's budget, are included in the model along with required taxes, and users can modify salary levels and benefits within the model. The number of staff is driven by the required ratio and group size regulations, as detailed in Table 4.

Table 4: New York State Ratio & Group Size Regulations for Child Care

	Adult:Child Ratio	Max Group Size
Child Care Centers		
Infants (0–18 mos)	1:4	8
Toddlers (18–36 mos)	1:5	12
Three-year-olds	1:7	18
Four-year-olds	1:8	21
School age (up to 9 yrs)	1:10	20
Home-based Child Care[III]		
Family Child Care	Up to six children under school age, plus two school-age	
Group Family Child Care	Up to 10 children under school age, plus two school-age	

In addition, the models include all non-personnel costs related to operating a program. Specifically, non-personnel costs are aggregated into the following categories:

- **Education/Program-Child:** Food/food related, classroom/child supplies, medical supplies, postage, advertising, field trips, transportation, child assessment materials
- **Education/Program-Staff:** Professional consultants, training, professional development, conferences, staff travel
- **Occupancy:** Rent/lease or mortgage, real estate taxes, maintenance, janitorial, repairs, and other occupancy-related costs
- **Program Management and Administration:** Offices supplies, telephone, internet, insurance, legal and professional fees, permits, fundraising, memberships, administration fees

Beyond the cost of operating a program that meets licensing or license-exempt requirements, the model includes several quality enhancements to understand program costs that go beyond these minimum standards. These variables are informed by requirements under QUALITYstarsNY and can be included in whole or in part. Users can select to run a scenario at either the licensing level or can select each of the different points for each variable.[16]

[III] Note: In New York State licensing, Family Child Care Homes are known as Family Day Care Homes and Group Family Child Care Homes are known as Group Family Day Care Homes.

Table 5: Additional Cost Drivers

	Licensing	QUALITYstarsNY
Training/Professional Development	15 hours per teacher and assistant teacher	Additional four hours lead teacher and assistant teacher.
Planning Release Time	None	Lead teachers one hour per week, one hour every other week for teaching team together; eight staff meetings per year.
Materials & Curriculum Supports	$250/child materials	Additional $50/child materials; $3,000/ classroom for curriculum.
Family Engagement Activities	None	Two family conferences annually; three social events annually.
Inclusion and Dual Language Supports	None	$250/child on IFSP/IEP; 10 percent increase to materials for translation.

The user can also choose to run the model at two salary levels: current salaries (estimated by Bureau of Labor Statistics data), or a living wage (estimated by the MIT Living Wage calculator). For the living wage salary level, assistant teachers were assigned the living wage value, while other salaries increased from this floor.[17] Lead teachers are assumed to make 30 percent more than assistant teachers, assistant directors receive a 22 percent increase over lead teachers, and directors receive a 21 percent increase over assistant directors. These adjustments are based on data collected on child care salaries across multiple states in recent years by P5FS. When the current salary option is selected, the model can run a regional estimate that represents the Capital-Northern NY region (which includes Clinton, Essex, Franklin, Fulton, Hamilton, Lewis, Montgomery, St. Lawrence) which is the closest region provided by the BLS data to cover the Adirondack region. When the living wage salary level is selected, the model can produce county-level results. In addition to salary, the model includes discretionary benefits. By default, the cost to employers of providing health insurance to employees can be included. When this selection is made, $6,800 per FTE is included in the model which could be used for health insurance or other benefits.[18] Twenty days of paid sick leave and 20 days of paid vacation are also included. At the QUALITYstarsNY level, the model also includes a 5 percent contribution to retirement.

Table 6 compares the current BLS salary average for the whole region with the MIT Living Wage estimate for each county.

QUALITYstarsNY is New York State's Quality Rating and Improvement System, or QRIS. It is designed to support early childhood programs to achieve excellence and to ensure families can trust the level of quality of the programs they chose. QUALITYstarsNY standards represent best practices and policies in ECE, informed by experts and validated research. Programs are assessed and rated based on these standards, earning points on key quality indicators such as the learning environment, family engagement, staff qualifications and experience, and management and leadership. Participating programs receive individualized support from experts, professional development opportunities, and data-driven assessment to support a quality improvement plan.
For more details visit *https://qualitystarsny.org*

Table 6: Salary defaults included in child care model

	BLS	MIT Living Wage				
	Capital-Northern Region	Clinton County	Essex County	Franklin County	Hamilton County	Warren County
Director	$57,490	$94,566	$94,207	$92,545	$94,719	$101,278
Assistant Director	$45,992	$78,153	$77,857	$76,484	$78,280	$83,700
Lead Teacher	$43,640	$64,060	$63,817	$62,692	$64,164	$68,607
Assistant Teacher	$31,140	$49,277	$49,090	$48,224	$49,357	$52,775
Floater/Substitute	$30,660	$49,277	$49,090	$48,224	$49,357	$52,775
FCC Provider/Owner	$60,005	$88,083	$87,748	$86,201	$88,226	$94,335

Note that the family child care model includes a salary for the provider/owner. Many family child care owners do not pay themselves a set salary, but rather their income is the net revenue after all expenses have been paid. This approach to family child care owner/provider salary drastically undervalues home-based providers and often results in income equivalent to less than $5 per hour when accounting for actual hours worked. To recognize family child care as a part of the early childhood system any cost estimate must include compensation for the provider/owner, which is a required position in state child care licensing. As such, in the Adirondack region child care cost model a salary is included for the provider/owner position in the family child care home. The annual salary is calculated using the hourly rate for a lead teacher in a center-based program but based on a 55-hour work week to account for the additional responsibilities of the provider/owner.

Modeling the Cost Per Child in Center-Based Care

For this report, the CFA team ran several models using a default program based on the most common sizes of centers and compositions of children. The default center-based program includes one infant classroom, one toddler classroom, one three-year-old classroom, one four-year-old classroom, and one school-age classroom, with a total capacity of 79 children. Under this program profile, the default model includes a full-time program director, program supervisor, financial/business manager, and administrative assistant. Each classroom has a lead teacher and an assistant teacher. The model includes time for "floaters" to maintain ratios during opening and closing and provide additional coverage throughout the day for activities. Table 7 presents the results from the child care cost model for child care centers, at the two salary levels.

Table 7: Monthly cost per child, Licensing, Centers

	BLS	MIT Living Wage				
	Capital-Northern Region	Clinton County	Essex County	Franklin County	Hamilton County	Warren County
Infants	$1,882	$2,599	$2,591	$2,555	$2,602	$2,742
Toddlers	$1,486	$2,027	$2,021	$1,995	$2,029	$2,134
Three-year-olds	$1,222	$1,646	$1,642	$1,621	$1,648	$1,729
Four-year-olds	$1,147	$1,537	$1,533	$1,514	$1,539	$1,614
School-age[IV]	$640	$863	$861	$850	$864	$907

As shown, even when running the model using current wages and at a level meeting licensing, current New York state subsidy rates are insufficient to cover providers' costs even at these basic levels. For example, the annual cost of care for an infant under this scenario is $1,882 which is $549 more than the current annual subsidy rate, ($1,333 for full-time care). Gaps are smaller for preschool and school-aged children but they still exist. Providers who rely on subsidy revenues lose money with every age child they serve. As shown, the gaps are much larger when the cost of care is estimated to include a living wage. For example, in Clinton County, infant care is estimated to cost $2,599 which is $1,266 more than the current subsidy rates. For a four-year-old in the same county care is estimated to cost $1,537 annually, which is $401 more than the current subsidy rate. These disparities illustrate the difficulty providers face when trying to increase employee compensation.

Table 8 presents results from the model when all the quality variables are included and aligned with QUALITYstarsNY. As shown, costs increase between 3–8 percent depending on the scenario.

Table 8: Monthly cost per child, Quality Stars, Centers

	BLS	MIT Living Wage				
	Capital-Northern Region	Clinton County	Essex County	Franklin County	Hamilton County	Warren County
Infants	$1,960	$2,678	$2,670	$2,634	$2,681	$2,824
Toddlers	$1,564	$2,106	$2,100	$2,073	$2,109	$2,217
Three-year-olds	$1,300	$1,725	$1,721	$1,699	$1,727	$1,812
Four-year-olds	$1,225	$1,616	$1,612	$1,592	$1,618	$1,696
School-age	$681	$905	$903	$891	$906	$951

[IV] School age results are displayed monthly but are based on a composite value to account for children being in full-time care during the summer and before/after school care during school terms.

Modeling the Cost Per Child in Home-Based Child Care

Family Child Care Homes can serve up to six children under school-age, plus two school-aged children. Group Family Child Care Homes can serve up to 10 children under school-age, plus four school-aged children. The family child care (FCC) and group family child care (GFCC) models developed for this analysis include salaries and benefits for providers and any assistants, and all non-personnel costs such as supplies, rent/occupancy, food, and utilities. As in the center-based scenarios, the model can produce cost estimates based on two salary levels, and with various costs related to QUALITYstarsNY included.

Tables 9 and 10 present results from the model at the two salary levels for home-based programs meeting licensing standards (Table 9) and meeting the higher quality standards discussed above (Table 10). Because home-based programs care for all children in a mixed-age setting, the cost model provides a single per-child cost estimate for children under five rather than different cost estimates for children of different ages. School-age children have a different cost because they do not require full-time care. For this report, the CFA team estimated the per-child cost for an FCC with eight children enrolled (one infant, one toddler, two three-year-olds, two four-year-olds, and two school-age children) and a group FCC with 16 children enrolled (three infants, three toddlers, three three-year-olds, three four-year-olds, and four school-age children).

Table 9: Monthly cost per child, Licensing, Home-based Child Care

	BLS	MIT Living Wage				
	Capital-Northern Region	Clinton County	Essex County	Franklin County	Hamilton County	Warren County
Family Child Care Home						
Infant/Toddlers/ Preschoolers	$1,587	$2,189	$2,167	$2,196	$2,283	$2,206
School-age	$843	$1,159	$1,147	$1,163	$1,209	$1,168
Group Family Child Care Home						
Infant/Toddlers/ Preschoolers	$1,100	$1,565	$1,563	$1,552	$1,566	$1,609
School-age	$582	$829	$827	$821	$829	$852

Table 10: Monthly cost per child, QUALITYstarsNY, Home-based Child Care

	BLS	MIT Living Wage				
	Capital-Northern Region	Clinton County	Essex County	Franklin County	Hamilton County	Warren County
Family Child Care						
Infant/Toddlers/ Preschoolers	$1,851	$2,596	$2,591	$2,569	$2,598	$2,685
School-age	$980	$1,374	$1,372	$1,360	$1,375	$1,421
Group Family Child Care						
Infant/Toddlers/ Preschoolers	$1,247	$1,785	$1,782	$1,772	$1,786	$1,829
School-age	$660	$945	$944	$938	$945	$968

As with center-based care, current subsidy rates in New York are insufficient to cover the cost of home-based care, even for a program meeting minimum licensing standards and paying current salaries. As shown in Table 9, the cost of full-time care for a child under five with current salaries in an FCC is estimated to be $1,587 per month, which is more than $400 above current subsidy reimbursement levels. Increasing wages to the MIT Living Wage level increases the cost of care to around $2,200 per child per month, which is more than $1,000 greater than current subsidy levels. Because group family child care homes receive the same subsidy rate, but have a lower estimated cost of care, the gaps are less pronounced, but are still present in most circumstances. Using current salaries, the cost of care is around $58 more per month than the subsidy rate for preschoolers. Using the living wage salaries, this gap increases to over $500 per month for preschoolers, and around $450 per month for infants and toddlers.

As shown in Table 10, all these gaps are even more pronounced at higher levels of quality. For an FCC meeting licensing standards and paying current salaries, the cost of care is estimated to be $1,851 per month, $705 more than the subsidy rate. For a group FCC, the estimated $1,247 per month cost is $110 more than the subsidy rate. For an FCC paying a living wage the monthly cost of care is estimated at over $2,500 per child per month, $1,000 more than the base subsidy rate. For a group FCC the monthly cost of care is around $1,800, compared to a subsidy rate of $1,145 per month.

In an example of how private funding is stepping in to help fill a portion of the gap that exists for programs meeting higher quality standards, the Cloudsplitter Foundation is providing 'Child Care Excellence Awards' for child care staff in QUALITYstarsNY programs in Clinton, Essex, and Frank-lin counties and the St. Regis Mohawk Territory. Employees can receive multiple $2,000 cash awards as they make measurable improvements in the quality of their services.[19]

To illustrate these findings, Figures 2–7 demonstrate the gaps under each of the scenarios discussed in this section.

Figure 2: Monthly gap between current subsidy rate, and true cost of care, Child Care Center, at Licensing level

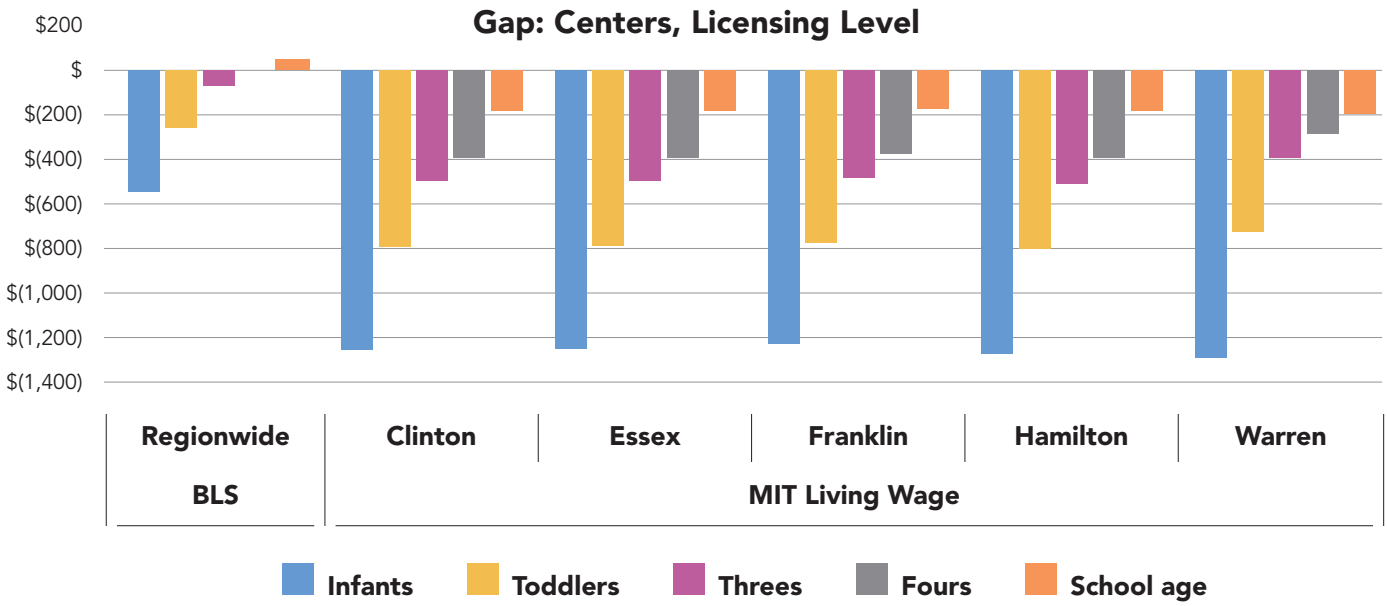


Figure 3: Monthly gap between current subsidy rate, and true cost of care, Child Care Center, at QUALITYstarsNY level

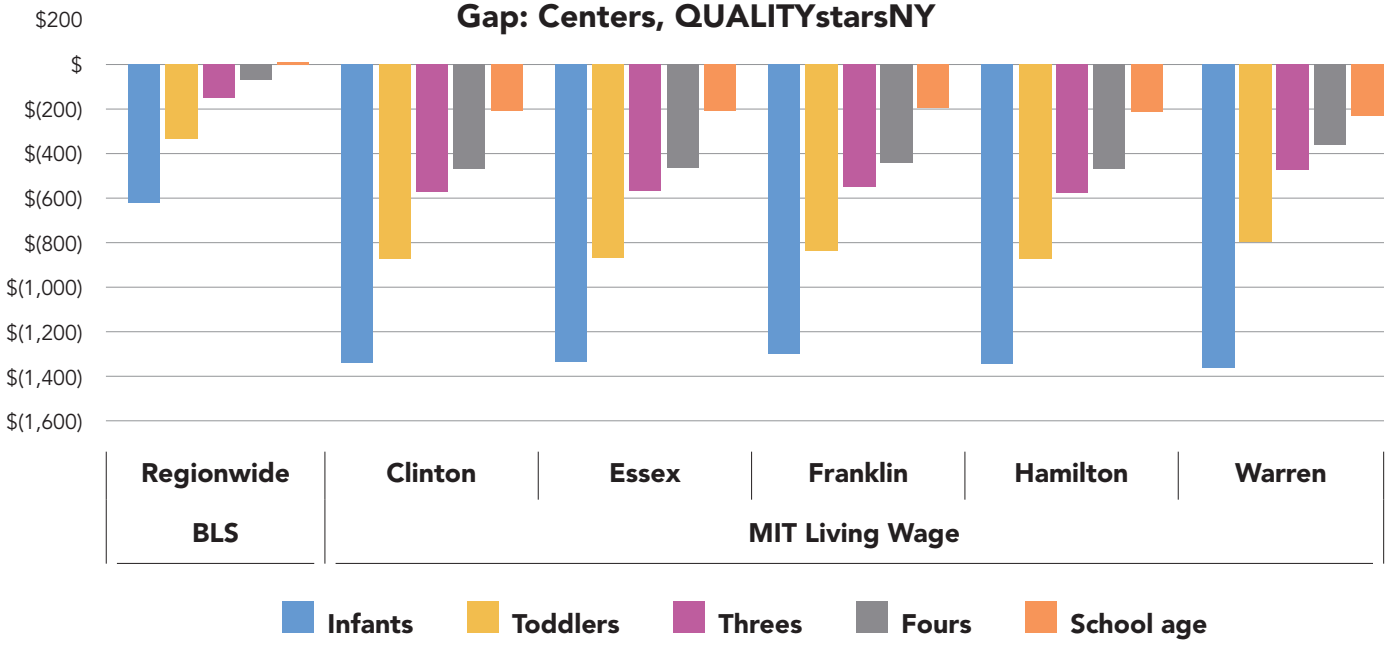


Figure 4: Monthly gap between current subsidy rate, and true cost of care, Family Child Care, at Licensing level

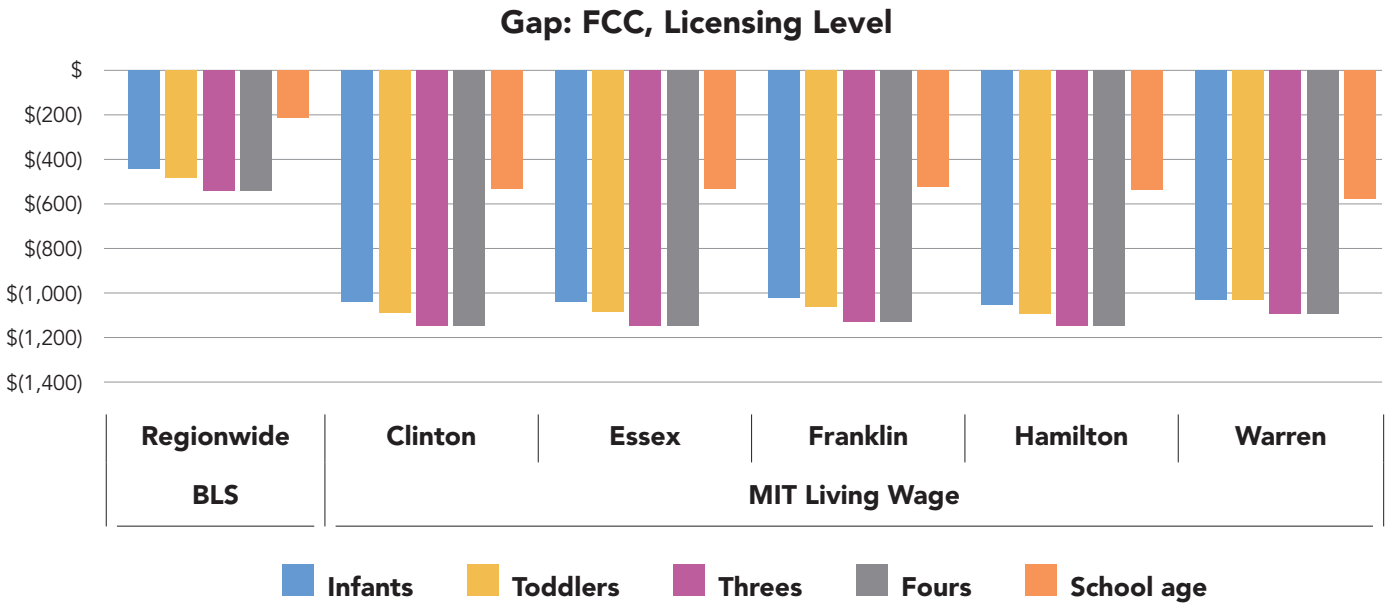


Figure 5: Monthly gap between current subsidy rate, and true cost of care, Family Child Care, at QUALITYstarsNY level

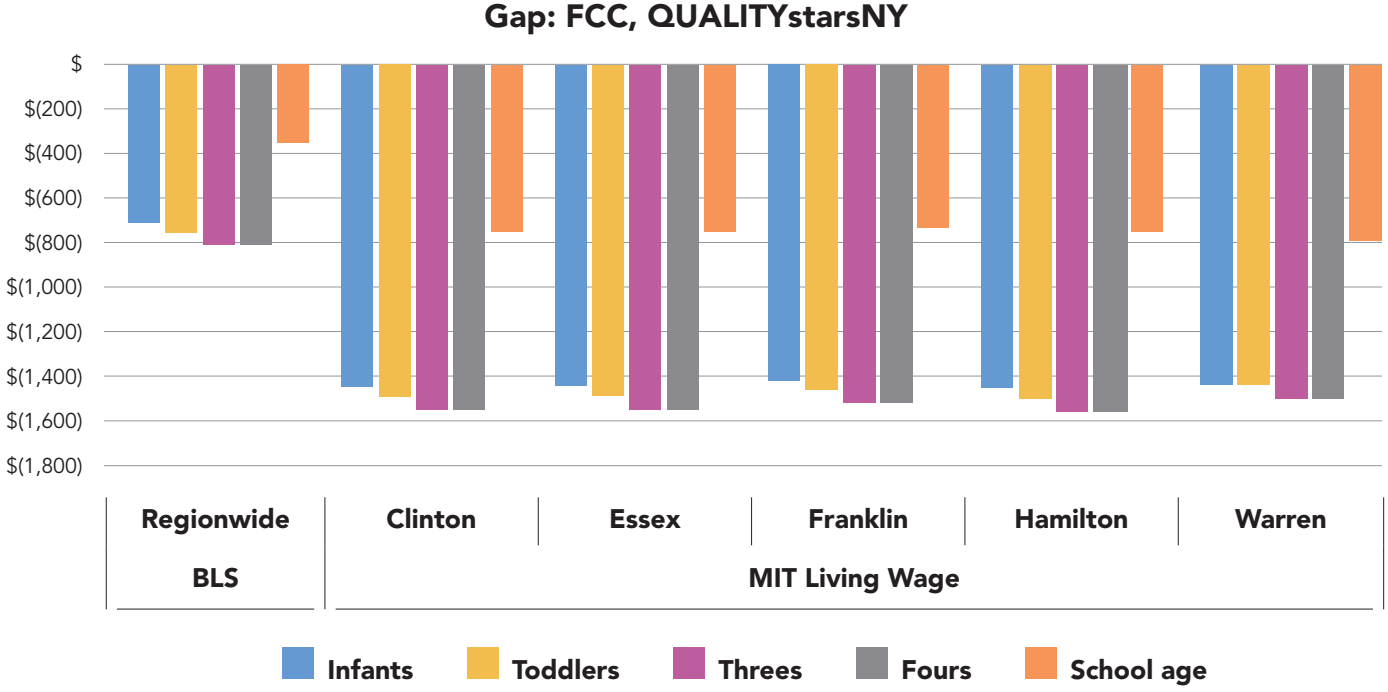


Figure 6: Monthly gap between current subsidy rate, and true cost of care, Group Family Child Care, at Licensing level

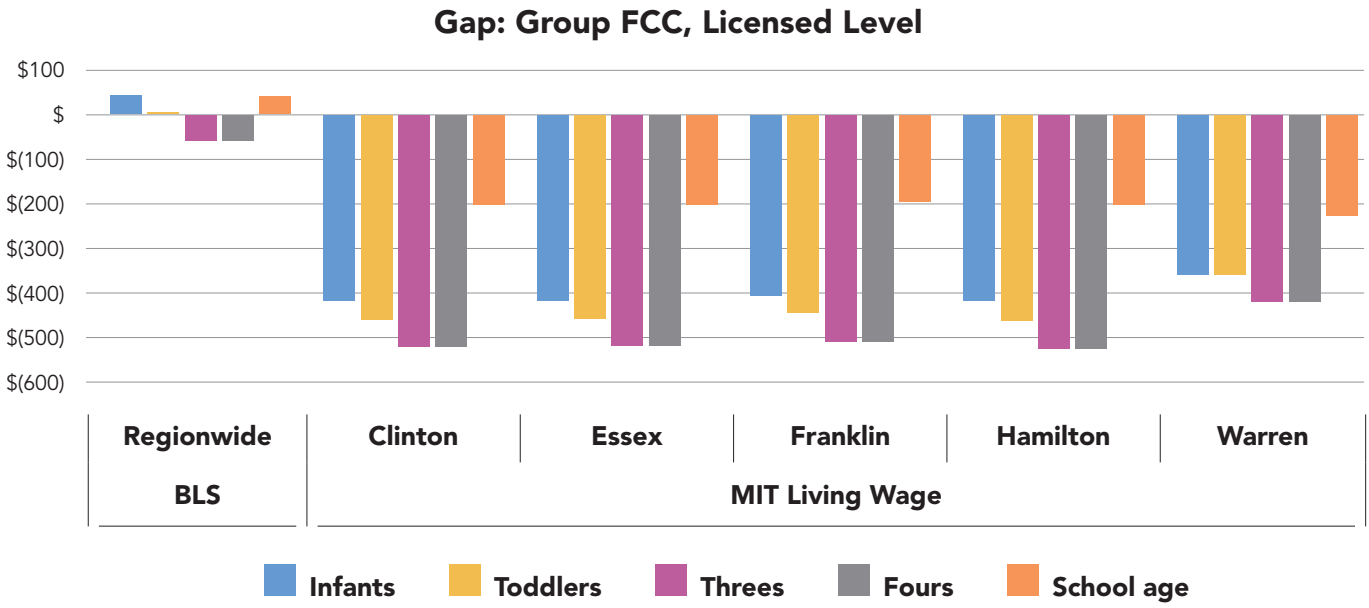
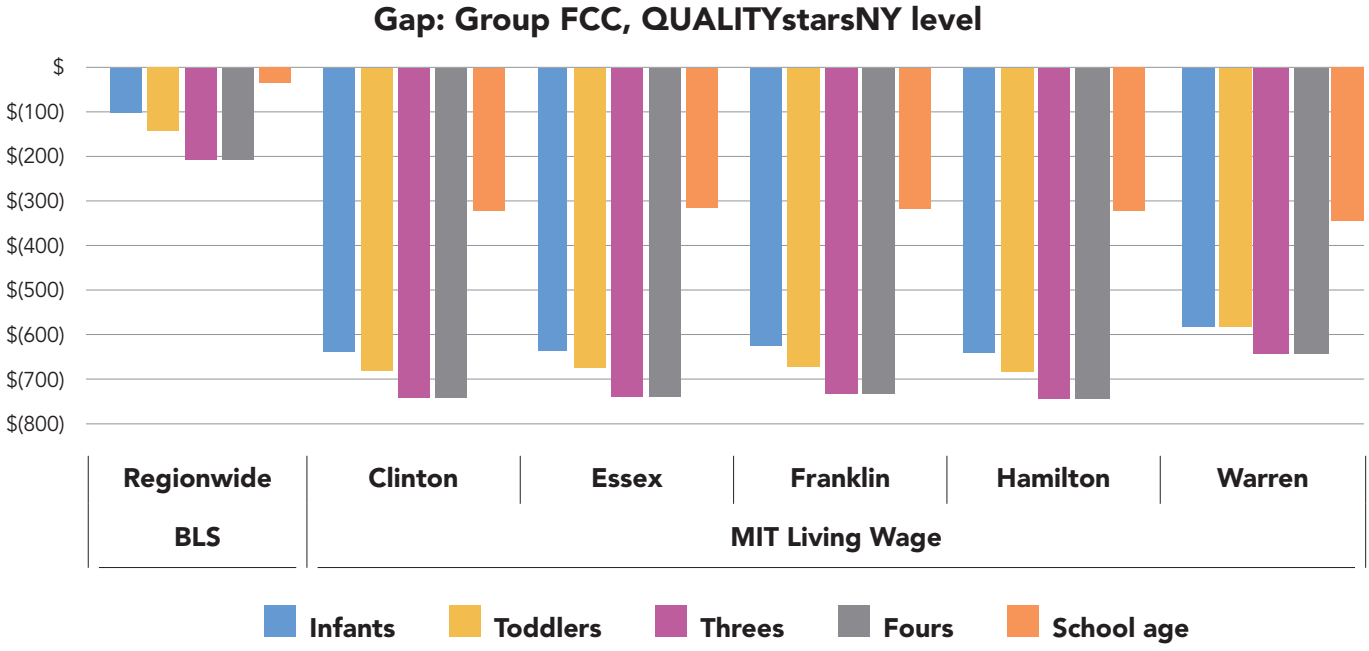


Figure 7: Monthly gap between current subsidy rate, and true cost of care, Group Family Child Care, at QUALITYstarsNY level



Estimating the True Cost of Child Care Across the Region

Through discussion with the Steering Committee, scenarios were developed using the cost models to determine the true cost of child care across the region, aligned with the fiscal vision and principles. The current child care subsidy system reaches less than 500 children in the Adirondack region on average each month, and as shown above subsidy rates are too low to cover the true cost of care. As a result, to build a sustainable and robust child care system that meets the needs of all children and families, it is necessary to increase *both* the number of children who are eligible to receive public support to afford child care, *and* to increase the reimbursement rate that provides receive when serving eligible children. To estimate the cost of this better system, P5FS developed three region-wide scenarios. Each of these scenarios use data from the child care cost model. To promote an integrated prenatal to five system that is fair to all the providers within the system, the scenarios use the living wage salary option and estimates the cost for a program meeting QUALITYstarsNY standards. The scenarios vary based on the number of children eligible for care, increasing in phases from current service numbers up to universal access:

- Phase 1 – Children under 5 currently served by child care subsidy
- Phase 2 – Children under 5 in families at or below 85 percent of the state median income (SMI)[v]
- Phase 3 – All children under 5.

In phase two and three it is estimated that 80 percent of eligible children participate. This is consistent with data from states and cities that have implemented universal preschool models, and similar to kindergarten enrollment data, that show a portion of eligible populations opt out of universal programming. Across each phase, the following assumptions are held consistent:

- Distribution of child care across program types is consistent with the current distribution of slots in the region: 29 percent in centers, 44 percent in family child care homes, and 27 percent in group family child care homes.
- The cost per child values in each scenario is based on a program achieving the QUALITY starsNY standards and using the living wage salary selection in the model.
- Resources are included to support system infrastructure at eight percent of total direct service costs.

Table 11 details the results for each of these scenarios including the estimated number of children served and the annual cost.

Table 11: Annual cost of enhanced child care system, statewide

	Phase 1: Children 0–5 currently served by subsidy	Phase 2: Children under 5 in families at or below 85 percent SMI	Phase 3: All children under 5
Children served	468	3,665	8,020
Direct Service Cost	$7,216,057	$88,273,084	$193,167,729
Infrastructure Cost	$577,285	$7,061,846	$15,453,418
Annual Cost	**$7,793,341**	**$95,334,930**	**$208,621,147**

[v] Data on family income from: *American Community Survey, 2020, 5 year estimates, table B17024, Age by ratio of income to poverty level in the past 12 months.* Only data from Clinton and Warren county were available from this source, so an average across the two counties was applied for the region as a whole.

Home Visiting and Parenting Education

Fiscal modeling has a unique role in understanding the costs of many types of home visiting and parenting education programming, implemented together in a community or state. Modeling provides key information to shif away from competition for funding between programs and toward a system, or array, of services delivered through multiple programs, supported and available to meet diverse needs. A fiscal model of multiple programs reinforces the fundamental understanding that no one home-visiting model will meet the needs of every family, community, or need profile; a complement of programs is necessary for every community. Fiscal modeling can support assessment and planning for the community or state, efforts to ensure adequate financing based on the actual cost of programs, and a shared advocacy strategy across programs. This section of the report details the methodology and assumptions embedded in the home visiting cost model and presents a sample of results, along with an analysis of these results.

Modeling the Cost of Home Visiting

The Adirondack region home visiting direct service cost model is designed to support communities in considering the multiple program models needed to serve their unique population of children and families. From this holistic vantage point, the cost model produces an output that incorporates all the program models selected, drawing unique service model data and expense details to inform that out-put. Table 12 details the programs included in the Adirondack region home visiting model.

The home visiting and parenting education cost model is built to model the ongoing operational costs of the programs, not the costs related to the startup of a program. To use the cost model, users select all the program models to be included in their desired scenario and the number of children or families served by each home visiting and parenting education model. The selection of program models draws on program specifics related to each model's operations. These specifics of operating a given model, such as home visitor caseload, ratio of staff to supervisor, and number of group services, are driven by program standards from the national service office or each model, as applicable.

Table 12: Adirondack Region Home Visiting and Parenting Education Cost Model Programs

MODEL
Power of Two (Attachment and Biobehavioral Catch-up)
Early Head Start Home Based
Healthy Families
Home Instruction for Parents of Preschool Youngsters (HIPPY)
Newborn Home Visiting Program
Nurse Family Partnership
Parent Education Programs
Parents As Teachers
Parent Child +
Perinatal and Infant Community Health Collaboratives
Safe Care

Program Characteristics

Different home visiting and parenting education models have variances in program characteristics,

or what is referred to as their program model. These variances are established by the model, often at the model purveyor level, and often include variations related to:

- **Services to children and families:** caseload capacity of the home visitor or parent educator, frequency of points of connection, duration of services, one-on-one activities, and/or group services.
- **Staffing and management:** caseload of home visiting staff to a program supervisor, reflective supervision approach and frequency, supervisor to program manager/director ratio.
- **Quality supports and infrastructure:** ongoing training requirements, credentialing or national accreditation, affiliation roles, and responsibilities.

While many program characteristics found across the home visiting models are established at the model purveyor level, there may be some characteristics with flexibility in local implementation, such as caseload size. A model may allow for a range of families to be served and allow local programs to determine their caseload within those parameters. The default data for these program characteristics are the model purveyor requirements. However, the Adirondack region home visiting and parenting education cost model allows for the user to select a smaller caseload for a higher-intensity service, based on feedback that programs prefer to assign smaller caseloads because of travel distances in rural areas or higher needs for families with certain characteristics. These options within the model are demonstrated in Table 13, referred to as Reduced Caseload 1 and Reduced Caseload 2. (Note that caseloads reflect the number of families a home visitor or parent educator can serve in one year, which may be more than one family in the same slot for programs with shorter durations.)

The expenses related to delivering these program characteristics were informed by data collection with models funded by all the public and private sources supporting the delivery of home visits within the Adirondack region.

Home Visiting Costs Per Child/Family

Home visiting and parenting education costs per child or family, depending on who is considered "enrolled" in the service, are largely driven by the intensity of the service and staff compensation. Some models, such as Early Head Start, are designed to provide more intensive services with more frequent visits and smaller caseloads per home visitor. Other home visiting models may be less intensive and provide fewer visits over a shorter duration, allowing home visitors to serve more families over a year. Parenting education programs are typically shorter in duration and less intense, with some services delivered entirely via a group setting, instead of one-on-one visits with families.

Like child care, home visiting is a labor-intensive service, and the salaries and benefits provided to staff members are important drivers of cost. Current salaries for home visitors were modeled using BLS data. During the constituent engagement conducted for this CFA, the challenge of attracting and retaining a qualified workforce was raised. Low salaries and a lack of benefits mean that program leaders have trouble filling vacancies and face high turnover, which has practical costs and leads to undermining trust and relationship-building with families. The desire for shared compensation standards across the early childhood field was also heard. To that end, the home visiting and parenting education cost model incorporates the MIT Living Wage scale, aligned with the child care cost model. The entry-level position, administrative support, is assigned a baseline

living wage of $41,039, and other positions are increased from there to reflect additional qualifications and responsibilities. Under this model, home visitors are assigned an annual salary of $53,351; clinical home visitors are assigned a salary of $64,021; and nurse home visitors are assigned an annual salary of $76,825, for Region 3 Adirondack region. Table 13 details the annual salaries by position, for current (BLS) salaries and MIT Living Wage salaries.

Table 13: Home Visiting Salaries, Adirondack Region

	Salaries Based on BLS – Region 3	Salaries Based on Living Wage – Region 3
Executive Director	$68,377	$79,407
Program Manager/Supervisor	$56,047	$65,088
Nurse Program Manager	$78,275	$93,727
Nurse Home Visitor	$64,160	$76,825
Clinical Home Visitor	$63,740	$64,021
Home Visitor/Parent Educator	$45,940	$53,351
Home Visitor Paraprofessional	$40,900	$45,553
Administrative Support	$35,230	$41,039

Modeling the Cost of Home Visiting Services

Home visiting and parenting education programs have variances in their cost per child/family served based on the program model. Variances in caseload size, term of the program services, and staff qualification requirements are key cost drivers. However, the CFA team created average cost per child/family results across the models implemented in the Adirondack region to illustrate results from the cost model, using current caseloads and at the two salary points discussed above. These results are presented in Table 14.

Table 14: Home Visiting and Parent Education Cost Model Results

Salary Point	Low Intensity	Medium Intensity	High Intensity
BLS	$2,232	$4,457	$7,543
MIT Living Wage, Region 3	$2,417	$5,100	$8,398

Understanding the range of costs is important to fully understand the cost of home visiting and parenting education services as the total cost will change if more families are served by models that have a higher cost per service. In many instances, it is appropriate for communities to focus on increasing service capacity with the more intense, and more expensive, home visiting models, as these models have a proven positive impact on at-risk family situations. As shown in Table 14, using BLS

salaries, the range of home visiting and parenting education costs in the Adirondack region is approximately $2,232 at the lowest intensity service model, $4,457 for medium intensity services, and $7,543 annually for the most service intense model. This range of costs, compared to an average across the models, demonstrates how much the cost of models varies and how much the needed investment for a region is determined by which model is selected and how many families are served by each model.

Running the model with the MIT Living Wage pay scale and services matching the service numbers gathered during the CFA increases the average cost per child/family to $2,417 for a low-intensity program or $8,398 for a high-intensity program. These costs are approximately $1,000 – $7,000 higher than current funding levels. The variance in the actual cost-per-model is important in understanding the overall cost and also reinforces the continuum of home visiting and parenting education models that exist and the need to not simply select the least expensive model but to understand which models will best meet the needs of the population of families they are designed to serve, and the cost associated with this service delivery.

The cost model also allows users to estimate the cost with smaller caseloads for higher-intensity services, which increases the cost further. Smaller caseloads may lead to higher-quality services for families with more intensive needs and may help to reduce home visitors' burnout and turnover. Smaller caseloads are particularly helpful in rural areas where the travel time between visits can be significant. The cost model can help provide transparency into the costs of offering these smaller caseloads.

Scenarios were developed in the cost model to understand to what extent the current funding for home visiting and parent education services covers the true costs of service. Current home visiting and parenting education services have a payment amount ranging between $500 to $4,000 per funded slot. Using the BLS salary option, the home visiting cost model estimates an average cost per slot of $4,996.[VI] The annual funding needed to continue serving all currently covered children/families using this average cost would exceed $2.7 million, as shown in Table 15.

Table 15: Home Visiting Cost Estimate

	Current Services, BLS Salaries
Total Families Served/ Slots	550
Average Cost of Child/ Family	$4,996
Home Visiting Direct Service	**$2,747,860**

Th s gap of averaging nearly $2,300 per child/family, or nearly $2 million across the system, illustrates that current funding of the home visiting system is not sufficient to cover the program costs even at current salary levels. Programs cope with these low funding levels by paying their staff less than the BLS salary levels; staff working more hours per week than compensated for; subsidizing their home visiting programs through cost-sharing across other parts of their organization; raising private funds from other sources; or some combination of these strategies.

Estimating the True Cost of Home Visiting

Research demonstrates that all families of young children may benefit from home visiting or parenting education services, yet not all types of home

[VI] To calculate this average cost, the model was run with a mix of families that mirrors the funded capacity by each model in the Adirondack region in FY 22.

visiting will meet the needs of every family.[20] With home visiting, there is an array of types of programs and intensity in services, which have different costs per child served. To understand the need for home visiting, the population of families of young children needs to be broken down according to the strata driven by high need or at-risk characteristics, reflective of the populations within the Adirondack region. As a rule, population-wide stratification of need seeks to sort the population into high, moderate, and low risk, according to population characteristics.

The Adirondack region is home to 235,802 people. Of those, approximately 6,850 (2.9 percent) are under three years of age.[21] On average, 2,280 are born each year in these five counties. Approximately, 6,978, or 18 percent, of children birth to 17 years of age live at or below the federal poverty level. The percentage of children under 18 living in poverty in New York State declined between 2015 and 2019. While New York State saw a decline of 4.1 percent, the Adirondack region saw a decline of only 3 percent. The percentage of children in poverty in the Adirondack region remains higher than the rest of the state (18.2 percent vs 14.9 percent).[22] Although the median household income in the Adirondack region rose 6–9 percent between 2015 and 2018, the region continues to lag behind the state average for median income and the U.S. average. (Clinton $55,178, Essex $56,196, Franklin $51,696, Hamilton $57,552, Warren $59,813, New York State $66,323, and the United States $63,998).[23]

Clearly family income is not the only driver of need, yet data demonstrates that income overlaps with other risk factors, including lack of access to stable housing and basic needs, higher rates of substance abuse disorders, and higher involvement with the child welfare system. When the rates of families of young children in poverty are high, these can serve as the first stratification for the highest need category, given this group encompasses many families with infants. Depending on the birth rate each year, these income percentages for families in the Adirondack region reflect 18 percent of families, or 1,100 families, with young children in poverty or deep poverty. This stratification data demonstrates that the greatest-need population is double the current home-visiting lots funded in the region, helping inform the inputs that drive the estimate of the true cost of home visiting. In this region, 32 percent of families of children under 5 years of age are at 185 percent of federal poverty level, qualifying for supports such as federal food assistance such as the WIC program. Table 16 delineates the details of the different levels of population need who could benefit from home visiting services. The highest and moderate need strata are also equal to the population of Medicaid eligible births in this region, which is 50.8 percent of the birth rate.

Table 16: Home Visiting Service Need Projections, Adirondack Region

	Annual Numbers
Highest Need Strata (18.8%)	
0–1	376
1–2 years	376
2–3 years	357
TOTAL UNDER 5	**1,109**
Moderate Need Strata (32%)	
0–1	640
1–2 years	640
2–3 years	602
TOTAL UNDER 5	**1,882**

An additional key consideration this data stratification points to is the need to retain the current home visiting services utilized within the region. Therefore, addressing the current underfunding of the services is another element of understanding the total true cost of home visiting. The current home visiting services need to be invested in at a cost reflective of wages that will not only retain staff but also attract new and qualified staff to work in these programs. The staff-family relationship is the critical space in which all home visiting impact occurs for families of young children.

Home Visiting System

Home visiting services in the Adirondack region are provided by a decentralized group of agencies that receive funding from various sources. There are some system-level investments at the state level in home visiting and parenting education across the models, including consultation support, monitoring and evaluation, training, and professional development provided by the agencies delivering the services. Supporting a more robust home visiting system requires investing in the capacity of state agencies and their community partners to fulfill various functions of a comprehensive system:

- Governance and administration
- Financing strategies and funding mechanisms
- Assessment and planning
- Continuous quality improvement, implementation, and evaluation
- Professional development, training, and technical assistance
- Monitoring and accountability.

A robust system investment could include activities such as more extensive data coordination and management; standardization of onboarding, training, and quality standards across models and funding sources; and state-level investment into family supports such as coordinated outreach and enrollment. Investment in system-wide education, awareness building, and outreach could help to increase the uptake of home visiting. In estimating the total cost for home visiting, the local infrastructure needs of the home visiting system are included separate from the direct service estimates. These are factored at 10% of the direct service costs, based on data gathered from other states and communities delivering on the system and infrastructure activities.

Home Visiting Cost Modeling

The home visiting cost model is a dynamic tool that can be used beyond this report, to allow program leaders to understand the true cost with variations in the type of home visiting services offered, intensity of the home visiting model, and population served. For the CFA, three scenarios were developed in model to estimate the true cost of home visiting in the region.

The first scenario demonstrates the investment needed to address the need for increased compensation within the home visiting field. This scenario includes all current home visiting models in place in the region, with staff moved to MIT Living Wage salaries, and current caseload intensity in line with the program model, increasing just 10 percent capacity. Under this scenario, the cost of home visiting is $3.5 million, requiring an increased investment in home visiting services of approximately $2.25 million annually from current investments.

The second scenario addresses the need to increase service capacity to serve more children and families. This scenario includes MIT Living Wage as the salary selection and increases the number of home visiting services by models that are medium-intensity and high-intensity, for a total of

1,150 slots. This scenario is based on the number of slots instead of families served, as there are many instances where more than one family is served in a year by a given slot. The third scenario, referred to as Phase Three in Table 17, retains the MIT Living Wage based costs for services, the increase in intensive home visiting and adds a universal touch model reaching at least 50 percent of the annual births in the region.

More intense caseloads have not been modeled at this time. A comparison of the cost per child with current caseload requirements and smaller caseloads has already demonstrated a significant increase in the cost per child/family with smaller caseloads (25 percent–30 percent increase in cost per slot).

Table 17: Home Visiting Cost Estimate

HOME VISITING COST ESTIMATE	Phase One: MIT Living Wage, Current Capacity	Phase Two: MIT Living Wage, Increased Capacity to serve Highest Need Populations	Phase Three: MIT Living Wage, Increased Capacity to Highest Need and Universal Touch
Total Families Served/Slots	600	1,150	1,150 intensive 1,100 universal touch
Home Visiting Direct Service	$3,143,470	$6,632,033	$7,442,543
Home Visiting System	$314,347	$663,203	$744,254
Total HV Costs	**$3,457,817**	**$7,295,236**	**$8,186,797**

Overall Cost Estimate

Using results from the child care cost model and the home visiting and parent education cost model as discussed in this section, the CFA team developed a system-wide cost estimate. Table 18 summarizes the results of this estimate. As shown, the total cost of providing universal access to child care and providing universal touch home visiting, and expanded intensive home visiting across the Adirondack region is nearly $217 million per year. Of this total, 89 percent is for child care direct service, three percent for home visiting direct service, and eight percent for infrastructure supports. The cost of the two additional scenarios discussed in this analysis are also shown in Table 18 for comparison. Note that these cost estimates do not account for current public investments, or for any family contribution that might be assessed.

Table 18: System-wide Cost Estimate

	Phase One	Phase Two	Phase Three
Child Care	$7,216,057	$88,273,084	$193,167,729
Home Visiting	$3,143,470	$6,632,033	$7,442,543
Infrastructure	$891,632	$7,725050	$16,197,672
TOTAL	**$11,251,158**	**$102,630,166**	**$216,807,944**

As shown in the fiscal mapping analysis in Section IV, current public investments in the prenatal to five system in the Adirondack region total over $36.7 million annually. While this is above the phase 1 estimates, this includes Head Start and Preschool Special Education funding, whose costs are not fully captured in the results in Table 18. Nevertheless, with the phase 3 cost estimate being nearly ten times higher than current investments there is a significant shortfall between the currently available funding and the investments needed to meet the goals set out in this fiscal analysis.

Early Intervention

The Steering Committee has long been concerned that infants and toddlers with developmental delays and disabilities across the region were unable to receive the services they need due to the lack of speech-language pathologists, physical and occupational therapists, and special instructors. This is a particularly severe problem in Franklin and Hamilton counties, neither of which have any therapists providing in-person early intervention services in their county. Across the region, many eligible children are continually unserved. Children eligible for early intervention receive services through the local health department in their county of residence.

In a recently published report on early intervention,[24] the Adirondack Birth to Three Alliance reviewed readily available data and concluded that:

- The Adirondack region (along with other rural parts of the state) is serving a far smaller percentage of children birth through two years of age than expected.
- Over 14 years, rural counties served on average, only 2.87 percent of children compared to the state median of 4.28 percent.
- Over that same 14-year period, the 16 counties and New York City that were above the state median served 5.23 percent of the population — nearly 1 percentage point higher than the state median and 2.4 percent higher than the group of counties serving below the state median.
- The number of speech-language pathologists, and physical and occupational therapists is lower in counties that served below the state median as compared to more suburban/urban areas of the state that served above the state median.

The group found that while sometimes the reason a smaller number of children is served is due to a lack of available therapists, this does not always correspond with the number of therapists who serve young children. Many therapists specialize in serving other populations (i.e., elderly, victims of accidents or strokes, school-age children, etc.) in settings that do not involve traveling between homes and other locations and which pay higher salaries and benefits. Therefore, these types of jobs

are more desirable than those with young children. Therapists also do not get paid when, after traveling to a child's home, the child is not there. As a result, there are built-in disadvantages to serving young children. In rural counties, those disadvantages are made more acute by the distances between children's homes.

Currently, there are an estimated 7,000 young children, birth to age three, who live in the region. Of note is that 18.8 percent of these children are in poverty, defined as 100 percent of the federal poverty level (FPL) and below, and 10 percent are in deep poverty, which means they are living at 50 percent of or below FPL. Thirty-three percent of the children are at 185 of FPL and under. Over 50 percent of births in the region are Medicaid.

Several potential factors contribute to fewer children being served in the rural areas of New York such as the Adirondack region. First, many families are isolated from primary healthcare providers, and therefore may not receive important screenings. The most important factor, as felt by the early intervention workgroup, is a lack of therapists who reside in or near a rural county. In early intervention, the program design does not consider the lack of therapists who reside within the area. New funding to help counties address provider shortages and proposals for rate increases, including small percentage increases for underserved communities, will not fix the problem.

The steering committee agrees there is more work to be done with state partners and local agencies. One idea is to create a new position called a child and family development specialist, who could fill in the gaps that exist due to a lack of licensed therapists. The committee has identified several possible areas that may aid in this crisis, and the committee will continue to explore all possible avenues to ensure services to qualified young children.

VI. Findings and Recommendations

As a result of this analysis, and with input from the Steering Committee, several recommendations have been developed to strengthen and support the prenatal to five system in the Adirondack region. These recommendations are intended to stabilize the system and lay the long-term foundation for the future system envisioned in the vision and principles discussed in Section III.

The recommendations fall into six broad categories, focusing on ensuring that the prenatal to five system:

1. coordinates and aligns to maximize the use of available funding,
2. implements a cost-based approach to rate setting,
3. strengthens and expands services to all eligible families,
4. develops a systematic approach to workforce development for all services,
5. ensures access to early intervention services for all eligible children, and
6. works to ensure all children and families have access to high-quality comprehensive services.

Table 19: Adirondack Region CFA Recommendations

Establish a comprehensive coordinated early childhood system that removes barriers for families, minimizes the burden on early care and education providers, and maximizes the use of available funding streams.	Foster collaboration between local agencies, organizations, local service providers and partners to support a coordinated and aligned early childhood system for the region.
	Work with state agencies to remove barriers for families to access early care and education programs and services by simplifying the enrollment process and reducing administrative burdens on families.
	Maximize existing funding sources and explore new financing strategies to improve quality and access to programs and services within the region.
Implement a cost-based approach to rate setting and contracting for child care, home visiting, and parenting education.	Reimburse for services at a rate in alignment with the true cost and based on enrollment or caseload rather than attendance to address barriers to providing services in rural areas and attracting a qualified workforce.
	Explore and implement appropriate strategies across the organization to support compensation paid at a living wage.
	Explore support programs such as staffed family child care networks, shared services, and business training.
Strengthen and expand access to prenatal to five services	Increase awareness of the importance of prenatal to five services through the development of a messaging and communication campaign.
	Support the development and implementation of supply-building strategies for all services reflective of the local context.
	Work with state partners to analyze child care licensing regulations that could be adjusted to allow for more viable business models.
Develop a systematic approach to workforce development; a pipeline, training, and support of qualified staff for prenatal to five programs in the Adirondack region.	Work with higher education representatives both locally and at the state level to ensure prospective professionals have access to higher education within the field, both at two-year and four-year institutions.
	Develop an advocacy campaign around the lack of a qualified workforce and identify priorities for attracting and maintaining quality service providers in rural areas.

continued

Table 19: Adirondack Region CFA Recommendations, *continued*

	Work with state partners, using the cost model for Adirondack regional services, to determine a reimbursement rate that reflects true cost of early education and care services in rural areas that allows for recruitment and retention of qualified staff along with delivery of comprehensive services.
Ensure access to early intervention services for all eligible children.	Increase awareness of the importance of early intervention along with the challenges to deliver in rural area, including lack of qualified staff.
	Develop a cost model for early intervention services in the Adirondack region, to illustrate the need for a different early intervention approach to meet the needs of families.
	Work with state partners to analyze legislative/regulatory policies that inhibit and support the delivery of early intervention services and formation of early intervention agencies.
Work to ensure all children and families have access to high-quality comprehensive services.	Update the programmatic application processes and eligibility requirements to ensure continuity of services for low- and moderate-income families for all prenatal to five programs.
	Increase opportunities for families to choose early childhood services that meet their unique needs and are culturally responsive.

With these recommendations, the prenatal to five system can more accurately meet the needs of every child and family. This section presents the major findings of the study and the rationale that supports each recommendation shown in Table 19.

Recommendation 1:

Establish a comprehensive coordinated early childhood system that removes barriers for families, minimizes the burden on early care and education providers, and maximizes the use of available funding streams.

The comprehensive fiscal analysis considered barriers to efficient use of funds and future funding needs. The fiscal map analysis identified some areas where existing sources of funding can be utilized more fully. While these areas are not sufficient to address the major gaps between current funding and the true cost of quality services and infrastructure, they nonetheless affect families' and providers' experiences. Addressing these barriers can increase the effectiveness of current funding sources and lay the foundation for future investments.

For funding streams to be maximized, local agencies, organizations, service providers and partners must work together to build a coordinated and aligned system. This group must also work with state agencies to remove barriers for families to

access programs and services by simplifying the enrollment process and reducing the administrative burdens on families. Leaders must explore new financing strategies to improve quality and access to programs within the region.

Recommendation 2:

Implement a cost-based approach to rate setting and contracting for child care, home visiting, and parenting education.

To ensure that staff is making a living wage, reimbursement for services must align with the cost of services. Leaders within the region must also work together to explore and implement other strategies across organizations and support programs such as staffed family child care networks, shared services, and business training.

Recommendation 3:

Strengthen and expand access to prenatal to five services.

Overall, to increase availability and access to programs, the steering committee should work to increase awareness of the importance of prenatal to five services by developing a messaging and com-munication campaign. The committee should also support the development and implementation of supply building strategies reflective of local context. Additionally, working with state partners will be key to explore how licensing regulations in child care might be adjusted to allow for more viable business models.

Recommendation 4:

Develop a systematic approach to workforce development; a pipeline, training, and support of qualified staff for prenatal to five programs in the Adirondack region.

Across the CFA, all parties involved cited workforce as a key barrier to providing high-quality services, even when a living wage is offered. Attracting qualified staff to a rural area can be challenging; therefore, BT3 with input from its steering committee and members should work with higher education representatives to ensure prospective professionals have access to higher education within the field. Included in the advocacy and communications campaign referenced in recommendation 3 will be highlighting the lack of qualified workers and identifying priorities for attracting and maintaining quality service providers. Finally, working with state partners to ensure rates set based on the true cost of care will support increased compensation for all providers.

Recommendation 5:

Ensure access to early intervention services for all eligible children.

Increasing the awareness of the importance of early intervention along with the challenges of delivering this key service will be crucial in ensuring public will building. Developing a cost model specific to early intervention services will illustrate the need for a different early intervention approach. Finally, working with state leaders to analyze legislative and/or regulatory policies that inhibit the delivery of these important services will serve as a key strategy to support the delivery of early intervention.

Recommendation 6:

Work to ensure all children and families have access to high-quality comprehensive services.

Updating the programmatic application processes and eligibility requirements to ensure continuity of services for low- and moderate-income families for all prenatal to five programs can work to reduce the administrative burden on families when applying to multiple programs. Ensuring that families have choices that meet their unique needs as a family will also provide an avenue for some families who are not currently utilizing these important services.

VII. Conclusion

There is increasing recognition of the importance of the early years in a child's life to cognitive, social, and physical development, and in turn, lifelong success. At the same time, the professionals who care for and support young children and their families during these crucial early years continue to be undervalued and underpaid. Unlike in K-12 education, there has historically been limited societal commitment to investing in young children's development and learning.

One of the first steps to shifting this paradigm is to understand the true cost of quality care and services for young children, including a level of compensation for providers who recognize the importance of their contributions. This comprehensive fiscal analysis summarized the fiscal and structural requirements to build such a system in the Adirondack region. The cost models developed as part of this analysis are dynamic tools that can be used on an ongoing basis to estimate the cost of changes to salaries, quality enhancements, and changing costs over time. When paired with structural and policy improvements, they can be powerful tools to build the comprehensive, high-quality systems that young children and their families deserve.

By commissioning this report, the Adirondack Birth to Three Alliance Steering Committee and membership has shown commitment to understanding the change needed to build a prenatal to five system that meets the needs of children and families. The recommendations outlined in the report provide a roadmap for leaders to enact this change. To support their implementation, the P5FS team provided an action plan template for the Steering Committee to work through each of their recommendations. A sample of this action plan template is provided in the Appendix. Adirondack Birth to Three Alliance will ensure the region remains committed to moving these recommendations forward to improve the lives of young children and their families within the Adirondack region.

Appendix

A. List of interviews conducted to inform the analysis.

Name	Entity	Agency
Lynn Sickles	CCR&R	Southern Adirondack Child Care Network
Jamie Basiliere	CCR&R	Child Care Coordinating Council of the North Country, Inc.
Alan Jones	CCR&R	Adirondack Community Action Programs, Inc.
Linda Beers	Early Intervention/Maternal Child Health Block Grant	Essex County Public Health
Erik Mastrianni	Early Intervention/Maternal Child Health Block Grant	Warren County Public Health
Suzanne Boiling	Preschool Special Education	NYS Department of Education
Kathleen Strack	Early Intervention/Maternal Child Health Block Grant	Franklin County Public Health
Christa VanCour	Early Intervention/Maternal Child Health Block Grant	Clinton County Health Department
Debbie Collette-Cromp	Teaching Improves Performance (parenting ed and QRIS)	Early Childhood Professional Development
Roxanne Macaulay Westcott	Parenting Education	Cornell Cooperative Extension, Warren County
Esther Piper	Healthy Families North Country	Behavioral Health Services North

B. Steering Committee Members

The following are members of the Adirondack Birth to Three Alliance Steering Committee that supported the work of this comprehensive fiscal analysis

Name	Affiliation
Michelle Adkins	BUILD Capacity Hub
Jamie Basiliere	Child Care Coordinating Council of the North Country (CCCNC)
Linda Beers	Essex County Health Department
Christina Frederick	Franklin County Health Department
Cali Brooks	Adirondack Foundation
Roger Catania	New York State Board of Regents
Debbie Collette-Cromp	Independent Early Intervention Special Instruction Teacher
Bob Frawley	NYS Early Childhood Advisory Council, BT3 Volunteer Consultant
Rich Frost	Chapel Hill Foundation
Alan Jones	Adirondack Community Action Program
Erik Mastrianni	Warren County Public Health
Esther Piper	Behavioral Health Services North (BHSN) – Healthy Families North Country
Jennifer Russell	Adirondack Foundation
Kate Ryan	Adirondack Birth to Th ee Alliance – Adirondack Foundation
Margie Sander	Hamilton County Health Department
Christa VanCour	Clinton County Public Health

C. Adirondacks Draft Action Plan

Recommendation	Local Action	State Action	Timeline	Who:
1. Establish a comprehensive coordinated early childhood system that removes barriers for families, minimizes the burden on early care and education providers, and maximizes the use of available funding.	Create a cross-sector team to dissect fiscal map to ensure better alignment and blending of services.	Ask state advocates to prioritize the simplification of subsidy enrollment process statewide as part of the ongoing administrative/legislative agenda.	Establish group membership by March 1, 2024 First meeting April 2024	Steering Committee
2. Implement a cost-based approach to rate setting and contract for child care, home visiting, and parent education.	Advocate for additional county funding to fill in gaps between subsidy payment rate, parent co-pay, and the true cost of care. Host a regional event for local elected officials to unveil the cost model and discuss the need for better funding.	Work with state advocates to add paying for true cost of care to legislative agenda for 2025 and future agendas.	Work through summer to get leg agenda done by September	Subcommittee

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