

Understanding the New Hampshire Birth through Five System

A Needs Assessment

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Preface

In December 2018, New Hampshire was one of 45 states that received a federal Preschool Development Grant (PDG) Birth through Five (B–5) grant. The one-year planning grant provided federal funds of \$3.8 million for New Hampshire stakeholders to conduct a needs assessment and develop a strategic plan. As the PDG grantee, the University of New Hampshire (UNH) contracted with the RAND Corporation to support analytic aspects of the PDG B–5 Needs Assessment. UNH and RAND collaborated with state partners, including Spark NH, the New Hampshire Department of Health and Human Services (NHDHHS) and the New Hampshire Department of Education (NHDOE). Guidance for the needs assessment was provided by the PDG B–5 Needs Assessment Subcommittee and the PDG Leadership Advisory Team.

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Abbreviations

ACS	American Community Survey
B–5	Birth through Five
BLS	Bureau of Labor Statistics
CSCCE	Center for the Study of Child Care Employment
DCYF	Department of Children, Youth and Families
DSA	data sharing agreements
ECCE	early childhood care and education
ECIDS	early childhood integrated data system
ECIT	Early Childhood Integration Team
FANF	Financial Assistance for Needy Families
FCCH	family child care home
FCES	Family-Centered Early Supports and Services
FERPA	Family Educational and Privacy Rights Act
FRC	Family Resource Center
FPG	federal poverty guideline
FPL	federal poverty level
FRPL	free or reduced-price lunch
GAO	Government Accountability Office
GDP	gross domestic product
HIPAA	Health Insurance Portability and Accountability Act
IDEA	Individuals with Disabilities Act
IEP	Individualized Education Plan
KEA	kindergarten entry assessment
KRA	kindergarten readiness assessments
LEA	local education agency

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MOU	memorandum of understanding
NAEYC	National Association for the Education of Young Children
NASEM	National Academies of Sciences, Engineering, and Medicine
NHDHHS	New Hampshire Department of Health and Human Services
NHDOE	New Hampshire Department of Education
NHDoIT	New Hampshire Department of Information Technology
NHFV	New Hampshire Family Voices
NSCH	National Survey of Children's Health
PIC	Parent Information Center
PDG	Preschool Development Grant
QRIS	quality rating and improvement system
SAU	School Administrative Unit
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families
UNH	University of New Hampshire
USDHHS	U.S. Department of Health and Human Services
WIC	Special Supplemental Nutrition Program for Women, Infants and Children

1. Introduction

In recent years, leaders in the public and private sectors in New Hampshire have been charting a course to increase the state's investment in its youngest citizens: children from birth to kindergarten entry. This stems from the growing recognition that these earliest years in a child's life establish a foundation for healthy development cognitively, socially, emotionally, and physically. Furthermore, although New Hampshire's children are often assessed as being relatively well-off on average compared with their counterparts in other states (Annie E. Casey Foundation, 2019), a substantial share of the youngest children in the state face risks in the early years that can compromise their development, such as inadequate access to healthy food and nutrition, health care, and secure housing; and exposure to violence, family trauma, and addiction; among other life stressors.

To support this commitment and provide further momentum toward investing in the earliest years, New Hampshire was one of 45 states that received a federal Preschool Development Grant (PDG) Birth through Five (B–5) by the U.S. Department of Health and Human Services (USDHHS) in December 2018. The one-year planning grant required a comprehensive needs assessment that would support the development of a strategic plan for advancing the state's B–5 system.

Drawing on the federal USDHHS guidance (USDHHS, 2019-b), the PDG B–5 Needs Assessment has multiple objectives including to:

- Define the **B–5 system** and other key terms
- Describe the population of **vulnerable children** and **underserved areas**
- Identify the current **availability and quality** of early childhood care and education (ECCE) and other B–5 services
- Assess **barriers** to the funding and provision of high-quality ECCE
- Address supports and gaps for **transitions** between B–5 services and school entry
- Assess ECCE **facilities** and facility-related concerns
- Examine other topics including **governance, financing mechanisms, and data linkages**
- Identify **gaps in data or research** and strategies to fill the gaps.

Another key priority was to determine the unduplicated number of children being served in existing programs and the unduplicated number of children awaiting services in existing programs.

In undertaking the PDG B–5 components and the associated intensive focus on policies to support families with young children, stakeholders in New Hampshire have been guided by respect for the central role of the family and communities. Families are viewed as serving as both recipients and providers of ECCE in particular, within the larger system of B–5 supports. Thus,

stakeholders in the state have a commitment to strengthening the B–5 system, while also building the capacity of all families to be a part of that system of supports. In the remainder of this introduction, we describe the approach to the New Hampshire PDG B–5 Needs Assessment more fully.

Approach to the Needs Assessment

The first objective of the PDG B–5 Needs Assessment required defining key terms for New Hampshire such as the B–5 system, vulnerable or underserved families and children, children in rural communities, and other concepts such as access to services; the quality, availability, and affordability of ECCE; and equity. The definitions were developed through an iterative collaborative process involving leaders and staff in the New Hampshire Department of Health and Human Services (NHDHHS) and the New Hampshire Department of Education (NHDOE), as well as other stakeholders in the public and private sectors. The definitions were informed by prior needs assessments, current agency organizational governance and operational structures, and available data and measures.

To address the remaining key objectives of the PDG B–5 Needs Assessment, the research team adopted a multi-pronged approach that drew on multiple sources of information and used both qualitative and quantitative data. Table 1.1 summarizes the specific sources of information that were consulted or collected to address the essential questions of interest. As indicated in the table, by using multiple sources of information, we typically could draw on findings from more than one source in examining any given topic. For example, the existing data sources and key informant interviews conducted as part of the needs assessment allowed us to examine each of the priority topics. We also drew on newly collected primary data from focus groups with families with young children, a survey of parents, a survey of ECCE workforce members, and a survey of kindergarten teachers. The family focus groups and family survey centered on the first four topics related to family B–5 system experiences. The workforce survey had a specific focus on issues relevant for the workforce, in addition to what we learned from the first two sources. Likewise the kindergarten survey was designed to gain a teacher perspective on the transition to kindergarten (among other topics that the survey examined), as part of understanding the continuity of services from early childhood into the school-age years.

For the new data collection, the development of interview guides, focus group protocols, and survey questionnaires was guided by a set of priority topics associated with key stakeholders in the B–5 system that we aimed to learn about through the data collection. Table 1.2 summarizes the topics for each group—with some topics overlapping across groups—where the groups consisted of B–5 system state and local leaders; parents with children in the B–5 age range; leaders/providers of B–5 programs; staff in B–5 programs who work with children and their families; and local education agency (LEA) leaders.

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Table 1.1. Needs Assessment Topics and Information Sources

Topic	Existing Data	Key Informant Interviews (N=91)	Family Focus Groups (N=140)	Family Survey (N=1,278)	Workforce Survey (N=316)	K Teacher Survey (N=209)
Parent knowledge of B–5 system	X	X	X	X		
Family experience with access and quality	X	X	X	X		
Transition to kindergarten	X	X	X	X		X
Coordination/continuity in the B–8 system	X	X	X	X		
B–5 workforce	X	X			X	
B–5 facilities	X	X				
B–5 data systems and data integration	X	X				
B–5 system governance	X	X				
B–5 system financing	X	X				
Priorities for PDG B–5 strategic plan	X	X		X	X	

In the remainder of this section, we provide more detail on the resources we relied on, especially the components that involved new data collection.

Review of Extant Documents

A variety of resources were identified, inventoried, and referenced including prior research studies, needs assessments, and strategic plans; publicly available statistics and data; and public sector information (e.g., information on program funding and service statistics). Over 100 documents were catalogued and reviewed, with relevant findings incorporated into the needs assessment. In addition, where information collected in representative surveys was relevant for our topics of interest, those statistics, specific to New Hampshire, were assembled. For example, the American Community Survey (ACS) conducted by the U.S. Census Bureau provides information on school enrollment starting at age three and therefore captures representative data for New Hampshire on preschool enrollment patterns by child age and other characteristics such as family income.

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Table 1.2. Priority Topics for Data Collection Through Surveys, Interviews, Focus Groups

Stakeholder	Priority Topics
State and local leaders	<ul style="list-style-type: none"> • Perceptions of current B–5 system: strengths, weakness, opportunities, challenges (I) <ul style="list-style-type: none"> ○ Knowledge, access, and participation in B–5 system on part of families and children (I) ○ Barriers in the current system with respect to family knowledge, access, and participation and implications for equity (I) ○ Extent of services coordination and coordination gaps (e.g., child developmental screening and parental depression screening in pediatric practices) (I) ○ Current quality and quality gaps, including quality measurement and report and quality improvement supports (I) ○ Opportunities to support workforce professional development and address gaps (I) ○ Adequacy of funding (I) ○ Governance structures and strategies for reducing silos and increasing coordination (I) ○ Data systems and barriers and opportunities for integration ○ Ideas for solutions; reactions to strategies embodied in other plans (e.g., Spark NH <i>Framework for Action</i>) • Priorities for state strategic plan (I)
Parents with children in B–5 age range	<ul style="list-style-type: none"> • Respondent background and family characteristics, including work status (S, F) • Knowledge of specific B–5 services (S) • Having ever used specific B–5 services, including early learning programs prior to K entry (S) • Among families using the specified B–5 services, sources of information and referral to services (S, F) • Among families not using the specified B–5 services, reasons for no service use (S, F) • Factors affecting choice of the specified B–5 services, including sources of information (F) • Experience with service coordination (at a point in time or through time) (F) • Experience with the transition to K and continuation of supports (F) • Barriers to accessing B–5 services in general (S) • Barriers to accessing specific B–5 services (e.g., mental health services) (F) • Access to other family supports (e.g., paid sick days, paid or unpaid family leave) • Ideas for solutions; reactions to strategies embodied in other plans (F)
B–5 program leaders/providers	<ul style="list-style-type: none"> • Program features, B–5 services offered, numbers of children/families served (I) • Evidence of unmet need on part of children/families (e.g., size of waiting list) (I) • Own assessment of current program quality and barriers to increasing program quality (I) • Access to quality improvement supports and experience with supports (I) • Experience with workforce quality and retention/turnover (I) • Adequacy and sustainability of current public and private funding sources, including braiding/blending of funds (I) • Opportunities for more efficient use of resources (I) • Quality of current facilities and access to funds for quality improvement or expansion (I) • Experience with coordinating services with other parts of B–5 system (I) • Experience with accessing and using data systems (e.g., entering data in Welligent; using data to inform their work) • Ideas for solutions; reactions to strategies embodied in other plans (I) • Specific sector topics (I) <ul style="list-style-type: none"> ○ <u>Pediatric practices</u>: If conduct child developmental screening and tools used; If conduct screening for parental depression and tool(s) used; knowledge of specific B–5 systems/services and referrals to those programs; if they have the tools/knowledge to support young patients and their families

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Stakeholder	Priority Topics
B–5 program staff working with families and children	<ul style="list-style-type: none"> • Background on education and credentials, time in the field, position held, hours worked (S) • Support in the workplace for professional practice (e.g., planning time, reflective practice) (S) • Professional development opportunities provided, take-up of the options, and perception of effectiveness (S) • Adequacy of compensation (S) • Family income and use of social safety net programs to make ends meet (S) • Expectations regarding continuation in the field (S) • Ideas for solutions; reactions to strategies embodied in other plans (I)
LEA leaders	<ul style="list-style-type: none"> • Program features, B–5 services offered (focus on preschool special education, preschool, transition to K), numbers of children/families served (I) • Use of K readiness assessment, tool used, and results (published?); if assessment not conducted, estimate of children that are “ready” (I) • Estimate of children entering K that have never been assessed/received services for developmental delays or other disabilities • Evidence of unmet need on part of children/families (e.g., size of waiting list) (I) • Own assessment of current program quality and barriers to increasing program quality (I) • Access to quality improvement supports and experience with supports (I) • Experience with workforce quality and retention/turnover (I) • Adequacy and sustainability of current public and private funding sources, including braiding/blending of funds (I) • Opportunities for more efficient use of resources (I) • Quality of current facilities and access to funds for quality improvement or expansion (I) • Experience with coordinating services/activities with other parts of B–5 system, including private child care/preschool providers in community (e.g., shared professional development for early childhood educators) (I) • Ideas for solutions; reactions to strategies embodied in other plans (I)

NOTES: F = focus groups; I = interviews; S = survey.

Key Informant Interviews: State and Local Leaders, B–5 Program Leaders, LEA Leaders

A total of 91 interviews were conducted with key informants at the state or local level between June 2019 and August 2019 in three groups: state and local leaders knowledgeable about the strengths and limitations of the B–5 system in New Hampshire, directors and other leaders of specific B–5 system programs and services, and leaders of LEAs (e.g., district superintendents). The goal was to interview individuals from various sectors to capture a wide range of perspectives about the B–5 system, including the themes and priority topics in Tables 1.1 and 1.2. Individuals were identified by the project leadership and the project partners and advisory group members. Some of the phone and face-to-face interviews were conducted with just one key informant, while others were sessions with two or more informants. Twenty-eight sessions were held in total. See Appendix A for additional information about the interviewees who participated in the semi-structured interviews. The interview protocol is available in Appendix F.

Family Focus Groups

Sixteen focus groups were held in June and July 2019 with 140 parents or guardians of one or more children under age seven living in a diverse array of communities across New Hampshire (see Figure 1.1). Thirteen of the groups recruited participants from the local community and were selected to provide geographic variation. Together the 13 groups covered all major regions of the state. Further, to ensure that we had input from key vulnerable groups, another three focus group sessions targeted specific populations, namely nontraditional parents (e.g., foster parents, grandparents and other relatives), recent immigrants, and Spanish speakers.

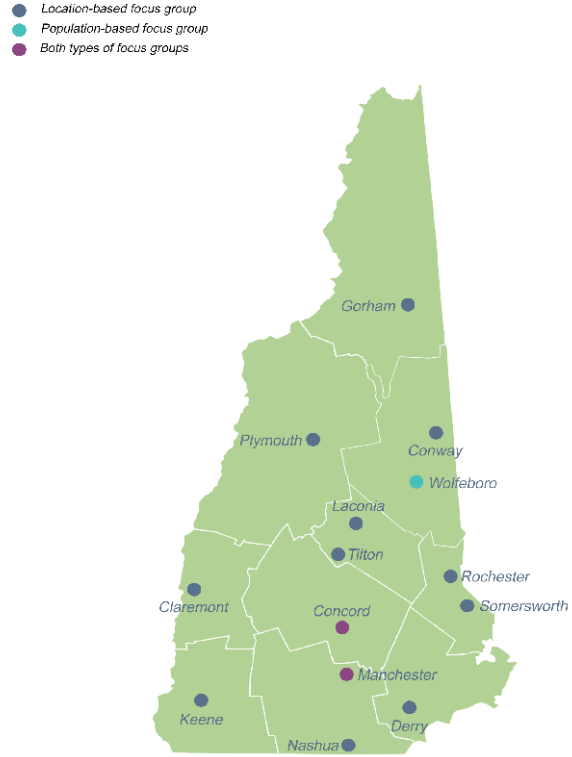


Figure 1.1. Location of 16 Family Focus Groups

New Hampshire Family Voices (NHFV) and the Parent Information Center (PIC)—two statewide organization with extensive networks for reaching families throughout the state—led the recruitment of focus group participants and conducted the focus group sessions. Prospective focus group participants who had seen or heard an announcement about a focus group session called a centralized number. Candidates were asked a series of questions to determine if they were eligible for a focus group, namely their age is 18 or over, they are currently the parent or primary caregiver for one or more children under age seven, and they are available to attend one of the sessions closest to them. The final number of participants ranged from 3 to 10 across the 16 groups.

Of the 140 participants, 8 were nontraditional parents (e.g., grandparent or other relative, foster parent), 16 identified as Hispanic or Latinx, 20 identified as nonwhite, 28 reported having a first language other than English, and 44 indicated that one or more of their children had special needs. Participants were diverse in terms of other characteristics such as education, family income, and employment status. All but 2 participants reported using at least one targeted or universal B–5 program. Compared with the statewide population of families with one or more children under age seven as measured in the ACS, the focus group participants were more likely to be in rural communities, to have somewhat younger children, to be Latinx or nonwhite, and to have lower family income (see Appendix A, Table A.3, for these comparisons). These differences are to be expected given the goal of having focus groups in each region (which

oversamples rural areas) and to capture diverse perspectives, especially from smaller groups in the overall population.

The focus group sessions followed a semi-structured protocol that addressed the key topic domains listed in Table 1.1 and the priority topics listed in Table 1.2. Participants received \$100 in recognition of their time. See Appendix A for additional information on the focus group settings and participants. The protocol that guided the discussions is included in Appendix F.

Family Survey

The PDG B–5 Family Survey was fielded online (by the University of New Hampshire [UNH] via Qualtrics) and using paper forms in July 2019. Given that no sampling frame was available, an invitation to complete the survey was distributed through various channels by UNH and other PDG partners, including NHFV and PIC. The survey topics reflected the range of themes and issues listed in Tables 1.1 and 1.2. The questionnaire was developed in English and translated into Arabic, Spanish, and Nepalese. Staff from NHFV and PIC also conducted outreach sessions at locations where parents congregate (e.g., libraries, grocery stores) in order to ensure broad representation among parents in the state. A total of 1,278 parents with one or more children under age seven responded to the online survey in English (1,222 in total, 967 with compensation and with 255 with no compensation), Spanish (5), and Nepalese (1). Another 50 respondents completed paper surveys, mostly in English. Most survey respondents received a \$20 store gift card in appreciation for their participation in the survey.¹

The resulting survey respondents should be viewed as a convenience sample. However, the respondents appear to be quite representative of families with young children in the state based on a comparison with the ACS (see the discussion in Appendix B). Notably, the survey sample is closely representative of families with one or more children under age seven in terms of the age of the youngest child, the age of the parent, parent gender, Latinx status, and rural status. The survey appears to somewhat overrepresent white families, families with higher parental education, and families in the middle of the income distribution but with differences that are close to the margin of error in the two surveys. The most substantial difference is the higher share of unmarried parents in the PDG B–5 Family Survey (39 percent) relative to the ACS (21 percent). In sum, where there are differences between the survey respondents and the population sampled, the parent respondents do not consistently overrepresent either the least advantaged

¹ The survey was advertised as providing a \$20 gift card for the first 1,000 respondents. During the first week that the survey was open, UNH detected suspicious survey responses that appeared to be providing invalid responses in order to obtain the gift card. Once the issue was detected, the gift card option was removed from the survey. In total 149 survey respondents were identified as suspect and purged from the valid data leaving 967 legitimate respondents who received the compensation. An additional 255 participants responded for no compensation. See Appendix B for additional information.

families or the most advantaged families as measured by marital status, parental education, or income.

Tabulations for survey respondents in total and disaggregated by the age of the youngest child, family income, and rural status are provided in Appendix B. The survey instrument is found in Appendix F.

Workforce Survey

The PDG B–5 Workforce Survey was also fielded online (by UNH using Qualtrics) in July 2019 with a focus on the themes and priority topics listed in Tables 1.1 and 1.2 specific to the B–5 workforce. In the absence of a ready sampling frame for the B–5 workforce, the survey was advertised in various digital forums and using other channels that would reach B–5 program directors, other administrators, and staff who work with children from birth to kindergarten entry in B–5 programs. A total of 316 valid responses were received, representing key positions in the field including program leaders and staff who work directly with children in early care and education settings, as well as home visiting, family support, and other B–5 programs.²

Like the family survey, the workforce survey provides a convenience sample but one that appears to have a reasonable representation of the B–5 workforce, although many occupations or sectors do not have sufficiently large numbers of respondents to support disaggregated analyses. Tabulations for survey respondents in total and disaggregated by the respondent’s position are provided in Appendix C. The survey instrument is included in Appendix F.

Kindergarten Teacher Survey

In a related effort, UNH fielded a survey of kindergarten teachers in New Hampshire in summer 2019. All kindergarten teachers in the 2018–2019 academic school year were invited to take the online survey (administered using Qualtrics) through an email communication directed to their school district superintendents. A total of 256 teachers responded, although 47 cases were excluded from the analysis because of invalid or incomplete information.³ This is out of an

² Like the family survey, an incentive of \$20 was initially offered, but later rescinded because of suspicious survey submissions. Once the issue was detected, the gift card option was removed from the survey. In total 261 survey respondent were identified as suspect and purged from the valid data leaving 316 legitimate respondents who received the compensation. See Appendix C for more information.

³ More specifically, 12 cases did not provide consent, 14 cases had little to no data, and 21 cases contained questionable data. For human subjects protection, all respondents were screened to confirm that they were age 18 or older, which would be expected for the population of kindergarten teachers.

estimated population of about 600 kindergarten teachers.⁴ Overall, the survey was designed to gauge kindergarten teachers' knowledge and use of indicators of kindergarten readiness, including kindergarten readiness assessment tools; the process of children and families transitioning to kindergarten; students' readiness for success in kindergarten; and experience with play-based kindergarten practices and classroom learning.

The portion of the survey regarding kindergarten readiness assessment tools and kindergarten transition practices was most relevant for the PDG B–5 Needs Assessment. Tabulations of the answers for the 209 respondents were prepared in aggregate, along with results disaggregated by the rural/nonrural status of the respondent's school district and the district percentage of students eligible for a free or reduced-price lunch (FRPL) relative to the state average. Findings were integrated into the analyses in Chapter 5, along with insights from the interviews with key informants, family focus groups, and family survey. Results for the questions referenced in the needs assessment are provided in Appendix D and the survey instrument is available in Appendix F. The full kindergarten teacher survey results are available in Henry et al. (2019).

Related Activities

In addition to the sources of information listed in Table 1.1, we drew on the work of NHDHHS and the UNH Research Computing Center staff, as part of the PDG B–5 funding, designed to assess the need for and strategies to advance an integrated B–5 data system. The needs assessment activities documented in this report independently addressed issues related to data systems in the context of services coordination, particularly as part of the key informant interviews (see Table 1.1). We also integrate findings from the related NHDHHS/UNH work (Ridgeway and Anderson, 2019).

Constraints and Limitations

The PDG B–5 Needs Assessment benefited from prior research and analysis for New Hampshire on key issues related to the B–5 system, as well as the new data collected to fill in gaps in the existing knowledge base. However, the timetable and available resources for the PDG B–5 Needs Assessment limited the options for extensive new qualitative and quantitative data collection. In particular, for each of the surveys, it was not feasible to undertake rigorous scientific sampling to produce a statewide representative sample of respondents, along with measures of the degree of uncertainty associated with any given survey result (e.g., estimates of standard errors). In the case of both the family survey and the workforce survey, there was not

⁴ This estimate is based on statewide kindergarten enrollment in New Hampshire of about 10,800 kindergarten students (average daily membership) in the 2018–2019 school year and an assumption of about 18 students on average in each kindergarten classroom. The study team did not have access to a centralized list of current kindergarten teachers statewide and their contact information.

sufficient time or budget to undertake a telephone poll or online survey for a randomly selected sample of the target population in the state, particularly without a current frame of the target population from which to sample. For example, there is no current source with contact information for all members of the B–5 workforce in New Hampshire from which respondents could be sampled. Thus, the PDG B–5 Needs Assessment surveys were implemented using convenience samples, although considerable outreach was conducted to ensure that the survey respondents were geographically dispersed and from diverse members of the target populations.

Although the interviews, focus groups, and surveys successfully gathered input from a geographically dispersed and diverse group of stakeholders in the state, the information primarily provides a statewide perspective on key aspects of the B–5 system. In some cases, we examined differences across rural versus nonrural communities and across certain demographic or economic subgroups, but the data collection was not designed to assess such differences in a rigorous way. Thus, there is some uncertainty in the statewide quantitative estimates based on the surveys, as well as any differences across population groups, given the absence of representative survey samples and the relatively small number of respondents in some subgroups. In addition, as is typical with data collection, the interview and survey data rely on the self-reports of stakeholders who voluntarily participated. Although we have no reason to expect bias in reporting, we did not seek to verify the accuracy of the responses provided.

Nevertheless, the data presented in this report provide valuable insights into the strengths and challenges of New Hampshire’s B–5 system from the perspectives of diverse stakeholders across the state. By drawing on multiple sources of information (see Table 1.1)—prior research, administrative data and statistics from population-based surveys such as the ACS, qualitative information from interviews and focus groups, and survey responses involving hundreds of respondents—and by triangulating our results, we are able to identify findings that are consistent across the available information sources and methods at the state level. Future qualitative and quantitative data collection within communities across the state defined by locale or population characteristics could provide a more nuanced understanding of how the nature of the B–5 system varies across the state and for different subgroups of families, providers, workforce members, and leaders.

Roadmap for Report

This PDG B–5 Needs Assessment report is organized by the key topics listed in Table 1.1. Before addressing these substantive issues, the next chapter focuses on defining the B–5 system and other key terms relevant for the needs assessment. The chapters that follow address: family knowledge of the B–5 system (Chapter 3), family experiences with access to and quality of B–5 programs (Chapter 4), the transition to kindergarten (Chapter 5), coordination and continuity of other services across the B–5 system (Chapter 6), B–5 system workforce (Chapter 7), B–5 system facilities (Chapter 8), B–5 system data systems and data integration (Chapter 9), B–5

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system governance (Chapter 10), and the adequacy and sustainability of current financing for the B-5 system (Chapter 11). A final chapter highlights the key findings and the implications for the B-5 system strategic plan.

2. Defining the B–5 System in New Hampshire and Other Key Terms

A key objective of the PDG B–5 planning grant was to focus on system building, using a broad conceptualization of the set of publicly funded supports and services for children ages zero through five and their families. This chapter provides a foundation for the remainder of the needs assessment by defining key concepts relevant for a systems-based orientation. Thus we begin by defining the set of programs and supports that constitute the B–5 system in New Hampshire. We take a broad-based approach that results in nearly 50 programs included in the system. These programs are mostly administered at the state level through NHDHHS and NHDOE, but several other programs that are administered at the national and local levels are captured as well.

In addition, as required under the needs assessment scope of work, we define other concepts including the population of *vulnerable children* and *children in rural areas*. Other key concepts that are defined include *access*, *quality ECCE*, *availability*, *affordability*, and *equity*. Another component of this chapter is reporting on efforts to estimate the unduplicated count of children receiving B–5 services and the count of the counterpart population that was not served.

B–5 System in New Hampshire

Following the USDHHS PDG B–5 Needs Assessment Guidance, the New Hampshire B–5 system was broadly defined to capture not only ECCE programs but also programs providing supports for children with disabilities and developmental delays, health care, behavioral health care, the child protection system, employment support programs, and economic assistance programs. These programs usually fall under NHDHHS or NHDOE, but we also looked to USDHHS and programs like Head Start, housing subsidies and supports administered by NH Housing, and publicly funded preschool programs funded by New Hampshire LEAs.

Figure 2.1 provides a visual representation of the resulting array of publicly funded programs at the federal, state, or local levels in New Hampshire, here organized into the following eight themes: environmental health, safety, food and nutrition, employment and income, health and well-being, housing stability, transportation, and education. (Note that some programs are listed under more than one theme, when relevant.) The resulting 48 unique programs are listed in Tables 2.1 and 2.2 based on the department and agency where the program is housed. In addition, the tables denote, for each program, the broad class of services provided and whether the funding stream supports direct services, provides subsidies for goods and services, issues cash or in-kind transfers, or provides various types of infrastructure support. The age range of children served by the program is indicated, along with whether the program is targeted or

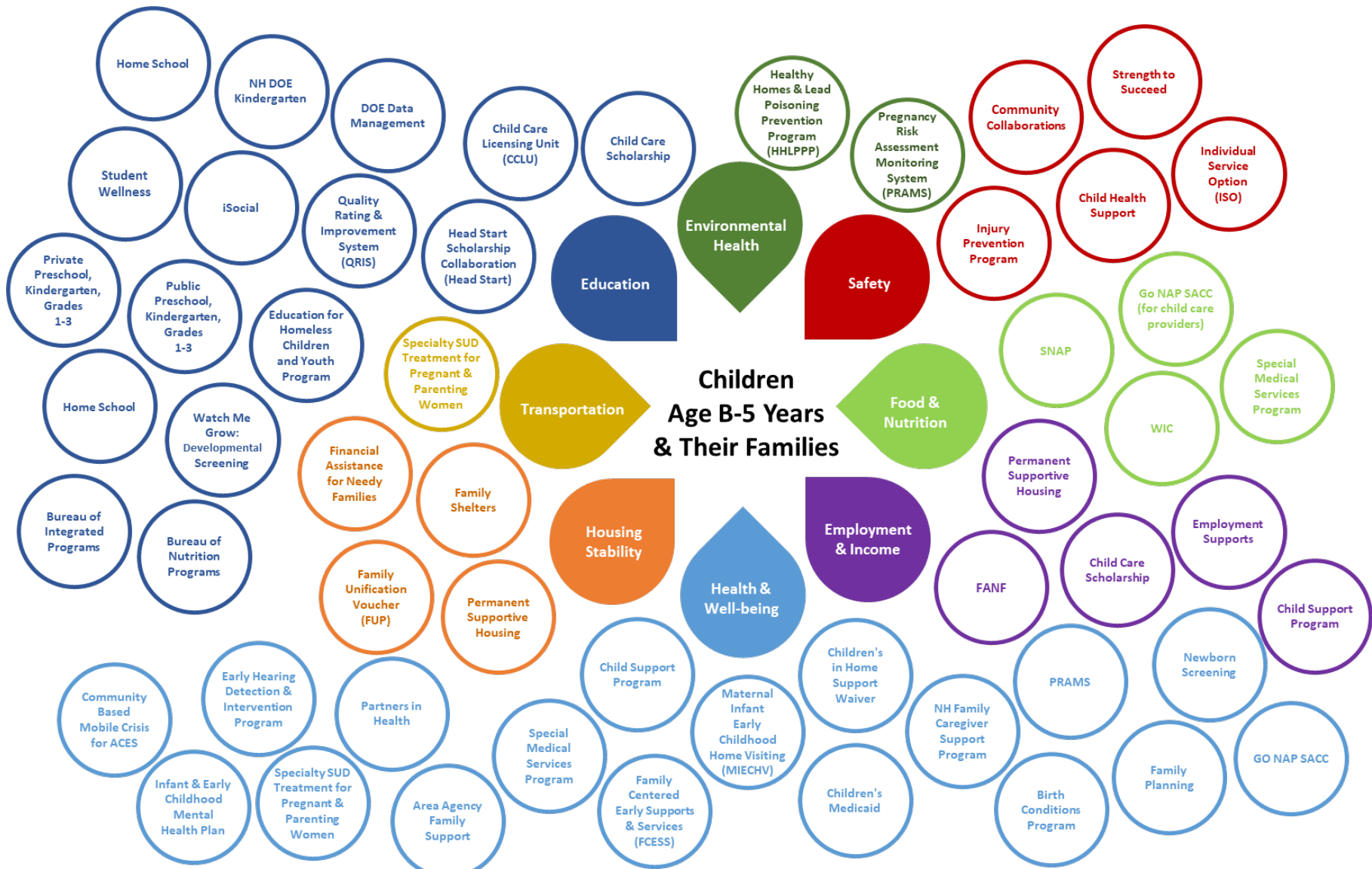
universal. The sources of public funding—federal, state, or local alone or in combination—are also noted.

Table 2.1 features 17 programs and 4 infrastructure supports that are specific to ECCE from birth to kindergarten entry; specialized services for young children with disabilities or development delays; home visiting starting as early as the prenatal period; services for pregnant women, birth outcomes monitoring, and newborn screenings; and other early family supports and services delivered in the first five years.⁵ All of the Table 2.1 programs, with the exception of Child Care Scholarship, serve children in the B–5 period exclusively. These programs include the federally funded Early Head Start and Head Start program, Child Care Scholarship, Family-Centered Early Supports and Services (FCESS) (Individuals with Disabilities Act [IDEA], Part C), Preschool Special Education (IDEA, Part B), Title I funds which may be used for preschool education, and preschool programs funded by LEAs. Infrastructure supports generally do not provide services and supports directly to children and their families, but rather support the B–5 system through licensing, workforce credentialing, quality assurance, data systems, and so on. With the exception of the universal monitoring and screening programs (e.g., Pregnancy Risk Assessment Monitoring [PRAMS], Watch Me Grow), the remaining Table 2.1 ECCE and related B–5 programs are typically targeted to low-resource and at-risk children in the early years. Further, for the direct service programs, most of the public dollars come from the federal government, with relatively less funding at the state level (Karoly, 2017).

Table 2.2 summarizes an additional 31 non-ECCE programs and 5 related infrastructure supports. This includes the broader set of programs that serve children from birth through adulthood, as well as children in the school-age years, either as the direct focus of a program or indirectly through supports and services for their families. Some extend their services and supports until children reach age 21. The Table 2.2 list includes various health care and prevention programs, behavioral health care programs, supports for children with disabilities or at risk of developmental delay, CPS, employment supports, and cash and in-kind economic assistance programs (e.g., Temporary Assistance for Needy Families [TANF], also known as Financial Assistance for Needy Families [FANF]). Table 2.2 captures both universal and targeted programs, where the eligibility requirements for the latter are tied to low income or those involved in with the Department of Children, Youth, and Families (DCYF). For most of these programs, the share of funding or the share receiving services attributable to the B–5 age groups is not readily known, largely because administrative data systems do not support disaggregation of funding or service statistics for these programs by age. This precludes generating an estimate of the total funding available for B–5 programs and determining the federal, state, and local shares.

⁵ The division of programs into the groups in Tables 2.1 and 2.2 represent just one way to configure the 48 programs identified for the B–5 system in New Hampshire. Other groupings are possible.

Figure 2.1. Conceptual Map of B-5 System



**Table 2.1. B–5 System Programs Active in State Fiscal Year 2019 Targeted to B–5 Population (including Support for Parents/Guardians),
By Federal, State, and Local Government Entity**

Program	Classification	Type	Ages Applies To	Targeted or Universal	Funding Source(s)
NHDHHS, Division of Public Health Services, Bureau of Population Health and Community Services					
Maternal Infant and Early Childhood Home Visiting (MIECHV)	Health Care (Prevention)	Direct services	Prenatal to 3	Targeted, parents and children in families at risk	Federal
Early Hearing Detection and Intervention (EHDI)	Health Care (Prevention)	Direct services	0	Universal	Federal
Newborn Screening	Health Care (Prevention)	Direct services	0	Universal	Federal
Pregnancy Risk Assessment Monitoring (PRAMS)	Health Care (Prevention)	Direct services	0	Universal	Federal
Birth Conditions Registry and Referrals	Health Care (Prevention)	Direct services	0 to 3	Universal	Federal
Women, Infants and Children Food and Nutrition Service (WIC)	Health Care (Prevention)	Direct in-kind transfer	0 to 5 (and pregnant women)	Targeted, income up to 400% of FPG	Federal
NHDHHS, Division of Behavioral Health, Bureau of Drug and Alcohol Services					
Specialty Substance Use Disorder (SUD) Treatment for Pregnant and Parenting Women	Behavioral Health System	Direct services and subsidized services	0 to 5	Targeted, receiving SUD treatment and income up to 400% of FPG	Federal
NHDHHS, Division of Long Term Supports and Services, Bureau of Special Medical Services					
Watch Me Grow: Developmental Screening System	Health Care (Prevention)	Direct services	0 to 5	Universal	Federal, state
Family-Centered Early Supports and Services (FCESS) (IDEA, Part C)	Support for Children with Disabilities/Developmental Delays	Direct services	0 to 3	Targeted, children with identified disabilities, with developmental delay(s), or who are at risk of developmental delay	Federal, state
USDHHS, Office of Head Start					
Early Head Start	ECCE	Direct services	0 to 3	Targeted, income up to 100% of FPG ^a	Federal
Head Start	ECCE	Direct services	3 to 5	Targeted, income up to 100% of FPG ^a	Federal

Program	Classification	Type	Ages Applies To	Targeted or Universal	Funding Source(s)
NHDHHS, Division of Economic and Housing Stability, Bureau of Family Assistance					
Child Care Scholarship (CCDF program)	ECCE	Subsidy for services	0 to 13	Targeted, income up to 220% of FPG at entry (up to 250% at redetermination)	Federal, state
NHDHHS, Division of Economic and Housing Stability, Bureau of Child Development and Head Start Collaboration					
Head Start Collaboration Office	ECCE	Infrastructure	0 to 5	Not applicable	State
Child Care Scholarship Quality Set Aside (CCDF program)	ECCE	Infrastructure	0 to 13	Not applicable	Federal, state
State QRIS	ECCE	Infrastructure	0 to 13	Not applicable	Federal, state
NHDHHS, Bureau of Facility Licensing and Certification, Office of Legal & Regulatory Services					
Child Care Licensing Unit	ECCE	Infrastructure	0 to 13	Not applicable	Federal, state
NH LEAs					
Other Public Preschool (e.g., LEA funded)	ECCE	Direct services	3K to 4K	Targeted or universal	Federal, local
NHDOE, Division of Learner Support, Bureau of Integrated Programs					
Helping Disadvantaged Children Meet High Standards (Title I, Part A)	ECCE, Transition	Direct services	3K to 12	Targeted, high-need school districts	Federal
NHDOE, Division of Learner Support, Office of Special Education					
Preschool Special Education (IDEA, Part B 619)	ECCE, Support for Children with Disabilities/ Developmental Delays	Direct services	3K to 4K	Targeted, children with identified disabilities	Federal, local
iSocial (part of IDEA, Part B 619)	ECCE, Support for Children with Disabilities/ Developmental Delays	Direct services	3K to 4K	Targeted, children with identified disabilities	Federal
NHDOE, Division of Learner Support, Office of Nutrition Programs and Services					
Child and Adult Care Food Program (CACFP)	ECCE	Direct in-kind transfer	All ages	Targeted, low income	Federal

SOURCE: Program websites, documentation, and discussions with NHDHHS and NHDOE staff.

^a Under the Head Start Act of 2007, programs have the option to serve a limited number of families with incomes over 100 percent of FPG.

**Table 2.2. Other B–5 System Programs Active in State Fiscal Year 2019 (including Support for Parents/Guardians),
By Federal, State, and Local Government Entity**

Program	Classification	Type	Ages Applies To	Targeted or Universal	Funding Source(s)
NHDHHS Division of Public Health Services, Bureau of Public Health Protection					
Healthy Homes and Lead Poisoning Prevention Program	Health Care (Prevention)	Direct services	0 to 18	Targeted, children with elevated blood lead level	Federal, state
NHDHHS, Division of Public Health Services, Bureau of Population Health and Community Services					
Family Planning (Title X)	Health Care (Prevention)	Direct services	Not applicable	Universal	Federal
Community Collaborations to Strengthen and Preserve Families	Health Care (Prevention)	Direct services	0 to 8	Universal, in two targeted communities	Federal
Injury Prevention	Health Care (Prevention)	Direct services	0 to 18	Universal	Federal
NHDHHS, Division for Children, Youth & Families, Bureau of Child Protective Services					
Child Protection Services	CPS	Direct services	0 to 18	Targeted, children involved with DCYF	Federal, state
NHDHHS, Division for Children, Youth & Families, Bureau of Family, Community & Program Support					
Child Health Support	Behavioral Health & CPS	Direct services	0 to 18	Targeted, children involved with DCYF	Federal, state
Home Based Therapeutic (HBT)	Behavioral Health & CPS	Direct services	0 to 18	Targeted, children involved with DCYF	State
Individual Service Option (ISO)	Behavioral Health & CPS	Direct services	0 to 18	Targeted, children involved with DCYF	Federal, state
Strength to Succeed	Behavioral Health & CPS	Direct services	0 to 10	Targeted, children involved with DCYF and parent/caregiver has SUD	Federal, state
NHDHHS, Division of Long Term Supports and Services, Bureau of Special Medical Services					
Special Medical Services (SSA, Title V)	Health Care	Direct services	0 to 21	Targeted, children with special health care needs	Federal, state
Partners in Health (part of Special Medical Services)	Health Care	Direct services	0 to 21	Targeted, children with special health care needs	Federal
Area Agency Family Support	Support for Children with Disabilities/Developmental Delays	Direct services	0 to 21	Targeted, families of children with special health care needs	Federal, state

Program	Classification	Type	Ages Applies To	Targeted or Universal	Funding Source(s)
Division of Long Term Supports and Services, Bureau of Developmental Services					
Children's in Home Support Waiver	Support for Children with Disabilities/Developmental Delays	Direct services	0 to 21	Targeted, children with special health care needs	Federal, state
NHDHHS, Division of Economic and Housing Stability, Bureau of Family Assistance					
Comprehensive Family Support Services (CFSS)	Healthcare (Prevention)	Direct services	0 to 21	Universal	Federal, state
Supplemental Nutrition Assistance Program (SNAP)	Economic Assistance	Direct in-kind transfer	0 to 18 (in families)	Targeted	Federal, state
Children's Medicaid	Healthcare Economic Assistance	Subsidy for services	0 to 19	Targeted, income up to 196% of FPG	Federal, state
TANF–Family Assistance Program	Economic Assistance	Direct cash transfer	0 to 18 (in families)	Targeted	Federal, state
TANF–Emergency Assistance Program	Economic Assistance	Direct cash or in-kind transfer	0 to 18 (in families)	Targeted	Federal, state
TANF–Nutritional Supplement for Working Families (NNSWF) Program	Economic Assistance	Direct in-kind transfer	0 to 18 (in families)	Targeted	Federal, state
TANF–New Hampshire Employment Program (NHEP)	Employment Support System	Direct services	0 to 18 (in families)	Targeted	Federal, state
NHDHHS, Division of Economic and Housing Stability, Bureau of Housing Supports					
Permanent Supportive Housing	Economic Assistance	Direct in-kind transfer	0 to 18 (in families)	Targeted	Federal
Family Shelters	Economic Assistance	Direct service	0 to 18 (in families)	Targeted	State
NHDHHS, Division of Economic and Housing Stability, Bureau of Child Support Services					
Child Support Program	Economic Assistance	Direct services	0 to 18 (in single-parent families)	Universal	Federal, state
NHDHHS, Bureau of Quality Assurance and Improvement					
Data Analytics	B–5 System	Infrastructure	0 to 18	Not applicable	Federal, state

Program	Classification	Type	Ages Applies To	Targeted or Universal	Funding Source(s)
NHDOE, Division of Learner Support, Bureau of Integrated Programs					
Homeless Children and Youth (Title X, Part C)	Transition	Direct services	K to 12	Targeted, high-need school districts	Federal
Education of Migratory Children (Title I, Part C)	Transition	Direct services	K to 12	Targeted, high-need school districts	Federal
Preparing, Training and Recruiting High Quality Teachers and Principals (Title II, Part A)	Transition	Infrastructure	K to 12	Targeted, high-need school districts	Federal
NHDOE, Division of Learner Support, Office of Nutrition Programs and Services					
National School Lunch Program (NSLP) (and related school-age nutrition programs)	ECCE, Transition	Direct in-kind transfer	K to 12	Targeted, low income	Federal
NHDOE, Division of Learner Support, Bureau of Instructional Support and LEAs					
K-3 Education	Transition	Direct services	K to 3	Universal	State, local
NHDOE, Division of Learner Support, Office of Student Wellness/School Health					
Student Wellness/School Health Programs	Transition	Direct services	K to 12	Universal	State
NHDOE, Bureau of Certification Credentialing					
Certification Credentialing	Workforce	Infrastructure	K to 12	Universal	State
NHDOE, Division of Educator Support and Higher Education					
Certification and Higher Education Commission	Workforce	Infrastructure	K to 12	Universal	State
UNDOE, Division of Education Analytics and Resources, Bureau of Education Statistics and Bureau of Data Management					
Data Management	3K-12 Education	Infrastructure	K to 12	Universal	State
NH Housing, Assisted Housing Division					
Section 8 Housing Choice Voucher (HCV) Program	Economic Assistance	Direct in-kind transfer	0 to 18 (in families)	Targeted, low income	Federal
Family Self-Sufficiency (FSS) Program (part of HCV) (also called GOAL Program)	Economic Assistance	Direct services	0 to 18 (in families)	Targeted, low income	Federal
Emergency Housing Services	Economic Assistance	Direct services	0 to 18 (in families)	Targeted, low income	Federal, state

SOURCE: Program websites, documentation, and discussions with NHDHHS and NHDOE staff.

Almost all these B–5 system programs are administered through either NHDHHS or NHDOE. One exception is the federally funded Head Start and Early Head Start programs which are administered by the federal government with grants directly to Head Start providers. Preschool programs funded by and administered through LEAs are another exception. The governor-appointed early childhood advisory council, the Council for Thriving Children, is another component in the B–5 governance structure, not depicted in Figure 2.1 or Tables 2.1 or 2.2.⁶

The Council for Thriving Children is the cornerstone of a change in the ECCE governance in New Hampshire to formalize governance at the state and regional/local levels and to engage stakeholders with defined roles and a shared vision. The ECCE system is further supported by the NHDHHS and NHDOE Early Childhood Integration Teams (ECITs), which support data driven policy and program coordination, integration, and development, while increasing performance and resource accountability across the ECCE system. The ECITs comprise staff from both agencies that directly administer or support early childhood programs, as well as parents, local program or education partners, and local/regional early childhood and public health coalitions. The ECITs coordinate across departments working in collaboration to expand boundaries and silos and seek to create a joint Office of Early Childhood Care and Education.

In addition, the Council for Thriving Children and ECITs are further supported by the ECCE stakeholders through the creation of the B–8 ECCE Advisory Team and the Early Childhood Experts Team. The B-8 ECCE Advisory Team is led by a parent-affiliated entity selected by NHDHHS and NHDOE and consists of parents, representatives from legislative or membership entities, providers, advocates, and other stakeholder groups. The B-8 ECCE Advisory Team is tasked with sharing emerging trends for children, families, communities, workers, and businesses, while generating learning and capacity across the ECCE system. The Early Childhood Experts Team is led by UNH and includes higher education, representatives from local and regional Early Childhood and Public Health Coalitions, and specialized entities such as the New Hampshire Pediatric Society. The Early Childhood Experts Team’s focus is to support system strengthening through the sharing of research and best practice, while also deepening connections to and within regions and local communities.

Vulnerable/Underserved Children and Children in Rural Communities

According to five-year estimates from the 2017 ACS, New Hampshire has approximately 79,000 children ages 0 through 5, or an average of about 13,000 children in each annual age

⁶ As of January 2020, Governor Sununu established the Council for Thriving Children to serve as New Hampshire’s early childhood advisory council, replacing the former council, Spark NH, in that role (New Hampshire Governor’s Office, 2020).

cohort. The PDG B–5 Needs Assessment required developing a definition of vulnerable or underserved families and children, as well as children in rural communities. We discuss the definitions that were developed for these two groups and the estimates of the relevant count and share of the B–5 population represented by these groups.

Vulnerable or Underserved Families and Children

For purposes of the PDG B–5 Needs Assessment, the term for *vulnerable or underserved families and children* was defined as follows:

Vulnerable or underserved families and children are not connected to, do not have access to, or do not have information on the supports and services they need in their natural environments.

Generating a specific population count for this conceptual measure of vulnerable or underserved families and children requires additional specificity. In later chapters, we examine results from the PDG B–5 Family Survey to gain insight into the percentage of families with knowledge and information gaps about key B–5 programs or who do not have access to B–5 services for which they may qualify. Here, we examine the size and population share of specific populations that are likely to meet this definition of vulnerable or underserved. This analysis examines one characteristic at a time and thus does not reflect the multiplicity of factors that may mean that families or young children would be identified as vulnerable or underserved. Nevertheless, it is important to understand the number of families and young children affected by specific conditions that are expected to place them at higher risk for being vulnerable or underserved as defined above. We focus on five illustrative groups: children living in poverty, children living with disabilities, families and children experiencing homelessness, children with incarcerated parents, and children experiencing adverse childhood experiences (ACEs). Where possible, the figures we present are specific to the B–5 population. Table 2.3 summarizes the indicators we examine and the associated estimates.

Table 2.3. Indicators of Disadvantage for Children Ages 0 through 5 in New Hampshire

Indicator	Year of Measurement	Estimated Number of Children Ages 0 through 5	Estimated Percentage of Children Ages 0 through 5
Poverty status			
Family income below FPL	2017	9,550	12.1
Family income below 250% of FPL	2017	30,020	38.0
Family income below 300% of FPL	2017	35,900	45.4
Children with special health care needs	2017–2018	7,270	9.2
Children living with homelessness	2017–2018	3,790	4.8
Children ever having an incarcerated parent	2017–2018	2,290	2.9
Children experiencing one or more of 8 ACEs	2017–2018	22,910	29.0
Children experiencing one or more of 9 ACEs ^a	2017–2018	29,860	37.8

SOURCES: Authors' analysis of sources cited in the text.

NOTES: The estimated number of children is rounded to the nearest 10s. Where percentages were calculated, they

were based on an estimated total population of children ages 0 through 5 of 79,000.

^a The 9th measure is one of experiencing economic hardship.

Poverty Status. An extensive body of research documents that experiencing low family resources, especially in the early years of life, can compromise a child’s development, with the potential for life-long consequences for health and well-being (Duncan, Ziol-Guest, and Kalil, 2010). Five-year estimates from the 2017 ACS for New Hampshire indicate that about 12 percent of children ages 0 through five (or about 9,600 children) were living in families with income below the federal poverty line (FPL) (see Table 2.4).⁷ Given the high cost of living in New Hampshire, the income required for a family to meet their basic needs and to be self-sufficient (i.e., not dependent on any government assistance) is about 2.5 to 3.0 times the FPL (New Hampshire Policy Institute, 2016; Karoly, 2017).⁸ With this in mind, as of 2017, about 30,000 children or 38 percent of the population of children age five and younger had family income below 250 percent of FPL. About 45 percent of these young children have family income below 300 percent of FPL (see Table 2.4). Thus, in New Hampshire, nearly half of all children live in families with income that does not ensure that their families can meet their basic needs on their own, including paying for food, housing, health care, and child care. These children and their families are expected to be less likely to be connected to or able to access the B–5 services they need compared with children and families with higher income.

⁷ The FPL income cutoffs used by the U.S. Census Bureau to estimate the poverty rate varies with family composition. For 2017, the FPL was \$16,895 for a family with one adult and one child and \$24,858 for a family with two adults and two children. (For the complete set of FPL income cutoffs by family size, see U.S. Census Bureau, 2020.) The FPL differs from the FPG established by USDHHS to determine eligibility for federal programs, although the FPG and FPL cutoffs are within a few hundred dollars in any given year.

⁸ For example, according to the Economic Policy Institute (2020) Family Budget Calculator, as of 2017, a family with one adult and one child living in the Manchester metro area required an annual income of \$61,876 to fully meet their basic needs for housing, food, transportation, health care, child care, other necessities, and taxes without any government support. The equivalent budget for the same family living in Coös County in that year was \$50,893. These family budget estimates are 3.7 and 3.0 times the 2017 FPL, respectively, for a family with that configuration. When the same ratio is computed for a family with two adults and two children in the same two New Hampshire communities, the ratios are 3.4 and 2.9 times the FPL, respectively (based on self-sufficiency budgets of \$83,721 and \$71,237 for Manchester and Coös County, respectively).

Table 2.4. Estimated Distribution of Children Ages 0 through 5 in New Hampshire by Income Relative to the FPL (2017)

Indicator	Children Ages 0 through 5		
	Number	Percentage	Cumulative Percentage
Total	79,007	100.0	100.0
By family income relative to FPL			
<100 percent of FPL	9,551	12.1	12.1
100–199 percent of FPL	13,969	17.7	29.8
200–249 percent of FPL	6,497	8.2	38.0
250–299 percent of FPL	5,886	7.4	45.4
300 percent and above	41,710	52.8	98.2
Missing	1,394	1.8	100.0

SOURCES: Authors' analysis of the 2013–2017 ACS PUMS.

NOTES: Percentage distributions might not total 100 percent because of rounding.

^a Indicates imputed estimate rounded to nearest 10.

Children with Disabilities. Children with a physical, mental, or behavioral disability or other conditions that may affect their healthy development, are a population that would ideally be readily identified and engaged to receive relevant supports and services. Information on the number of young children in New Hampshire with identified disabilities or at risk of developmental delay can be gleaned from the National Survey of Children’s Health (NSCH), a periodic national survey which provides estimates at the state level (Child and Adolescent Health Measurement Initiative, undated). As of 2017–2018, the NSCH reports that 9.2 percent of New Hampshire children ages zero through five were identified as having special health care needs, which includes a variety of diagnosed health conditions, including behavior problems and developmental delay. That percentage increases as children age, reaching about 29 percent for children ages 6 to 11. About 20 percent of the B–5 age group was reported to have one or more functional disabilities according to the NSCH. Based on these prevalence rates, about 7,300 New Hampshire children ages zero through five would be classified as having special health care needs and nearly 16,000 would have at least one functional disability.

Children Living with Homelessness. Experiencing homelessness in the early childhood years can compromise healthy development (Yamashiro and McLaughlin, 2019), placing children in greater need for supports and services for themselves and their families. Information on the population that is homeless or without stable housing, especially disaggregated by age, is not routinely collected in New Hampshire.⁹ Yamashiro and McLaughlin (2019), using a special methodology, report that an estimated 3,790 children in New Hampshire under age 6 experienced homelessness as of 2016–2017 or about 5 percent of the B–5 population.

⁹ NHDOE does report annually the count of children, by school district, that are identified as experiencing homelessness. However, this is not cover the population of children from birth through age five.

Experiencing homeless, for purposes of this estimate, includes children lacking a fixed, regular, and adequate nighttime residence; living in a public or private place not designed for human beings (e.g., a car, park, or abandoned building); living in a temporary shelter, including hotels, motels, and transitional housing; living in housing that will imminently be lost (e.g., those about to be evicted or sharing temporarily with others), or fleeing violence.

Children with an Incarcerated Parent. Having an incarcerated parent is considered one of the ACEs that together are associated with adverse consequences in terms of health and other aspects of well-being in adulthood (Felitti and Anda, 2010).¹⁰ Estimates reported by the State of New Hampshire Office of the Child Advocate (2019) indicate that about 1,500 New Hampshire children of all ages were known by authorities to have one or more parents in prison as of March 1, 2019. Viewed across the early childhood years, the 2017–2018 NSCH indicates that 3 percent of New Hampshire children from birth through age five had ever experienced having a parent in jail (Child and Adolescent Health Measurement Initiative, undated). Applied to the total population of children in this age group, this equates to about 2,300 young children ever having this experience. Regardless of the prevalence, this is a more readily identifiable population that can be engaged with B–5 services.

Children Experiencing ACEs. The indicators already covered focus on specific indicators of risk that may identify young children and their families who are vulnerable or underserved. However, many children and their families will experience multiple risk factors at a point in time or over time. One way to capture exposure to multiple disadvantages is the measure of ACEs discussed earlier. The 2017–2018 NSCH indicates that nearly 3 out of 10 children (29 percent) under age six have experienced one or more of eight specific ACEs at some point during their early years (Child and Adolescent Health Measurement Initiative, undated). The more prevalent of these ACEs include ever experiencing divorce or separation of a parent or guardian (20 percent); living with anyone who had a problem with alcohol or drugs (9 percent); and living with anyone who was mentally ill, suicidal, or severely depressed (9 percent).¹¹ If the ninth ACE which measures exposure to economic hardship—defined as being “hard to cover the basics like

¹⁰ ACEs include experiencing extreme economic hardship, experiencing family disorder leading to parental divorce or separation, living with someone who had an alcohol or drug problem, being a victim of or witness to neighborhood violence, living with someone who was mentally ill or suicidal, witnessing domestic violence in the home, having a parent who served time in jail or prison, being treated or judged unfairly due to one’s race or ethnicity, and experiencing the death of a parent. A growing body of research documents a relationship between ACEs and measures of adult health and well-being.

¹¹ The remaining ACEs cover witnessing domestic violence (4 percent), experiencing a parent or guardian who died (4 percent), experiencing a parent or guardian spending time in jail (3 percent), experiencing being a victim or witness of neighborhood violence (2 percent), and being treated or judged unfairly because of his/her race or ethnic group (2) percent.

food or housing, on the family’s income”—is included, the percentage of young children in New Hampshire experiencing one or more ACEs rises to 38 percent.

Children in Rural Communities

For purposes of the PDG B–5 Needs Assessment, the definition of rural when assigning *children in rural areas* was as follows:

Children in rural areas include those living in a town or city with a population of 10,000 people or fewer and a density of 150 people or fewer per square mile.

This definition of rural versus nonrural corresponds to the one used by New Hampshire’s Regional Public Health Network, the system established by NHDHHS to align public health priorities across the state into an integrated system. NHDHHS provided the needs assessment team with a file linking New Hampshire zip codes with the associated rural/nonrural designation. This same linkage was used in analyzing data from the PDG B–5 Family Survey and the PDG B–5 Workforce Survey in order to examine survey tabulations separately for respondents in rural and nonrural communities.

Based on this definition and using five-year 2017 ACS data, an estimated 27 percent of New Hampshire children birth through five reside in a rural area as defined above. A similar estimate resulted when using 2018 population data from the New Hampshire Office of Health Statistics and Data Management, part of NHDHHS.¹²

Access to and Quality of Early Childhood Care and Education

The PDG B–5 Needs Assessment also required defining additional key terms as follows:

¹² The estimate provided by the NHDHHS Office of Health Statistics and Data Management showed 26.3 percent of children birth to 5 lived in rural areas as of 2018.

- **Access.** Families are connected to and engaged in information, services, and resources that meet their needs and preferences across available environments.
- **Quality ECCE.** Child development and learning, family engagement, family and child health and wellness are optimized by: ensuring family voice, perspective, and lived-experience are at the forefront of all work; ensuring evidence-informed, strengths-based, play-based, and trauma-informed strategies; integrating systems, programs and services; and consistently evaluating for positive family outcomes.
- **Availability.** Home, child care, and school environments are equipped to support the needs of the child and their families by: balancing availability to support all families in their choice of environment; prioritizing affordability and equity; and ensuring funding is available for families to receive supports/service
- **Affordability** Out-of-pocket expenses/forgone earnings are compared to overall family income, number of subsidies, and funding available; maintaining respect and recognition for families who chose home-based ECCE due to lost wages.
- **Equity.** All children and families have the supports, services, and resources to thrive; barriers that prevent all families and children from thriving are identified and eliminated.

This set of concepts do not lend themselves to ready measurement given existing data and information. Thus, in designing interview and focus group protocols and the family and workforce surveys as part of the needs assessment, these concepts were addressed in various ways such as asking about periods in the last year when care could not be obtained and the reasons why. Likewise, in asking about participation in various B–5 programs, those not using programs were asked about the factors that affected their use including reasons related to access, quality, availability, affordability, and equity. In this way, the needs assessment was able to delve deeper into these key issues using both qualitative and quantitative data.

Estimating Unduplicated Numbers of Children/Families Served and Waiting for Services

The federal PDG B–5 Needs Assessment Guidance requested identifying “to the extent possible, the unduplicated number of children being served in existing programs and the unduplicated number of children awaiting service in such programs” (USDHHS, 2019-b, p. 1). Given the multiple publicly funded B–5 programs in New Hampshire, such an estimate requires the ability to link administrative records on participating children and families across programs within the same agency (e.g., MIECHV and FCESS both administered within NHDHHS), across programs in different agencies (e.g., IDEA Parts B and C administered respectively by

NHDHHS and NHDOE), and across programs administered by nonstate agencies (e.g., Head Start administered through federal grants directly to grantees in New Hampshire or district-funded preschool programs administered by local school districts). If administrative linkages could be made to measure program participation across multiple B–5 programs, a count of the “unduplicated number of children being served in existing programs” would be relatively straightforward to produce.

Generating a count of the “unduplicated number of children awaiting service in such programs” would also require knowing either the count of children or families seeking to participate in a program but who could not be served (e.g., if funding was limited) or the count of all potentially eligible children, regardless of whether families expressly sought to enroll. In general, programs do not track the number of families who did not receive services through a waiting list or some other mechanism. Given that many of the B–5 programs listed in Table 2.1 are targeted to a specific population defined by low family income, a child’s disability status, or other child or family characteristics, demographic data may be required to determine the size of the potentially eligible population. The number receiving services could then be subtracted from the potentially eligible population to arrive at an estimate of the number who are awaiting services.

For reasons discussed further in Chapter 9, the ability to link the required administrative data in New Hampshire is currently limited, especially for programs administered by different agencies. In the remainder of this section, we first feature estimates from a pilot effort to produce an unduplicated count of children ages 0 to 3 participating in FCESS and the Child Care Scholarship program. This estimate was possible because both FCESS and Child Care Scholarship are administered by NHDHHS.

Unduplicated Count of Participants in FCESS and Child Care Scholarship

The unduplicated number of children younger than age three being served by FCESS or the Child Care Scholarship program—both administered by NHDHHS—was estimated to be 6,643 as of 2018–2019 (see Table 2.5). That total consists of about 3,900 children served by FCESS only, about 2,500 children served by Child Care Scholarship only, and just over 300 children served by both programs. Notably, there is relatively little overlap between the two programs: the 300 children participating in both programs represent about 5 percent of the unduplicated count. This is not surprising given the different populations that are served by the two programs. In particular, FCESS serves children with identified disabilities, with developmental delay(s), or who are at risk of developmental delay. The program is open to all age-eligible children regardless of family income. Only a subset of those served by FCESS would also qualify for Child Care Scholarship, which requires family income below 220 percent of the federal poverty guideline (FPG) at application and 250 percent of FPG at redetermination. The 8 percent of FCESS participants who also receive Child Care Scholarship is below what we might expect given that up to 38 percent of children 0 to 5 would be eligible for Child Care Scholarship based

only on family income (see Table 2.4). Likewise, among low-income families receiving Child Care Scholarship, only those with identified disabilities or who are at risk of developmental delay would also be eligible for FCESS. The 12 percent of those receiving a Child Care Scholarship who also receive FCESS services is consistent with estimated rates of disabilities among young children (see the earlier discussion in this chapter).

Given estimates of the size of the population under age three potentially eligible for FCESS (namely children with an identified physical or mental health condition, assumed to be 12 percent) and those potentially eligible for Child Care Scholarship (namely those with family income up to 220 percent of FPG, estimated to be 38 percent), we conclude that up to 6 percent of eligible children are not being served by FCESS. The comparable figure for Child Care Scholarship is that 80 percent of potentially eligible children are not served.

Table 2.5. Unduplicated Counts and Potentially Eligible Population for Children Young Than Age 3: FCESS and CCS (2018–2019)

Indicator	FCESS	CCS	Unduplicated Count
Count of children young then age 3 (N)			
FCESS only	3,860	0	3,860
CCS only	0	2,454	2,454
FCESS and CCS	329	329	329
Total	4,189	2,783	6,643
Estimated eligible population (N)	4,458	14,118	–
Estimated unserved population (N)	269	11,335	–
Estimated percentage of population unserved (%)	6.0	80.3	–

SOURCE: Participant counts: NHDHHS tabulations of administrative data for June 2018 to June 2019. Estimated eligible population: 2013–2017 ACS.

NOTE:– = not applicable.

3. Family Knowledge of the B–5 System

Family engagement with B–5 programs starts with knowing about the available programs and services. This requires having trusted, up-to-date information on programs that families can readily access in real time. The sources of information that parents rely on, their ease in accessing those sources, and whether the information is provided in a culturally and linguistically sensitive manner are critical factors in understanding the extent to which families are aware of the options available to them and participate in the programs for which they are eligible. This can be an overlooked issue when examining the array of B–5 services available in a state or locality and the patterns of family participation in those programs.

Thus, as a starting point for the needs assessment, this chapter centers on family knowledge of the programs in the B–5 system as defined in the prior chapter.¹³ (Families’ experiences with accessing services and the quality of those services are considered in the next chapter.) We present qualitative and quantitative information on the extent of family knowledge of specific B–5 programs, the sources of information that families rely on, and the difficulties, if any, that families experience in accessing the available information. We start in the next section by reviewing prior initiatives on this topic for New Hampshire. Indeed, family knowledge of the B–5 system has been an understudied issue in past needs assessments and other investigations. We then turn to key insights obtained from the data collection activities carried out for this needs assessment, namely key informant interviews, family focus groups, and the PDG B–5 Family Survey.

Background on Family Knowledge of B–5 Programs in New Hampshire

As part of past needs assessments in New Hampshire, barriers associated with gaps in parent knowledge have been recognized as critical issues to address. For example, improving parent education and knowledge was one of the stated goals for Claremont, Mt. Washington Valley and Carroll County, and Rochester in a 2017 strategic planning process (New Hampshire Listens, 2017). This resulted from considering the question: “What resources are hardest [for families] to find and understand?” (New Hampshire Listens, 2017; p. 4). The need for current, centralized information sources is referenced in the Spark NH *Promising Practices Guide* (Spark NH, 2018) and *Framework for Action* (Kieschnick and Milliken, 2019). Efforts to implement New Hampshire 211 as a phone and online resource, Family Resource Centers (FRCs) as knowledge

¹³ As part of our data gathering through interviews, focus groups, and surveys, we did not address knowledge of or participation in the child welfare system, given the sensitivity of that topic.

hubs, and the use of the app-based tool, Vroom!, are illustrative examples of the initiatives to address this issue. These and other initiatives also serve to strengthen families' knowledge of child development across relevant domains in the early years, the role of families in supporting their child's growth in each domain, and the value of early childhood programs and services to further support families in their primary role as children's first teachers.

At the same time, there is little systematic information about the knowledge that New Hampshire families have of the B–5 system and how that understanding varies across families according to their circumstances. This motivated a focus on this issue as part of the needs assessment data gathering activities.

Insights from Key Informant Interviews, Family Focus Groups, and the Family Survey

Overall, participants in all stakeholder interview sessions (29 of 29 sessions) discussed families' knowledge of the B–5 system. Interviewees who spoke to this topic included state and local leaders, service providers (including child care providers, health care providers, community organizations that provide a variety of services, and social service providers, such as NHDHHS) and LEA leaders. In addition, participants in all of the family focus groups discussed their knowledge of various programs and services that constitute the B–5 system and where they access information about early childhood services. Participants in all family focus groups talked about these issues, including parents in urban and rural settings, nontraditional parents (e.g., foster parents, grandparents, and other relatives), non-English speaking parents, and parents of children with special needs.

Finally, the PDG B–5 Family Survey included a series of questions asking respondents if they had ever heard of specific B–5 programs.¹⁴ (In the next chapter, we report on responses to subsequent survey questions about participation in each of the programs covered.) Survey respondents were also asked to indicate their primary sources of information about ECCE programs in particular. Full tabulations of responses to the survey questions are included in Appendix B, including results for subgroups of respondents defined by the age of the youngest child, family income group, and rural versus nonrural location. When viewing survey results, it is important to keep in mind that some parent subgroups are somewhat underrepresented, including families with lower parental education, families in the bottom and top of the income distribution, two-parent families, and nonwhite families. But other subgroups of parents are well represented such as subgroups defined by child age, parent age, parent gender, and Latinx status. Thus, a

¹⁴ We did not include questions in the survey about knowledge of more generic programs such as child care and early learning programs. Questions on the use of these programs were included and discussed in Chapter 4.

fully representative sample may produce somewhat different estimates for statewide averages, but the patterns across subgroups are likely to hold.

Drawing on these sources of information, we identified a series of key findings.

Families' Knowledge of B–5 Programs Varies by Program Type and Family Circumstances

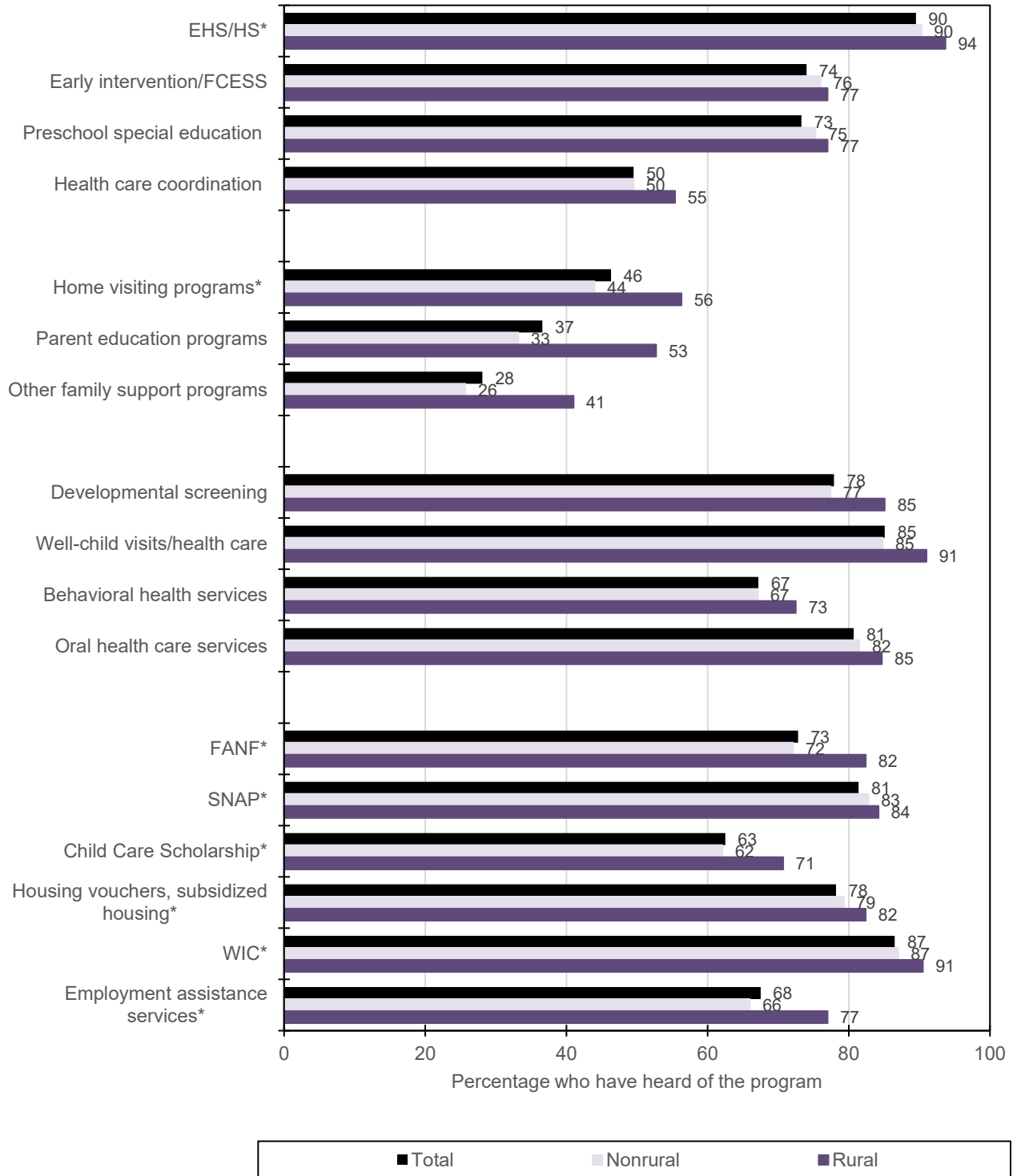
Among the B–5 programs included in the survey, respondents were most knowledgeable about Early Head Start and Head Start, with about 90 percent of survey respondents indicating that they had ever heard of the programs (Figure 3.1). Overall awareness was almost as high for the WIC program (87 percent). Both of these programs are targeted to lower-income families as part of the social safety net (those programs listed in Figure 3.1 with an asterisk), but the high level of awareness may reflect the fact that they are long-standing components of the safety net programs, especially Head Start. SNAP and subsidized housing are other targeted safety net programs with a high-level of awareness (nearly 80 percent). In contrast, it is notable that awareness of the Child Care Scholarship program was the lowest among the means-tested programs: fewer than two-thirds of survey respondents indicated that they had heard of the program. Awareness is nearly as low for employment assistance programs.

Among the universally available programs, about 4 in 5 respondents indicated they had ever heard of developmental screening, well child visits/health care, and oral health care. About 3 in 4 respondents had heard of early intervention/FCESS, and preschool special education. Knowledge of health care coordination services for children with special health care needs such as Partners in Health, home visiting programs, parent education programs, and other family supports was considerably lower (28 to 50 percent of survey respondents had heard of these programs).

For most programs, knowledge was somewhat higher for respondents in rural communities compared with nonrural areas (Figure 3.1), which likely reflects higher poverty rates in rural communities. Program knowledge tends to increase with the age of the youngest child, which is consistent with parents gathering more information about available programs over time (Tables B.4, B.8, B.10, and B.12).

Programs that target low-income children and families such as Early Head Start and Head Start and the various means-tested programs tend to be better known among families with lower income compared with their higher-income counterparts (Tables B.4, B.8, B.10, and B.12). For example, awareness of home visiting programs reaches 51 to 52 percent for lower- and middle-income respondents, respectively, compared with 39 percent for higher-income respondents. Awareness of FANF is 84 percent, 76 percent, and 65 percent in moving from lower-, to middle-, to higher-income families. In other cases, such as preschool special education, knowledge is highest for the higher-income respondents (78 percent) compared with those with lower income (69 percent). Developmental screening is one service that has a similar rate of awareness among survey respondents across income levels (77 to 80 percent).

Figure 3.1. Percentage of Survey Respondents Reporting They Have Heard of Specific Programs: Total and by Nonrural/Rural Subgroups



SOURCE: PDG B-5 Family Survey, Table B.4 in Appendix B.

NOTES: Responses are tabulated for all 1,278 family survey respondents. Program names with an asterisk are targeted to lower-income children and families. Abbreviations: EHS = Early Head Start; HS = Head Start.

Most Families Learn About B–5 Services from Multiple, Mostly Informal Sources

According to respondents to the PDG B–5 Family Survey, the most prevalent sources that families turn to first to learn about ECCE resources are primarily informal: family or friends (78 percent), Google search (63 percent), and Facebook or other social media outlets (53 percent) (Table B.14).¹⁵ Far less common as a top-choice resource is the use of official sources such as a New Hampshire state-run website (31 percent) or provider-based sources such as a local community organization (16 percent). Fewer than 10 percent of respondents selected 211 New Hampshire—the online and phone-based resource for state residents initiated by Granite United Way—as a top-three choice.

The reliance on friends and family as the dominant source of information is consistent regardless of the age of the youngest child, family income, and rural status, albeit with small differences across groups. Respondents in rural communities were somewhat less likely to rely on the informal sources (i.e., family/friends, Google, and social media) and somewhat more reliant on the official sources or providers (i.e., 211, state-run websites, and local community organizations). In contrast, higher-income respondents compared with their counterparts with lower income made more use of informal sources, while reporting lower rates of use of more official resources. Use of 211 New Hampshire is higher as the age of the youngest child increases.

These findings from the PDG B–5 Family Survey were reinforced during the focus group discussions. A majority of families who participated in the focus groups reported acquiring information through multiple informal sources, such as word-of-mouth, bulletin board postings, parent groups, social media, and/or online research. These reports are consistent with state and local leaders’ and providers’ understanding of how families access information about B–5 services. Other sources of information mentioned by interviewees that may or may not be accurate included service providers such as child care providers, pediatricians, medical specialists, therapists, school staff (depending on age of child), FRCs, state agency staff, and case workers. Many families who participated in the focus groups reported receiving information from all of these sources but said that there was no central repository of information that met their needs and no one to help them navigate the system. As one family member said, “Do you know if they have like advocates or ombudsmen for Early Head Start and early intervention? ...Because when you try to navigate all these systems, it’s impossible.”

Stakeholder interviews reinforced this point. State and local leader and provider interviewees noted that channels of communication, particularly among providers, and between providers and parents, are not always consistent throughout the state because some providers are not always

¹⁵ Respondents were asked to name the three most common sources of information they used among a list of seven options.

well-informed and do not always share information with families. Interviewees reported that the ability of pediatricians, child care organizations, and schools to share accurate information with families and to make helpful referrals depends, at least in part, on those groups networking with other service providers, which does not routinely happen.

These same interviewees believed that the extent to which families were well-informed about B–5 services varied depending on several factors—parental income level, current use of services—particularly child care, region of residence, their pediatrician’s level of knowledge about services, and type of service. Interviewees also generally agreed that vulnerable families were most at risk for gaps in knowledge. As one leader said, “...most families do not know about the services that are available, and there’s no obvious way to learn about them unless you know who to ask. If a parent is lucky enough to happen upon providers who know, they’ll get the services.”

Consistent with this view, some families among the focus group participants reported having more knowledge of the B–5 system than others. Specifically, families who were already engaged with the system—such as those with case workers, who were brought into the system through FCESS, who had children with complex medical needs, or who already used social services—reported having the most information. Guardians and parents who homeschooled their children, as well as parents in rural areas (particularly Conway and Plymouth), reported having the least information about the B–5 system. As one guardian said, “Guardianship is literally just a piece of paper that says you’re [a child’s] legal guardian. It doesn’t tell you where to go to get day care assistance, it doesn’t tell you any of those things.”

Families Had Difficulty Finding Information About ECCE and Other Early Childhood Services

According to the families in our focus groups, finding information about services in the B–5 system was time-consuming and required both a computer and computer skills, assets not everyone has. Although many families reported that they were able to access the Internet from their smartphones, they added that some program and provider web sites were difficult to navigate on a small screen. Further, lack of access to printers made it difficult for families to print necessary materials, such as enrollment forms. Although a lack of internet access was not specifically mentioned as a barrier to accessing information, families did report challenges with accessing information electronically.

More generally, family focus group participants reported that it was difficult to find information about most B–5 programs. For example, many families reported that B–5 program staff—across a range of programs—would often not return their calls and could not answer their questions. Families that needed more services, such as those with children with special needs or complex medical conditions, or those in need of financial support programs, engaged with the system more and thus faced more challenges to finding information and accessing benefits. One bright spot was reported experiences with WIC: many participants reported that information on

WIC was easy to find, staff were helpful, and that they often received such information from multiple sources. As one parent recounted, “I learned about WIC from the hospital when I gave birth to my kids. I learned about WIC from the doctor’s office. I learned about WIC walking in for fuel assistance.”

The state and local leaders and providers we interviewed believed that information about healthy child development, information about services for children with disabilities, eligibility for financial assistance, and how to apply for financial assistance were the topics that were most difficult for parents to understand. However, most family focus group participants reported they had the most trouble understanding information on insurance choices in the context of health-related services and coverage, and program eligibility and application requirements. Healthy child development was an area where a few families wished for more information, but in general, the challenges families experienced related to accessing information rather than difficulty understanding information. In the experience of one family,

“My daughter just turned 19 and she was on the state insurance and we just got a notice in the mail saying she didn’t have insurance. And when we called the number to try to find out what our options were, we got no information. They wanted her to pay some ridiculous price that she couldn’t afford, because she works. She provides her own income to a certain amount. She can apply [for state insurance] on her own, so she did, but then that kicked my other kids out of the insurance. So there was just no clear answer of the best way to handle it.... just no information whatsoever.”

Families Suggested Several Ways to Improve Access to B–5 System Information

During the family focus groups, participants referenced options for improved information access, including an up-to-date online database of information on available services; people who can help caregivers in person, such as a county intake officer, referral office, or family navigator; physically posting information in places parents frequent, such as schools, libraries, pediatrician offices, town halls, recreation centers, and stores; mailers; and placing advertisements on local TV networks and in local newspapers. Similarly, state and local leaders and providers believed that building relationships and cultivating an environment in which parents felt comfortable asking questions was an important strategy for building parent knowledge. Families in our focus groups, however, reported they did not have trouble asking questions but instead felt like the information they got from their providers was not helpful. As one parent said, "There’s a disconnect between the provider and what they’re telling patients, and then what’s reality and going on in our homes."

Providers and state and local leaders believed that a single, easily-accessible source of information, such as an improved 211 system or outreach coordinator, was the preferred strategy to improve parent knowledge. Interviewees acknowledged the challenges of implementing these solutions effectively and noted that any materials (online or hard copy) that are provided should

be at the appropriate literacy level and translated into multiple languages. Among families who participated in the focus groups, however, some reported that 211 was not easy to use or up to date, although a few found it helpful. Similarly, the NH Easy portal was viewed positively by a few participants, but most found it difficult to use. One caregiver described it as “anything but easy.” The families in our focus groups described the information they could find as not centralized, uncoordinated, difficult to understand, and at times, conflicting. In the words of one family member:

“We do have a one stop shop phone number, the 211. But, you know, even with that you get no information. They’re like, “Oh, you can call this person, or I can send you to this.” That’s why I’m calling you, because you’re supposed to be able to answer these questions. A lot of information on 211 is also outdated.”

Implications for the Strategic Plan

Qualitative and quantitative information examined in this chapter demonstrate important gaps in the extent to which New Hampshire families are aware of the array of B–5 programs that may support them and their young children. Throughout the interviews with state and local leaders and providers and the family focus group sessions, the relationship between information and access emerged as a common theme. Most families in the focus groups reported they were not well informed about available services or how to access them, particularly those in more-vulnerable groups, such as guardians and parents of children with special needs or complex medical conditions. Similarly, many stakeholder interviewees believed that families who had trouble accessing information about services often faced similar challenges accessing the services themselves. The responses from the PDG B–5 Family Survey participants further suggest that parent knowledge of specific programs varies considerably, both in aggregate, and to some extent by family circumstances, such as the age of the youngest child, family income, and rural status. The relatively low rate of knowledge among survey respondents of key B–5 programs such as home visiting, parent education, and Child Care Scholarships merits further attention.

Families’ reliance on informal sources of information such as family and friends and internet searches likely reflects the limitations of official resources such as the 211 website and provider-based information brokers. New Hampshire has already invested in formal resources to support the information needs of parents. The strategic plan can continue this focus by assessing the progress and effectiveness of initiatives to date and refining approaches as needed to ensure that they effectively and efficiently deliver the accurate, culturally and linguistically appropriate information that parents need to assess the opportunities and resources available to them. Learning from best practices implemented in other states would further benefit New Hampshire’s efforts.

The same channels that provide information on B–5 services could be used to share more general resources for families of young children, such as education-oriented materials describing children’s developmental trajectories across relevant domains; opportunities for parents to support their children’s cognitive, social, and emotional progress through developmentally appropriate activities; and other supports that promote families as their children’s first teachers.

4. Family Experiences with Access to and Quality of B–5 Programs

As defined in Chapter 2, two key aspects of B–5 programs and services are access and quality. Access to B–5 programs, for purposes of this needs assessment, means that families are connected to information, services, and resources that meet their needs and preferences (see Chapter 2). Knowledge of B–5 programs, discussed in the prior chapter, is one aspect of access. In this chapter, we further operationalize the concept of access by examining the extent to which parents report participating in specific B–5 programs and the factors that appear to affect their participation. We also consider the extent to which access patterns differ for publicly funded targeted programs—which are often not fully funded to serve all eligible families—and public and private programs available to all age-eligible children and their families, but which may not be affordable for lower-income families.

Experiences with quality—defined for this needs assessment as having multiple features, from family voice to evidence-informed practice—is captured through information provided by parents who participated in focus groups and the family survey on such topics as what they look for with respect to program quality. The key informants interviewed also provided context regarding the quality of B–5 programs in the state. By examining differences in access and quality by family income level and rural/nonrural status, we contribute to our understanding of equity in the context of B–5 program and service utilization.

With this focus, we start the chapter with a brief synthesis regarding prior efforts to understand access and quality issues in New Hampshire for B–5 services. We then incorporate key findings from interviews with varied stakeholders, the family focus groups, and the family survey on these issues of access and quality. We also integrate other information sources as appropriate, such as information on preschool participation for three- and four-year-olds based on representative ACS data. In the two chapters that follow, we consider aspects of access and quality in the context of coordination and continuity of B–5 programs, starting first with the transition to kindergarten (Chapter 5), followed by coordination and continuity of other B–8 services (Chapter 6).

Background on Family Experiences with Access to and Quality of B–5 Programs in New Hampshire

Issues of access to and quality of B–5 services have previously been examined in New Hampshire. For example, estimates for New Hampshire indicate that 70 percent of B–5 children have all available parents in the labor force, suggesting that the vast majority of families with young children need care to allow the parents to work (Károly, 2017). At the same time, Child

Care Aware of America (2019-b) estimates that New Hampshire needs an additional 22,000 licensed child care spaces to meet the care needs for the 53,000 children under age six with all parents in the labor force. Mapping supply and demand demonstrates that gaps in care access occur in both urban and rural parts of the state (Child Care Aware, 2019-b). Furthermore, the price of child care relative to family income, especially in single-parent families, is one of the highest across the states (Child Care Aware of America, 2019-a).

Increases in funds for the Child Care Scholarship program supported with federal and state monies can address the affordability issue for the lowest-income families, but funds are not sufficient to reach all eligible families. For example, as of 2015, estimates indicate that available Child Care Scholarship funds in New Hampshire were covering about 17 percent of children ages zero to five with family income below 200 percent of FPL and an even smaller share of eligible families, which extends up to those with income below 250 percent of FPL (Karoly, 2017). Likewise, the federally funded Head Start slots in New Hampshire as of 2015 could serve about 40 percent of three- and four-year-old children in families with income below the poverty level, the population that the program is designed to serve. Special education preschool services are available to New Hampshire for children with disabilities, prior to kindergarten entry, through federal funding under IDEA Parts C and B. At the same time, New Hampshire does not allocate state funds to make subsidized preschool more widely available for families that would choose to enroll their typically developing children in a preschool program but cannot afford the full cost on their own and are not able to qualify for or access one of the limited federally subsidized options (Friedman-Krauss et al., 2020).

As noted in Karoly (2017), New Hampshire has limited information on the quality of B–5 services. With respect to the quality of ECCE programs, the state quality rating and improvement system (QRIS) is currently under revision. The system, in place since 2005, differentiates between three quality tiers. All programs that meet state licensing requirements are in the first tier. Licensed providers may apply to be in a second tier known as Licensed Plus. Programs with this designation have been evaluated on eight categories based on a document review; no observational assessment of program quality is made, as is common with many other state QRISs (BUILD Initiative, 2019). Licensed programs that are accredited by the National Association for the Education of Young Children (NAEYC) are assigned to the top tier.

As of 2018, among licensed center-based programs serving young children (including Head Start programs), about 65 percent (345 programs) were at the lowest tier (licensed), 24 percent (125 programs) at the middle tier (Licensed Plus), and 11 percent (57 programs) at the top tier (accredited) (BUILD Initiative, 2019).¹⁶ Almost no family child care home (FCCH) providers have attained the top two rating tiers. Thus, little is known about quality, beyond licensing, for

¹⁶ These counts do not include licensed family child care providers or school-age only providers.

the vast majority of ECCE providers. And there is no systematic measurement or monitoring of quality in other B–5 service areas.

Insights from Key Informant Interviews, Family Focus Groups, the Family Survey, and Other Sources

Participants in 27 of the 28 stakeholder interview sessions (representing 90 out of 91 interviewees) discussed access to and the quality of programs and services in the B–5 system. Participants who spoke to these topics included state and local leaders, service providers (including child care providers, health care providers, community organizations that provide a variety of services, and social service providers, such as NHDHHS) and LEA leaders. State and local leaders' comments about access to and the quality of services focused largely on ECCE, as did the comments of ECCE service providers. Some comments made by other providers (e.g., pediatricians, FRC staff) focused on the quality of the services they provided, but these comments were relatively sparse.

In addition, participants in most of the family focus groups discussed all of the following topics: access to services within the B–5 system, barriers to accessing those services, and how they define high-quality services. These discussions involved focus group participants from diverse circumstances in urban and rural settings, along with families that may be more vulnerable such as nontraditional parents, non-English speaking parents, and parents of children with special needs. Focus group participants reported numerous challenges when describing their experiences accessing B–5 services in New Hampshire. Families also described several bright spots, and reported positive experiences with WIC, FRCs, most ECCE providers, home visiting services, and individual providers across a variety of services.

Further, the PDG B–5 Family Survey included questions about the use of an array of particular B–5 services, specifically for the respondent's youngest child (under age seven), both ever having used the program since the reference child was born and used in the past 12 months. Survey respondents were also asked to select the top reasons for not participating in various types of B–5 programs and services. Other questions delved into more detail about experiences with ECCE (discussed in this chapter), the transition to kindergarten (discussed next in Chapter 5), and developmental screening (discussed in Chapter 6 as part of service coordination). As noted earlier, the survey respondents somewhat underrepresent some groups of families with young children (e.g., families with lower parental education, families in the bottom and top of the income distribution, two-parent families, and nonwhite families), but subgroups of parents are well represented (e.g., subgroups defined by child age, parent age, parent gender, and Latinx status). Thus, a fully representative sample may produce somewhat different estimates for statewide averages, but the patterns across subgroups are likely to hold.

Finally, we examine one secondary data source, the ACS, which includes a question on enrollment in school for children ages 3 and older. We use the latest ACS data for New

Hampshire, pooled for survey years from 2013 to 2017 to estimate the early education participation rate overall for three- and four-year-olds in the state and how participation varies by family income relative to the FPL.

We first discuss themes that emerged from these information gathering activities related to accessing B–5 services, before turning to considerations of program and service quality.

Findings Regarding Access to B–5 Programs and Services

Family Survey Responses Indicate Varied Participation in B–5 Programs and Services, in Part Because Some Programs Are Targeted Based on Income or Other Factors

As noted in Chapter 3, there is tremendous variability in the awareness that parents have of the array of early childhood programs and other family supports. The PDG B–5 Family Survey also showed varied rates of participation in B–5 programs, reflecting in part that many programs are designed to target the lowest-income families or are for other targeted populations (e.g., children living with disabilities).

For example, although Early Head Start and Head Start were the most recognized programs (Figure 3.1), just 8 percent of survey respondents reported that their youngest child had ever attended either Early Head Start, Head Start, or both (Table B.4). When restricted to five- and six-year-olds, the Head Start participation rate reached 15 percent; the participation rate was 14 percent among survey respondents with lower income. More generally, for the set of targeted B–5 programs, participation rates reached a maximum of about 23 percent in the case of WIC, the program with one of the broadest eligibility criteria in terms of family income and with the most expansive funding to serve the potential participants (Figure 4.1). For these programs, participation rates generally tend to decline with income, consistent with their targeted nature.

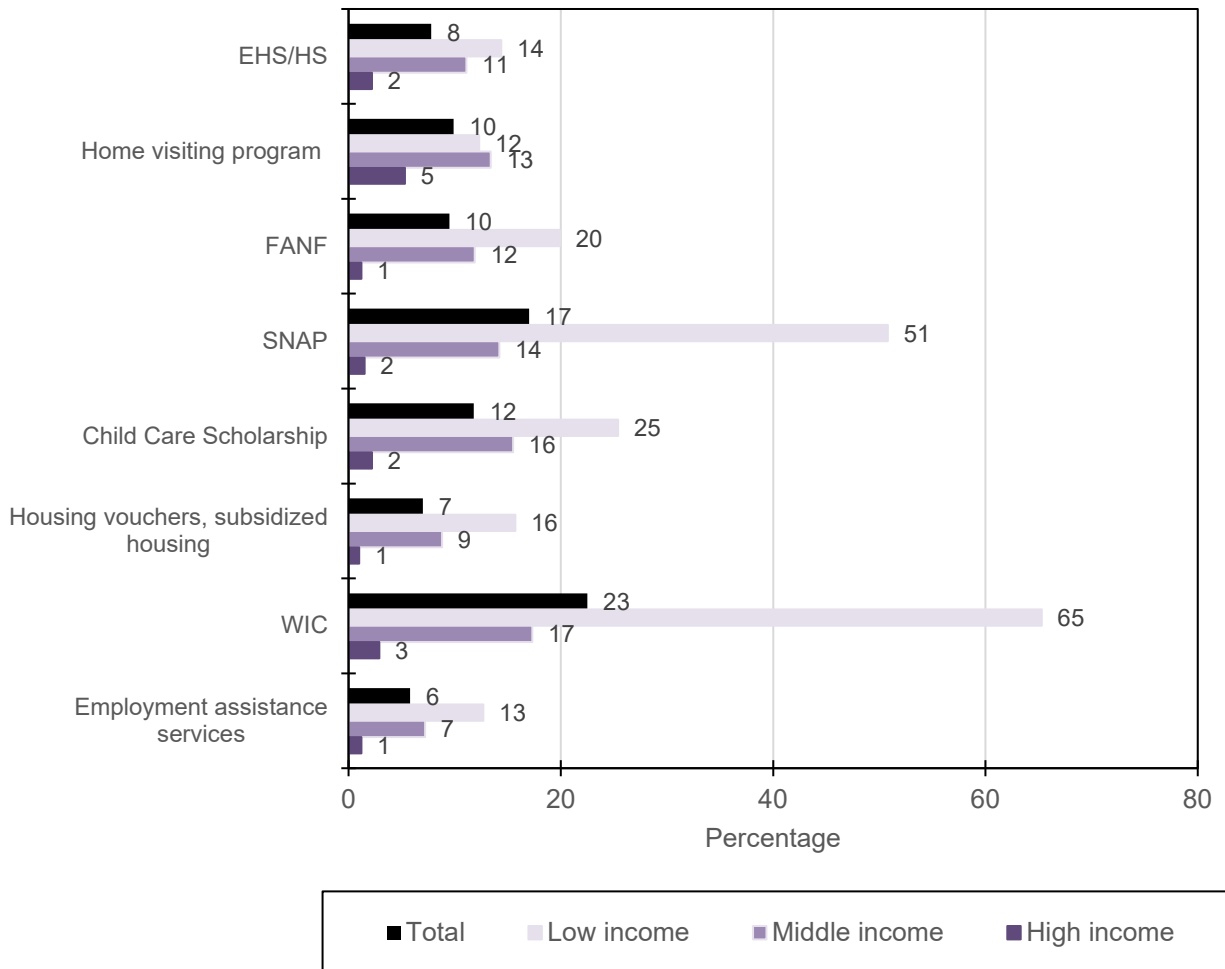
Participation rates are considerably higher for many of the programs with universal access, especially health-related programs or services, although not all of the programs have public subsidies (e.g., private school preschool) (Figure 4.2). Participation in well-child visits was reported for 69 percent of children, the highest rate. Participation in developmental screening occurred for about half of children. On the other hand, despite being well known, family survey responses indicated that about 16 percent of children were served by early intervention supports (FCESS), a rate consistent with the prevalence of child disability. For these programs, there is a tendency for participation to rise with income, such as increased enrollment in ECCE as family income increases. There is also a tendency for higher participation rates in rural communities.

Many Families Are Not Able to Access ECCE When Needed According to Family Survey Responses

About half of the parents with children under age seven who responded to the survey indicate that they had some or a lot of difficulty finding the ECCE program they wanted for their child's current or most recent enrollment. Just over one in four parents indicated that they do not have good ECCE choices where they live. A similar share reported needing for care during

nonstandard hours such as evenings, nights, or weekends. And about 24 percent of parent respondents indicated that there was a time in the past 12 months when they could not find child care for a week or longer. The top reasons listed for why they could not find care were an inability to afford the available options (43 percent), an inability to find a provider with the quality they wanted (35 percent), and the available hours and locations did not fit their needs (33 percent). Somewhat less prevalent was not being able to find a provider with a space (27 percent) and not being able to afford the quality of care they wanted (27 percent). Most notably, nearly 1 in 5 parents reported that there was a time in the past 12 months when they quit a job, school, or training activity or that they were unable to take a job or participate in education or training because of problems arranging for child care.

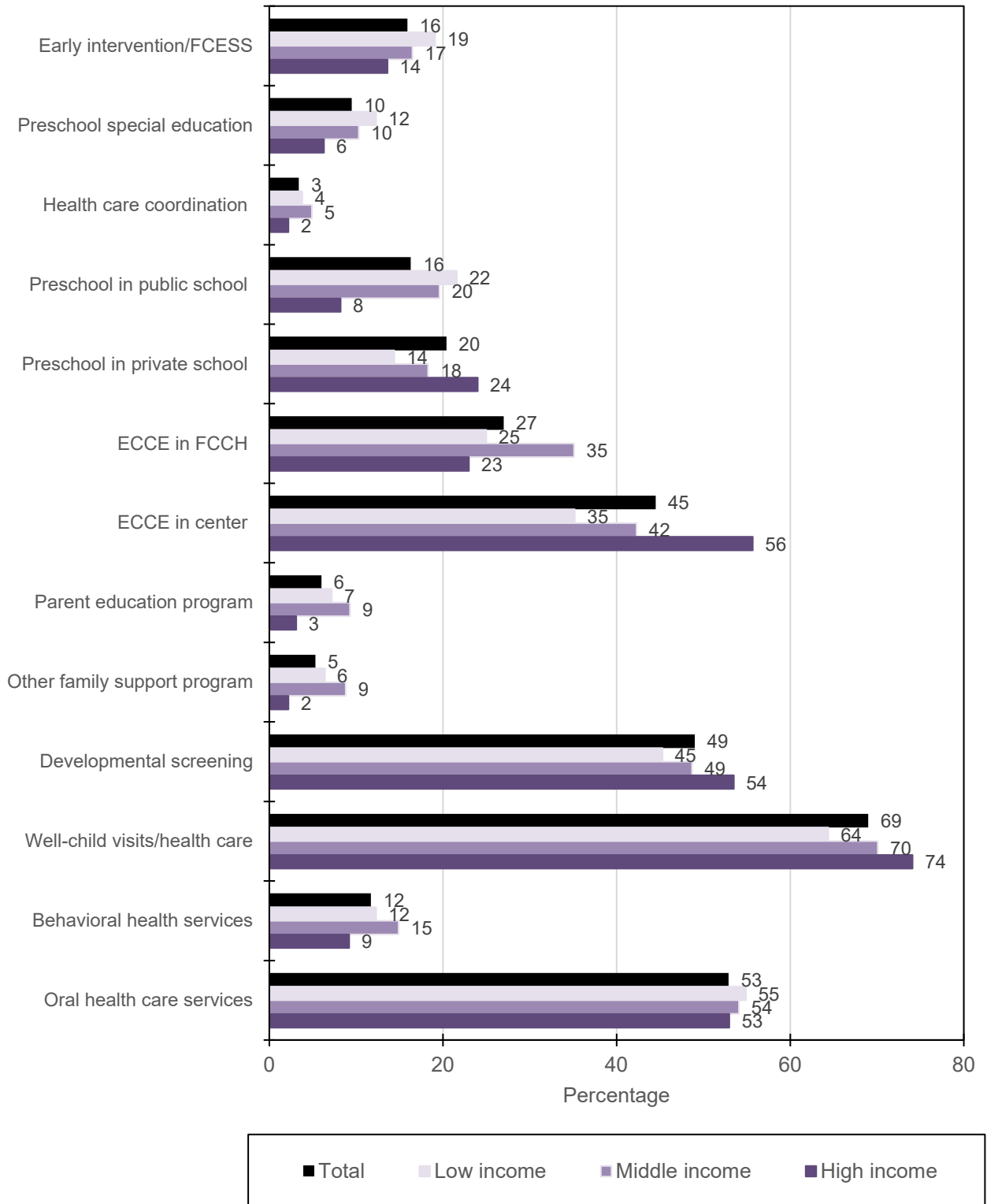
Figure 4.1. Percentage of Survey Respondents Reporting Family or Youngest Child Ever Participated in Targeted B-5 Programs: Total and by Income Subgroups



SOURCE: PDG B-5 Family Survey, Tables B.4, B.6, B.8, and B.12 in Appendix B.

NOTES: Responses are tabulated for all 1,278 family survey respondents. Abbreviations: EHS = Early Head Start; HS = Head Start.

Figure 4.2. Percentage of Survey Respondents Reporting Family or Youngest Child Ever Participated in Universal B-5 Programs: Total and by Income Subgroups



SOURCE: PDG B-5 Family Survey, Tables B.4, B.6, B.8, and B.10 in Appendix B.
 NOTES: Responses are tabulated for all 1,278 family survey respondents.

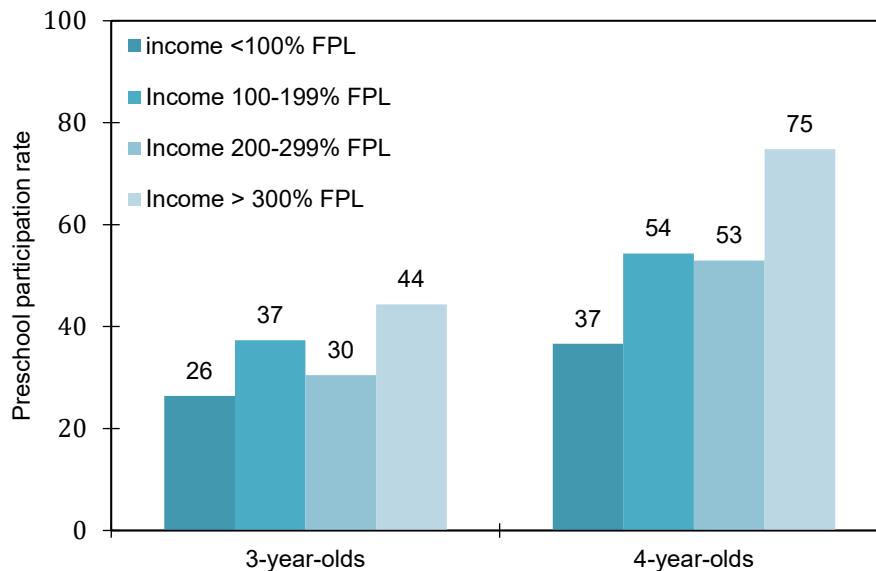
These issues with accessing ECCE and experiencing consequences related to work, education, or job training were typically most prevalent for lower-income families compared with their higher-income peers. For example, the need for care during nonstandard hours was most common for low- and middle-income families (27 percent to 33 percent) compared with the high-income group (18 percent). The view that there were no good ECCE choices where they live was most common for the middle-income group (31 percent) compared with the low- and high-income groups (25 percent and 24 percent, respectively). But both low- and middle-income parents were most likely to report quitting or not starting a job, school, or training because of a lack of care (23 percent each compared with 13 percent for the high-income group). On the other hand, the low-income group was least likely to state that they had some or a lot of difficulty finding the care they wanted (25 percent) compared with the middle- and high-income group (42 percent each). Many of these issues were similar for parents in nonrural and rural communities. The inability to find care was more prevalent for parents in rural areas, as was finding providers with the needed hours. These parents in rural communities were also more likely to report needing care during nonstandard hours. In contrast, care affordability was more of an issue in nonrural areas. These issues were similar across child ages, although the issue of finding a provider with a space was more common for parents with infants or toddlers.

Data from the ACS Confirm Participation in ECCE Rises with Family Income

The ACS includes a question about enrollment in school for everyone age 3 and older and the response options include being in nursery school or preschool. Tabulations using microdata for New Hampshire demonstrate that there is a strong income gradient in preschool participation rates (Figure 4.3), despite the availability of subsidies such as the Child Care Scholarship and programs such as Head Start. Among three-year-olds, the estimated preschool participation rate increases almost 20 percentage points from children with family income below 100 percent of FPL (26 percent) to children with family income at 300 percent of the FPL or higher (44 percent). This similar gradient is seen for four-year-olds, where participation ranges from just 37 percent for children with family income below the FPL to 75 percent for children in families with income more than three times the FPL. This is a potentially narrow measure of enrollment in preschools and other types of early learning programs. Nevertheless, it suggests there is a sizable difference in preschool participation rates across family income tiers in New Hampshire.¹⁷

¹⁷ In order to expand access to voluntary high-quality early learning programs one or two years before kindergarten entry, 44 states and the District of Columbia, as of the 2018–2019 school year, have allocated state funds to support expansion of subsidized preschool for four-year-olds (and in some states for three-year-olds, as

Figure 4.3. Estimated Preschool Participation Rate by Family Income Relative to the FPL (2013–2017)



SOURCES: Author’s analysis of the 2013–2017 ACS PUMS.

NOTES: The preschool participation rate is measured as the percentage of children in the age group enrolled in nursery school or preschool in the last three months.

Most Prevalent Reasons Given by Family Survey Respondents for Not Participating in B–5 Programs Include Awareness, Eligibility, Cost, and Program Hours

Parent survey responses indicate varied reasons for not participating in B–5 programs (respondents could select up to three reasons) (Table 4.1). For most of the program types, the most common reason for nonuse was “I thought my child did not need or would not benefit from the program(s)” (26 to 55 percent) or, in the case of child care or preschool, the child not being age-eligible (35 percent). Not knowing about the program was most common for home visiting/parent education and family support programs (60 percent). Aside from home visiting and related programs, in the other program areas defined by the columns in Table 4.1, a lack of knowledge was an issue for 17 to 30 percent of respondents.

Not expecting to qualify or actually not qualifying was the most common reason for nonuse of cash and in-kind assistance programs (41 percent). This was also the most prevalent response (after the child not needing/benefiting) for Head Start/Early Head Start, early intervention, special education preschool, and health care coordination (31 percent and 25 percent, respectively).

well) on a targeted or universal basis (Friedman-Krauss et al., 2020). In Oklahoma, where the voluntary preschool program is free for all four-year-olds, the families of 76 percent of four-year-olds statewide choose to enroll their child in the part- or school-day option in the year before they enter kindergarten, effectively erasing the preschool participation gap across income groups evident for New Hampshire (Friedman-Krauss et al., 2020).

Table 4.1. Percentage of Respondents Selecting Reasons for Nonparticipation in Categories of B–5 Programs

Answer	EHS/HS; Early Intervention, Special Education Preschool, Health Care Coordination	Public and Private Child Care and Preschool	Home Visiting, Parent Education, Family Support Programs	Developmental Screening, Well-Child Visits, Behavioral Health, Oral Health	Cash and In- kind Assistance (FANF, SNAP, CC Scholarship, WIC, Subsidized Housing)
My child is not of age to qualify for the program(s).		35.0			
I thought my child did not need or would not benefit from the program(s).	48.3	25.6	34.8	54.7	43.4
I did not know about the program(s)/service(s).	19.1		59.6	29.7	17.4
There are no providers of the service(s) in my area.				6.0	
I thought my child or family would not qualify for the program(s).	30.5	13.7	19.4		41.4
My child or family did not qualify for the program(s).	25.2	10.2	12.3		41.0
It was too difficult to enroll in the program(s) (e.g., paperwork).	4.0	3.1	3.1		7.3
My family did not have transportation to participate in the program(s).	3.9	4.3	3.2	2.2	3.2
The distance to the program(s) was too far to travel.	2.8	4.1	3.4	2.7	2.4
I thought that others would think less of my family for using the program(s).	1.6	0.8	1.8	0.8	3.5
The hours of the program(s) did not fit my family's schedule		16.6		6.2	3.8
The waiting list to see the provider(s) was too long.				5.2	
The quality of the program(s) was low.	3.1	6.5	1.3	1.5	
My family could not afford the cost of the program(s).	6.7	18.1	4.3	7.0	
My insurance does not pay for the cost of the service(s).				7.7	
Other	13.7	17.9	7.0	10.7	4.3
Prefer not to say	2.0	3.8	3.1	7.3	2.1

SOURCE: PDG B–5 Family Survey, Tables B.5, B.7, B.9, B.11, and B.13 in Appendix B.

NOTE: Responses are tabulated for all 1,278 family survey respondents. Cases with missing responses are excluded from the tabulations. Cells with gray shading indicate the answer in that row was not among the available response options for the program category in the column. Abbreviations: EHS = Early Head Start; HS = Head Start.

Focus Group Participants Likewise Described Similar Barriers to Accessing B–5 Services

Many of the key factors affecting participation in B–5 programs and services identified by PDG B–5 Family Survey respondents surfaced in the focus group discussions. Common issues included provider shortages, high costs, a lack of family-friendly hours, and access to transportation and the required travel times. These barriers were equally relevant for ECCE and for other early childhood services and there were no differences in barriers experienced by family focus group participants in urban and rural areas.

Gaps in the availability of providers was a key access barrier that was mentioned in all the family focus groups. In some areas, families reported no or few providers, long waits for appointments or waitlists, and extended travel time and related transportation costs. Family focus group participants reported that infant care and providers who could make accommodations for special needs children could be especially hard to find. Provider shortages were also frequently mentioned for ECCE (particularly early and extended-day options; evening, nights, and weekend care; and summer hours), mental and behavioral health specialists, medical specialists, and therapists. As one parent said, “I quite literally made a list of every pediatric neurologist I could find in the state, and I called them all. And the one who had the shortest waitlist won, but even that was a six-month waitlist.”

The high cost of child care was another barrier to access mentioned in all focus groups. Although participants acknowledged the availability of financial supports, many participants reported that they earned too much to receive subsidies but not enough to afford services. This was particularly true among families trying to access ECCE, and a few participants said that they had to settle for lower quality child care services because higher quality child care was not affordable. In the opinion of one family member:

“I think overall there’s a marked trend where the cost of high-quality early childhood education in this state is not affordable for the average family, and not even close. And so we felt that really acutely. We didn’t qualify for the Child Care Scholarship and so the price of some of the programs that we thought would have been a best fit weren’t even on the table for us.”

In addition, cost was an obstacle for families trying to access other early childhood services, such as health care, particularly if the provider a family was trying to access was out of network, if services and related costs were not covered by insurance, or if insurance co-pays were too high. One family member said, “My son has private insurance and Katie Beckett,¹⁸ and we still

¹⁸ Subsidized home care for severely disabled children up to age 19 who qualify for Social Security Supplemental Security Income (SSI) and institutional care, is commonly known in New Hampshire as the “Katie Beckett” (Medicaid) option, as only the child’s income and resources are counted when determining eligibility for the program.

pay nearly \$800 a month out of pocket. So [there are] huge gaps in what’s covered. And huge gaps if you fall into Partners in Health and out of the area agency system. The systems are not equitable as far as services available to our children. That is a huge issue.”

Participants across the family focus groups discussed the lack of family-friendly hours as a key barrier to accessing services, particularly ECCE services. In addition to limits on nontraditional hours with ECCE providers, participants reported difficulties in finding other early childhood service providers with evening or weekend appointments.

Lack of transportation and the time required for travel were barriers for families living in urban areas as well as those living in rural areas. Participants in both urban and rural areas reported that the scarcity of providers in their area (particularly behavioral and mental health therapists and specialized medical providers) made accessing available providers difficult if they did not have a vehicle and because their work schedules could not accommodate the time required to travel. Similarly, some participants in rural areas reported that they did not make use of child care because providers were too far away, and the associated travel was too time-consuming. One family member described the issue this way:

“Say somebody lives in Barrington and [doesn’t] drive, and [doesn’t] have a car. How are you going to get into Rochester to go to DHHS? And how are you going to get your kid to child care? And how are you going to get to work? Because there’s no buses that are going to go out to Barrington.”

The state and local leaders and providers we interviewed appeared to have a good sense of the barriers to accessing B–5 services faced by families: nearly all of the barriers mentioned by families were raised in the stakeholder interviews, as well. As one state leader remarked, “The lack of access [to licensed child care] is compounded by the fact that if parents have to work, they find unregulated care. It makes the parents bad employees if the care is unreliable, but it also hurts the child to not have access to professionals and all the services they’d otherwise access.”

Families in Vulnerable Groups Face Additional Barriers to Accessing Services

Interviews and focus groups pointed to several specific vulnerable groups: families of children with special needs or complex medical conditions and families with young children led by a legal guardian. Parents of children with special needs or complex medical conditions reported more stress and barriers when interacting with the B–5 system in large part because they interacted with the system much more frequently. For example, one family said they worked with 21 different medical providers:

“Somebody asked us, ‘How many providers and doctors do you have?’ And my wife and I counted 21 at that particular time. When you say that out loud it’s like, I did not realize that. You know, until we just now are counting and it’s like it’s 21, just for my daughter...So that in itself is very overwhelming. When you put a number to it you’re like, no wonder I’m overwhelmed.”

These same families also reported financial stress stemming from high transportation costs and time required for travel because their children needed care that was not available locally; families without access to their own vehicle were particularly affected by these challenges. Some families with children with special needs or complex medical conditions reported challenges accessing services through referrals, saying that pediatricians and schools often prefer a “wait and see” approach and delay providing referrals for evaluations when parents have concerns about their child’s development or health. Parents reported that this approach resulted in a delay in diagnosis for their child and late access to early interventions and/or other care.

“So I was asking the doctor [for a referral] and everyone was telling me everything was fine, some kids develop differently. So finally at about eight months the doctor said she would make the referral to early intervention ...but it was a two month waiting [period] to actually get the appointment and for the assessment. ... We finally got a diagnosis at about 13 months. At that point we already were receiving some early intervention services, but ... the docs were like, “He needs to be having PT and OT every single day.” I had to be really, really pushy with early intervention, with the area agency, to get more services.”

Parents of children with special needs and complex medical conditions were particularly affected by the amount of time it took to care for their child (e.g., time needed to find information, apply for programs, and schedule, drive to, and keep appointments; the need to keep track of a lot of information), the financial costs (e.g., struggling to or being unable to afford the services their children need; being forced to leave the workforce to care for their children and/or to qualify for benefits; being forced to take unpaid leave to care for children; dealing with unexpected expenses); and the emotional and physical burdens of care giving, including the need to learn how to be an advocate for one’s child.

Parents whose children did not have special needs or complex medical conditions also desired more advocacy services and supports, such as parenting classes, support groups, and counseling services, noting that these services are more easily accessible when they are affordable or free and when child care is provided.

Caregivers who were legal (or de facto) guardians reported several unique barriers to accessing services, which were largely related to not having other children at the same time or not anticipating raising children. In particular, guardians such as grandparents or other relatives reported financial stress related to unexpected child-rearing obligations, as well as difficulty accessing insurance and other benefit programs because they were not the birth parents of their child. As one guardian said, “If DCYF had not been involved to take the child [because the mother was incarcerated at time of birth], and I had not had that frank conversation with them about how we going to pay for all these things, I don’t know how I would have known.”

On the other hand, when we spoke to a group of families who were new arrivals to the United States and for whom English was not their first language, they reported benefitting from a great deal of support from their FRC and did not experience barriers to accessing programs. In

other focus groups, an insufficient number of parents self-identified as new citizens to generalize about their experience. Although state and local leaders and providers thought more could be done to provide services and information in a culturally and linguistically sensitive manner, barriers due to language were not mentioned by the few focus group participants who spoke a language other than English.

Parent Mental Health Issues Further Challenge Access to B-5 Services

Many focus group participants spoke about their own mental health needs as presenting a barrier to accessing services for their children. The focus group participants who raised the issue said that there was no routine screening for post-partum depression or other mental health concerns (e.g., anxiety). As a result, either a spouse raised concerns about their partner's mental health or the affected parent had to self-disclose to their child's pediatrician or health care provider their struggles with depression. Another perspective was offered by several focus group members who noted that they felt accessing support services—particularly support for postpartum depression—was stigmatized, which made them less likely to seek or access those supports and services.

When the issue was addressed, several mothers in the focus groups said that they were referred to counseling but that there were no counselors who specialized in postpartum depression and/or it was difficult to access services. As one parent noted: “There is an insane gap in New Hampshire for postpartum depression care... There are two therapists in New Hampshire that dealt with postpartum depression and they were drowning in patients.”

Other focus group members described issues with job loss and being uninsured, resulting from postpartum depression, that meant they could not access needed care. One participant relayed the following story:

“When I had my son I ended up getting severe postpartum depression... to the point I lost my job. I was denied unemployment because I was medically unable to work due to my postpartum depression, and I lost my health insurance, and didn't qualify for Medicaid. So that was really a really tough time, and again even without me working, we still did not qualify for any of these [insurance programs] because we own a home.”

Some state and local leaders interviewed understood the pressures families face, and how trauma, mental health issues, or lack of support could impede families' ability to care for their children. As one local leader put it, “Some families are under so much stress that they can't even begin to think about their child's development and needs because of all of the other trauma and stress happening in their [parents'] lives.”

Families Who Applied for Social Safety Net Programs Reported Numerous Access Barriers and a Perception that the System Was Not Designed to Help Them

Overall, families reported that the system for social safety net (or means-tested) programs was difficult to navigate, services were not easy to access, and their experiences with staff were frequently negative, which led to the belief that the system was not, in fact, designed to help them. Most participants who commented on this topic said that social safety net programs were difficult to navigate because information was not clear, difficult to find and understand or conflicting; application materials and eligibility requirements differed; and programs did not share information. Participants found social safety net programs difficult to access for a wide variety of reasons related to eligibility, poorly-managed application systems, and families' limited resources.

Barriers to access related to eligibility included restrictive eligibility conditions (e.g., parents who are in school rather than in the workforce were not eligible for some programs, and participation in one program rendered families ineligible for another), benefit restrictions or limits (e.g., WIC benefits cannot be used for infant formula even when it is prescribed by a pediatrician, and income limits can result in lost benefits if one receives a wage increase or gets married and reports the combined incomes), and unrealistic cost of living calculations (e.g., caps are placed on the amount that can be claimed for out-of-pocket medical costs).

Poorly-managed application systems included situations involving duplicative and confusing application materials that were then lost by agencies and required frequent resubmissions or updates, requests for which were often mailed to old addresses. As one family member said, "They told me this whole list of all this stuff I've got to do. I was like, 'No. It's more of a hassle than what [the benefits] I'd be getting.'" Some families also reported being dropped from programs (usually Medicaid) without notification and finding it difficult to get time off work to return calls and keep appointments with program staff during business hours.

Many families who tried to access safety net programs said their own lack of resources was a barrier to access. For example, many families didn't have use of computers to research programs or apply online, and didn't have access to printers, or the money to print hard copies of application materials. Some parents also noted that programs' lack of resources was a barrier, and many programs were not able to provide services to all applicants due to limited funding.

Focus group participants also reported negative experiences with program staff that made it more difficult to access safety net programs. Poor communication was an experience reported by many families, who found staff did not return phone calls, were unable to answer their questions, and were told their applications were rejected for being incomplete without receiving a prior notification. As one participant said, "I have faxed stuff to DHHS for my families because they don't have a printer and they don't have a fax machine. Then then when you do fax it, it comes distorted and then (the program) shuts (all the services) off." In addition, some participants reported interacting with program staff who were rude or disrespectful, made them feel bad for needing benefits, and acted as though they would rather cut services than find a way to provide

help. As one parent said, “It’s almost insulting. It almost made me feel like scum, the way that they were like, ‘well why isn’t this working for you?’”

In sum, many participants who applied for social safety net programs reported that the combination of barriers made them feel as though the system was designed to be as difficult as possible to navigate and to deny benefits rather than provide them. According to one participant, “it’s like they [state program staff] look for a reason to take things away from you. It’s not like they’re there to help you. It’s like they’re there to give you the bare minimum and with an attitude.”

Many Family Survey Respondents Do Not Have Employer-Provided Supports As a Supplement or Alternative to Publicly Funded Programs

The PDG B–5 Family Survey inquired about respondents’ access to employment-based supports that could supplement or serve as an alternative to publicly funded programs (Table B.20). Among employed respondents, the most common benefits are paid holidays (70 percent), paid sick leave (67 percent), and paid vacations (66 percent). About 60 percent reported having flexible scheduling or work hours. Much less common was unpaid maternity or paternity leave (39 percent) and paid maternity or paternity leave (34 percent).

About 19 percent of respondents indicated that they had a Dependent Care Assistance Plan, which helps pay for child care expenses using pre-tax dollars. Onsite child care with an employer-provided discount was reported by just 10 percent of survey respondents. Onsite child care at market rates was even less prevalent (6 percent).

For respondents with an employed spouse/partner, the pattern of benefits through the spouse’s employer was very similar. Access to paid holidays, paid sick leave, and paid vacations were again most common and at rates that were somewhat higher for the spouse (78 percent, 72 percent, and 79 percent, respectively) compared with those for the respondent.

In contrast, flexible scheduling/work hours was somewhat less common (46 percent), as were either unpaid or paid maternity/paternity leave (25 percent and 31 percent). A Dependent Care Assistance Plan, as well as onsite child care with or without an employer-provided discount were even more rare for the spouse, just 11 percent and 3 percent of respondents, respectively. As might be expected, access to these benefits increased with family income. However, prevalence of these benefits was quite similar across rural and nonrural communities.

We also asked focus group participants about employment-related supports, such as parental leave, paid time off, flexible work hours, the ability to work from home, the ability to bring their children to work, and health insurance, and how the presence or absence of these supports affected their ability to access B–5 services for their children. About half of the participants in the family focus groups did not have such supports at their jobs. In the experience of one parent:

“The doctor gave me maternity leave, to stay home and have the baby, or go to work and lose the baby, and I chose to stay home. I gave [my employer] the doctor’s note. I didn’t know they fired me until I went to apply for food stamps.

I'm like really? I've been with you guys for four and a half years and you're just going to fire me because I have to be at home for the baby?"

Many participants, including those employed at small businesses, noted that small businesses often will not provide paid benefits, such as parental leave, paid time off, or health insurance. Several participants believed that there is no job security for expectant mothers or new parents. For example, some participants reported losing their jobs or being forced to leave the work force because of the time off they needed during pregnancy, to care for newborns, or to care for children with complex medical conditions. Many stakeholder interviewees, particularly state and local leaders, expressed similar concerns, noting that the expense and scarcity of child care services, combined with a lack of employment supports, kept some parents out of the workforce. As one provider noted, "And then the cost of child care is so high, sometimes it's better to stay home with your kid and collect [income assistance]." In addition, participants who had children with special needs or complex medical conditions reported using most or all their leave for appointments related to caring for their children.

Several Strategies to Improve Families' Access to B–5 Services Were Identified, But They Did Not Constitute Comprehensive Solutions

Many of the state and local leaders and providers interviewed suggested strategies for improving families' access to B–5 services and agreed that access could also be improved by expanding parent knowledge and awareness of high-quality services (as discussed in Chapter 3). Many of the suggested strategies directly address the information and access barriers described in this section, while increased funding so providers could expand their services was viewed as essential, as well. The specific suggestions included:

- Expanding provider knowledge of the B–5 system to pass on to parents and support effective referrals (e.g., Child Care Aware's efforts to train providers that are considering expanding services; training pediatricians to make referrals; increased coordination between pediatricians and child care providers; professional development for staff to discuss quality services with families).
- Encouraging service providers to adopt a "no wrong door" approach, so that any service provider would be able to inform and refer families to the appropriate services, regardless of which program the family came to first.
- Encourage providers to develop partnerships to share space and co-locate complementary services. One interviewee cited Manchester's in-school family cafes, suggesting that other FRCs around the state might partner with other organizations (like libraries) to share space and provide services. This strategy might help families for whom transportation presents a barrier.

Findings Regarding the Quality of B–5 Programs and Services

Families' Definition of a "High-Quality Service" was Primarily Based on Personal Interactions with Staff and Their Experience Working with the Provider

When we asked family focus group participants how they defined high-quality B–5 services, they described it in similar ways for both ECCE and other early childhood services. Families defined high-quality services as those where they had positive relationships and good communication with staff, where services were easy to access, where care was consistent and supportive, and, for ECCE providers, had high-quality facilities.

Positive relationships and regular communication. Families viewed providers as high-quality when they perceived staff and caregivers to be friendly and warm, and who seem to care about their children and the family. In the words of one participant, "They love the kids like I would if I was there. That's priceless. It's not just a job." Families also preferred providers who treated them with respect, did not seem rushed, who returned their calls, listened to parental input and provided regular updates and useful referrals based on the family's needs. One family member described high-quality services in this way:

"Feeling welcomed, and people are actually wanting to answer your questions, and want to help you, and provide information to you. Where you don't have to pull the information from them, you know? One thing that makes it feel good quality is people that work there are passionate, and they are helpful."

Easy access. Families in our focus groups valued providers who were easy to access in that wait times were not excessive, hours were family-friendly, multiple services were offered, and sufficient services were offered. For example, several families said that they wanted their children to receive enough care; and reported being frustrated when providers and schools wanted to reduce services. One parent described using these criteria to choose child care:

"It just depended on availability, not many had spots for, you know, placing both children in the same place. Or I would say some were low on flexibility as well. Like you didn't want to start with all five days a lot of them I looked at you still had to pay for all five. So I kind of - I based it off of who was flexible, could take both, and I liked the people, I guess."

Consistent, supportive care. Families sought providers where the staff were consistent, care was individualized to their child's needs, and their child was making progress. Some families mentioned provision of direct supports (e.g., diapers, formula, clothes, nutritious food) as an additional valuable resource. For child care providers, families also valued small class sizes and opportunities for outside play. One parent defined high-quality child care as follows:

"With child care I would define quality as having hours that run the length of the workday so that you can have a job and have your child in child care. And have it

be affordable, and then just like a good experience for the kids—a safe environment, and some time outside would be great.”

High-quality facilities. In the case of ECCE providers, focus group participants sought providers with facilities that were clean and safe. In the words of one parent:

“I definitely feel [the child care center] was quality. They’ve mostly maintained the same staff, so you go in and know the person you’re dropping your kids off with. Just nice, caring staff, and a nice, safe seeming building, and good consistency, and good communication from all the staff people.”

Families described several characteristics of services they found to be high-quality: staff were friendly and provided good information and referrals; services were easy to understand, access, and use; and multiple services were provided. Specific services viewed as meeting quality expectations included WIC, FRCs, home visiting services, some specific child care providers and health care providers in a variety of specialties, and advocates. Advocates often were therapists, doctors, and other professional caregivers who dedicated additional time and energy outside of what was typically offered to help ensure that a child’s or family’s needs were met. Some participants who said they would like to have an advocate were under the impression that it was a service that they could not afford, and other participants noted there was no systematic way of obtaining an advocate. One parent said, “If that’s something that can ever get added to any sort of funds, somebody that can sit in with families and help advocate for children is amazing and should be done.”

State and local leader and provider interviewees, on the other hand, generally worried that most parents didn’t have a good understanding of what high-quality services—particularly ECCE—looked like, and favored availability, affordability, and convenience over quality because the need for care while they worked took precedence.

“I really think, with regard to child care, that most parents don’t know what quality is. If you do know what quality is, you’re faced with tough decisions about access. You might know quality is not good, but if it’s the only thing available or what you can afford, you’d send their kid there,” remarked a family advocate.

Although some families agreed that their need for child care generally took precedence over quality and chose all types of providers based on quality when they could, they often settled for providers that they considered lesser quality because high-quality providers were scarce, too far away, or too expensive. One parent referred to it as the “illusion of choice.”

Stakeholders singled out provider-parent communications as an area where quality gaps persist. The stakeholders who commented on this topic agreed that the quality and frequency of such communications depended on the program, and that programs with staff shortages and high staff turnover tended to experience more challenges in this area than others. A few providers mentioned that they utilized apps or daily worksheets to communicate with parents and one LEA leader indicated that their own school-based preschool program did do a good job with engaging

parents about their child's development due to their strong professional development in this area. One interviewee noted that there's no statewide program or infrastructure that is focused on educating parents about child development and that most services are focused on addressing developmental issues rather than preventing them.

Focus Group Respondents Had Varied Views on the Value of Quality Ratings for ECCE Providers

A potential state rating system for ECCE providers was discussed in a few focus groups. Feelings about such a system were mixed. Some participants thought it was a good idea and would like to see a system that rated all types of early childhood service providers. However, other participants were skeptical of how facilities were rated, and some felt that even a state rating system that was intended to be objective would not be useful because they did not think highly of state services generally. Likewise, a few participants in rural areas did not want a rating system. They feared that if their child's caregiver was rated poorly, they would be in a situation in which they would knowingly send their child to a poorly-rated provider but would not have the ability to make a change given that they needed child care in order to work and had no other options for care.

Implications for the Strategic Plan

Access to and the quality of B–5 services and supports is a topic with many interrelated issues that are relevant for all stakeholders in the system: parents, providers, funders, and others. The array of qualitative and quantitative information assembled for this chapter paints a fairly consistent picture of the current system. Namely, there is great variation in the extent to which families engage with and participate in specific B–5 system programs and the quality of those experiences. For programs with public funding or subsidies, participation may be below what is desired because programs are not fully funded to reach all eligible families. Other programs that require parents to pay may be unaffordable for families with lower income. Shortages in specific provider specialties (e.g., postpartum depression, infant mental health) require focused efforts to understand the reasons for the shortages and how to remedy them. Parents' experiences with some providers failing to be respectful and empathetic is another area of concern. These equity issues are further complicated by the set of barriers that preclude participation or limit program quality including awareness of programs and who qualifies, costs to parents, and programs hours that meet family needs.

The same vulnerable groups identified in the prior chapter regarding knowledge gaps emerged in the context of access and quality challenges as well, including families with children living with disabilities or complex health care needs, lower-income families, and families contending with substance abuse issues or adult mental health concerns. In some families, the

employed parent(s) may have access to benefits that supplement or serve as alternatives to public-sector programs.

Addressing issues of access and quality, together with strategies to resolve knowledge gaps, is an essential component of building a well-coordinated and functioning B–5 system. To some extent, the issues and possible solutions may vary depending upon whether programs and services are targeted to at-risk children and families, or intended to serve families more generally as they experience a need for additional supports. Other issues such as measuring, improving, and monitoring quality cut across most programs. Ideally, continued or new initiatives draw on best practices established in New Hampshire and elsewhere that are evidence-informed, strengths-based, and trauma-informed. Families should be key partners in advancing these issues, drawing on emerging approaches to human-centered design.

5. Transition to Kindergarten

The historical separation of the B–5 system from K–12 education creates a need to focus on the transition from early childhood settings to the start of formal schooling at kindergarten. Recognizing the importance of the kindergarten entry experience, school districts have begun to implement more intentional approaches to ensuring a successful transition for children and their families into the kindergarten setting. These strategies go beyond providing prospective parents with a brochure or online information about the kindergarten program and registration process. These low-intensity activities may be accompanied by more intensive strategies, such as providing opportunities for incoming students to visit the school or their kindergarten classroom; dedicated efforts on the part of kindergarten teachers to obtain information from prior early learning teachers and providers about the child’s past developmental progress and areas for growth; and one or more home visits between the kindergarten teacher and the child’s family to get acquainted and share expectations for the coming year. Nationwide, research suggests that these more intensive and intentional activities are less likely to be made available to families and children in lower-income neighborhoods compared with those in higher-income communities (Loewenberg, 2019). Identifying differences across subgroups of children in the opportunities for a productive transition to kindergarten is a first step toward providing equitable access to these supports.

With increased investments in early childhood programs and a recognition of gaps in school readiness, especially among vulnerable children, states and school districts have turned to kindergarten entry assessments (KEAs) (also known as kindergarten readiness assessments [KRAs] or kindergarten inventories) to measure children’s cognitive, social, and emotional developmental status (Regenstein et al., 2017). KEAs are typically administered by classroom teachers just before or soon after the start of the kindergarten year. In the classroom, the assessments are used by teachers to determine gaps in student knowledge and abilities and to individualize instruction. When aggregated to the classroom, school, district, or state level, KEAs have the potential to provide a metric for identifying shortfalls in readiness in specific domains of development overall and for subgroups of students. The results at a point in time and over time can shape strategies for early learning programs in the public and private sectors.

In this chapter we focus on the transition to kindergarten in New Hampshire as part of a broader interest in the continuity of B–5 services into the early elementary grades. (The next chapter focuses on other aspects of service coordination and continuity.) We also examine the use of KEAs in New Hampshire. We begin with a summary of the current understanding of the transition to kindergarten in the state and relevant policies, before turning to new findings that follow from the data collection activities for the PDG B–5 Needs Assessment. In particular, the interviews with key informants, family focus groups, and family survey each addressed the issue.

In addition, the survey of kindergarten teachers, collected for the purpose of also examining play-based kindergarten, provides another source of information about both kindergarten transition practices and the use of KEAs.

Background on the Transition to Kindergarten in New Hampshire

New Hampshire is one of several states where enrollment in kindergarten is not mandatory (i.e., compulsory schooling begins at age six). In 2009, New Hampshire mandated that every public school district offer at least a half-day kindergarten program. State funding for full-day kindergarten, approved in 2017, was added in 2019. As of the 2018–2019 school year, 139 of 154 regular (noncharter) school districts offered a full-day option.¹⁹ State-level enrollment data by grade show that there were 11,415 students enrolled in kindergarten as of October 1, 2017, 92 percent of the number of students enrolled in first grade one year later as of October 1, 2018 (12,351) (NHDOE, 2019). This suggests that enrollment in kindergarten is now the norm, even though it is not mandatory.

Along with the high levels of kindergarten enrollment and shift toward full-day programs, there has been a growing interest in measuring kindergarten readiness and providing supports to ensure a successful transition into the early elementary grades (Bernstein, Barnett, and Ackerman, 2019). At the same time, there is no universal definition of “readiness” in the literature or across the states (Diffey, 2018; Pierson, 2018). Consequently, there are a variety of tools available to measure readiness, each with a different combination of skills that are assessed. New Hampshire does not currently mandate the use of a KEA, but NHDOE, NHDHHS, the Office of Head Start, and the Head Start Director’s Association endorsed a set of kindergarten readiness indicators in 2012, although a specific tool for assessing the indicators was not recommended or developed (NHDOE, 2014). Districts are therefore free to set their own approach to assessing readiness and there is no centralized repository with the KEA results.

A number of communities across New Hampshire are focused on strategies to improve the kindergarten transition experience. One example is *Ready Together!*, an initiative in Somersworth, a city of about 12,000 residents with an above-average poverty rate and evidence that nearly half of entering kindergarten students lack basic literacy skills. As part of the initiative, the Somersworth Ready Together Early Childhood Coalition established a Kindergarten Teacher Family Visit Program where kindergarten teachers make a home visit to welcome families with an entering kindergartner to the public school system. The goal is to reach at least 70 percent of the entering class through this initiative and engender greater family engagement (Spark NH, 2018).

¹⁹ Enrollment counts in New Hampshire are not collected separately for part- and full-day kindergarten programs. Thus, it is not possible to determine the proportion of kindergarten students in full-day programs.

Insights from Key Informant Interviews, Family Focus Groups, and Surveys of Parents and Teachers

As part of the key informant interviews, five state and local leaders and service providers addressed the kindergarten transition. This count includes two LEA leaders, one child care provider, and two state and local leaders. All of the family focus groups addressed this topic. Tabulations of the questions in the family survey pertaining to the kindergarten transition are provided in Appendix B (see Table B.18). Questions were asked of the 248 family survey respondents with a child who entered kindergarten in the fall of 2018 and had already experienced the transition. A similar set of questions was asked of the 224 parent respondents with a child who was starting kindergarten in the fall of 2019 and thus were currently experiencing the process. Tabulations from the kindergarten teacher survey are available in Appendix D. Synthesizing across these data sources, we highlight the most salient findings. Again, it is important to keep in mind that the respondents to both surveys are not weighted to represent the underlying population, although the Family Survey closely matches many of the characteristics of the targeted families when compared with the ACS.

Kindergarten Entry Assessments Are Being Used by a Majority of Teachers but Practice Is Not Standardized

About 60 percent of the surveyed kindergarten teachers reported using a KEA, although just 32 percent reported being familiar with the set of indicators endorsed by NHDOE, NHDHHS, and other stakeholders in 2012 (NHDOE, 2014). Among those conducting an assessment, 40 percent indicated that they employ a commonly used commercial tool such as the Teaching Strategies GOLD, Braken School Readiness Assessment, Brigance, HighScope COR Advantage, or Work Sampling System, while the remainder use one of the lesser-known commercial tools or a locally-developed measure. The most common domains assessed are literacy, language, mathematics, and fine motor skills. It is far less common to assess social and emotional skills or approaches to learning, even though almost all the teachers reported that these were the most important skills for success in kindergarten.

When assessments are used, they are typically performed by the kindergarten teacher, most commonly during scheduled kindergarten registration days, with 16 or more minutes required on average for the majority of assessments. Overall, about 40 percent of responding teachers rated the kindergarten entry assessment process as good or very good. These patterns were fairly similar across teachers in rural and nonrural districts, but the use of formal assessment tools appears to be somewhat less prevalent in districts in higher-income communities compared with districts in lower-income areas (based on the percentage of students eligible for a free or reduced-price lunch [FRPL]).

Less-Intensive Kindergarten Transition Practices Are Most Common But Practice Varies

Nearly all kindergarten teachers responding to the survey reported that they have general information about entering children before the school year begins. Having information on students with an IEP is close to a universal practice. A majority of teachers (about 60 percent) also report having access to information from a family questionnaire. It is far less common, however, for teachers to have results of child assessments conducted by the early childhood program the child attended or any other information from the prior program that would help the kindergarten teacher get to know the child. That type of information sharing reportedly occurs for about one in three kindergarten teachers.

A comparison of the kindergarten teacher survey responses regarding these practices across teachers in rural and nonrural districts indicates some differences. The use of a parental questionnaire, for example, appears to be more common among teachers in rural districts, as is communication between the kindergarten teacher and the student's prior ECCE program. There is also some evidence that teachers in lower-income communities, as measured by the FRPL share, are more likely to engage in some of the more intensive kindergarten transition practices, such as receiving prior assessment data or asking families to complete a questionnaire.

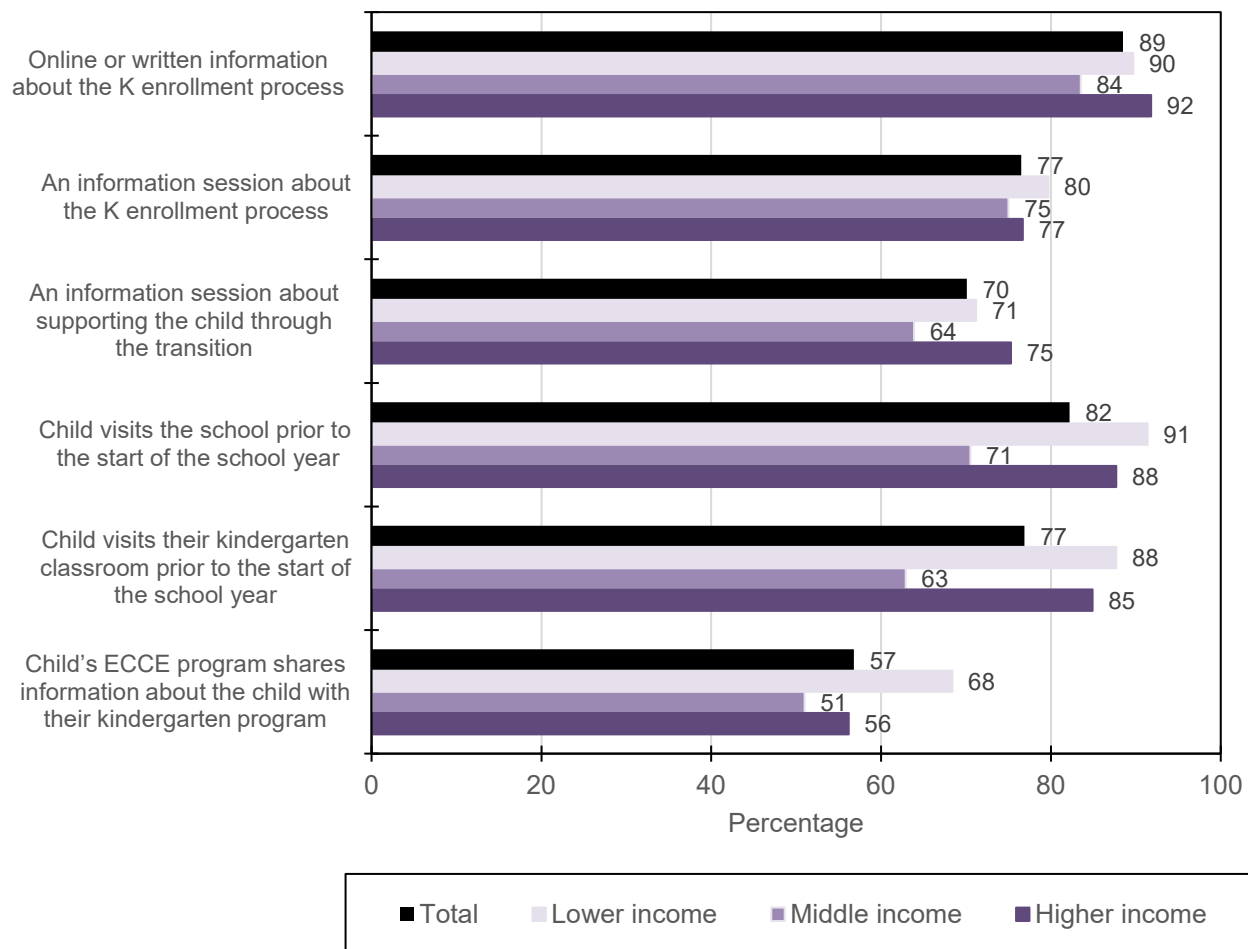
Variation in the kindergarten transition process across districts or regions was a theme that also emerged from the key informant interviews. Further, successful coordination during the transition process could be attributed to the special efforts on the part of LEA leaders. For example, several interviewees mentioned examples of specific LEA leaders making efforts to connect with early learning providers or with the English-language-learning community to share the requirements for kindergarten entry and help coordinate the transition. One LEA leader described conducting home visits in the summer with students about to enter kindergarten and another mentioned structured summer visits at the school site for entering kindergarten students before the start of the school year. Other LEA leaders, however, said that their schools did not have a formal transition process and expressed concern that the low quality of local preschool programs was a challenge to successful coordination.

Parents Report Varied Transition Experiences, with Less Intensive Practices More Common

We also learned about the nature of the kindergarten transition process from parents. Parents responding to the survey who either had a child who started kindergarten in fall 2018 or a child who would be starting in fall 2019 were asked about specific kindergarten transition practices available to them and their satisfaction with the process. Consistent with the findings from the kindergarten teacher survey, families were more likely to have been offered the less intensive activities. For example, almost 90 percent of the 472 respondents to the family survey with a child who entered kindergarten in the 2018–2019 school year or would be entering kindergarten in the 2019–2020 school year reported that online or written information about the kindergarten

entry process was available to them, but just 70 percent said the school or district offered an information session for parents to learn how they could support their child through the transition, and fewer than 60 percent indicated that they had the opportunity to grant permission for their child’s ECCE program to share information about their child with the kindergarten teacher (see the black bars in Figure 5.1).

Figure 5.1. Percentage of Family Survey Respondents Reporting Kindergarten Transition Practices Were Made Available: Total and by Income Subgroups



SOURCE: PDG B–5 Family Survey, Table B.18 in Appendix B.

NOTES: Responses are tabulated for the 472 parents who either had a child start kindergarten in fall 2018 or a child who would be starting in fall 2019.

Notably the prevalence of having access to these practices was very similar for survey respondents in rural and nonrural parts of the state (Table B.18). For most of the practices, however, families in the middle-income group were less likely to have access to each practice compared with families in both the lower-income and the higher-income groups (see the purple bars in Figure 5.1). Interestingly, parents in the lower-income group were more likely than their counterparts in either of the two higher-income groups to have had developmental information

about their child communicated from the ECCE program to the kindergarten program (almost 70 percent versus about 51 to 56 percent). This may reflect intentional efforts on the part of Head Start programs and other providers serving lower-income children to ensure a flow of information from the ECCE setting to the elementary school to support a smooth transition.

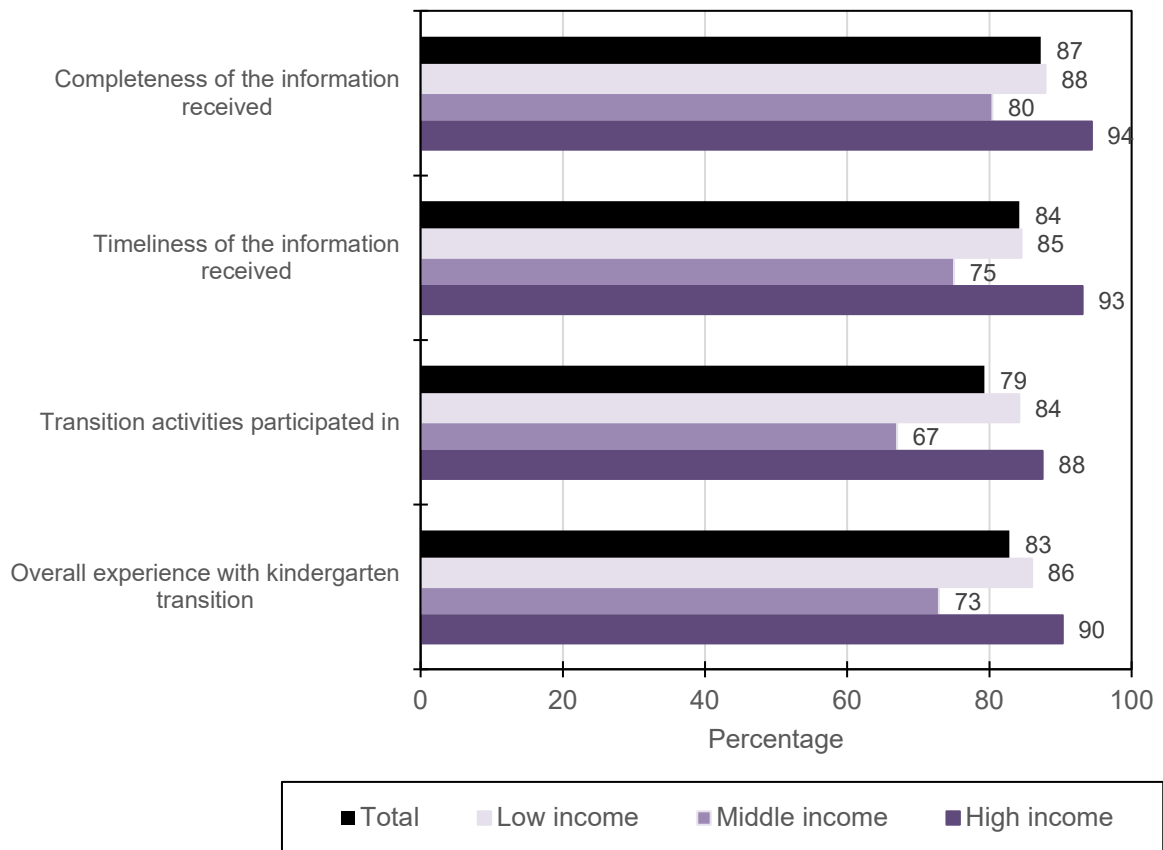
Parents Are Generally Satisfied with the Kindergarten Transition Experience

The vast majority—about 80 percent or more—of the 472 parents responding to the survey who either had a child start kindergarten in fall 2018 or a child who would be starting in fall 2019 reported that they were satisfied or very satisfied with the kindergarten transition experience for their child. This favorable assessment held for the completeness of the information received, the timeliness of the information received, the transition activities that the family participated in, and the overall kindergarten transition experience. For the most part, this pattern held for respondents in rural and nonrural communities and for those in the low- and high-income groups. Interestingly, satisfaction was consistently lower, by 10 to 20 percentage points, on all dimensions of the kindergarten transition experience for families in the middle-income group, compared with their more- and less-advantaged peers. This pattern was especially true for the 248 family survey respondents whose child was enrolled in kindergarten in fall 2018 (see Figure 5.2). This is consistent with our earlier observation that the survey data show that this same middle-income group of respondents had fewer transition supports available to them, but their dissatisfaction may not fully emerge until after the kindergarten year, when they realized that the supports could have been better. Alternatively, schools may have become more supportive between the fall 2018 and fall 2019 kindergarten entry cohorts.

The family focus groups reinforce our conclusion that the transition to kindergarten works well for most families, but some participants expressed a desire for more information from the school or district. Most focus group participants reported that their elementary schools provided some type of open house to help orient incoming students and families. For parents and caregivers whose children attended preschool at a public school, most said the transition was “seamless.” As one parent described,

“And then for preschool we didn’t even have to do anything, they just registered him for us. I think from preschool into kindergarten I got a typical registration form in his home-to-school folder. I confirmed my name and our address, and it went back to school with him. That was really easy.”

Figure 5.2. Percentage of Family Survey Respondents With a Child Entering Kindergarten in Fall 2018 Who Were Satisfied or Very Satisfied with the Kindergarten Transition Process: Total and by Income Subgroups



SOURCE: PDG B-5 Family Survey, Table B.18 in Appendix B.

NOTES: Responses are tabulated for the 248 parents who had a child start kindergarten in fall 2018.

However, most caregivers said they were surprised that they did not receive any information from their school, district, or town government about when to enroll their child in kindergarten. Most reported learning about the timing for kindergarten enrollment from other sources, including word-of-mouth, calling the school, signs outside the school, notices on bulletin boards or in the newspaper, or through their child’s preschool.

Families with Children with Special Needs Benefit from Greater Coordination Throughout the Transition to Kindergarten

As noted earlier, about one third of family focus group participants had a child younger than age seven with special needs. In the discussions with those participants, it was evident that the transition to kindergarten went more smoothly when parents, other caregivers, and school staff met beforehand to discuss needs and accommodations.

Several parents of children with special needs described their positive experiences with planning for their child’s transition to kindergarten. One focus group participant relayed how her

child’s occupational therapist acted as an advocate, attended all the planning and IEP meetings, and helped make the transition “seamless.” Another participant with a child who is legally blind and hard of hearing described how her child’s visual impairment specialist arranged for the child to visit the school beforehand so she could figure out how she would navigate the building, and that this helped the child to understand and be excited about starting kindergarten. In the words of another parent, “My current child is on an IEP for speech that will follow him into the public school, which is great. And the speech pathologists work together so there will be sharing of information.”

However, about half of the family focus group participants who would have benefitted from this type of planning reported that they did not receive it, and not all families in this situation experienced smooth transitions. Some parents of children with special needs said that schools refused to provide services, citing lack of resources or an inability to provide accommodation. One participant reported that when she told the school that her child with autism needed a dedicated paraprofessional, they told her that they could not afford it. In the words of this parent,

“I said no, she needs a one-on-one. ‘Well, we can’t afford it.’ That’s not an acceptable answer....Navigating the special education departments of public schools is a nightmare, and most people can’t afford to hire an advocate. I have a degree in early childhood education, and I’ve taken special education law recently, and I’m still ripping my hair out at IEP meetings.”

Implications for the Strategic Plan

In New Hampshire, as with many other states, the nature of the supports available to families as their children transition to kindergarten is largely a local decision. School districts and schools determine the practices to engage with and support families as their children approach their kindergarten year and to ensure that the kindergarten teachers start the year with knowledge of the readiness—academically, socially, and emotionally—of the children in their classrooms. The latter may be facilitated by the use of a KEA or communication between ECCE providers and the kindergarten program. The combination of information from key informants, kindergarten teachers, and parents presented in this chapter suggest that many schools in the state offer a set of common, albeit less intensive practices (e.g., providing information to parents about registration for kindergarten and the kindergarten entry process). Most parents (e.g., 80 percent or more of the family survey respondents) appear satisfied with the supports they receive. However, there is a minority of parents (disproportionately including middle-income families as noted in Figure 5.2) for whom the transition experience was not as positive. The focus group data also suggest that the transition is more challenging for all parties involved when a child has a developmental delay or other special needs. For some parents with children with special needs, the transition is very positive but that appears to be linked to receiving a more intensive set of coordinated supports to prepare them and their children for the new learning setting. For families without

such focused supports for their special needs children, the transition to kindergarten can be more frustrating, with potential adverse consequences for their children's continued developmental progress. Further, formal or informal connections between ECCE providers and kindergarten programs, when working well, can benefit all stakeholders: families and their entering children, ECCE providers, and elementary school teachers and administrators.

Given the importance of ensuring a strong start in kindergarten, these findings suggest an opportunity for stakeholders in New Hampshire to strengthen the kindergarten transition process. There is an opportunity for public and private ECCE programs to help parents understand the expectations for academic, social, and emotional school readiness. There is scope to ensure that school districts understand and adopt evidence-based equitable practices that support ECCE providers, parents, children, and kindergarten classroom teachers in the transition, either on a universal or targeted basis. Thus, some practices, such as the less intensive supports, could be made equally available to all families with an entering kindergartener, whereas more intensive supports could be concentrated on families whose children have special needs or other circumstances that require more services to ensure a smooth and productive transition.

Pilot initiatives, such as the kindergarten teacher home visit model used in Somersworth, can be implemented, evaluated, and disseminated to other districts if found successful. State and local leaders can assess the value of using a common KEA, both for tracking patterns of readiness across groups of students and trends in readiness over time, and for providing information that kindergarten teachers can use to individualize their instruction. More formal ties between ECCE providers and public schools can be fostered through a P–3 approach that incorporates continuity in the curriculum between preschool providers and the early elementary grades, shared professional development for educators across these same programs, and other strategies to ensure a seamless continuum in moving from ECCE settings to formal schooling (Jacobson, 2016; Atchison and Diffey, 2018). Attention is needed to assess the adequacy and effectiveness of kindergarten transition supports for children with special needs. For some districts, adopting this array of practices may require additional resources, both financial and in the form of technical assistance or peer supports.

6. Coordination and Continuity of Other Services Across B–8 Systems

When viewing the B–8 system as a whole, the transition to kindergarten is just one aspect of service coordination and continuity. Creation of a well-functioning B–8 system requires similar attention to coordination and continuity issues in the context of the full array of B–5 services, both the coordination of different services at a point in time, and the continuity of services as children progress through the early childhood years and into the school-age years. Coordination at a point in time includes supports for families with young children that address access to ECCE programs, health and mental health services, parenting education and other family-related services and supports, and services for children with developmental delays and other special needs. Key transitions through time occur when funding streams end and begin, such as at age three, when children move from being eligible for IDEA Part C early intervention services (FCESS) provided through NHDHHS to IDEA Part B services administered through NHDOE. Another such juncture occurs at the time of kindergarten entry, when a handoff is required from B–5 programs to K–12 programs. At the same time, we have a growing body of evidence that service coordination is key for ensuring that young children and their families access the services and supports available to them and get the most from evidence-based practices that can address various early disadvantages (Bipartisan Policy Center, 2018a, 2018b).

One key objective of the PDG B–5 planning grant activities is to consider the B–5 system as a whole and the coordination and continuity across system components. In the prior chapter, we placed a spotlight on the transition to kindergarten. In this chapter, we take a broader look at coordination and continuity of other B–5 services. From this broader perspective, New Hampshire faces similar challenges as other states given the multiplicity of programs, funding streams, and administrative units (see Chapter 2) (Bipartisan Policy Center, 2018a, 2018b). This often complex and fragmented system extends to the local level, as well, where services are delivered in various settings, through an array of public and private providers, all with varied rules about who is eligible based on the requirements of the funding stream. The lack of an integrated data system, a topic discussed in more depth in Chapter 9, presents a further barrier to a well-coordinated system, as does the disjointed structure of the governance system, addressed in Chapter 10.

With this context, we begin in the next section with a brief review of issues already identified with service coordination and continuity in New Hampshire and recent initiatives that seek to improve this aspect of service delivery. We then turn to a summary of what we learned from our interviews with key informants on these topics, and what we heard from the family focus groups, as well as the results from several questions in the family survey centered on experiences with developmental screening.

Background on Coordination and Continuity of B–5 Services in New Hampshire

A central goal in the Spark NH *Framework for Action* is a coordinated early childhood system, one where “New Hampshire’s young children and their families have the benefit of well-coordinated early childhood programs and services that work effectively together on their behalf” (Spark NH, 2016, p. 3). Among the recommendations identified with this goal is to ensure all children are screened for developmental concerns and receive any required services to support their development. That recommendation has led to the continued refinement and expansion of the Watch Me Grow Developmental Screening and Referral System. Watch Me Grow is New Hampshire’s developmental monitoring, screening, referral, education, evaluation, diagnosis, treatment, and service system for families of young children ages birth through five years. The developmental screening results are documented in a centralized database and, with parent permission, the primary care physician is notified of the findings. The current goal is to expand the system to improve its reach and effectiveness, a goal that will require additional funding. Formal supports are also available as children transition at age three from early intervention services as part of FCESS (under IDEA Part C) to school-based special education services (under IDEA Part B), such as those provided by PIC.

As noted in Chapter 2, service coordination is the focus of the ECITs, a joint effort of NHDHHS and NHDOE, which seek to address opportunities for greater coordination of services across programs within and between the two department. Coordination of services is also a priority for many of the Regional Early Childhood Coalitions in New Hampshire. Coös County is often identified as a leader in this area, but the advances made in that region have come about, in part, because of philanthropic resources to support service coordination (Károly, 2019). Within communities, resources focused on service coordination include the FRCs located across the state, which are perhaps the closest vehicle in New Hampshire to a “one-stop” approach to early childhood service coordination. However, the existing FRCs in New Hampshire currently are not consistently funded to meet the needs of the families they serve or to support service coordination, and centers do not exist in every part of the state (Lockwood, 2016).

A well-understood barrier to a better coordinated system is the inability to link administrative data systems to understand the combination of services young children and their families access at a point in time and over time. Such data can supplement information obtained from families and providers, as we do for this needs assessment, to understand current progress and pitfalls toward a more coordinated system.

Insights from Key Informant Interviews, Family Focus Groups, and the Family Survey

We begin our summary of findings from our data collection activities with a focus on developmental screening. We then turn to service coordination and continuity more generally.

Developmental Screening

Developmental screening provides a gateway for linking children identified with developmental delays or other developmental concerns to providers for further assessment and identification of appropriate services. In total, interviewees in 14 of 29 sessions addressed this topic, with input from state/local leaders, providers (including a pediatrician and FRC staff), and LEA leaders. The family survey also had several questions specifically about developmental screening and follow-up (see Tables B.10 and B.17).

There Were Mixed Views among Key Informant Interviewees Regarding the Adequacy of Developmental Screening in New Hampshire

Of the interviewees who commented on developmental screening in New Hampshire, the providers (i.e., the pediatrician and FRC staff) thought developmental screening was well-coordinated, but the state/local leaders thought the current screening system was not working as well as it could. From the perspective of their own practice, the four providers who specifically addressed this topic described the resources they dedicate to coordinating with and informing parents about developmental screening. One provider has a social worker who can help parents with the paperwork and has cultivated information-sharing partnerships with related agencies. As a result, the provider would be notified of screenings and results, which in turn allowed the provider to communicate the information to the child's parents. Another provider said that developmental screenings occurred during home visits and in playgroups and parenting programs organized by the program, which allowed the provider to connect families with further resources as required. A pediatrician noted that screening is done at every well-child visit and that providers discuss the results with families and refer them to additional services as needed. An LEA leader said that students are screened upon entry to kindergarten and connected with an IEP, if appropriate.

In elaborating on their concerns from a broader view of their community or the state as a whole, the state and local leaders noted that parents and child care providers often lack information about developmental screening—particularly the difference between a screening and an assessment. Further, the interviewees noted that providers do not always communicate with parents that they had conducted a screening and the associated results. As one leader mentioned, this lack of communication could become problematic if families are coordinating services themselves. Further, because not all screenings are conducted as part of Watch Me Grow and entered into the associated database, there is incomplete information about which children or

subgroups of children are and are not routinely screened. Further, in the absence of complete information on which children are screened and the screening process, it is not clear if the exemplary practices described by the direct service provider interviewees are being consistently implemented throughout the state.

Despite these different viewpoints, all interviewees agreed it was important to connect developmental screenings to follow-up services, and to clearly communicate with parents about screening events and results.

Most Parents Responding to the Survey Described Following Up on the Results of Developmental Screenings

As noted in Chapter 2, nearly 80 percent of respondents to the family survey indicated that they had heard of developmental screenings, a share that was slightly higher for parents of preschool-age children compared with parents of infants and toddlers. Over 50 percent of parents whose youngest child was preschool-age reported that their child had ever had such a screening; the share ever having a screening was somewhat lower for infants and toddlers, a pattern we would expect as the likelihood of “ever having been screened” would increase as children age. To the extent that parents may not be aware that their child was screened or misunderstand the purpose of an assessment of their child, the true screening rate may be higher or lower than this report from the family survey respondents.

Among the group who reported ever having a screening (about half of the survey respondents), additional questions were asked about what the findings showed and the nature of the follow-up that occurred. In reference to the most recent screening, most parents reported that the screening showed no concerns (74 percent), while 15 percent stated that there were concerns and that a referral was made for further assessment. We cannot say whether those who did not receive a referral, even though concerns were identified, should have received a referral or if it was best practice not to make a referral given the circumstances. Among those where a concern was identified, now a much smaller number of survey respondents, most took some action such as meeting with their child’s doctor (nearly 70 percent), meeting with their child care provider (about 30 percent), or taking some other step such as communicating with those parties. Among those where a referral was made to a specialized service (again, a small number of respondents), just 6 percent of parents indicated they did not follow through with the referral, meaning that 94 percent did follow through. The percentage reporting that they did not follow through was slightly higher when the child was a toddler or preschool-age child compared with an infant and somewhat higher for families in the middle income group. The differences were not as sharp across rural and nonrural families.

Overall, these results suggest that most parents who have their child undergo a developmental screening are able to follow-up if an issue is identified and a referral made. However, there are potential gaps in the system. The family survey responses suggest that about half of children are screened by the time they are almost ready to start school, although this may

be underreported if some parents are not aware of a screening being done. Moreover, according to the survey, a small share of parents chose not to follow-up even when a referral was made for specialized service. Whether these actions are appropriate or instead point to a gap in addressing developmental concerns as early as possible, we cannot say with the information available. Further, given limitations with current data systems (see the discussion in Chapter 9), we cannot seek answers in administrative data systems, such as confirming follow-through and service receipt in medical records or using the Watch Me Grow database for complete information on which screening tool was used, the results of the screening, follow-through, and service receipt, if any. The potential for children and families to fall through the cracks in the system merits further investigation, especially given the concerns on the part of some state and local leaders that the system may not be serving all children and families well.

Service Coordination and Continuity More Generally

Overall, participants in 10 of the 29 interview sessions (attended by 21 participants) addressed the topic of service coordination and transitions, although fewer interviewees discussed transitions than discussed coordination. Participants who spoke to this topic included state and local leaders, service providers (including child care providers, community organizations that provide a variety of services, and social service providers, such as NHDHHS) and LEA leaders. Participants in all of the family focus groups discussed coordination of early childhood services and barriers to service coordination, including participants in urban and rural settings, nontraditional parents, non-English speaking parents, and parents of children with special needs. We highlight the most salient findings.

Most Informants Reported That Early Childhood Services Across Domains Were Not Well-Coordinated, and That the Work of Coordination Fell Largely on Families

Family focus group participants said that most early childhood service providers, including state-administered programs, tended not to coordinate as evidenced by separate applications using different methods (e.g., online, in-person), the absence of information sharing across programs, a lack of familiarity by providers in one domain with the services offered by other programs, and separate program administration. In the words of one family member who participated in the focus groups,

“[coordinating services for my children is] a time consuming thing - there’s no mechanism to support a family in that moment. Especially ...the phone calls with the insurance - that’s a part-time job right there. ... I was like, ‘How do people do this if they’re working?’”

As another family member said, “I think caring for an individual with complex medical needs in this state is a full time job. So you can have referrals, but chasing them down is another kettle of fish.” Likewise, state and local leaders described coordination as “a full-time job” for families that not only includes researching services and doing paperwork, but which also involves, in the

words of one interviewee, “coordinating a lifestyle of people coming in and out of your house, helping you,” which is challenging for families. In addition, one provider noted that early childhood services are scattered throughout the state and are generally not well-coordinated at a local level, which further increases the burden on families.

Multiple Barriers Preclude Effective Service Coordination and Vulnerable Families Tend to Be Most Affected

Key barriers to effective service coordination identified in the interviews and focus groups include a lack of data integration, lack of a guide or concierge to help families coordinate, and children aging out of a service without a connection to the next provider. As one stated, providers generally “do not do warm handoffs.” Other barriers noted by focus group participants or interviewees included the disparate physical location of services (co-location of services may support better coordination), limited funding, unwillingness of leaders to invest in service coordination, staff turnover, lack of communication among services across different domains (e.g., preschool providers and school districts), and limited awareness among providers of the services provided by other agencies and organizations. For example, one LEA leader opined that many school districts reject information from child care providers (e.g., Ages and Stages Questionnaire/developmental information) because of a prejudice against child care.

In addition, families in vulnerable groups, such as those affected by substance misuse or parental mental health issues, were perceived by interviewees to be more at-risk for gaps in services arising from lack of coordination. Consistent with this view, several parents of children with complex medical issues spoke of being overwhelmed with navigating the system of care for their child. One participant in the key informant interviews who worked for an Early Head Start program made this observation (in the context of having to fill out forms multiple times): “In Early Head Start, a lot of our families have serious mental health issues. So those little barriers for you are little barriers, but for them it makes it impossible.” Focus group participants often voiced being grateful for small emotional supports, such as child care during parenting classes, so that they could have a break and socialize; staff at doctor’s offices or child care centers who would ask how they are doing; and advocates who helped relieve some of the logistical and related emotional burdens of navigating the system.

Families Reported a Range of Situations That Can Cause Gaps in Services

The most common reasons for gaps in services reported by family focus group participants were long wait times to access services; physicians making referrals to out-of-network providers or those that do not provide the needed services; providers closing; families unexpectedly being dropped from state programs; families moving; families experiencing issues with insurance coverage; and families unable to continue programs and access services during the summer months. According to families, the gaps that occur during the summer are the result of child care providers reducing hours during these months or the need to make other arrangements for

services (e.g., occupational therapy or physical therapy) that are typically provided by the school district. One parent described the gap in services caused by a provider closing in this way:

“So we had gone there [provider] for years. That’s where my kids got all their therapy. They shut their doors, but then you had to wait to get a spot in the [other provider]. So we had to wait, wait, wait to do that. And then we got in - the person transferred there - but then when she left, they had to wait for a replacement. So there were months that went by that the kids weren't getting therapy because they didn't have a person filling the position and getting in.”

Service Providers Viewed Themselves as Playing a Key Role in Service Coordination, but Lack of Information Sharing Among Providers Made Effective Referrals Challenging

Most providers reported playing a role in coordinating services by providing referrals to families, but some said their ability to provide effective referrals was hampered by limited knowledge about other providers’ services. Although the providers we interviewed said they would prefer to receive information about other services directly from those providers, they tended to receive it from families. Information sharing among providers was rare because of barriers related to data sharing (more on that in Chapter 9 on data systems). Despite these barriers to information sharing among providers, some FRCs are able to provide service coordination to families through home visitors or on-site case managers. Similarly, one interviewee reported that their Community Action Program was successfully coordinating with local hospitals and social service providers to meet families’ needs. Even with this help, however, the providers noted that accessing services (e.g., housing, SNAP, fuel assistance) required completing complex forms and navigating poorly-designed websites.

State and Local Leaders Identified Several Regions and Specific Agencies That Are Doing a Good Job Coordinating Services, but No Statewide Examples Emerged

We asked state and local leaders to discuss examples of successful B–5 or B–8 service coordination locally, regionally, and statewide. The examples cited by leaders were local (e.g., specific agencies) or regional (e.g., specific counties or regions that were successfully coordinating across a range of services). Leaders did not mention any statewide examples and stated that service coordination was not yet successful at the state level. Some examples of successful regional coordination mentioned were Coös County, which was cited by multiple interviewees as a model for service coordination; the Keene region, which has a system of care for behavioral health that helps families coordinate across different service providers; Laconia and Concord school districts, which are coordinating across multiple services; and PIC and FRCs. Some examples of successful local coordination mentioned by interviewees included individual case workers in Nashua; Youth Village, which supports children with behavioral health needs while proactively helping families find other needed support; a community care team monthly meeting funded by Region One and Citizens Health Initiative, which allows local

social service providers to share information and build relationships; and FRCs within state prisons which can form relationships with judges, lawyers, school leaders, and other stakeholders to benefit the lives of children with incarcerated parents. Typically these coordination activities receive additional public or private funds to cover the added resource requirements. For example, the Coös County regional coordination approach has had multi-year funding from a private foundation to support the initiative.

A few families who participated in the focus group mentioned trying to use the statewide system New Hampshire Easy, but found it to be challenging. As one focus group participant said,

“Applying for anything on New Hampshire Easy... is a nightmare because if you forget one piece of paper it knocks everything out..... I love that it’s called New Hampshire Easy, because it’s not.”

Stakeholders Nominated Strategies to Support Greater Coordination, Those Focused on Holistic Services, Inter-Agency Collaboration, and Building Relationships

Each of the interviewees who spoke to this topic mentioned a variety of different approaches to successful service coordination, but there were three common themes. One was providing services in a holistic way, through various means: a medical home, which interviewees described as a good strategy for coordinating health care services; through home visiting services, which interviewees noted often focus on family wellness and access to multiple services (e.g., housing support, job training, income, health of parent and of child); or through community coalitions, which often coordinate transitions from child care settings to school districts, and focus on identifying children who need to be screened for special needs services. A second common theme was inter-agency collaboration, such as one program notifying another when a family is eligible, as in the example offered by one provider: “when someone certifies for FANF we get a ping for WIC to contact that family.” The third common theme was building relationships among providers that facilitated concrete, personal referrals to needed services—a practice several interviewees described as a “warm handoff.” Providers mentioned various strategies for building relationships that would enable warm handoffs, such as establishing memoranda of understanding (MOUs) that would allow data sharing, building personal relationships with other agencies and organizations (although this strategy was jeopardized by staff turnover), or using the Pyramid Model.

Implications for the Strategic Plan

The challenges with coordinating and supporting the transition to kindergarten, discussed in the last chapter, are amplified, in many respects, when considering the coordination and continuity of services across the full range of supports and services for young children and their families. These challenges are no surprise to policymakers and practitioners who experience them in daily work or families who continually experience these issues. Parent frustrations and

struggles are evident in the voices of participants in the focus groups held for this needs assessment and their stories demonstrate why this is a critical area to address. Further, these issues are not necessarily the fault of the providers who deliver early childhood programs and services, nor the agency officials who administer them. These stakeholders are constrained by barriers that preclude the use of data and evidence to inform their decisionmaking. Rather, the lack of coordination is almost an inevitable result of a system with a multiplicity of funding streams, each with its own set of requirements for eligibility, procedures for applying, and processes for maintaining ongoing support. Ultimately, the persistent issues with service coordination and continuity have implications for the efficiency of supports and services for young children and their families and the impact that is realized from these investments. Efforts to improve coordination and continuity has the potential to result in improved efficiency and better outcomes, even for the same level of resources.

Just as service coordination was front and center in the Spark NH *Framework for Action*, the need for further progress in this area suggests it should remain a central priority for the B–5 system strategic plan. Additional guidance is now available to overcome existing barriers and to bring a new level of coordination to a system acutely in need of greater integration. The Bipartisan Policy Center (2018a) is one such source of detailed recommendations for system-level improvements. Furthermore, as noted by interview participants, New Hampshire has already begun experimenting with alternative approaches that can provide a foundation for further testing of new strategies. Improvements in this area will likely benefit from advances in domains covered in other chapters, such as a functional integrated data system and a more coherent governance structure.

7. B–5 System Workforce

It is increasingly understood that a well-prepared, well-supported, and well-compensated workforce is essential for the delivery of high-quality early childhood programs (Institute of Medicine, 2015). From home visiting programs to early intervention to child care and early learning programs, the program leaders and the staff who work directly with young children and their families constitute key stakeholders in and contributors to the B–5 system. Essential elements for an early childhood workforce policy include qualification, compensation, work environments, financial resources, and workforce data (Whitebook et al., 2018).

Research at the national level shows that members of the early childhood workforce, especially ECCE caregivers and teachers in home- and center-based settings do not typically have access to the supports they need to ensure that they are well prepared for their work in terms of the knowledge, skills, and competencies required to support the development of young children and the needs of their families (Institute of Medicine, 2015). The working conditions typically do not provide the opportunities for daily planning and reflective practice needed to be effective, and professional development opportunities are often too limited to ensure further advancement of skills and practice. Finally, compensation in terms of salaries and benefits, especially for ECCE providers in private settings—home- and center-based care—is not commensurate with expectations for degrees and credentials (Whitebook et al., 2018). Consequently, the field is often marked by high turnover rates among staff, staff with unaddressed mental health issues such as depression, and staff who must rely on public-sector subsidies for food and health care to make ends meet (Institute of Medicine, 2015).

In this chapter, we focus squarely on issues affecting the B–5 system workforce in New Hampshire. We first review prior work in the state to assess workforce issues. We then examine the findings that emerge from the key informant interviews with state and local experts and providers, as well as the findings from the workforce survey conducted as part of this needs assessment. We also integrate data from external sources such as the U.S. Bureau of Labor Statistics (BLS) occupational wage data for New Hampshire (BLS, 2019).

Background on the B–5 System Workforce in New Hampshire

Although New Hampshire has a formal early childhood workforce professional registry, there is otherwise little systematic information collected about the workforce, including the estimated 6,000 child care workers, preschool teachers, and preschool/child care center directors in the state (Center for the Study of Child Care Employment [CSCCE], 2018). Coös County administered a workforce survey in 2017 with a focus on the economic well-being of workforce members (Horsch, 2017). The study found that although job satisfaction was relatively high

among ECCE workers in the county, pay and benefits were relatively low, as were opportunities for advancement. For example, while paid sick leave and time off for holidays was common, fewer Coös County workforce survey respondents had health insurance coverage, parental leave, or paid retirement benefits (Horsch, 2017). Consequently just a minority of the workforce reported feeling financially secure and receipt of public benefits for Medicaid and other low-income supports was not uncommon. In addition, meeting professional development requirements was viewed as a challenge, with barriers of time and cost being most prevalent.

These findings are reinforced in a national state-by-state assessment of the early childhood workforce. According to the 2018 *Early Childhood Workforce Index*, published by CSCCE, New Hampshire workforce policies were rated as “stalled” in most areas including qualifications and educational supports, work environments, compensation and financial relief strategies, and workforce data systems (Whitebook et al., 2018). The only domain rated as having some progress was in financial resources (CSCCE, 2018). The *Index* further concluded that “...large swaths of early childhood teachers [in New Hampshire]—even those with college degrees—earn unlivable wages” (p. 1, CSCCE, 2018). As of 2017, the median hourly wage for child care workers was \$10.79, with no change since 2015. The same figure for preschool teachers was \$13.75, 1 percent higher compared with 2015. (The state minimum wage is \$7.25.) When adjusted for the cost of living, the median wage for child care workers in New Hampshire was almost the lowest among the 50 states (Hawaii had the lowest median wage adjusted for the cost of living, just behind New Hampshire). The adjusted median wage for preschool teachers in New Hampshire also ranked among the lowest.

Improving supports for the early childhood workforce has been a priority for a number of the Regional Early Childhood Coalitions in New Hampshire, such as training in trauma-informed care and other professional development supports (Spark NH, 2018). This priority also appears in the Spark NH *Framework for Action* (2018).

Insights from Key Informant Interviews, the Workforce Survey, and Other Sources

The interviews with key informants included questions related to the B–5 system workforce, inclusive of those in ECCE as well as service areas such as early intervention, family support, and health-related services. Interviewees in all of the stakeholder interview sessions (28 of 28) spoke to this topic. These interviewees included state and local leaders, service providers (including ECCE providers, community organizations such as FRCs, and social service providers, such as NHDHHS) and LEA leaders. This topic also came up in family focus groups, although it was not one of the topics identified in the protocol.

In addition, as noted in Chapter 2, we fielded a survey open to individuals in the B–5 system workforce. Tabulations from the 316 respondents are provided in Appendix C. Because of differences across workforce members based on their position (or role) in the B–5 system, we

first focus on findings for the group of respondents who serve as ECCE classroom staff. In the workforce survey, we had responses from 118 individuals who indicated they were a lead teacher/caregiver. Another 48 individuals were in supporting roles in the classroom as teaching associates, assistants, or aides. We then feature differences for program leaders, followed by staff in home visiting or other family support roles. For the survey, we had 48 responses from program leaders and 60 responses from home visitors or those providing other family supports.

Findings Regarding ECCE Classroom Staff

Arguably ECCE classroom staff comprise the largest portion of the early childhood B–5 system workforce. The findings pertaining to this segment of the workforce are based on key informant interviews and the workforce survey (tabulations in Appendix C). In some cases, we incorporate insights from the family focus groups.

There Is a Shortage of Qualified ECCE Staff, Which Hinders the Provision of High-Quality Care

Interviewees who spoke to workforce issues unanimously agreed that New Hampshire faces a critical workforce shortage in the B–5 services sector. This shortage affects a number of service areas within the B–5 system, but interviewees most frequently discussed this issue in the context of ECCE services. Interviewees mentioned a series of interconnected factors that contribute to the shortage of staff—particularly high-quality staff—in child care centers and early learning programs. These issues included low wages, few benefits, a stressful work environment, burnout, turnover, the perception that ECCE work is low-value, and limited ability of ECCE employers to raise wages because of funding constraints. Moreover, many interviewees expressed concerns about the quality of training programs for ECCE staff, which creates barriers to improving workforce quality.

The workforce shortage in the B–5 sector hinders ECCE providers' ability to provide high-quality services to New Hampshire families with young children. Stakeholders we interviewed noted that the shortage of staff often forces ECCE programs to close classrooms and curtail pursuit of opportunities for expansion, ultimately limiting the number of children who can be served. As one ECCE center director reported, “I would never expand [my center] right now. Even if we had all the funding in the world, I couldn't find the staff.” As noted in Chapter 4, parents echoed this concern in focus groups, reporting difficulty finding affordable, available child care that was convenient to their homes. This challenge was exacerbated for parents of children with special or complex needs, who said they struggled to find available, affordable child care equipped to support their children's needs. “We have programs that have asked children to leave because they can't meet the needs... We see a lot of behavior-related issues,” explained an ECCE program leader.

ECCE providers reported in interviews that their centers faced persistent vacancies for classroom staff positions and that they struggle to find workers to fill open positions. Burnout and turnover also affect their staff, resulting in stressed workers leaving their jobs, and in some

cases, the ECCE field. Parents in the focus groups shared concerns about what one person called “work-force churn,” explaining that, “You might have a really good individual [child care provider], and then if that person leaves the program it’s almost a whole new program.” Moreover, ECCE providers reported that many applicants for open positions are sub-par, and frequently do not meet the minimum qualifications required of the position. “Now the quality of applicants is down. [Applicants] don’t have experience,” said one ECCE provider.

Compensation Data Confirm Low Pay and Limited Benefits for ECCE Classroom Staff, with Consequences for Economic Security of Current Staff and Willingness for New Staff to Enter the Field

Occupational earnings data collected and reported by the BLS confirm the low hourly and annual pay for ECCE classroom staff, particularly for those classified as child care workers (see Table 7.1). As of 2018, the average hourly wage was about \$11.50 for child care staff, while average annual earnings was just under \$24,000. For a single-parent household with two children, this annual rate of pay would be just above the 2019 FPL threshold of \$21,330 (USDHHS, 2019-a). Hourly wages and annual earnings are somewhat higher for those classified as preschool teachers (just under \$15 per hour or \$31,000 per year). This category will include both preschool teachers in private centers, as well as those in public school programs.²⁰ Notably,

Table 7.1. New Hampshire Earnings for Child Care Workers and P–3 Classroom Teachers (2018 dollars)

Occupation (BLS Code)	Mean	10th	50th (Median)	90th
a. Hourly Wage				
Child care workers (39-9011)	11.51	8.32	11.11	15.43
Preschool teachers, except special ed. (25-2011)	14.84	10.59	14.05	19.97
Kindergarten teachers, except special ed. (25-2012)	–	–	–	–
Elementary school teachers, except special ed. (25-2021)	–	–	–	–
Teacher assistants (25-9041)	–	–	–	–
b. Annual Earnings				
Child care workers (39-9011)	23,940	17,300	23,100	32,100
Preschool teachers, except special ed. (25-2011)	30,860	22,030	29,230	41,530
Kindergarten teachers, except special ed. (25-2012)	56,710	39,140	57,080	76,850
Elementary school teachers, except special ed. (25-2021)	58,230	40,000	58,240	78,100
Teacher assistants (25-9041)	30,770	20,230	30,380	42,670

SOURCE: BLS (undated).

NOTES: BLS data for New Hampshire are for May 2018. – = not applicable.

²⁰ The average reported hourly and annual pay for respondents in the PDG B–5 Workforce Survey (Table C.7) is somewhat higher for teachers and assistant teachers compared with the BLS data (Table 7.1). The workforce survey is not necessarily representative of the ECCE workforce and the position titles reported will not necessarily match the occupational titles used by BLS.

average annual earnings are more than \$25,000 per year higher for kindergarten teachers compared with preschool teachers.

The PDG B–5 Workforce Survey provides information on other aspects of compensation and access to employer-provided benefits, information that is not collected by BLS. For example, regular wage increases are contingent on funding for about 40 to 50 percent of teachers and assistant teachers who responded to the survey (Table C.7). The most common benefits are paid holidays, sick leave, and vacations, available to about two-thirds of teacher respondents and 50 to 60 percent of assistant teacher respondents. A paid retirement or pension plan is less common for both groups (Table C.7) and even rarer is employer-provided health insurance, received by 22 percent and 14 percent, respectively, of responding teachers and assistant teachers (Table C.15).

Among teachers and assistant teachers responding to the workforce survey, about 23 percent and 19 percent, respectively, reported working one or more additional jobs, some for as much as 20 or more additional hours per week (especially assistant teachers) (Table C.6). Staff in these two positions also reported receiving tax credits or means-tested cash or in-kind benefits. About 45 percent of responding teachers and 52 percent of responding assistant teachers with health insurance are covered through Medicaid or Medicare (Table C.15). Among assistant teachers who responded to the survey, about 20 to 27 percent take the child care tax credit, receive a Child Care Scholarship, or have subsidized housing (Table C.14). The equivalent rates are 14 to 19 percent for teachers.

Indicators of financial insecurity are also relatively high for both teachers and assistant teachers who responded to the survey. For example, about 30 to 35 percent of staff in these two positions are not that confident or not at all confident that they could weather a financial crisis. About the same percentage felt they are not that secure or not at all secure in their current financial situation (Table C.16). And one half or more of respondents indicated they are fairly worried or very worried about not being able to pay monthly bills, not being able to pay for routine health care costs, not being able to pay student loans, and not having enough money for retirement. Having hours cut back at work, having job benefits reduced, and not being able to take time off when needed are other areas of concern affecting as many as half of responding ECCE classroom staff (Table C.16).

Our key informant interviews provided further insight into the ability to recruit individuals into the field (a group not covered by our survey, which was limited to individuals currently in the B–5 field). Notably, interviewees agreed that there is not a strong pipeline in New Hampshire of workers coming into the ECCE field, due in part to the low wages and negative perceptions of ECCE work. Interviewees reported that low wages discourage staff from entering the field for a variety of reasons: difficulty of paying off student loans, planning for the future, or saving for retirement. Additionally, as noted earlier based on the survey data, the field tends to offer few benefits (e.g., particularly health or dental insurance, child care subsidies, paid time off, or

flexible scheduling). According to interviewees, these attributes of ECCE positions, combined with the stress of the job, discouraged talented workers from entering the field.

A few interviewees mentioned funding structures as a barrier to increasing salaries. At multi-service agencies, title determines salary bands, which limit salary flexibility. One ECCE center director reported changing job titles for their employees in order to implement higher salaries. Interviewees also brought up certification requirements as a barrier to entry for workers. Potential candidates might be unwilling to invest the time/money into ECCE, considering low wages. At the same time, workers with degrees in other fields are unable to easily change careers to work in ECCE. Finally, some interviewees suggested that differentiating certification for B–5 and K–12 providers dissuades some workers from entering the ECCE field, due to the pay disparities between pre-K and K–12 educators.

Many ECCE Classroom Staff Have Opportunities for Participation in Professional Development, But There Are Important Barriers to Participation, Especially in Activities That Can Improve Practice

Responses to the workforce survey by ECCE classroom staff indicate that a majority of respondents have access to training and other professional development supports, but these opportunities were far from universally available (Table C.8). These included new staff orientations of various types (up to 69 percent); periodic refresher training for emergency, safety, and health procedures (60 to 68 percent); in-service training opportunities (about 60 to 70 percent); and support to attend courses, conferences or workshops that are not provided by the program (66 to 68 percent). Monthly staff meetings with professional development activities were less common (48 to 52 percent), as was access to a good professional library (57 percent). A majority of respondents have regular supervisory meetings (about 60 percent) and most teachers (77 percent) and somewhat fewer assistant teachers (67 percent) reported receiving a formal review or feedback on their performance (Table C.11).

Most teacher and assistant teacher respondents (87 to 94 percent) stated they get to choose the type of professional development to participate in (Table C.8). About 4 in 10 reported access to assistance with tuition or fees (39 to 41 percent) but even less common was release time for professional development (30 percent for teachers and 13 percent for assistant teachers) and reimbursement for child care expenses (about 20 to 25 percent). In the last 12 months, most common was participating in noncredit courses, seminars, or workshops (70 percent for teachers and 81 percent for assistant teachers), compared with taking credit-bearing college or university courses (46 percent for teachers and 66 percent for assistant teachers), or conducting observation visits with other early childhood programs (53 to 57 percent). Just over half (55 to 61 percent) reporting experiencing coaching or mentoring as part of a formal arrangement (Table C.9). Given that the research literature suggests that more intensive professional development activities (e.g., coaching) are associated with improvements in professional practice compared with less intensive activities (e.g., workshops) (U.S. Department of Education, 2010), the survey

responses suggest that most professional development in New Hampshire for ECCE classroom staff falls in the latter category.

For those who participated in one of the above activities, about half of teacher respondents and a somewhat smaller share of assistant teachers stated that they found the professional development activity helpful or very helpful (Table C.9). For teachers responding to the survey, noncredit courses, seminars, or workshops, as well as formal mentoring arrangements, were judged to have the lowest rating of helpfulness among those who participated in that activity in the prior year. For assistant teachers, credit-bearing college or university classes and coaching had the lowest helpfulness rating. Overall, participation in professional development activities was rated as very helpful or helpful by just over half of teacher respondents and the percentage was somewhat higher for assistant teachers. The most prevalent barriers to participating in professional development, as rated by teachers and assistant teachers, were activities that were too far away or difficult to get to (32 to 35 percent), too expensive (27 to 31 percent), or there was not enough time in their schedule (21 to 22 percent). Fewer than 15 percent of ECCE classroom staff respondents stated that there were language barriers or a lack of incentives (Table C.10).

Discussions with interviewees add to our understanding of the factors that may be associated with ensuring that ECCE staff access meaningful professional development opportunities. In particular, state and local leaders attributed limited funding for professional development on the part of ECCE programs as one explanation for reduced opportunities for high-quality training activities. ECCE program directors, on the other hand, attributed limited training to the workforce shortage. Even if they have a budget to support professional development, program directors struggled to support the needed release time by backfilling with other program staff or bringing in substitutes. “Our issue [is] coverage for classrooms. We have budget [to hold trainings], but we can’t excuse the teachers,” explained one ECCE provider. Another agreed: “We’ve tried to find substitute staff, but that’s hard too.” Child care center directors are forced to choose between closing their center for a day of professional development, asking staff to attend trainings on nights and weekends (sometimes without pay), or not holding professional development sessions at all.

Interviewees also expressed concern that existing professional development for ECCE providers is insufficient to improve teacher practice. According to the interview participants, trainings tend to occur in isolated sessions (i.e., a topic is covered in only one session), making it difficult for providers to implement changes in their practice. More intensive training, such as coaching, is too costly for many ECCE providers. Interviewees, including ECCE providers/leaders as well as B–5 leaders, mentioned a dearth of training on the following topics: child development, trauma-informed care, and communicating with families.

Finally, the interviewees who addressed this topic had varying impressions about the quality of college programs that prepare ECCE providers. “The people joining the workforce come unprepared to be employed. They don’t know how to show up on time, follow rules, or interact

professionally with peers... So many times we have to say that a [student teacher from local community college] isn't employable," explained one ECCE center director. However, other interviewees praised specific community college programs and their ability to prepare individuals for effective classroom practice.

Despite These Issues with Compensation and Professional Development Opportunities, the Majority of ECCE Classroom Staff Are Satisfied with Their Jobs, Although There Are Sources of Stress and Many Plan to Change Jobs Within a Few Years

Overall about 75 percent of teachers and 71 percent of assistant teachers agreed or strongly agreed that they are satisfied with their job (Table C.12). A similar share agreed or strongly agreed that they felt empowered to do their job, but a somewhat smaller share gave the same ratings to the statement "I feel prepared for the challenges of meeting the learning, social-emotional, and other developmental needs of young children and their families." There was less satisfaction with some specific aspects of the work environment. For example, nearly half of teachers and one-quarter of assistant teachers agreed or strongly agreed that they were required to complete too much paperwork. Only about one-half agreed or strongly agreed that they have sufficient preparation time, while a somewhat larger share felt they had time "to reflect on my work and improve my practice." Despite these majority views, the counterpart is that a nontrivial segment of ECCE classroom staff who responded to the survey disagreed or strongly disagreed with these favorable assessments. Indeed, just about half of classroom staff agreed or strongly agreed with the statement that "I am often overwhelmed at work."

When respondents were asked to state where they expected to be in two to four years, just under half of teachers and fewer than one-quarter of assistant teachers expected to be in the same position (Table C.13). Teachers who expected to change were about equally split between being in a different job with the same program versus being in a new position with another employer. Most assistant teachers who expected a change anticipated being in a similar position with a different employer. Fewer than 4 percent of either teachers or assistant teachers expected to leave the field completely. For those planning a change, common reasons given were to obtain a higher paying job (22 percent of teachers and 27 percent of assistant teachers) and obtaining better benefits (16 percent for both groups).

Findings Regarding B-5 Program Leaders

The workforce survey was completed by a smaller number of B-5 program leaders compared with ECCE classroom staff, but there are some general patterns that are worth highlighting. For the most part, B-5 program leaders face better circumstances in their positions compared with the ECCE classroom staff that were the focus of the prior section. For example, according to the BLS occupational wage data, with the exception of preschool and child care program directors, salary levels are generally higher for education administrators and social and community services

managers (Table 7.2). The higher salaries are also evident in the survey responses for program leaders (Table C.7).

Program leaders are reportedly more likely to have access to some benefits compared with classroom staff (e.g., sick leave, paid holidays, paid vacation, paid professional development time) but are less likely to have others (e.g., paid overtime, paid maternity/paternity leave, paid retirement plan) (Table C.7). They also report higher family income and lower rates on various indicators of economic instability (Table C.16).

Program leaders who responded to the survey have higher rates of access to various trainings, but they participate in a somewhat different mix of professional development activities, such as fewer credit-bearing courses (because many already have post-secondary or post-graduate degrees) and coaching, as illustrative examples (Tables C.8 and C.9). Having enough time is the biggest hindrance to professional development participation for program leaders, even more so than other B–5 workforce members (Table C.10).

Overall job satisfaction is higher for program leaders compared with ECCE classroom staff, as were favorable assessments of other aspects of the work environment (Table C.12). For example, program leader survey respondents were more like to agree that they feel prepared, supported, and empowered. Leaders reported the most “voice” in decisionmaking compared with respondents in other positions, consistent with their role, but they were also most likely to agree that they have too much paperwork.

There were sharp differences in future plans by position (Table C.13). Leaders were most likely to see themselves in the same position in two to four years (63 percent) (and also as retired, 10 percent). Like respondents in other staff positions, among program leaders planning to move, obtaining better pay was one of the most prevalent reason for wanting to change, along with wanting to reduce hours of work.

Table 7.2. New Hampshire Earnings for B–5 Leader Occupations (2018 dollars)

Occupation (BLS Code)	Mean	10th	50th (Median)	90th
a. Hourly Wage				
Education administrators, preschool and child care center/program (11-9031)	24.36	14.11	23.13	36.47
Education administrators, elementary and secondary school (11-9032)	–	–	–	–
Social and community services managers (11-9151)	31.43	20.58	29.97	45.39
b. Annual Earnings				
Education administrators, preschool and child care center/program (11-9031)	50,660	29,340	48,100	75,850
Education administrators, elementary and secondary school (11-9032)	87,570	63,840	87,570	112,910
Social and community services managers (11-9151)	65,380	42,800	62,340	94,400

SOURCE: BLS (undated).

NOTES: BLS data for New Hampshire are for May 2018. – = not applicable.

Findings Regarding Other B–5 Family Support Staff

The category of other B–5 staff includes a combination of home visitors and other family support staff. In many respects, responses to the workforce survey for this group are very similar to those just reviewed for program leaders and sometimes they are similar to ECCE teachers. For example, the average hourly and annual earnings reported in the survey are similar to those for teachers (Table C.6). However, that average masks variation across different positions. BLS data for positions that are most relevant for the non-ECCE part of the B–5 system workforce indicate average annual salaries in New Hampshire ranging from about \$18,000 for community and social service specialists to \$45,500 for health care social workers (Table 7.3). Some staff in these roles work for government agencies, which often means higher pay scales and a wider array of benefits. The relatively higher compensation for this segment of the workforce in turn translates into lower rates of economic insecurity, as well as higher rates of job satisfaction.

It is worth noting that in the key informant interviews, other workforce segments within the B–5 system were reported to have challenges similar to those faced by the ECCE sector. These challenges did not come up as frequently in the interviews, but they did emerge. For instance, interviewees expressed concern about the lack of home visitors, (DCYF) case managers, and

Table 7.3. New Hampshire Earnings for Family Support Occupations (2018 dollars)

Occupation (BLS Code)	Mean	10th	50th (Median)	90th
a. Hourly Wage				
Substance abuse, behavioral disorder, and mental health counselors (21-1018)	20.96	13.12	19.87	30.83
Child, family, and school social workers (21-1021)	25.44	18.19	23.82	36.46
Healthcare social workers (21-1022)	31.04	21.89	31.04	39.15
Mental health and substance abuse social workers (21-1023)	27.46	18.80	27.37	36.88
Social workers, all other (21-1029)	34.10	21.16	34.95	44.18
Health educators (21-1091)	28.41	15.79	28.13	43.14
Community health workers (21-1094)	23.58	15.80	22.33	33.20
Community and social service specialists, all other (21-1099)	20.34	8.90	20.21	29.55
b. Annual Earnings				
Substance abuse, behavioral disorder, and mental health counselors (21-1018)	43,600	27,280	41,330	64,120
Child, family, and school social workers (21-1021)	52,920	37,840	49,540	75,840
Healthcare social workers (21-1022)	64,570	45,530	64,560	81,440
Mental health and substance abuse social workers (21-1023)	57,110	39,090	56,940	76,700
Social workers, all other (21-1029)	70,920	44,020	72,690	91,890
Health educators (21-1091)	59,100	32,840	58,520	89,740
Community health workers (21-1094)	49,050	32,870	46,460	69,050
Community and social service specialists, all other (21-1099)	42,310	18,520	42,040	61,460

SOURCE: BLS (undated).

NOTES: BLS data for New Hampshire are for May 2018.

health care providers (including mental health providers, specifically infant mental health care professionals). For many of these positions, low wages and benefits and stressful working conditions contributed to this challenge. Interviewees also discussed a lack of high-quality training opportunities across sectors to improve workforce quality.

Workforce Survey Respondents and Interviewees Had Similar Views on Priorities for Improving Early Childhood Programs and Services

Respondents to the workforce survey were asked to pick their top three priorities among a list of seven options for improving the B–5 system. Among the strategic options listed, respondents gave highest priority to increasing compensation of the workforce (60 percent), enhancing service coordination (42 percent), and improving equitable access to early childhood programs and supports (41 percent). For the most part, preferences over the strategic priorities were very similar across the four categories of the workforce we examined (Table C.17). Increasing compensation was the first or second most highly ranked issue for all four position subgroups and improving equitable access was another high priority for all groups. Teachers and assistant teachers also placed high priority on enhancing service coordination, raising program quality, and improving equitable access for vulnerable children and families. Leaders placed a somewhat higher priority on improving the quality of facilities compared with respondents in the other positions. Other concerns expressed in open-ended comments included addressing the cost of ECCE and other barriers for families such as transportation, addressing shortages in program services (e.g., child care and early learning slots), enhancing the mixed delivery system, and focusing on workforce professional development.

Interviewees were also asked about strategies for improving the quality of the ECCE workforce and expanding the reach of services. The most common response to this question was to increase the wages and benefits of ECCE workers. Interviewees suggested that this strategy, combined with scholarships or student loan forgiveness programs, would encourage more talented workers to enter and remain in the field. In addition, interviewees advocated for improved professional development to help bolster the skills of the existing workforce. Some interviewees suggested that mentorships and coaching could help; others suggested pooling resources to provide trainings in tandem with local school systems or other ECCE providers. Finally, interviewees suggested alternate accreditation pathways to allow mid-career professionals to easily transition into the early childhood workforce.

Implications for the Strategic Plan

Ensuring that New Hampshire has a well-prepared, well-supported, and well-compensated B–5 system workforce requires understanding the multiple segments of the workforce essential for a well-coordinated B–5 system. Staff who work in ECCE programs as caregivers, teachers, and assistants is one obvious subset of the workforce that merits attention, but other segments

include the staff in other components of the B–5 system who directly serve young children and their families, such as home visitors, parent educators, early intervention specialists, and family support workers, among others. Program leaders for B–5 system programs is another critical segment. For each of these groups, there are both challenges and opportunities for improving workforce qualifications, ongoing professional development, and other aspects of the work environment, including compensation.

The qualitative and quantitative information collected for this needs assessment provides key information about workforce issues that are not systematically covered by existing information sources. These data show that there are critical issues for the B–5 workforce in New Hampshire, particularly for the ECCE segment and specifically for the ECCE staff that work directly with children in center and home settings. First, there is a concern about a shortage of ECCE classroom staff—lead teachers and assistants—who can provide high-quality care and early learning experiences. The shortage likely had multiple causes including the overall strong economy in New Hampshire and the state’s low unemployment rate; the relatively low levels of compensation for staff in these positions, particularly in the private sector; and perceptions of the ECCE sector as undesirable, in part because of the low compensation, as well as other aspects of the work environment. Second, there is an issue of ensuring that staff in the sector receive effective pre-service education and training and that there are well-defined career pathways with opportunities for advancement, including the needed professional development supports. These are issues shared with many other states and there may be opportunities to learn from other states based on innovative approaches to these issues.

For example, compensation issues for the workforce have been addressed through financing mechanisms directly tied to the workforce such as the T.E.A.C.H scholarships and the WAGES program (Károly, 2017). Using tiered reimbursement along with a QRIS can provide another mechanism for increasing the payments that providers receive as they increase their quality, a portion of which can be used to increase workforce compensation. More structured evidence-based opportunities for professional development, such as coaching, can be introduced as part of developing a statewide workforce professional development system. Improving the quality of the higher education system that trains the ECCE workforce could be another priority. Other supporting infrastructure would be a workforce registry that would be used to identify members of the B–5 system workforce and their qualifications; track participation in approved evidence-based professional development opportunities; qualify trainers, coaches, and other professional development providers; and compile available professional development opportunities.

8. B–5 System Facilities

Facilities are often overlooked as an essential component of a coordinated high-quality B–5 system (National Academies of Sciences, Engineering, and Medicine [NASEM], 2018; Bipartisan Policy Center, 2019). The facilities where ECCE programs are housed, including both indoor and outdoor space, contribute to the quality of early learning environment. At a minimum, home- and center-based ECCE programs need to meet basic health and safety standards. These licensing requirements are designed to ensure adequate square footage in the facility, as well as freedom from hazards and other conditions that would be unsafe. Other aspects of facility design, often not addressed by licensing requirements, ensure that the ECCE environment is developmentally appropriate and supportive of children’s physical, social, emotional, and cognitive development (Bipartisan Policy Center, 2019). These features include child-size fixtures (e.g., toilets, sinks) to encourage independence and good hygiene; windows in classrooms and common areas with sufficient natural light that allows children to feel connected to the outside world; common spaces to promote engagement with other children and adults; acoustics that foster the development of memory, attention, and learning; and access to outdoor spaces that support connections to natural environments, the development of gross motor skills, and other benefits of physical activity. The ability of non-ECCE B–5 programs to provide quality service—from early intervention to family support—likewise depends upon the nature of the facilities where staff interact with families and children, as well as each other. Again, these aspects of quality typically go beyond what might be covered by building codes or specific licensing requirements.

Nationally, investigations into ECCE facilities show that, despite licensing standards, many are deficient in basic health and safety features, not to mention the array of other aspects of the design environment that constitute high-quality settings (USDHHS, 2013). One challenge in assessing the status of facilities is the dearth of systematic sources of information at the national or state level on current ECCE facilities and their features. Efforts to improve ECCE facilities are constrained in that program annual operating funds are typically insufficient to cover capital improvements in indoor or outdoor spaces. Many providers do not have access to loans at reasonable rates or cannot afford to take on additional debt (NASEM, 2018). In some parts of the country, states, counties, and cities have established special facility investment funds that are available to individual ECCE providers in the form of grants or low-interest loans to support improvements (NASEM, 2018). Other communities have instituted development impact fees on new commercial and residential developments as a source of revenue to invest in ECCE facility improvement and expansion (Bipartisan Policy Center, 2019).

In this chapter, we begin by considering prior efforts in New Hampshire to examine issues pertaining to B–5 facilities in the state. In general, this issue has not received as much attention

as other aspects of the B–5 system covered in other chapters, in part because of limited information. We then present insights from interviews with stakeholders in the state regarding the issue of facilities.

Background on B–5 Facilities in New Hampshire

In the absence of routine data collection regarding ECCE facilities, New Hampshire, like many other states, does not have current information on the features of existing facilities. Another gap is information about the extent to which the availability of affordable, well-designed facilities is a barrier to ensuring that current programs are delivered in high-quality settings or whether further expansion of high-quality program models in existing facilities or new ones is feasible. Perhaps because of this dearth of information, facilities issues are rarely covered in regular assessments of the ECCE landscape in the state, such as the snapshots and fact sheets produced by the Bipartisan Policy Center (2018-b), Child Care Aware (2019-b), and the Center for American Progress (2019). The issue of facility needs does not receive much, if any attention, in either the Spark NH *Framework for Action* (Kieschnick and Milliken, 2015) or the *Promising Practices Guide* (Spark NH, 2018).

In assessing local investments in early childhood programs in four case study communities in New Hampshire, Karoly (2019) noted that district-operated preschool programs, in particular, were housed in varied facilities, such as elementary school classrooms, stand-alone centers, and in one case, a high school with an early childhood workforce training program. The availability of appropriate indoor and outdoor spaces was identified in the study as one of the constraints on further expansion of district-operated preschool classrooms, in particular, but similar issues apply in early childhood centers and home-based facilities. Even when space is available, funds are required to cover the cost of retrofitting the facility to serve younger children (e.g., child-sized toilets and sinks). Outdoor spaces may likewise need modification to be developmentally appropriate for younger children. Notably, one of the district-supported preschools in a stand-alone center included in the Karoly (2019) study had raised funds through grant applications to create a dedicated sensory room in support of children with various developmental challenges and to enhance the center’s outdoor play area.

In terms of financing investments in ECCE facilities, New Hampshire has the distinction of establishing one of the first community development financial institutions in the country. Since 1983, the New Hampshire Community Loan Fund has been leveraging resources from diverse funders and investors to finance a range of community needs, from low-cost housing to matched family savings programs to facilities for nonprofits. Financing for quality improvement and expansion of home- and center-based ECCE facilities is one of their focus areas. The Fund also provides trainings and other technical assistance to ECCE providers to promote their business skills in such areas as financial management, accounting, fundraising, and human resources. Their 2017–2018 loan portfolio included about \$1.2 million for child care facilities out of a total

loan fund of nearly \$120 million (New Hampshire Community Loan Fund, 2018). A community-based loan fund is one of the models for financing early childhood facilities referenced in the inventory of funding options compiled by the Bipartisan Policy Center (2019).

Insights from Key Informant Interviews

As part of the interviews with key informants, we inquired about issues related to facilities for B–5 programs, both ECCE facilities and those required for other service areas. Sixty-seven of the 91 stakeholder interview participants (interviewed in 24 of the 28 sessions)—or about three-quarters of the individuals interviewed—addressed the topic. This group of individuals included state and local experts and providers of child care, health care, and housing services, as well as community-based organizations that provide a variety of other B–5 services. A majority of the providers were leaders of ECCE programs and most interviewees who addressed this topic discussed ECCE program facilities.

B–5 System Facilities are Generally in Poor Condition, Particularly in Lower-income Communities

Issues with B–5 system facilities cut across service areas and providers in New Hampshire. Lack of adequate space, and of space that is constructed and organized to meet the requirements of service providers, were the key issues raised by leaders and service providers alike. Interviewees reported that the condition of New Hampshire child care facilities and the spaces used by community service providers (e.g., FRCs) was generally poor because programs were in old or inadequate spaces that had not been well-maintained. Providers located in repurposed spaces, such as churches, indicated that retrofitting these spaces to meet the service provider requirements is difficult and costly. Providers reported that high-quality facilities, with sufficient space to meet families’ needs (for child care centers) or have private consultations with clients (for community service providers), and which offered necessary amenities, such as outdoor space or accessibility for people with disabilities, were scarce. Interviewees who spoke about the condition of health care facilities noted that some do not have appropriate equipment to provide specialized services, such as neck stretching for infants. Likewise, in some regions of the state, there are few hospitals with high-quality childbirth facilities.

For providers who wish to expand services, space is one of many constraints, along with limited funding and workforce challenges. Furthermore, upgrading or renovating lower-quality facilities—particularly for ECCE facilities—is difficult because of limited funding and changing regulatory requirements (e.g., building codes). Taken together, providers reported that these conditions limited the amount and quality of the services they were able to provide to families. As one provider said, “There are code issues every time a town gets a new fire or health inspector. There can be costly changes ... These changes happen all the time because so many people use our facilities. If folks don’t have money put away, the facility can fall into disrepair

which is a risk for children, staff, and the organization in general.” Interviewees agreed that facilities challenges are greater in lower-income communities compared with higher-income areas.

Creative Solutions May Address Facilities Shortages and Quality Concerns

The child care providers and community service providers we interviewed said that developing partnerships with businesses, building property managers, or other community service organizations (e.g., churches) could help address facility shortages and provide extra space. One child care provider said they had been successful in developing partnerships with property managers, who provided well-maintained space at reduced cost. The same provider described developing partnerships with businesses to provide on-site child care services, taking advantage of space made available by the company. Similarly, one community service provider talked about co-locating their services in the same building with other, similar social service organizations—a “one-stop” solution that was convenient for families and allowed the space to be used efficiently. Stakeholders and providers also discussed the benefits of community financial resources, such as community loan funds or financing from community development corporations, which can offer service providers low-cost loans or other financial resources to maintain or improve facilities.

Implications for the Strategic Plan

Access to high-quality facilities is often overlooked as an essential component of developing a well-coordinated B–5 system, largely because there is little systematic information about the state of current facilities and the availability of appropriate space to support program expansion. At the same time, there is growing understanding of the important role that well-designed and well-maintained facilities play in ensuring that B–5 providers can deliver high-quality services and achieve the desired impact on children’s development and the well-being of their families. In New Hampshire, there is a key information gap in understanding the extent of the shortfall in current facilities and the limitations on further expansion, beyond the information gleaned from qualitative information such as the key informant interviews summarized in this chapter. Those interviews suggest that the B–5 facilities in use in the state are in dire need of improvement, especially in lower-income communities. Limitations on funding for facility improvements and the preparation of new facilities appear to be a key barrier to addressing shortfalls in access and quality of B–5 programs. The existence of the New Hampshire Community Loan Fund represents one approach to financing that could be expanded or replicated to meet the B–5 system facility needs.

These findings point to the importance of addressing facility issues in the state B–5 system strategic plan. One priority could be conducting a comprehensive needs assessment to address the gaps in knowledge about the quality of current facilities and the resource needs for facility

quality improvement and program expansion. Another priority is identifying funding strategies at the state and local level to support facility improvement and access to new facilities for program expansion. In this area, the Bipartisan Policy Center (2019) has identified an extensive menu of options for securing funding—from existing federal B–5 funding streams to dedicated funding mechanisms at the state and local levels, such as grant and loan programs funded by dedicated taxes or fees. The New Hampshire Community Loan Fund is one such model, although funding for ECCE facilities currently represents about 1 percent of their loan portfolio, given their focus on a broader range of investment needs in low-income communities. After identifying strategies that are a good fit for New Hampshire, pilots could be conducted in parts of the state before taking successful approaches to scale.

9. B–5 Data Systems and Data Integration

As U.S. states have moved toward comprehensive B–5 systems to support families with children in the early years, a statewide early childhood integrated data system (ECIDS) has been recognized as a critical infrastructure component. An ECIDS can be used to examine service utilization within and across publicly funded programs; the quality of programs that serve children and families; and the relationship between program participation and school readiness, educational performance, and health outcomes (King and Perkins, 2019). Integrated data may capture information at the level of the child, family, program, or workforce member. Such data has a primary focus on the early childhood sector, covering subsidized child care, preschool and prekindergarten programs, early intervention services, home visiting programs, and other early childhood family supports. But ideally an ECIDS also allows examination across other systems such as K–12 education, health, and social services.

According to the 2018 Early Childhood Data Systems Survey (King et al., 2018), just 22 states had the capacity to link child-level data for at least one early childhood program and only two states were able to link data across six key programs (namely IDEA Parts B and C, state pre-kindergarten, state-funded Head Start, federally funded Head Start, subsidized child care, and home visiting programs). Recognizing the value of integrated data systems, another 12 states in the 2018 survey reported plans for data linkages. New Hampshire was one of 16 states recorded as having no current linkages or plans to create such linkages.

The 2018 Early Childhood Data Systems Survey does not recognize the steps that New Hampshire had taken prior to receiving a PDG B–5 award, including a comprehensive assessment of the data systems for a set of key publicly funded early childhood programs in the state and the barriers to further data integration (Spark NH, 2013). The PDG application reflected this foundation, establishing a priority of creating an integrated longitudinal data system starting at birth and continuing to adulthood.

In this chapter, we first provide background on the prior work in New Hampshire focused on integrated data for the early childhood sector. We then feature key findings from the PDG B–5 Needs Assessment data gathering activities, in this case interviews with B–5 state and local leaders, service providers, and LEA leaders. In Chapter 2, we featured estimates of the unduplicated count of children ages 0 to 3 served by IDEA Part C services and Child Care Scholarship. In this chapter, we identify the steps required to produce those estimates as a way of highlighting the challenges of integrating data, even within the same government agency (NHDHHS in this case). We also summarize findings from focused work as part of the PDG activities conducted by the Early Childhood Data Integration Working Group, led by NHDHHS, NHDOE, and the UNH Research Computing Center (Ridgeway and Anderson, 2019).

Background on B–5 Data Systems in New Hampshire

In 2013, Spark NH published findings from the Early Childhood Data Systems Committee, which had been tasked with issuing an early childhood data system blueprint and recommendations (Spark NH, 2013). The committee identified 10 fundamental elements for a high-quality early childhood data system, including unique statewide identifiers for children, sites/providers, and workforce members; child-level data on demographics, program participation, and outcomes; linkages between early childhood and K–12 data systems; linkages across children, sites/providers, and workforce members; transparent privacy protections and security policies and practices; and a state governance body to manage data collection and use. At the time of the report, New Hampshire’s data systems would generally not support these features, as data systems were partitioned within agencies or offices with little ability to link systems at a point in time or over time (Spark NH, 2013).²¹ It was also recognized that the state’s strong privacy laws, while designed to protect sensitive information about individuals in state data systems, could limit greater data integration in their current form. The resulting recommendations, modeled on best practices for other states, included options for a federated database system, a data warehouse, and use of common standards. A major barrier to moving forward with an integrated data system has been the required resources to build the system architecture and convert legacy systems, an estimated \$4.7 million multi-year effort as of the 2013 report.

In subsequent systems-building work by stakeholders in New Hampshire, issues with the quality of data were identified with such data systems as the one used for Watch Me Grow to track developmental screening results, where inconsistencies in how data are entered were noted, which then hinder the usefulness of the data (Spark NH, 2018). Resolution requires clear protocols for data entry and coding, as well as appropriate training and support for staff entering the data. Furthermore, the collection and use of data have been a focus of the Spark NH Community of Practice centered around 11 regional initiatives (Spark NH, 2018).

Insights from Key Informant Interviews

The protocol for the stakeholder interviews included questions on integrated data systems for the early childhood sector. Participants in 22 of the 28 interview sessions addressed the topic. This subset consisted primarily of state and local leaders but also included a few providers of child care, health-related services, and human services, as well as one LEA leader. We summarize two findings that emerged from these discussions.

²¹ In an assessment for the Cöos Coalition for Young Children and Families, similar issues were identified regarding the ability of stakeholders in Cöos County to access state early childhood data systems covering B–5 services for the county’s young children and their families (Wauchope, 2014).

Lack of Integrated B–5 Systems Data Hinders Service Coordination

The interviewees who commented on this topic agreed that B–5 data systems were not integrated across sectors and providers in New Hampshire. This lack of integration introduces multiple challenges to using data to coordinate services, understand program quality and effectiveness, and inform policy. More specifically, interviewees cited the difficulty of accessing data (e.g., on families or children served or services provided) and the inability to follow individual children or families across services and programs. These are key challenges to coordinating services across providers—including between B–5 systems and the K–5 school system—and understanding program quality. To interviewees, an integrated data system would link the various data collected across different B–5 agencies and service providers so that a user could see, for example, the full range of services in which a child was enrolled, whether the child had special developmental or health care needs, where the child attended preschool, and whether the child’s family received Child Care Scholarship funds.

There are Multiple Barriers to Data Integration

Interviewees mentioned numerous barriers to integrating data systems, ranging from a lack of funding to the multiplicity of software used by providers. The most commonly mentioned barriers were lack of resources, such as staff capacity and funding, and lack of support among state and agency leaders, driven, in part, by a perception that data integration would be too difficult or infeasible given federal privacy laws, such as under the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational and Privacy Rights Act (FERPA), along with state statutes. In addition, one interviewee noted that the lack of data sharing also adversely affects families, who wonder why providers in one part of the system cannot see their records from another part of the system and are frustrated by having to tell their story multiple times to different service providers.

Lessons Learned from Generating an Unduplicated Count of Participants in FCESS and Child Care Scholarship

Chapter 2 presented the results of an analysis to generate an unduplicated count of children ages 0 to 3 served by FCESS (Part C of IDEA) and Child Care Scholarship. These estimates were produced as part of a joint effort on the part of NHDHHS, NHDOE, and UNH involving program administrators, information services staff, the relevant data systems experts, and legal

counsel.²² After cataloguing the data systems across the focal programs, the team identified a number of factors that constrained data integration. These included the absence of a common ID across systems, systems that could not deduplicate records, privacy protections that require parental consent in order to share some data outside of the original system, federal HIPAA and FERPA requirements, and state privacy laws, which are more restrictive than the federal requirements. Broader considerations encompassed concerns on the part of families and other stakeholders with tracking children over time and whether there is a clear justification for sharing data across agencies.

The production of a deduplicated estimate of children receiving FCESS and Child Care Scholarship was possible because the data systems were both in NHDHHS. Nevertheless, matching of records required manual intervention because there was no common identifier across the systems for the two programs. Advances toward greater integration will require putting in place MOUs and data sharing agreements (DSAs), with the possibility of requiring approval by the New Hampshire Governor and Executive Council or revisions to state law to permit data integration.

Key Findings from Integrated Data Systems Needs Assessment

As part of the PDG B–5 planning grant, a systematic needs assessment was conducted for an ECIDS in New Hampshire under the leadership of NHDHHS and the UNH Research Computing Center, together with data stewards, data system managers, and other decisionmakers from NHDOE and New Hampshire Department of Information Technology (NHDoIT) involved in the management, collection, use, and reporting of B–5 system data. The multi-agency working group conducted a series of activities to support the development of a strategic approach to establishing an ECIDS for New Hampshire. The activities included cataloguing the various databases associated with B–5 system programs and their features (see Appendix E), as well as conducting interviews and a survey to further assess the current landscape. These efforts identified multiple challenges with the current system (Ridgeway and Anderson, 2019):

- **The absence of a unique child identifier assigned from birth.** This is a well-known issue and affects databases within and across agencies, as the example discussed earlier demonstrates. Establishing such an identifier raises concerns with privacy and whether the benefits from being able to follow children through time outweigh the risks of disclosure, especially with the electronic storage of large amounts of data.

²² The team originally planned to also examine preschool special education (Part B of IDEA) in order to test data integration both within programs administered by NHDHHS and across programs administered by NHDHHS and NHDOE. However, the barriers to integrating data across agencies could not be resolved at the time the analyses were conducted.

- **State and federal privacy laws.** These important legal protections can also limit data integration and use of the resulting data to support decisionmaking. In New Hampshire, state laws—such as those under the Student and Teacher Information Protection and Privacy chapter of the New Hampshire Education Laws (State of New Hampshire, 2019)—can be even more restrictive than federal rules under HIPAA, FERPA, and other similar regulations. Frequent amendments to state statutes require updates to policies and procedures.
- **Ownership of some data by the state and other data by state contractors.** Depending on the B-5 program, data may be managed inhouse or by an external contractor. The addition of other parties complicates data sharing and often requires establishing MOUs or DSAs, often specific to each case, a step that can further delay obtaining the desired information.
- **Limited staff capacity to perform requests for data integration or execute more systematic system-level changes.** Current staff are occupied with the need for data within their own agencies and have little time or incentive to fulfill requests for shared data or to invest in a new data system. Further, conflicting policies across agencies present data stewards with the responsibility for resolving differences.
- **Inability to meet federal reporting requirements.** Federally funded programs require periodic reporting on program operations and outcomes, and the ability to combine data across programs and agencies may be involved. The current constraints on data integration in New Hampshire jeopardizes the ability of the state to meet current or future federal reporting requirements.
- **The lack of a formal data governance structure.** With data currently housed within varied agencies, the absence of a formal data governance structure makes it unclear who is responsible to fulfill requests for cross-agency data and other data integration needs. A well-resourced and effective data governance structure would ensure that standardized data access and use policies are in place and updated as needed, that data are securely stored and best practice information security procedures protect data from unauthorized use, and that data can be accessed in a timely manner (King and Perkins, 2019).

Despite these issues, it is notable that some data sharing does occur. For example, NHDOE receives data from NHDHHS’s New Heights database identifying children who are potentially eligible for a free or reduced-price lunch under the federally funded National School Lunch Program, based on participation in NHDHHS programs (e.g., FANF or Medicaid). However, the matching of children from the NHDHHS files into the NHDOE student roster is problematic, because the two systems do not have a common identifier. Thus, considerable NHDOE staff time is required to perform the eligibility checks.

Another development worth noting is that plans are proceeding to implement a robust enterprise data system across various state agencies. In particular, some state agencies are in the

process of awarding contracts for improvements to their data systems. This creates a window of opportunity for addressing data integration issues at the same time as the system-by-system upgrades.

Ultimately, these findings reinforce those from the 2013 Early Childhood Data Systems Committee, as well as those from the key informants interviewed as part of the PDG B–5 Needs Assessment. Further, these challenges are not unique to New Hampshire, as other states have faced similar barriers, including those who have established ECIDSs. The strategies adopted by other states can provide a roadmap for New Hampshire to advance an ECIDS. At the same time, the experience of other states demonstrates that developing such systems is typically a multi-year effort that requires a significant one-time infusion of resources, along with the funds required for ongoing maintenance and upgrades.

Implications for the Strategic Plan

Stakeholders in New Hampshire have recognized the need for improved data integration within and across agencies that supports a coordinated data-driven B–5 system, perhaps with the eventual goal of an ECIDS. The lack of integrated data for the early childhood sector is a fundamental barrier to advancing the desired B–5 system in the state. If an ECIDS can achieve its promise, this missing element means that young children and their families are less likely to experience coordinated supports and services at a point in time (e.g., follow-up supports) or over time (e.g., a handoff from one program to another as a child ages), that providers will be limited in the information they have to inform their day-to-day activities, and that decisionmakers at the local and state levels will be unable to meet reporting requirements or benefit from real-time information about the inputs and outcomes of the system they manage. Given these potential consequences, New Hampshire can consider prioritizing an investment in an ECIDS or similar system as a strategic goal.

Establishing and maintaining a well-functioning ECIDS requires substantial resources for design, implementation, and ongoing support. Fortunately, New Hampshire stakeholders have already completed foundational work toward an ECIDS and there is an opportunity to leverage data system upgrades that are in process. Further, there are other states that provide models for how to structure a system, along with valid tools and other resources to draw from for implementation. Any effort to advance an ECIDS for New Hampshire would ideally ensure that all stakeholders that contribute to data systems (e.g., families, agency field staff, providers), as well as eventual end-users (e.g., agency information technology staff and analysts; external researchers) are consulted in the process to ensure that the burden of supplying data is reasonable for the former and that the resulting data are timely and useful for the latter. It will also be essential to address barriers that may be unique to New Hampshire - such as the state's strict privacy laws.

10. B–5 System Governance

As states expand their support of early childhood programs, an effective governance structure is recognized as a key pillar for a comprehensive, coordinated B–5 system (Atchison and Diffey, 2018). Governance captures the structures for decisionmaking authority and accountability; budgeting and fiscal management; data collection and management; and planning, implementing, and monitoring policies and regulations (Regenstein and Lipper, 2013). Given the fragmented nature of B–5 programs and funding streams across the United States, state governance structures are typically segregated, with some programs housed within a state’s human services agency, while others may be located within the education agency or a separate health agency. Often components of the same funding stream, such as IDEA Parts B and C, are located in different departments, with Part C early intervention services assigned to the human services department, while Part B special education preschool services are in the education department. Governance at the local level also includes school districts that administer preschool programs along with K–12 education.

These varied government entities at the state and local levels can present challenges in setting policy and regulation, administering and monitoring programs, and ensuring accountability. From the perspective of families and children served by B–5 programs, this fragmented approach can result in inefficient duplication of services or gaps in service delivery. From the perspective of providers, the multiplicity of agencies and funding streams can present complex bureaucracies and regulatory structures that are difficult to navigate. There are also potential implications for the coordination of professional development supports and other aspects of the B–5 workforce professional environment.

In recognition of these potential limitations, U.S. states have been experimenting with new governance models, such as consolidating all relevant B–5 programs in an existing agency (e.g., Maryland), creating a new dedicated early childhood agency to house applicable programs (e.g., Alabama, Georgia, Massachusetts), or creating a new shared cross-agency organization that bridges existing agencies (e.g., Colorado, Pennsylvania) (Regenstein and Lipper, 2013; Atchison and Diffey, 2018). In addition, state early childhood advisory councils, created under the Head Start Act, serve in an advisory capacity to support coordination across state and local agencies in the public and private sectors.

As noted in Chapter 2, the programs that constitute the B–5 system in New Hampshire are housed primarily in various divisions of either NHDHHS or NHDOE. Local school districts represent another administrative layer. As with other states, this multiplicity of departments, bureaus, and other agencies in New Hampshire is viewed as a barrier to a comprehensive, well-coordinated B–5 system (New Hampshire Early Childhood Governance Task Force, 2018). Indeed, one of the stated goals for New Hampshire’s B–5 system is to ensure that the governance

system has greater alignment, with a particular focus on braiding/blending of funding and data integration. Data systems integration was the focus of the prior chapter, while issues of financing are taken up in the chapter that follows. In this chapter, we focus more specifically on the governance structure. We present both past efforts in New Hampshire to improve the governance structure, as well as insights gained from key informant interviews conducted as part of the PDG B–5 Needs Assessment.

Background on B–5 System Governance in New Hampshire

Stakeholders in New Hampshire have drawn attention to the limitations of the state’s current governance structure for the B–5 system and options for reorganization to ensure better coordination within and across NHDHHS and NHDOE. In 2018, Spark NH led the New Hampshire Early Childhood Governance Task Force to evaluate early childhood governance at the state level. The task force drew on the knowledge and experiences of its members, as well as external experts in the early childhood field with experience implementing and operating new governance models. These resources were tapped to carefully review the current system in the state, the alternative structures adopted by other states, and evidence of effectiveness of the other governance models. The resulting report provided a menu of governance strategies for streamlining and coordinating B–5 systems at the state level, which can then extend to the sub-state level, as well (Spark NH, 2018).

Three specific modified governance models were presented by the Task Force, which largely mirror the three basic models in use by other states: a Coordination/Teaming Approach, a Consolidation Approach, and a Single Entity Approach. Each of these approaches has strengths and limitations, thus the best approach for New Hampshire requires consideration of these benefits and drawbacks given the state’s context. One common challenge across these alternative designs is that some programs that serve families with young children also extend their services to children at older ages (e.g., family income support programs such as FANF and SNAP). Thus, some programs that serve children across a broader age range may not be candidates to include in a new or consolidated agency focused on B–5 programs. The Task Force report (Spark NH, 2018) ultimately favors either a Coordination/Teaming Approach or a Consolidation Approach and recommends further assessment of the two approaches in collaboration with the Governor’s Office and existing agencies. The report also recommends a reexamination of the role of Spark NH and a regional approach to B–5 governance to ensure the greatest possible coordination.

In concert with the work under the PDG B–5 initiative, starting in early 2019, the Associate and Deputy Commissioners from NHDHHS and NHDOE, respectively, have been leading their ECITs, described in Chapter 2. Collaboration across the two agencies has extended to the activities associated with this needs assessment, represented in the mapping of components of the B–5 system presented in Chapter 2 and the investigation of data integration issues and opportunities reviewed in Chapter 9. As discussed in more detail in Chapter 2, Governor Sununu

established the Council for Thriving Children as the state’s early childhood advisory council as of January 2020. Together with the newly established B–8 ECCE Advisory Team and the Early Childhood Experts Team, the Council for Thriving Children will support greater integration and coordination of B–8 programs and services.

Insights from Key Informant Interviews

The protocol for the interviews with key informants included a section on governance for the state’s B–5 system. The topic was the focus of some discussion during 13 interview sessions with state/local leaders (including sessions with multiple participants) and one session with a service provider, all attended by 44 interviewees. These interviewees included public sector agency leaders and staff, advocates for early childhood education and services, and nonprofit program directors. (These interviews were held in summer 2019 before the most recent governance changes were announced in January 2020.) Two key findings emerge from these conversations.

State Governance Structure for B–5 or B–8 Services Needs Improvement

All interviewees who discussed the topic of state governance structures recognized the need for advances. Interviewees discussed challenges within and between NHDHHS and NHDOE that often lead to fragmented efforts to provide and coordinate services for families and children in New Hampshire. The limits on data-sharing between agencies and the lack of a one-stop shop for information about available services exacerbate the challenge. One interviewee remarked, “The state has all these bureaus and departments that [provide services], but they don’t know each other and talk to each other. [They’re very siloed.]... people don’t know how to connect the dots.” This interviewee went on to provide an example about a state-sponsored professional development training, illustrating how information about government services is often spread through informal professional networking rather than formal, organized channels: “The state wanted us to provide emergency prep training, but they couldn’t tell us where to get [information to prepare the] training. We ended up finding [that] the resources [were already] provided by the state. It’s wild how much they [the state] don’t know. You build relationships with people, figure out what they provide.”

A Range of Changes to Governance Structures Were Proposed

A suggestion made by more than one interviewee was to streamline services for early childhood, but interviewees disagreed about the best way to accomplish this. Suggestions included establishing formal coordination structures with MOUs and DSAs between agencies or grouping similar services under the purview of one agency (e.g., move all early childhood services either to NHDHHS or NHDOE, rather than having services housed in both agencies). One interviewee described the vision for grouping early childhood services in this way: “We’d

keep the programs as they are within NHDOE and NHDHHS, but we'd move them into a consolidated model and all the EC programs would fall into one structure. So then all the data could be integrated, that front door could be unified, just greater unity in the system.” Another suggestion was to create a new governance structure to oversee and coordinate B–5 services, such as a cabinet position, or a bureau of early childhood programs and services. Interviewees noted that funding is an important component of suggested changes: state funds must accompany any changes to the governance structure to support planning and implementation of new structures. However, a few interviewees noted that acquiring adequate funding for such changes could be a challenge; New Hampshire is unlikely to either allocate additional funding or approve a tax to fund early childhood services. Finally, one interviewee suggested that any conversation about governance must include staff at all levels of government and relevant agencies—from leadership and mid-level staff to ground/field staff.

Implications for the Strategic Plan

A more rational, streamlined governance structure is a critical component of a coordinated and efficient B–5 system. Some of the consequences of the current complex, fragmented system in New Hampshire likely include shortfalls in parent knowledge of the B–5 programs available to serve them, complexities families face in navigating the current system, and gaps in continuity of services at a point in time and over time (see Chapter 3 and 4). The fragmented system also presents challenges for B–5 program providers who face varied standards, regulations, and other aspects of the multipart structure. Similar challenges arise for the B–5 system workforce in terms of professional development and other workforce development supports (see Chapter 7). In addition, issues with creating an integrated data system (see Chapter 9) are tied, in part, to the partitions in the current governance structure.

The input from the key informants regarding governance issues is consistent with a broader recognition on the part of B–5 system stakeholders that a strategic priority for New Hampshire is to identify and execute a modified governance structure in support of a more coherent, coordinated, and efficient B–5 system. Important groundwork has been documented in the report issued by the Early Childhood Governance Task Force, which describes the actions and resources needed to achieve each of the three possible governance models, along with an assessment of how well each approach performs against a set of guiding principles. The need to extend governance reforms to the sub-state level have been recognized as well. The coordination efforts across NHDHHS and NHDOE through their ECITs provide a further step toward an improved governance structure, one that would encompass the set of B–5 programs identified in Chapter 2 as constituting the B–5 system in New Hampshire. Alternative solutions mentioned by interviewees capture the range of options implemented in other states that have experimented with new ways of organizing early childhood systems, whether through a new dedicated agency, consolidation in an existing agency, or greater coordination within the current structure.

11. Adequacy and Sustainability of Financing for the B–5 System

With the increased focus on early childhood programs and B–5 systems more generally, attention has turned to the financing of the array of services and supports for young children and their families (BUILD Initiative et al., 2019; Center for Health Care Strategies, 2019; GAO, 2019). There is both a need to understand the cost of providing high-quality services and how to pay for those services, recognizing that there is potentially a role for funding from both the private sector (e.g., families themselves) and the public sector (e.g., federal, state, and local governments). Where government funds are allocated to support B–5 services, policy considerations include whether those funds are targeted to families in greatest need—often those who could not afford to pay the full cost of the services themselves—or if programs are made universally available without regard to child or family circumstances. The relative contribution of public funds from the federal, state, and local levels is another policy issue. In the case of preschool programs, for example, state and local governments have recognized that relying on federal funding streams alone (e.g., Head Start) results in an underfinanced system, one that leaves many families, especially those with low to middle incomes, with few options that they can afford on their own. Consequently, state and local policymakers have been increasing their share of the public funding for preschool programs for three- and four-year-olds relative to the funding from the federal government (Friedman-Krauss et al., 2019). Finally, a growing concern is the complexity of the current system in terms of the multiplicity of funding streams and the associated challenges for families and providers in navigating the complex system, especially in light of the desire to create a coordinated, integrated system (Center for Health Care Strategies, 2019).

Among recent efforts to address the adequacy and sustainability of financing for early childhood programs, much of the attention has centered on ECCE programs. For example, NASEM (2018) provides a national estimate of the cost to provide high-quality child care and early learning programs to children from birth to kindergarten entry, following recommendations from an earlier NASEM study regarding the features required for high-quality ECCE services with a well-qualified and well-compensated workforce (Institute of Medicine and National Research Council, 2015). The estimates indicate that the United States would spend about 0.75 percent of gross domestic product (GDP), a figure consistent with the level of expenditures on such programs by other high-income countries (NASEM, 2018). Even assuming that families pay a share of the cost of ECCE according to their ability to pay, the NASEM study concludes that a significant increase in public funding is required to ensure that high-quality ECCE during the B–5 period is affordable for all families who choose to use such services. BUILD Initiative et al. (2019) suggest that state and local funding options represent an untapped source of funds to fill the gap between current public investments in the B–5 system and the funds required for an

adequately funded system. The BUILD Initiative analysis documents an array of state and local revenue-raising mechanisms—from general sales taxes to dedicated business taxes, estate and inheritance taxes to sin taxes (e.g., taxes on alcohol or cigarettes)—with illustrative examples from states and localities across the country.

Ultimately, the issues addressed in prior chapters—access and quality of services, workforce compensation and supports, high-quality facilities, system-level infrastructure such as integrated data systems, and governance—all require a B–5 system that has adequate and sustainable financing from the public sector. Thus, addressing system financing is a central issue in advancing a B–5 system. In the remainder of this chapter we provide additional background on prior efforts to document financing for the B–5 system in New Hampshire and summarize the input received on the topic during the key informant interviews.

Background on Financing for the B–5 System in New Hampshire

One recent study that examines financing in New Hampshire estimated funding levels for several key early childhood programs, namely MIECHV home visiting, Early Head Start and Head Start, Title I, and Child Care Scholarship (Karoly, 2017). As of 2014–2015, funding for those programs totaled about \$37.1 million. Funding at the district level for preschool programs was not available.

As noted in Karoly (2017), most of these key funding streams, however, represent federally funded programs. (Child Care Scholarship is federally funded with a state contribution.) Moreover, the available public funds for these programs targeted to low-income families—MIECHV, Early Head start, and Head Start—do not reach all eligible children and families in New Hampshire. Nor does New Hampshire invest state funds to fill the gap. As noted earlier, New Hampshire does not allocate funds for targeted or universal preschool as of the 2018–2019 academic year, which leaves many children without the benefit of a high-quality early learning experience that their parents would choose if it was affordable for them (Friedman-Krauss et al., 2020; GAO, 2019). Likewise, unlike other states, New Hampshire does not add funds to the federal MIECHV program, which reaches a few hundred families per year with home visiting services that help parents support their children’s development. Given the low level of federal funding, this is well below the number of families that could potentially benefit from such services (Karoly, 2017).

New Hampshire has yet to conduct a comprehensive inventory of all public sector funding for B–5 programs in the state. Such an inventory is often called a state “children’s budget” or “fiscal map” (Center for Health Care Strategies, 2019; Virginia Early Childhood Foundation, 2019).²³ A

²³ A similar approach is taken at the federal level. One example is the annual Children’s Budget publication from the Children’s Budget Coalition (First Focus on Children, 2019).

children’s budget or fiscal map typically starts with an initial comprehensive inventory of public sector resources that support children and their families, with the ability to track changes in the public sector commitment as the inventory is updated on a periodic basis. For example, Virginia’s most recent *2020 Children’s Budget Report* provides a detailed map of public-sector early childhood spending in the state. The analysis documents that B–5 funding amounts to 2.3 percent of the state’s budget, while young children comprise nearly 6 percent of the state’s population (Virginia Early Childhood Foundation, 2019).²⁴

Insights from Key Informant Interviews and Other Data Sources

The key informant interview protocol included questions related to funding for the B–5 system in New Hampshire. Participants in 21 of the interview sessions, attended by 55 participants, addressed this topic. These interviewees included state and local leaders, service providers, and LEA leaders. We draw on those discussions to identify key themes.

Public Funding for the B–5 is Inadequate, with Consequences for Program Reach and Quality

All interviewees who spoke to this topic agreed that the B–5 system in New Hampshire is underfunded, which adversely affects many aspects of B–5 services, especially access and quality. The leaders and service providers interviewed reported that lack of funding affects many aspects of program operation, including service providers’ ability to spread awareness of their services, hire and retain talented staff, improve program quality, and maintain and build high-quality facilities. Providers especially noted the link between inadequate funding and compensation for the B–5 workforce (discussed previously in Chapter 7). Given limited funding, providers are not able to provide wages and benefits at a level that would attract and retain the desired caliber of staff. Some interviewees noted that fewer young people were entering the field because of a perceived inability to pay off student debt given the available compensation. These funding challenges affect organizations across the B–5 system, including child care providers, FRCs, health centers, and state agencies.

Program providers and state and local leaders described a variety of funding sources they use to support B–5 programs including Medicaid, HRSA, Title 5, Title 1, FANF, and SAMHSA, along with private grants from foundations such as United Way, the Tillotson Foundation, and

²⁴ A similar statewide budget could be prepared to document the private spending on the part of families on their children from birth to kindergarten entry, including direct expenditures on items such as food, shelter, clothing, health care, child care, books and toys, and so on. Indirect expenditures through foregone earnings of parents who do not work in order to provide care during the early years could also be imputed. The U.S. Department of Agriculture, based on the annual Consumer Expenditure Survey, estimates direct spending on children in a series of periodic reports about the cost of raising a child in the United States (Lino et al., 2017).

the New Hampshire Charitable Foundation. Even with these funds, however, the providers interviewed noted that funding is limited. One FRC leader remarked, “So much of my time is spent doing fundraising and grant writing. Every year it feels quicker and quicker that we run through our fiscal year. [Funding is] not a given. Costs go up but people don’t want to give you more in grants.” In addition, some interviewees mentioned that New Hampshire has low rates of Medicaid reimbursement, which led stakeholders to question its sustainability as a funding source.

Interviewees Discussed Possible Approaches to Addressing the B–5 System Funding Gap

One approach, mentioned by a child care provider, was to address possible inefficiencies in the current system. For example, the use of a shared services model would allow child care and other B–5 service providers to reduce their cost structure and thereby deliver more services with the same budget. With this approach, smaller service providers might share the time of one family case manager or administrative staff member such as an accountant. In addition, interviewees mentioned some of the alternative funding streams that are being used in other states and localities. For example, a sugar-sweetened beverage tax was mentioned, which could provide more local or state revenue for the B–5 system. A child care provider suggested that tax incentives might prompt building owners to provide free or reduced price rent to child care facilities (an option discussed in the prior chapter on facilities). Finally, a few interviewees suggested that the Families First Protection Services Act—part of the 2018 Bipartisan Budget Act, which changes the way states can spend Title IV-E and Title IV-B Social Security Act funds to provide services to families at risk of entering the child welfare system—might provide additional prevention-oriented funds for the B–5 system (First Focus, 2018).

Implications for the Strategic Plan

An adequately and sustainably financed B–5 system is critical to meeting the other goals of the system: ensuring equal access, providing high quality services, supporting a well-prepared and adequately compensated workforce, operating well-designed facilities, implementing effective governance, and providing the required state-level system supports. At the same time, this is one of the most challenging issues to address in a system that is currently underfunded and where public sector investments in B–5 services must compete with other state and local priorities for public funds. Nevertheless, there is a need to think strategically about financing issues as part of a short- and longer-term approach for advancing the B–5 system.

A starting point for advancing discussion about B–5 financing would be to create a children’s budget or early childhood fiscal map for New Hampshire, through a thorough analysis of current funding streams and potential future funding streams. In addition to documenting the current funding landscape, each current and potential funding source could be assessed in terms of the

potential funds that could be raised and the sustainability over time of the funding source, where the burden of the tax or other revenue mechanism would fall and whether the mechanism would be progressive or regressive, whether the funds can be dedicated to B–5 programs, and whether the revenue source would be politically feasible (BUILD Initiative et al., 2019). The effort could also identify opportunities for efficiency gains in the current system so that existing funding amounts can be made more effective. There may be other untapped funding sources that could support B–5 services, as well. This exercise would provide a basis for a menu of options that policymakers can consider for incremental improvements in the available financing, as well as strategies for more fundamental changes. Studying and monitoring the approaches taken by other states and localities may also identify approaches that could be adopted in New Hampshire.

12. Conclusions and Implications

The PDG B–5 Needs Assessment for New Hampshire began with a broad conceptualization of the B–5 system in the state. Largely administered through NHDHHS and NHDOE and supported through a combination of federal, state, and local funding, the B–5 programs in the system comprise over 48 distinct programs that are inclusive of not only programs to provide or subsidize ECCE, but also those that provide home visiting services and other family supports, deliver services to children with disabilities, subsidize health care services for children and their families, and provide other cash and in-kind transfers. In addition to the programs that provide direct services, supports, and subsidies, various other programs support system infrastructure such as data systems, quality measurement and improvement systems, and workforce professional development. Some programs are designed to reach the youngest children (e.g., infants and toddlers), while others support preschool-age children. Programs tend to be targeted toward those with low income or other identifiable risk factors. The few universal programs, designed to reach all children and families regardless of circumstance, tend to be for screening for health or developmental conditions. Among the targeted programs, few are funded to reach all of the young children and their families who are eligible.

Through a review of existing information and new data collection, the PDG B–5 Needs Assessment has produced a number of key findings that have helped to fill knowledge gaps and reinforced evidence produced in earlier needs assessments and related research. In this final chapter, we highlight the most relevant findings, point to remaining information gaps, and compile the implications for the strategic plan featured at the end of each substantive chapter.

In reviewing the findings it is important to keep in mind the strengths and limitations of the information that supported the assessment. First, we drew on existing data sources, from representative surveys to administrative data, where feasible. However, many of these sources do not capture information on the knowledge, use, and experiences with B–5 services on the part of New Hampshire families and their young children, nor do they address the strengths and limitations of other aspects of New Hampshire’s B–5 system. Prior research studies and needs assessment also provided a foundation for the current knowledge of the B–5 system in New Hampshire.

In addition, we relied on qualitative information from interviews with over 90 key informants—state and local leaders and service providers—and focus groups with about 140 New Hampshire parents and other guardians of young children. Such qualitative information is not intended to provide representative data but rather an understanding of the diversity of experiences and viewpoints across the stakeholders of interest. We also conducted surveys of nearly 1,300 New Hampshire families, over 300 ECCE workforce members, and about 210 kindergarten teachers. Each of these was a convenience sample. However, in the case of the

family survey, we could compare the characteristics of the respondents with the known characteristics of the target population based on the ACS. That comparison showed that the family survey respondents closely matched the known population, particularly on key characteristics such as age of the youngest child, the age of the parent, parent gender, Latinx status, and rural status. There were some differences with marital status, parent education, and family income, but the differences were mostly consistent with the margin of error and did not consistently over- or underrepresent either more or less advantaged family types. Thus, we have no reason to believe that the family survey is systematically biased in capturing the experiences of parents with young children in the state.

Key Findings from the Needs Assessment

We organize our summary of key findings according to the focus of Chapters 3 to 11.

Family knowledge of the B–5 System (Chapter 3)

- **Awareness of many specific B–5 services is low** among New Hampshire parents. Head Start and Early Head Start are the most recognized, even among higher income families who are not eligible for the programs, which are open to children in families with income below the poverty level. Awareness of other key B–5 programs is low, especially for programs targeted to families with lower incomes, such as home visiting, parent education, and the Child Care Scholarship.
- **Top information sources** for parents are friends and family, social media, and Google. Parents report turning less often to more formal sources such as the state’s 211 system or a state-run website.
- **Parents report difficulty with accessing information** about B–5 services. Families who already receive services typically feel most informed. Key issues with accessing information include limitations with navigating information on smartphone screens, limited access to printers for paper application forms, and a lack of time to seek out the needed information.
- **Providers also report gaps in their knowledge** of other service providers and the services they offer, which affects their ability to refer clients to other appropriate services.

Family Experiences with Access to and Quality of B–5 Programs (Chapter 4)

- **Issues with accessing ECCE affect many families** in New Hampshire. Based on the PDG B–5 Family Survey, about half of all families report having some or a lot of difficulty finding the ECCE program they wanted. One in four stated that they feel they do not have good ECCE choices. About the same share could not find the care they wanted for a week or more at least once in the past year and about one in five report

quitting or not starting a job, school, or training in the last year because of issues with accessing care. Notably, one in four survey respondents stated that they need care during nonstandard hours such as evenings, nights, and weekends. More generally, family survey respondents showed varied rates of participation in B–5 programs, reflecting in part that many programs are designed to target the lowest-income families or are for other targeted populations (e.g., children living with disabilities).

- **Issues with access are greatest for some groups** of families, typically those with the lowest income (although middle-income families sometimes reported similar difficulty as their lower-income counterparts) and those with children with special needs or complex medical issues. For example, just 37 percent of four-year-olds in families with income below poverty participate in preschool compared with 75 percent of four-year-olds in families with income three times the poverty level or higher.
- **There are various barriers that affect access to and participation in B–5 programs.** Many parents lack understanding of the services available, their benefits, and whether they are eligible. Other common barriers include provider shortages, the high cost of ECCE in particular, a lack of family-friendly hours for other types of services, poorly structured and managed application processes, and a lack of transportation for reaching the provider. Navigating insurance options is an issue specific to accessing health-related services. These and other barriers are especially salient for parents of children with special needs or complex medical conditions, grandparents and other types of guardians, and immigrants and refugees. Parents’ own mental health needs, such as postpartum depression, can present a barrier to accessing services for themselves and their children. Parents stress the need to advocate for their family and child or to work with a family advocate or navigator, especially when program staff who interface with families are not supportive.
- **Many parents reportedly do not have employment-related supports to ease the burden,** such as jobs that offer family-friendly or flexible hours. For instance, about 40 percent of employed parents do not have flexible scheduling or work hours, and unpaid or paid maternity or paternity leave was even less common.
- **In terms of quality, parents often settle** for what is available or affordable, even if viewed by the parent as lower quality. For many parents, the range of programs and providers gives an “illusion of choice.”
- **Parents often define quality differently than experts,** with more of an emphasis on the nature of the interactions with provider staff, the ease of the logistics, and the features of the setting. Outside of ECCE, parents reported more favorable experiences with WIC, FRCs, home visiting services, and specific health care providers.
- **Parents facing complex situations would benefit from supports to better navigate the system,** such as a navigator or advocate who could ease the challenges with accessing and continuing services. Mental health services and respite care emerged as other needs.

Family Experiences with the Transition to Kindergarten and Service Coordination and Continuity More Generally (Chapters 5 and 6)

- **Most New Hampshire parents reported receiving at least some support for their child’s transition to kindergarten.** Most common was receiving information from the school and a child visit to the school/classroom, practices that kindergarten teachers also reported using on a routine basis. More time-intensive supports were less common, such as the sharing of information between a child’s ECCE program and kindergarten teacher. Even so, almost all kindergarten teachers reported having at least some information about their incoming students.
- **Parents reported being generally satisfied** with the information, timeliness, and activities associated with the kindergarten transition for their child. Nevertheless, a minority of parents did not feel well informed. Some parents of children with special needs report issues with accessing special services in kindergarten.
- **Kindergarten entry assessments are being used by a majority of teachers but practice is not standardized.** The survey of kindergarten teachers revealed widespread use of KEAs of any kind, but there is substantial variation in the specific tools being used, the domains of children’s development assessed, and how and when the assessments are conducted. Only about 40 percent of surveyed teachers rated the KEA process as good or very good.
- **More generally, coordination of services is an issue**, both at a point in time or over time, especially when children have special needs or complex medical conditions. Examples of the coordination issues facing parents were requiring separate applications across programs they wanted to access and having to repeat the explanation of their circumstances and needs multiple times. Limited coordination across providers and parents’ limited knowledge of the range of provider options further impeded continuity of services. Other complexities with implications for service coordination include waiting lists for services, providers that close, families that move, and gaps in insurance coverage or access to specific service providers, especially during school breaks. Parents with advocates or navigators reported better experiences addressing these issues.

B–5 System Workforce (Chapter 7)

- **B–5 workforce members have varied backgrounds and positions.** Members of the B–5 workforce include not only leaders and classroom staff in ECCE programs, but also leaders and providers in other B–5 programs such as early intervention specialists, home visitors, case managers/case workers, social workers, and functional support/family support providers or specialists. These individuals bring varied backgrounds in terms of prior education and experiences working with young children and their families.

- **A shortage of qualified ECCE staff hinders the provision of high-quality care.** There was widespread agreement among key informants from the policy and provider communities that New Hampshire faces a critical workforce shortage in the B–5 services sector. This shortage affects a number of service areas within the B–5 system, but the implications for ECCE delivery are most salient. Interviewees, including providers, noted that ECCE programs are forced to close classrooms or curtail expansion plans because of the lack of qualified staff.
- **Compensation data confirm low pay and limited benefits for ECCE classroom staff.** According to government data, wages for the typical New Hampshire child care work barely rise above the federal poverty level and limit the attractiveness of these positions for new entrants to the field, especially those who have attained a post-secondary degree and are carrying student loan debt. Access to employment-related benefits is limited according to respondents to the workforce survey. Up to one in five ECCE teachers and assistants reported working other jobs and accessing government subsidies in order to make ends meet. Indicators of financial insecurity are also high for this segment of the workforce. These conditions can create negative perceptions of ECCE employment and obstruct the future ECCE workforce pipeline.
- **Opportunities for professional development exist for the ECCE workforce, but various barriers limit participation.** These barriers included limited release time or paid time to support professional growth activities, distance or difficulty of reaching opportunities, and expense. State and local leaders attributed limited funding for professional development on the part of ECCE programs as one explanation for reduced opportunities for high-quality training activities, while providers cited difficulty finding substitute teachers to cover classrooms while staff participated in trainings. And the available pre-service and in-service training may not be of sufficient quality and intensity to improve providers’ practice.
- **Overall the commitment to the field and job satisfaction is high for the ECCE workforce, despite these issues with compensation and professional supports.** About three in four ECCE teachers and assistant teachers agreed or strongly agreed that they are satisfied with their job. Aspects of the work environment such as too much paperwork and insufficient preparation time were areas of dissatisfaction and about half of classroom staff report being “overwhelmed at work.” The majority of ECCE teachers and assistants expect to change positions in the next two to four years, mostly to improve pay and benefits. Fewer than 4 percent expect to leave the field entirely.
- **These issues are not as prevalent for other segments of the B–5 workforce but concerns remain.** The issues of compensation, professional development supports, and working conditions are not as prevalent among ECCE program leaders or other professionals in the B–5 field. Nevertheless, areas of concern include staffing shortages for qualified home visitors, (DCYF) case managers, and health care providers (including

mental health providers, specifically infant mental health care professionals). For many of these positions, low wages and benefits and stressful working conditions contribute to the recruitment and retention challenges.

B–5 infrastructure: Facilities, Data, Governance, Financing (Chapters 8, 9, and 10)

- **There is near universal concern among providers and other leaders in the field with the shortage of quality B–5 facilities.** These issues concern both a lack of adequate space overall and of space that is constructed and organized to meet the requirements of B–5 service providers. Limited options for funding facility needs hinder quality improvements and expansion within existing sites and into new locations.
- **Likewise, key informants almost unanimously acknowledged that the lack of integrated data is problematic,** especially in limiting the options for care coordination and data-driven decisionmaking. The barriers to integrated data include a lack of staff capacity and funding. The process of generating an unduplicated count of children participating in FCESS and Child Care Scholarship, two programs within NHDHHS, demonstrated key challenge such as state and federal privacy laws, the absence of a common identifier across data systems, and the need for MOUs or DSAs when combining data across agencies.
- **Another point of general agreement across those who were interviewed is that the state governance structures need to be improved,** with the potential for reduced administrative burden and better coordination across the B–5 system. Prior efforts to assess the strengths and limitations of the current governance structure provide a foundation for considering alternative governance models and adopting modifications that meet the needs of families, providers, state administrators, and other stakeholders.
- **Across the stakeholders interviewed, there was a common expression of the need for more funding to ensure that families with young children can access high-quality services that would support healthy development.** For example, funding constraints limit the ability to expand awareness of and access to B–5 programs such as home visiting, parent education, and early learning programs, especially among lower-income families and other vulnerable groups. More funding would be required to also address quality shortfalls, workforce challenges, and facilities issues. The multiplicity of existing funding streams presents further challenges for families and providers when navigating the complex system.

Data and Research Gaps

The analyses in Chapters 3 to 11 point to a number of gaps in terms of data and research that are relevant for understanding the B–5 system. Following the themes in those chapters, the following needs are evident:

- **Family knowledge of the B–5 system and experience with access and quality.** The family focus groups and family survey conducted as part of the needs assessment helped to fill in gaps in understanding about families’ knowledge of the B–5 system and their experience with access and quality. A process to systematically collect some of this information would be valuable. Adding questions to the UNH Granite State Poll on a periodic or rotating basis would be one strategy for producing more representative information on these topics that can be tracked over time. There is also a need to understand these issues at a local level, as many of these issues vary across communities in the state and for specific populations.
- **Family service coordination and continuity in B–8 system.** Similar knowledge gaps were evident in service coordination and continuity that the needs assessment information gathering helped to address. In some cases, administrative data may be used to systematically track participation in specific programs and whether children and families are receiving related services at a point in time or transition to the next phase of services over time. These issues also have a local component that is important to understand.
- **B–5 system workforce.** Systematic information on the B–5 workforce is relatively rare. One strategy for collecting routine information is through the use of a workforce registry. This type of database can provide information on the qualification and experience of members of the workforce, their participation in professional development opportunities, their turnover in positions across time, and their retention in the field.
- **B–5 system infrastructure: facilities, data, governance, and financing.** Perhaps the biggest gap in this area is information on the features of existing facilities and potential new facilities. A centralized facilities registry would provide systematic information about needed investments in current facilities and where other facilities may be used for quality upgrades or for program expansion. A systematic accounting of funding streams in New Hampshire at the federal, state, and local level in the form of a children’s budget is another need in order to understand how existing resources can be used more effectively and where new resources might be invested.

Implications for New Hampshire’s B–5 Strategic Plan

As part of Chapters 3 to 11, we identified implications of the findings from the needs assessment for the strategic plan. We bring those assessments together in this final section. In addition, we address measurable indicators that would be incorporated into the strategic plan in order to track progress toward desired outcomes.

Family Knowledge of the B–5 System

New Hampshire has investments underway in formal resources to support the information needs of parents. The strategic plan should continue this focus by assessing the progress and

effectiveness of initiatives to date and refining approaches as needed to ensure that they effectively and efficiently deliver the accurate, culturally and linguistically appropriate information that parents need to access the opportunities and resources available to them. There is also an opportunity to use the same channels that provide information on B–5 services as more general resources for families of young children to access education-oriented materials describing children’s developmental trajectories across relevant domains; opportunities for parents to support their children’s cognitive, social, and emotional progress through developmentally appropriate activities; and other supports that promote families as their children’s first teachers.

Family Experiences with Access to and Quality of B–5 Programs

The strategic plan should address issues of access and quality, together with strategies to resolve knowledge gaps. The issues and possible solutions are expected to vary depending upon whether programs and services are targeted to at-risk children and families or intended to serve families more generally. Other issues such as measuring, improving, and monitoring quality cut across most programs. Ideally, continued or new initiatives draw on best practices established in New Hampshire and elsewhere that are evidence-informed, strengths-based, and trauma-informed. Families should be key partners in advancing these issues, drawing on emerging approaches to human-centered design.

Transition to Kindergarten and the Coordination and Continuity of Other Services Across B–8 Systems More Generally

New Hampshire has already begun experimenting with alternative approaches to transitions across programs through time and coordination of services at a point in time. These efforts can provide a foundation for further testing of new strategies as a priority in the strategic plan. Additional guidance is now available to overcome existing barriers and to bring a new level of coordination to a system acutely in need of greater integration. The Bipartisan Policy Center (2018a) is one such source of detailed recommendations for system-level improvements. Improvements in this area will likely benefit from advances in other areas, such as a functional integrated data system and a more coherent governance structure.

B–5 System Workforce

The strategic plan should look within and beyond New Hampshire for strategies to address the challenges facing the B–5 workforce and advance toward a statewide workforce professional development system. These include programs such as T.E.A.C.H scholarships and supplements to workforce wages, tiered reimbursement along with a QRIS, and more structured evidence-based opportunities for professional development such as coaching. Other supporting infrastructure would be a workforce registry that would be used to identify members of the B–5 system workforce and their qualifications; track participation in approved evidence-based

professional development opportunities; qualify trainers, coaches, and other professional development providers; and compile available professional development opportunities. Addressing any barriers facing the ECCE workforce in accessing the higher education system and any shortfalls in the quality of the early childhood degree programs should be another priority.

B–5 System Facilities

This often overlooked issue should be another priority in the strategic plan. One priority could be conducting a comprehensive needs assessment to address the gaps in knowledge about the quality of current facilities and the resource needs for facility quality improvement and program expansion. Another priority is identifying funding strategies to support facility improvement and access to new facilities for program expansion. The New Hampshire Community Loan Fund is one such model that could be scaled up to reach more communities and more providers. Pilots could be conducted in parts of the state before taking successful approaches to scale.

B–5 Data Systems and Data Integration

This fundamental component of a B–5 system infrastructure merits priority status in the strategic plan. New Hampshire stakeholders have already completed foundational work toward greater data integration, and perhaps an ECIDS, and there is an opportunity to leverage data system upgrades that are in process. Further, other states provide models for how to structure a system, along with valid tools and other resources to draw from for implementation. All relevant stakeholders—from those that contribute to data systems (e.g., families, agency field staff, providers) to the eventual end-users (e.g., agency information technology staff and analysts; external researchers)—would ideally be consulted in the process to ensure that the burden of supplying data is reasonable for the former and that the resulting data are timely and useful for the latter. Addressing potential issues that may be unique to New Hampshire, such as the state’s strict privacy laws, will be essential.

B–5 System Governance

Another strategic priority for New Hampshire should be to identify and execute a modified governance structure in support of a more coherent, coordinated, and efficient B–5 system. The Early Childhood Governance Task Force provides a starting point for alternative governance models tailored to New Hampshire, along with an assessment of how well each approach performs against a set of guiding principles. The need to extend governance reforms to the sub-state level should be another goal, as well. The coordination efforts across NHDHHS and NHDOE through their ECITs provide a further step toward an improved governance structure, one that would encompass the set of B–5 programs identified in this needs assessment as

constituting the B–5 system in New Hampshire. Again, other states provide models and lessons from their revised governance systems from which New Hampshire could draw.

Adequacy and Sustainability of Current Financing for the B–5 System

A central element of the strategic plan should include further assessment of financing for the B–5 system. A potential starting point would be to create a New Hampshire children’s budget or early childhood fiscal map to document the current funding landscape and potential future funding streams and assess the merits and drawbacks of each option in terms of tax burden, sustainability, political feasibility, and other considerations. Identification of opportunities for efficiency gains in the current system can be another objective. This exercise would provide a basis for a menu of options that policymakers can consider for incremental improvements in the available financing, as well as strategies for more fundamental changes. Studying and monitoring the approaches taken by other states and localities may also identify approaches that could be adopted in New Hampshire.

Measurable Indicators of Progress

As New Hampshire continues its investment in the B–5 system, there are a number of key indicators that would support understanding the status of the system and progress toward desired goals. These indicators are summarized in Table 12.1. These indicators include measures to assess family knowledge of sources of information about the B–5 system in general and knowledge of specific components of the system, such as specific programs. Indicators related to access and quality would capture both family experiences, as well as the characteristics of program providers. Service coordination and continuity indicators would reflect subjective indicators of family experiences, but also objective indicators based on administrative data to capture specific service coordination processes and outcomes. Measures associated with the workforce would also have subjective indicators (e.g., job satisfaction), as well as objective indicators (e.g., turnover rates). Finally, indicators pertaining to key infrastructure elements could measure status and process aspects of the supports these resources are intended to provide.

Table 12.1. Key Measurable Indicators of Progress

Domain	Key indicators
Family knowledge of the B–5 system	<ul style="list-style-type: none"> • Number/percentage of families who report knowing where to find the state’s centralized information source on B–5 supports and services • Number/percentage of families who report knowing what B–5 information and local support is available • Number/percentage of families who report knowing about specific programs or initiatives (e.g., Watch Me Grow, the QRIS) • Number/percentage of families who report understanding basic child development milestones
Access to and quality of B–5 programs	<ul style="list-style-type: none"> • Number/percentage of families who report difficulty finding care • Number/percentage of families who report lack of care led to quitting a job or school • Number/percentage of families receiving subsidized care (overall and by type) and among those eligible • Number/percentage of families enrolled in home visiting or parent education programs • Number/percentage of licensed ECCE providers in the QRIS overall and by rating tier • Number/percentage of licensed ECCE providers with national accreditation • Number/percentage of family resource centers of quality
Service coordination and continuity in B–8 system	<ul style="list-style-type: none"> • Number/percentage of newborns receiving relevant screenings • Number/percentage of B–5 children receiving a developmental or behavioral health screening • Number/percentage of B–5 children with access to a medical home and covered by health insurance • Number of transition agreements in place with B-5 programs and providers • Number/percentage of children who transition from early intervention services to preschool special education • Number/percentage of children who are entering kindergarten who experience transition supports
B–5 system workforce	<ul style="list-style-type: none"> • Share of ECCE workforce by highest degree, certifications, and credentials • Average compensation of ECCE workforce members by position • Number/percentage of ECCE workforce members enrolled in public benefits programs • Turnover and vacancy rates in ECCE programs • Retention of the ECCE workforce in the field
B–5 system infrastructure: facilities, data, governance, and financing	<ul style="list-style-type: none"> • Number of high-quality facilities • Number of high-quality ECCE slots • Value of B–5 facility investments made and value of unmet needs • Number of programs/agencies with data in the early childhood IDS • Value of public sector funding available to support B–5 programs

Appendix A. Methods for Qualitative Data Collection

This appendix includes additional information about the two qualitative data collection components: the key informant interviews and family focus groups. In both cases, we provide additional information about the participants. Additional information about the family survey, workforce survey, and kindergarten teacher survey are in Appendixes B, C, and D, respectively. The protocols used to guide the semi-structured interviews and focus groups and the instruments for the three surveys are provided in Appendix F.

Key Informant Interviews: State and Local Leaders, B–5 Program Leaders, LEA Leaders

The semi-structured interviews took place in one-on-one sessions or group settings, reaching 91 individuals in total, interviewed one-on-one or in larger groups for a total of 28 interview sessions. Although we cannot list the interviewees by name, we summarize the types of interviewees by our three stakeholder groups: state and local leaders, B–5 program leaders, and LEA leaders (see Table A.1).

Table A.1. Illustrative Key Informants by Category

Stakeholder	Illustrative key Informants
State and local leaders	<ul style="list-style-type: none">• State agency leadership staff• Regional early childhood coalition leader• Philanthropic organization director or staff• QRIS task force member• Advocacy organization executive director or staff
B–5 program leaders	<ul style="list-style-type: none">• FRC director or program staff• Family-centered early supports and services provider• Head Start program director• Private center-based child care program director• Community Action Agency executive director• Pediatrician
LEA leaders	<ul style="list-style-type: none">• District superintendent or assistant superintendent• School principal• Special education administrator

Family Focus Groups

As noted in Chapter 1, a total of 16 focus groups were conducted which reached a combined total of 140 participants. Table A.2 provides information about the location of each focus group and summary characteristics of the participants in each group. Table A.3 shows more detail about the demographic and economic characteristics of the 140 participants.

As noted, the focus groups were designed to capture a diverse group of participants with one or more children under age seven. The locations for the focus groups covered all major regions of the state, and communities that range in size from rural (including the White Mountains) to small and larger cities. Although the focus group participants were not intended to be representative of the state population of families with children under age seven, a comparison of the key demographic and economic characteristics collected for the focus group participants that are also available in the ACS for the same group of families shows both similarities and differences (see Table A.3).²⁵ For example, compared with the ACS statewide population estimates, the focus group participants were more likely to be in rural communities, to have somewhat younger children, to be Latinx or nonwhite, and to have lower family income, all groups that were intentionally oversampled. Given that the focus group information was analyzed as qualitative rather than quantitative information (e.g., describing reported experiences and how they varied across groups, rather than generating statistics such as sample means), the small differences between the focus group sample and the state population for other characteristics (e.g., age, education levels) should not affect our findings.

²⁵ Keep in mind that the ACS is also a sample survey that when weighted produces population-level estimates for New Hampshire. Given the size of the ACS New Hampshire sample, the margin of error is about ± 2 percentage points.

Table A.2. Features of 16 Focus Groups: Location- and Population-Based Groups

Group	Region ^a	Rural / Nonrural ^b	Level of Urbanization ^c	Number of Participants	Participant Characteristics			
					Number of Nontraditional Parents	Number of Nonwhites	Number Whose First Language is Not English	Number with Special Needs Children
a. Location-Based Groups								
Claremont	Greater Sullivan	Rural	Urbanized Cluster	14	0	1 Asian	0	4
Concord	Capital Area	Nonrural	Urbanized Cluster	10	0	1 self-described	0	5
Conway	Carroll County	Rural	Urbanized Cluster	10	0	1 self-described	1 Spanish	2
Derry	South Central	Nonrural	Urbanized Cluster	9	1 foster parent	1 Black/African American	1 Other	4
Gorham	North Country	Rural	Urbanized Cluster	6	0	1 self-described	1 Other	4
Keene	Greater Monadnock	Rural	Urbanized Cluster	8	1 other relative	0	0	3
Laconia	Winnepesaukee	Rural	Urbanized Cluster	9	0	0	0	2
Manchester	Greater Manchester	Nonrural	Urbanized	8	0	2 self-described	0	3
Nashua	Greater Nashua	Nonrural	Urbanized	10	0	2 self-described	1 Spanish 1 Other	4
Plymouth	Central NH	Rural	Urbanized Cluster	10	1 foster parent	1 Asian	0	0
Rochester	Strafford	Nonrural	Urbanized	10	1 other relative	1 Asian 1 American Indian/ Alaska Native	1 Nepali	5
Somersworth	Strafford	Nonrural	Urbanized Cluster	9	0	0	1 Spanish	3
Tilton	Winnepesaukee	Rural	Urbanized Cluster	9	0	0	0	2

Table A.2. Features of 16 Focus Groups: Location- and Population-Based Groups, Continued

Group	Region ^a	Rural / Nonrural ^b	Level of Urbanization ^c	Number of Attendees	Number of Nontraditional Parents	Number of Nonwhites	Number Whose First Language is Not English	Number with Special Needs Children
b. Population-Based Groups								
Nepali (Concord)	Capital Area	Nonrural	Urbanized Cluster	8	1 grandparent	7 Asian	7 Nepali	0
Nontraditional Parents (Wolfeboro)	Carroll County	Rural	Urbanized Cluster	3	1 grandparent 1 foster parent 1 other relative	0	0	1
Spanish Speakers (Manchester)	Greater Manchester	Nonrural	Urbanized	7	0	1 self-described	7 Spanish	2
Totals				140	8	20	21	44

SOURCE: PDG B–5 Family Focus Group data.

^a The regions used are those defined and used by NHDHHS as Regional Public Health Networks (RPHN). Two RPHNs were not included in the sample: Seacoast and Upper Valley.

^b The rural / nonrural designations are NHDHHS definitions based on population and population density measures. RPHNs with a population of 100,000 or less and with a population density of 150 people per square mile or less are considered rural; otherwise they are considered nonrural.

^c Level of urbanization is based on US Census Bureau definitions. Urbanized Areas are those with 50,000 or more people; Urbanized Clusters have at least 2,500 people but less than 50,000 people.

Table A.3. Comparison of Characteristics of New Hampshire Families with One or More Children Less Than Age Seven: PDG B-5 Family Focus Group Participants and ACS

Characteristic	Focus Group Participants			ACS
	Number	Percentage or Percentage Distribution With Missing Values	Percentage or Percentage Distribution Without Missing Values	
Participant lives in rural community				
Yes	69	49.3	49.3	76.8
No	71	50.7	50.7	23.2
Missing	0	0.0	–	–
Age of participant's youngest child				
0	18	12.9	13.6	19.3
1	17	12.1	12.9	16.9
2	25	17.9	18.9	14.4
3	27	19.3	20.5	13.5
4	16	11.4	12.1	12.5
5	16	11.4	12.1	11.8
6	13	9.3	9.8	11.7
7	2	1.4	–	–
Missing	6	4.3	–	–
Number of participant's children younger than age 7				
0	0	0.0	0.0	–
1	77	55.0	57.5	–
2	46	32.9	34.3	–
3	8	5.7	6.0	–
4	3	2.1	2.2	–
Missing	6	4.3	–	–
Participant's relationship to child younger than age 7				
Birth parent	125	89.3	94.0	–
Grandparent	2	1.4	1.5	–
Foster parent	3	2.1	2.3	–
Other relative	3	2.1	2.3	–
Missing	7	5.0	–	–
Participant has one or more children with special needs				
Yes	44	31.4	32.4	–
No	92	65.7	67.6	–
Missing	4	2.8	–	–
Participant identifies as female				
Yes	126	90.0	91.3	90.0
No	12	8.6	8.7	10.0
Missing	2	1.4	–	–
Age of participant				
18 to 20	2	1.4	1.5	1.4
21 to 25	8	5.7	5.8	9.2
26 to 30	32	22.9	23.4	20.3
31 to 35	33	23.6	24.1	30.2
36 or older	62	44.3	45.3	38.9
Missing	3	2.1	–	–

Characteristic	Focus Group Participants			ACS
	Number	Percentage or Percentage Distribution With Missing Values	Percentage or Percentage Distribution Without Missing Values	
Participant identifies as Hispanic or Latinx				
Yes	16	11.6	11.6	5.6
No	122	87.1	88.4	94.4
Missing	2	1.4	–	–
Participant identifies as nonwhite				
Yes	20	14.3	14.7	9.3
No	116	82.9	85.3	90.7
Missing	4	2.8	–	–
First language of participant is other than English				
Yes	20	14.3	14.6	–
No	117	83.6	85.4	–
Missing	3	2.1	–	–
Home language of participant's child includes a language other than English				
Yes	28	20.0	20.4	–
No	109	77.9	79.6	–
Missing	3	2.1	–	–
Education of participant				
0 to 11 years	15	10.8	10.9	6.7
High school graduate	27	19.3	19.7	19.9
Some 2-year college	18	12.9	13.1	18.4
Graduated from 2-year college	22	15.7	16.0	10.9
Graduated from 4-year college	33	23.5	24.1	25.6
Completed graduate or professional school	22	15.7	16.1	18.5
Missing	3	2.1	–	–
Family income of participant				
\$0 to \$7,500	10	7.1	8.3	3.2
\$7,501 to \$15,000	13	9.3	10.7	4.6
\$15,001 to \$22,500	14	10.0	11.6	4.4
\$22,501 to \$30,000	12	8.6	9.9	5.6
\$30,001 to \$45,000	14	10.0	11.6	9.0
\$45,001 to \$60,000	19	13.6	15.7	8.7
\$60,001 to \$75,000	8	5.7	6.6	10.4
\$75,001 to \$90,000	11	7.9	9.1	7.8
\$90,001 or more	20	14.3	16.5	46.4
Missing or don't know	19	13.6	–	–
Number of persons in participant's household				
2	12	8.6	8.8	–
3	33	23.6	24.1	–
4	45	32.1	32.8	–
5	22	15.7	16.1	–
6	21	15.0	15.3	–
7	2	1.4	1.5	–
Other	2	1.4	1.5	–
Missing	3	2.1	–	–

Characteristic	Focus Group Participants			ACS
	Number	Percentage or Percentage Distribution With Missing Values	Percentage or Percentage Distribution Without Missing Values	
Employment status of participant				
Employed full time	54	38.6	39.7	–
Employed part time	31	22.1	22.8	–
Looking for work	9	6.4	6.6	–
Disabled	10	7.1	7.4	–
Not employed or looking for work	11	7.9	8.1	–
Other	21	15.0	15.4	–
Missing	4	2.8	–	–
Any service use by participant				
Yes	138	98.6	99.3	–
No	1	0.7	0.7	–
Missing	1	0.7	–	–
Specific service use by participant				
Head Start/Early Head Start	42	30.0	30.0	–
Other child care, nursery school or preschool	94	67.1	67.1	–
Home visiting, family support or parent education	66	47.1	47.1	–
Services for children with special needs	57	40.7	40.7	–
Behavioral health	34	24.3	24.3	–
Health care	104	74.3	74.3	–
Income or financial assistance	92	65.7	65.7	–
Employment assistance	0	0.0	0.0	–
None	1	0.7	0.7	–
Number of respondents	140	140	140	2,813

SOURCE: PDG B–5 Family Focus Group data and ACS 2014–2018 public use microdata file for New Hampshire.

NOTE: Survey weights are used to produce the ACS estimates. Percentages may not sum to 100 because of rounding. – = not applicable.

Appendix B. PDG B–5 System Family Survey Methods and Tabulations

The New Hampshire PDG B–5 System Family Survey received a total of 1,278 valid responses from respondents with one or more children under age seven. As noted in Chapter 1, the online survey was developed in English and translated into Arabic, Spanish, and Nepalese. A paper version of the survey was also available in each of these languages. Those responding to the online survey completed it in English (967 cases with compensation; 255 with no compensation), Spanish (5 cases), and Nepalese (1 case). Another 50 respondents completed paper surveys, mostly in English. We excluded 106 cases that either did not provide consent or who dropped out before starting the core questionnaire. This appendix provides additional information about the characteristics of the Family Survey respondents and includes survey tabulations. See Appendix F for the survey instrument.

As referenced in Chapter 1, the survey was advertised as providing a \$20 gift card for the first 1,000 respondents, but suspicious responses were detected early in the survey administration. Suspect respondents were identified based on several defining characteristics: 1) IP addresses located outside of the New Hampshire, 2) duplicate IP addresses, 3) email addresses comprised of random letter and number strings, 4) duplicate email addresses, 5) selection of all items options for questions with multiple-selection criteria, 6) nonsensical or repetitive responses to open-ended questions, and/or 7) lack of response to any item after consent. All respondents flagged as questionable were sent an email requesting a physical mailing address to receive the gift card. Data from the 149 respondents who did not provide a physical mailing address were purged from the survey.

Characteristics of Respondents and Survey Representativeness

As noted in Chapter 1, the PDG B–5 Family Survey was implemented without a sampling design that would produce a representative sample. To assess the representativeness of the survey, we can compare the characteristics of the survey sample with the same population of families in New Hampshire in the ACS, those with one or more children under age seven.²⁶ This comparison is made in Table B.1 where basic demographic and economic information about the survey respondents is compared with the same indicators that are also available in the ACS for

²⁶ The U.S. Census Bureau provides weights with the ACS micro data that we used to produce representative results.

the same population.²⁷ Note that the sampling error, given the number of respondents for the PDG B–5 Family Survey is about ± 3 percentage points, while the comparable margin of error is about ± 2 percentage points for the ACS. Thus, in comparing distributions between the surveys, it is important to keep in mind the uncertainty in the reported estimates from both sources.

Responses to these questions show the following characteristics:

- As required by the survey criteria, the youngest child for all respondents in the PDG B–5 Family Survey ranges from age 0 to 6, with a somewhat greater share of survey respondents with younger children in the required range relative to older children. In particular, the largest age group (19 percent) is the one-year-olds; the smallest is the six-year-olds (9 percent). This closely mirrors the pattern in the ACS.
- Respondents to the family survey were predominantly female (89 percent) which is almost identical to the ACS when the mother in two-parent families was assumed to be the person most knowledgeable about their children’s experiences, as was effectively the case for the PDG B–5 Family Survey.
- The majority of survey respondents were ages 30 to 39 (66 percent), which is somewhat higher than what we would expect based on the ACS (57 percent), although within the margin of error.
- Almost all survey respondents were white (97 percent) and not Latinx (96 percent). According to the ACS, the target groups of families for the survey are 9 percent nonwhite and 6 percent Hispanic. Thus, both groups are somewhat underrepresented, although the difference is within the margin of error for the representativeness of the Latinx population.
- The predominant marital status was married/partnered (43 percent), well below the population share of 70 percent. The survey therefore overrepresents single-parent families.
- Over half of the PDG B–5 Family Survey respondents (58 percent) reported having a college degree or higher, a figure that exceeds the ACS estimate of 44 percent. This gap holds for both the college degree group (34 percent versus 26 percent) and the graduate or professional degree group (24 percent versus 19 percent). At the other extreme, 13 percent of the survey respondents had a high school degree or less, compared with 27 percent in the ACS. This suggests that the survey is overrepresented by respondents at the higher end of the educational attainment distribution.
- Annual income shows the reverse pattern, however, with 40 percent of survey respondents reporting family income above \$90,000 per year, compared with 46 percent

²⁷ These comparisons are made when the missing data cases are excluded from the PDG B–5 Family Survey, as the ACS imputes most item nonresponse.

in the ACS. Families with income up to \$45,000 are also somewhat underrepresented in the survey (23 percent versus 27 percent in the ACS), although this is within the margin of error. The middle income group between these two extremes is a somewhat higher proportion of the survey respondents compared with the ACS (37 percent versus 27 percent). In sum, the survey appears to overrepresent the middle-income group (\$45,000 to \$90,000) and somewhat underrepresent the lower and upper income groups.

- About 79 percent of the survey respondents that reported a zip code were in communities defined as nonrural according to the definition adopted for the PDG B–5 Needs Assessment (see Chapter 2). This is almost the same as the 77 percent estimated nonrural share in the ACS using the same rural/nonrural designations based on zip code.

Several other characteristics of the PDG B–5 Family Survey are worth noting, although they cannot be compared against the ACS (because the same characteristics are not measured in the latter):

- Most respondents are birth, step, or adoptive parents of the focal child (99 percent); just a few are grandparents or foster parents.
- About 10 percent of respondents reported that their youngest child had one or more disabling conditions, most common being Autism (27 percent) and ADD/ADHD (17 percent).

In sum, the PDG B–5 Family Survey captures a diverse population of New Hampshire families with at least one child under age seven. The survey sample is closely representative of this group of families in terms of the age of the youngest child, the age of the parent, parent gender, Latinx status, and rural status. The survey appears to somewhat overrepresent white families, families with higher parental education, and families in the middle of the income distribution, but the differences are never more than 10 percentage points at the detailed subgroup level, just above the margin of error. The most substantial difference is the higher share of unmarried parents in the survey relative to the ACS. Thus, it is important to keep in mind that the survey respondents are not fully representative of all New Hampshire families with children under age seven. At the same time, it does not consistently overrepresent either the least advantaged families or the most advantaged families as measured by marital status, parental education, or income. All responses should be viewed as representative of the set of individuals who responded to the survey, which closely mirrors many of the population characteristics, but not all. In addition, for the subgroup analyses (described next), results are based on a smaller set of respondents. Thus, small differences across subgroups are not likely to be statistically significant.

Tabulations

Results in the tabulations that follow are shown for all respondents (1,278 cases) and for three subgroups based on child age, family income, and rural/nonrural status. The subgroups are defined as follows:

- **Child age.** Based on the age of the respondent's youngest child (Q2), respondents were classified into the following three groups;
 - Youngest child ages 0, 1, or 2 (53 percent)
 - Youngest child ages 3 or 4 (26 percent)
 - Youngest child ages 5 or 6 (22 percent)
- **Family income.** Parent respondents were classified into one of three groups based on their reported family income (Q51) as follows:
 - Low income: up to \$45,000 (27 percent)
 - Middle income: \$45,001 to \$90,000 (27 percent)
 - High income: \$90,000 and above (46 percent)Respondents who did not report their income (19 percent), either as refusals or item nonresponse, are not included in these tabulations (or the above percentages).
- **Rural status.** Consistent with the definition adopted for the PDG B–5 Needs Assessment, parent respondents were classified into two groups based on the New Hampshire Regional Public Health Networks designation of zip codes as rural (21 percent) or nonrural (79 percent). Respondents who did not report their zip code (18 percent) are not included in these tabulations.²⁸

The distribution of the respondents by the subgroups is shown in Table B.1, both for the total respondents and for the valid cases included in the subgroup analyses. Note that for tabulations based on family income and rural status, the percentages and percentage distributions for the subgroups will not be a weighted average of the results for all respondents because of the exclusion of cases with missing income or zip code, respectively.

In Tables B.2 to B.21, results are shown for survey respondents disaggregated by the age of the youngest child, by family income, and by rural status. The results for all respondents is recorded in the last column of each table. As indicated in the row labels, results are either

²⁸ This percentage rural (21 percent) among family survey respondents (where the family is the unit of analysis) is below the estimated share of children birth through five (where the child is the unit of analysis) classified as rural using the same rural/nonrural definition (27 percent). This difference would be expected if families in rural communities have, on average, more children ages birth through five compared with their nonrural counterparts. There is some evidence that this is the case in the family survey tabulations (see Table B.2).

percentage distributions (summing to 100 percent) when only one response was allowed or percentages when respondents could select all response options that applied. Note that some respondents did not complete the full survey or did not respond to specific survey items. Unless otherwise indicated, tabulations exclude cases with no response, either because of an incomplete survey or item nonresponse.

Table B.1. Comparison of Characteristics of New Hampshire Families with One or More Children Less Than Age Seven: PDG B–5 Family Survey Respondents and ACS

Indicator	Family Survey Respondents		ACS
	With Missing Values	Without Missing Values	
Age of youngest child in the family (percentage distribution)			
Less than 12 months	17.1	17.1	19.3
Age 1	19.3	19.3	16.9
Age 2	16.2	16.2	14.4
Age 3	13.5	13.5	13.5
Age 4	12.1	12.1	12.5
Age 5	12.9	12.9	11.8
Age 6	8.8	8.8	11.7
Parent gender (percentage distribution)			
Male	10.1	10.2	10.0
Female	89.3	89.8	90.0
Nonbinary/other	0.5	–	–
Prefer not to say	0.2	–	–
Parent age group (percentage distribution)			
18 to 29	20.8	20.8	26.2
30 to 39	66.1	66.1	56.5
40 to 49	12.5	12.5	15.1
50 and older	0.6	0.6	2.2
Parent identifies as Hispanic or Latinx (percentage distr.)			
Yes	3.8	3.8	5.6
No	95.7	96.2	94.4
Prefer not to say	0.7	–	–
Parent race (percentage distribution)			
White	95.7	96.7	90.7
Nonwhite	3.3	3.3	9.3
Prefer not to say	1.0	–	–
Parent marital status (percentage distribution)			
Single	38.7	38.7	20.8
Married or domestic partnership	42.6	42.6	70.0
Divorced	13.6	13.6	7.0
Separated	5.1	5.1	2.2
Prefer not to say	0.0	–	–
Parent highest education level (percentage distribution)			
0 to 11 years	1.2	1.2	6.7
High school graduate or GED/HSET	11.9	12.0	19.9
Some college with no degree	17.2	17.3	18.4
Associates (two-year) degree	11.4	11.5	10.9
College (four-year) degree	33.5	33.7	25.6
Graduate or professional degree	24.3	24.4	18.5
Prefer not to say	0.5	–	–

Indicator	Family Survey Respondents		ACS
	With Missing Values	Without Missing Values	
Family income (percentage distribution)			
\$0 to \$7,500	1.6	1.7	3.2
\$7,501 to \$15,000	2.7	2.9	4.6
\$15,001 to \$22,500	3.4	3.6	4.4
\$22,501 to \$30,000	4.7	5.0	5.6
\$30,001 to \$45,000	9.1	9.6	9.0
\$45,001 to \$60,000	10.0	10.6	8.7
\$60,001 to \$75,000	12.6	13.3	10.4
\$75,001 to \$90,000	12.8	13.5	7.8
\$90,001 or more	37.7	39.8	46.4
Prefer not to say	5.4	–	–
Family income groups (percentage distribution)			
Low (up to \$45,000)	21.5	22.8	26.7
Middle (\$45,001 to \$90,000)	35.4	37.4	26.9
High (\$90,001 and above)	37.7	39.8	46.4
Prefer not to say	5.4	–	–
Family lives in a rural community (percentage distribution)			
Nonrural	64.9	78.9	76.8
Rural	17.4	21.1	23.2
Missing zip code information	17.8	–	–
Number of respondents	1,278	1,278	2,813

SOURCE: Tabulations from PDG B–5 Family Survey and ACS 2014–2018 public use microdata file for New Hampshire.

NOTE: The reference child may be the respondent's birth, step, adoptive, or foster child. Survey weights are used to produce the ACS estimates. Percentage distributions may not sum to 100 because of rounding. – = not applicable.

Table B.2. Characteristics of Respondents

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Gender (percentage distribution)									
Male	5.7	13.4	16.9	5.1	16.8	7.8	10.0	9.5	10.1
Female	93.6	85.9	82.7	94.1	82.7	92.0	89.5	90.1	89.3
Nonbinary/other	0.3	0.0	0.4	0.8	0.5	0.0	0.3	0.5	0.5
Prefer not to say	0.2	0.4	0.0	0.0	0.0	0.2	0.1	0.0	0.2
Age group (percentage distribution)									
18 to 29	28.4	15.7	8.4	36.5	25.5	7.6	19.5	24.8	20.8
30 to 39	66.1	68.7	63.0	52.4	66.8	75.1	67.3	63.1	66.1
40 to 49	5.2	15.0	27.3	11.2	7.0	16.6	12.3	12.2	12.5
50 and older	0.4	0.7	1.3	0.0	0.8	0.7	0.9	0.0	0.6
Identifies as Hispanic or Latinx (percentage distribution)									
Yes	3.0	5.3	4.1	3.4	5.9	1.7	4.4	1.4	3.8
No	96.4	94.0	95.1	95.7	95.6	97.3	95.7	98.2	95.7
Prefer not to say	0.7	0.7	0.8	0.9	0.5	0.0	0.6	0.0	0.7
Race (percentage distribution)									
White	95.3	95.4	96.7	95.7	95.6	97.3	95.7	98.2	95.7
Nonwhite	3.3	3.6	3.3	3.0	4.4	1.9	3.5	1.8	3.3
Prefer not to say	1.4	1.1	0.0	1.3	0.0	0.7	0.9	0.0	1.0
First language (percentage distribution)									
English	98.3	97.2	97.5	96.6	98.5	97.8	97.6	99.1	97.8
Other	1.7	2.5	2.1	3.0	1.6	2.2	2.3	0.9	2.0
Prefer not to say	0.0	0.4	0.4	0.4	0.0	0.0	0.1	0.0	0.2
Marital status (percentage distribution)									
Single	13.5	12.7	13.6	38.7	8.8	2.4	11.7	20.3	38.7
Married or Domestic Partnership	82.2	80.9	73.3	42.6	87.4	95.6	81.3	73.9	42.6
Divorced	2.3	4.2	9.5	13.6	2.3	1.2	4.1	5.4	13.6
Separated	1.2	1.8	3.3	5.1	1.0	0.7	2.2	0.5	5.1
Prefer not to say	0.9	0.4	0.4	0.0	0.5	0.0	0.7	0.0	0.0

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Highest education level (percentage distribution)									
0 – 11 years	0.7	1.8	1.2	4.6	0.3	0.0	1.1	1.4	1.2
High school graduate or GED/HSET	13.3	11.7	8.7	28.8	10.1	2.9	10.6	16.7	11.9
Some college with no degree	16.4	19.4	16.5	30.1	20.7	7.3	17.0	18.5	17.2
Associates (two-year) degree	6.9	17.7	14.9	14.4	16.0	5.8	8.8	18.9	11.4
College (four-year) degree	30.7	23.7	29.3	13.6	31.3	34.9	30.9	21.6	28.6
Some graduate or professional school with no degree	5.4	3.9	5.0	3.0	5.9	5.6	4.3	6.8	4.9
Graduate or professional degree	26.1	20.9	24.0	4.2	15.8	43.3	27.0	15.3	24.3
Prefer not to say	0.4	1.1	0.4	1.3	0.0	0.2	0.2	0.9	0.5
Number of children in the household by age group (average)									
6 years or younger	1.7	1.4	1.2	1.4	1.5	1.5	1.5	1.6	1.5
Between 7 and 12 years old	0.3	0.4	0.6	0.5	0.4	0.3	0.4	0.4	0.4
Between 13 and 18 years old	0.1	0.1	0.2	0.2	0.1	0.1	0.1	0.1	0.1
Number of adults in the household (average)	1.2	1.4	1.2	1.2	1.3	1.3	1.2	1.3	1.3

SOURCE: Tabulations from PDG B–5 Family Survey.

NOTE: The reference child may be the respondent's birth, step, adoptive, or foster child. Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.3. Characteristics of Respondent's Youngest Child

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Child age (percentage distribution)									
Less than 12 months	32.6	0.0	0.0	18.2	15.2	18.6	16.9	18.0	17.1
Age 1	36.6	0.0	0.0	16.5	16.0	22.3	18.8	17.1	19.3
Age 2	30.8	0.0	0.0	17.4	15.2	18.2	16.0	17.6	16.2
Age 3	0.0	52.7	0.0	11.4	13.9	12.4	13.9	12.6	13.5
Age 4	0.0	47.3	0.0	10.2	17.0	8.7	12.2	12.6	12.1
Age 5	0.0	0.0	59.4	16.1	14.4	10.9	12.7	13.5	12.9
Age 6	0.0	0.0	40.7	10.2	8.3	9.0	9.5	8.6	8.8
Relationship of child to the parent respondent (percentage distribution)									
Biological, step, or adopted child	99.3	98.8	98.2	98.7	99.0	99.8	99.5	98.2	99.0
Grandchild	0.6	0.6	0.7	0.4	1.0	0.0	0.5	0.5	0.6
Other relative	0.1	0.3	0.7	0.4	0.0	0.0	0.0	0.5	0.3
Foster child	0.6	0.3	0.4	1.3	0.0	0.5	0.1	1.8	0.5
Other relationship	0.3	0.0	0.0	0.0	0.0	0.2	0.1	0.0	0.2
Child has any physical, behavioral, or mental health conditions that prevent him/her from doing the things most children of the same age can do (percentage distribution)									
Yes	6.9	8.5	17.4	14.9	10.6	4.8	8.9	12.2	9.6
No	92.7	91.2	82.3	85.1	89.4	95.2	90.8	87.3	90.0
Prefer not to say	0.5	0.3	0.4	0.0	0.0	0.0	0.2	0.5	0.4
Languages child speaks with parent (percentage)									
English	98.8	97.8	99.6	96.6	97.4	98.5	98.8	99.0	98.7
Other	5.7	5.1	4.6	7.2	6.5	3.3	5.1	4.6	5.4
Prefer not to say	0.3	0.0	0.4	0.8	0.0	0.0	0.2	0.5	0.3

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: – = not applicable. The reference child may be the respondent's birth, step, adoptive, or foster child. Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.4. B–5 Service Knowledge and Use: EHS/HS, Early Intervention, Preschool Special Education, or Health Care Coordination

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
EHS/HS (percentage)									
I have heard of this (type of) program	88.8	90.5	89.9	92.8	92.3	87.9	90.3	93.7	89.5
My youngest child has ever participated	3.3	11.3	14.7	14.4	11.1	2.2	5.9	15.8	7.8
My youngest child has participated in the last 12 months	2.1	7.0	5.8	7.6	6.2	0.5	2.9	8.6	4.1
None of the responses apply	9.4	7.0	7.2	4.7	5.9	10.9	8.2	4.5	8.3
Prefer not to say	0.7	0.6	0.0	0.4	0.3	0.2	0.2	0.5	0.5
No response	0.9	2.1	2.9	2.1	1.5	1.0	1.2	1.4	1.6
Early intervention/FCESS (percentage)									
I have heard of this (type of) program	72.2	76.8	75.2	68.6	75.5	80.4	76.0	77.0	74.0
My youngest child has ever participated	12.8	17.7	21.2	19.1	16.5	13.6	14.8	21.2	15.9
My youngest child has participated in the last 12 months	8.8	7.9	5.0	8.9	9.3	5.8	7.1	10.8	7.7
None of the responses apply	17.7	11.9	15.8	18.6	14.4	15.3	15.9	14.4	15.8
Prefer not to say	0.9	0.9	0.4	1.3	0.5	0.5	0.5	0.9	0.8
No response	9.2	10.4	8.6	11.4	9.5	3.9	7.6	7.7	9.4
Preschool special education (percentage)									
I have heard of this (type of) program	70.2	75.9	77.7	68.6	76.3	78.0	75.3	77.0	73.3
My youngest child has ever participated	3.0	12.8	21.6	12.3	10.3	6.3	8.8	10.4	9.5
My youngest child has participated in the last 12 months	2.4	10.1	10.4	8.5	6.2	3.9	5.3	7.2	6.1
None of the responses apply	18.8	14.3	12.9	19.9	14.2	16.2	16.3	14.4	16.4
Prefer not to say	0.7	0.6	0.4	0.4	0.5	0.5	0.4	0.5	0.6
No response	10.3	9.1	9.0	11.0	9.0	5.3	8.1	8.1	9.7
Health care coordination (percentage)									
I have heard of this (type of) program	46.0	51.2	55.8	47.9	51.3	51.6	49.5	55.4	49.5
My youngest child has ever participated	0.7	2.1	11.5	3.8	4.9	2.2	3.3	5.0	3.4
My youngest child has participated in the last 12 months	0.4	1.2	7.2	2.1	2.8	1.7	1.9	3.2	2.1
None of the responses apply	35.1	29.0	28.1	33.1	32.0	34.9	33.1	31.1	32.0
Prefer not to say	0.9	0.6	0.7	0.4	1.0	0.5	0.6	0.5	0.8
No response	18.0	19.2	15.5	18.6	15.7	13.1	16.9	13.1	17.8

SOURCE: Tabulations from PDG B–5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations. Abbreviations: EHS = Early Head Start; HS = Head Start.

Table B.5. Top Reasons for Not Participating in EHS/HS, Early Intervention, Special Education Preschool, or Health Care Coordination

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Top reasons (percentage)									
I did not know about the program(s)/service(s).	20.1	18.7	17.0	23.0	16.1	19.0	19.7	14.4	19.1
I thought my child did not need or would not benefit from the program(s).	50.2	46.2	46.4	41.6	47.4	56.1	51.9	39.5	48.3
I thought my child or family would not qualify for the program(s).	30.7	30.1	30.6	26.1	29.7	34.9	31.4	27.0	30.5
My child or family did not qualify for the program(s).	21.0	30.4	29.4	22.6	26.3	26.1	24.5	28.8	25.2
It was too difficult to enroll in the program(s) (e.g., paperwork).	2.1	4.4	7.9	3.1	7.8	1.7	3.9	5.6	4.0
My family did not have transportation to participate in the program(s).	2.8	4.7	5.7	8.0	3.1	1.5	3.3	5.1	3.9
The distance to the program(s) was too far to travel.	2.1	2.2	4.9	4.4	4.2	1.7	2.6	5.1	2.8
I thought that others would think less of my family for using the program(s).	0.8	1.3	4.2	1.3	2.9	0.5	1.3	2.3	1.6
The quality of the program(s) was low.	1.8	1.9	7.5	0.4	4.2	3.4	3.3	3.3	3.1
My family could not afford the cost of the program(s).	8.0	6.3	3.8	12.8	8.9	1.7	6.6	7.9	6.7
Other	16.3	10.8	10.9	17.7	12.0	11.7	12.2	17.2	13.7
Prefer not to say	1.8	2.5	1.9	1.8	1.3	1.7	1.7	2.3	2.0

SOURCE: Tabulations from PDG B–5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.6. B-5 Service Use: Public or Private Child Care and Preschool

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Preschool/preK in public school (percentage)									
My youngest child has ever participated	5.5	19.7	37.6	21.6	19.6	8.2	15.3	15.8	16.3
My youngest child has participated in the last 12 months	2.7	13.1	20.3	11.9	11.3	5.3	8.2	10.8	9.2
None of the responses apply	90.3	75.2	56.1	72.9	76.5	88.1	80.8	79.3	78.8
Prefer not to say	1.1	0.6	0.4	2.5	0.3	0.2	0.6	1.4	0.8
No response	3.1	4.5	5.9	3.0	3.6	3.4	3.3	3.6	4.1
Preschool/preK in private school (percentage)									
My youngest child has ever participated	7.2	29.3	41.3	14.4	18.3	24.0	21.1	16.2	20.4
My youngest child has participated in the last 12 months	3.9	22.0	21.0	8.5	10.8	14.5	12.4	9.9	12.3
None of the responses apply	84.4	59.6	46.5	75.4	70.9	69.0	69.1	76.6	69.6
Prefer not to say	1.3	0.6	0.4	0.8	1.3	0.5	0.8	0.9	0.9
No response	7.2	10.5	11.8	9.3	9.5	6.5	8.9	6.3	9.1
Child care/early learning in FCCH (percentage)									
My youngest child has ever participated	18.5	35.0	37.6	25.0	35.1	23.0	26.1	37.4	27.0
My youngest child has participated in the last 12 months	9.4	18.2	10.0	11.0	15.5	9.9	10.7	18.5	11.8
None of the responses apply	73.2	55.1	51.3	63.1	56.7	71.2	65.4	56.8	63.7
Prefer not to say	0.9	0.3	0.4	1.7	0.3	0.0	0.2	1.4	0.7
No response	7.4	9.6	10.7	10.2	8.0	5.8	8.3	4.5	8.7
Child care/early learning in center (percentage)									
My youngest child has ever participated	38.7	52.5	49.1	35.2	42.3	55.7	48.1	36.9	44.5
My youngest child has participated in the last 12 months	25.7	35.0	19.2	20.3	25.5	33.2	28.6	23.4	26.6
None of the responses apply	51.8	34.4	38.0	52.1	47.4	37.3	42.3	52.7	44.3
Prefer not to say	1.1	0.3	0.7	1.3	0.8	0.5	0.8	0.5	0.8
No response	8.5	12.7	12.2	11.4	9.5	6.5	8.7	9.9	10.4

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Abbreviations: FCCH = family child care home. Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.7. Top Reasons for Not Participating in Public or Private Child Care and Preschool

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Top reasons (percentage)									
My child is not of age to qualify for the program(s).	51.2	22.4	9.6	35.8	30.9	39.0	34.4	38.1	35.0
I thought my child did not need or would not benefit from the program(s).	26.5	22.7	26.7	23.5	23.5	28.5	26.4	23.3	25.6
I thought my child or family would not qualify for the program(s).	11.7	16.1	15.9	14.6	13.3	13.4	14.9	9.8	13.7
My child or family did not qualify for the program(s).	6.8	14.7	13.5	7.1	15.2	7.7	11.0	8.4	10.2
It was too difficult to enroll in the program(s) (e.g., paperwork).	1.8	3.8	5.6	0.9	5.6	2.0	2.9	3.7	3.1
My family did not have transportation to participate in the program(s).	2.9	5.6	6.0	7.1	4.5	1.7	3.7	5.1	4.3
The distance to the program(s) was too far to travel.	2.9	6.3	4.4	5.8	4.8	2.7	2.9	8.4	4.1
I thought that others would think less of my family for using the program(s).	0.3	0.0	2.8	0.4	1.9	0.2	0.9	0.9	0.8
The hours of the program(s) did not fit my family's schedule	9.8	22.7	26.3	16.8	17.6	17.4	17.1	15.8	16.6
The quality of the program(s) was low.	4.9	5.6	11.6	3.5	4.0	10.2	6.2	7.9	6.5
My family could not afford the cost of the program(s).	17.9	18.2	18.3	28.3	23.2	8.9	18.7	17.7	18.1
Other	17.2	18.2	19.1	15.0	16.8	19.4	16.9	21.9	17.9
Prefer not to say	2.6	5.6	4.8	5.8	2.9	2.2	3.2	2.3	3.8

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.8. B-5 Service Knowledge and Use: Home Visiting, Parent Education, or Family Support Programs

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Home visiting program (percentage)									
I have heard of this (type of) program	43.9	47.8	50.2	51.3	51.8	38.5	44.0	56.3	46.3
My family has participated since the birth of my youngest child	7.3	12.3	13.5	12.3	13.4	5.3	9.0	12.6	9.9
My family has participated in the last 12 months	3.2	4.7	5.0	4.7	5.9	1.5	3.4	5.0	4.0
None of the responses apply	54.2	49.5	47.9	46.2	47.4	60.5	54.9	41.9	51.6
Prefer not to say	1.5	1.0	0.0	2.1	0.3	0.5	0.5	1.8	1.0
No response	0.5	1.7	1.9	0.4	0.5	0.5	0.6	0.0	1.1
Parent education program (percentage)									
I have heard of this (type of) program	32.9	38.9	42.9	41.1	42.5	32.4	33.2	52.7	36.6
My family has participated since the birth of my youngest child	2.4	10.3	9.7	7.2	9.3	3.1	5.2	9.9	6.0
My family has participated in the last 12 months	1.1	7.3	5.4	3.0	6.2	2.7	3.0	6.8	3.6
None of the responses apply	58.2	52.5	50.2	49.2	50.5	62.5	59.5	41.4	55.0
Prefer not to say	1.3	1.7	0.0	1.7	0.8	0.5	0.8	1.4	1.1
No response	7.6	7.0	6.9	8.1	6.2	4.6	6.5	4.5	7.3
Other family support program (percentage)									
I have heard of this (type of) program	24.7	29.9	34.0	33.1	34.5	23.5	25.7	41.0	28.1
My family has participated since the birth of my youngest child	1.9	9.0	9.3	6.4	8.8	2.2	4.2	10.4	5.3
My family has participated in the last 12 months	1.5	6.3	5.8	3.0	7.0	1.9	3.3	5.9	3.6
None of the responses apply	62.4	59.8	56.4	53.8	55.4	69.2	64.3	50.0	60.4
Prefer not to say	1.5	1.0	0.0	1.7	0.5	0.5	0.7	1.4	1.0
No response	11.5	9.3	9.7	11.4	9.5	6.8	9.3	7.7	10.5

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.9. Top Reasons for Not Participating in Home Visiting, Parent Education, or Family Support Programs

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Top reasons (percentage)									
I did not know about the program(s)/service(s).	61.7	58.4	55.8	59.3	56.0	62.9	63.4	47.7	59.6
I thought my child did not need or would not benefit from the program(s).	36.8	32.6	32.5	29.4	32.1	42.0	35.0	34.1	34.8
I thought my child or family would not qualify for the program(s).	18.9	19.2	20.9	16.0	21.2	21.2	20.6	16.8	19.4
My child or family did not qualify for the program(s).	9.7	15.1	15.3	8.7	16.2	11.5	12.0	13.1	12.3
It was too difficult to enroll in the program(s) (e.g., paperwork).	1.3	4.8	5.6	2.2	6.1	1.5	3.2	3.3	3.1
My family did not have transportation to participate in the program(s).	2.0	4.5	4.8	4.3	5.6	1.0	2.8	5.1	3.2
The distance to the program(s) was too far to travel.	2.0	4.5	5.6	3.9	5.0	1.7	2.7	5.6	3.4
I thought that others would think less of my family for using the program(s).	0.7	2.1	4.4	1.3	3.4	1.0	2.1	1.4	1.8
The quality of the program(s) was low.	0.7	2.1	2.0	0.9	1.6	1.2	1.0	2.8	1.3
My family could not afford the cost of the program(s).	4.6	3.1	4.8	9.1	5.3	0.7	3.9	5.6	4.3
Other	8.4	5.8	5.2	8.7	5.0	6.6	5.8	10.7	7.0
Prefer not to say	3.1	3.1	3.2	5.2	1.3	2.0	2.2	2.8	3.1

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.10. B-5 Service Knowledge and Use: Developmental Screening, Well-Child Visits, Behavioral Health, or Oral Health

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Developmental screening (percentage)									
I have heard of this (type of) program	75.6	81.6	79.1	77.1	78.1	80.4	77.4	85.1	77.9
My youngest child has ever participated	43.7	56.8	52.4	45.3	48.7	53.5	47.9	59.0	49.0
My youngest child has participated in the last 12 months	29.5	33.7	24.0	23.7	28.6	34.6	27.6	37.8	29.4
None of the responses apply	22.3	16.7	19.3	20.8	20.9	18.2	21.1	14.0	20.2
Prefer not to say	1.3	0.3	0.0	1.7	0.3	0.2	0.6	0.9	0.8
No response	0.8	1.7	1.6	0.8	0.8	1.2	0.8	0.5	1.2
Well-child visits/health care (percentage)									
I have heard of this (type of) program	84.0	88.4	83.8	85.2	84.3	87.9	84.8	91.0	85.1
My youngest child has ever participated	67.3	71.7	70.0	64.4	70.1	74.1	69.1	74.3	69.0
My youngest child has participated in the last 12 months	47.0	47.4	49.8	43.6	42.8	56.7	46.4	55.9	47.7
None of the responses apply	9.9	8.2	10.3	8.1	10.1	9.9	10.4	5.9	9.5
Prefer not to say	0.5	0.0	0.0	0.4	0.0	0.0	0.0	0.5	0.3
No response	5.6	3.4	5.9	5.9	5.4	2.2	4.4	2.7	4.9
Behavioral health services (percentage)									
I have heard of this (type of) program	62.9	69.3	75.2	67.4	67.0	69.5	67.1	72.5	67.2
My youngest child has ever participated	5.0	15.4	23.6	12.3	14.9	9.2	11.7	12.2	11.7
My youngest child has participated in the last 12 months	2.8	12.6	16.9	9.3	10.6	6.3	8.1	9.5	8.4
None of the responses apply	29.7	23.9	18.5	24.2	25.3	27.1	26.9	21.2	25.8
Prefer not to say	1.0	0.3	0.0	1.3	0.5	0.0	0.2	1.4	0.6
No response	6.4	6.5	6.3	6.8	7.2	3.4	5.6	5.0	6.3
Oral health care services (percentage)									
I have heard of this (type of) program	78.4	85.3	81.0	77.9	81.6	84.3	81.5	84.7	80.7
My youngest child has ever participated	38.8	68.5	68.8	54.9	54.1	53.0	53.5	55.9	52.9
My youngest child has participated in the last 12 months	27.6	51.7	55.3	39.1	38.6	42.9	39.3	45.0	39.8
None of the responses apply	8.9	6.2	7.5	6.8	8.8	8.2	8.1	5.9	7.9
Prefer not to say	0.8	0.0	0.4	0.9	0.3	0.0	0.0	1.4	0.5
No response	11.9	8.6	11.1	14.5	9.3	7.5	10.0	8.1	10.6

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.11. Top Reasons for Not Participating in Developmental Screening, Well-Child Visits, Behavioral Health, or Oral Health

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Top reasons (percentage)									
I did not know about the program(s)/service(s).	30.1	29.0	29.6	30.8	28.6	29.0	32.4	16.5	29.7
I thought my child did not need or would not benefit from the program(s).	57.7	51.1	51.1	43.9	49.6	67.3	57.6	47.1	54.7
There are no providers of the service(s) in my area.	4.1	8.8	7.6	7.5	9.0	3.3	4.8	12.1	6.0
My family did not have transportation to participate in the program(s).	0.7	4.4	3.6	3.3	3.8	0.8	2.4	2.4	2.2
The distance to the program(s) was too far to travel.	1.0	6.3	2.7	2.3	4.6	1.5	2.1	4.9	2.7
I thought that others would think less of my family for using the program(s).	0.5	0.4	2.2	0.9	1.4	0.3	0.8	1.0	0.8
The hours of the program(s) did not fit my family's schedule	3.9	8.1	9.9	8.4	8.4	3.3	5.2	9.2	6.2
The waiting list to see the provider(s) was too long.	3.1	6.6	9.0	5.6	7.9	2.5	4.3	7.8	5.2
The quality of the program(s) was low.	1.5	1.5	1.3	0.9	1.6	1.5	2.0	0.0	1.5
My family could not afford the cost of the program(s).	6.2	7.0	9.4	12.1	9.8	2.0	7.1	7.3	7.0
My insurance does not pay for the cost of the service(s).	7.9	7.7	7.2	5.6	12.0	4.8	7.8	8.7	7.7
Other	13.5	5.9	9.0	10.7	8.4	11.3	9.6	13.6	10.7
Prefer not to say	6.8	10.3	4.9	11.2	6.5	5.3	6.1	9.7	7.3

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.12. B-5 Service Knowledge and Use: Cash and In-kind Assistance Programs

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
FANF (percentage)									
I have heard of this (type of) program	69.5	74.7	78.2	84.3	76.3	64.6	72.1	82.4	72.8
My family has participated since the birth of my youngest child	5.6	12.5	15.5	19.9	11.9	1.2	8.8	13.5	9.5
My family has participated in the last 12 months	3.2	8.0	7.5	10.6	7.2	0.7	4.9	7.7	5.4
None of the responses apply	28.6	24.0	18.7	13.1	22.7	34.4	26.9	16.2	25.2
Prefer not to say	0.8	0.3	1.2	1.7	0.3	0.7	0.6	0.9	0.8
No response	1.0	1.0	2.0	0.8	0.8	0.2	0.4	0.5	1.2
SNAP (percentage)									
I have heard of this (type of) program	80.2	80.9	84.9	88.6	81.2	79.9	82.8	84.2	81.4
My family has participated since the birth of my youngest child	13.0	19.4	23.4	50.8	14.2	1.5	13.8	29.3	17.0
My family has participated in the last 12 months	8.5	10.1	10.7	33.9	4.4	0.5	7.0	17.6	9.4
None of the responses apply	13.7	13.2	9.5	5.5	13.4	16.2	12.2	11.7	12.6
Prefer not to say	1.2	0.7	1.2	1.7	0.3	1.0	0.7	1.4	1.1
No response	4.9	5.2	4.4	4.2	5.2	2.9	4.3	2.7	4.9
Child Care Scholarship (percentage)									
I have heard of this (type of) program	56.3	67.7	71.0	69.5	65.7	58.4	62.1	70.7	62.5
My family has participated since the birth of my youngest child	4.9	16.0	23.4	25.4	15.5	2.2	11.0	17.1	11.8
My family has participated in the last 12 months	3.2	8.3	9.1	14.4	6.7	0.7	5.9	6.3	5.8
None of the responses apply	37.1	27.8	24.2	23.3	29.1	38.5	33.5	23.4	31.8
Prefer not to say	0.8	0.3	0.4	2.1	0.0	0.2	0.4	0.9	0.6
No response	5.8	4.2	4.4	4.2	5.2	2.9	4.0	5.0	5.0
Housing vouchers, subsidized housing (percentage)									
I have heard of this (type of) program	77.3	78.1	80.6	79.7	80.4	78.5	79.3	82.4	78.2
My family has participated since the birth of my youngest child	3.9	9.4	11.5	15.7	8.8	1.0	6.2	11.7	7.0
My family has participated in the last 12 months	2.7	6.6	6.3	9.7	5.7	1.0	4.5	5.9	4.5
None of the responses apply	16.1	16.3	13.9	12.7	14.7	17.7	15.4	14.0	15.6
Prefer not to say	1.4	0.7	0.8	3.0	0.3	0.7	0.8	1.4	1.1
No response	5.2	5.2	4.8	5.1	4.6	3.1	4.5	2.7	5.1

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
WIC (percentage)									
I have heard of this (type of) program	87.1	83.7	88.1	92.4	86.9	85.5	87.0	90.5	86.5
My family has participated since the birth of my youngest child	20.8	22.2	27.0	65.3	17.3	2.9	18.9	36.0	22.5
My family has participated in the last 12 months	11.5	8.7	5.2	31.4	4.4	1.2	6.4	19.8	9.4
None of the responses apply	7.8	10.4	4.8	2.5	7.2	11.4	8.3	4.5	7.8
Prefer not to say	0.3	1.4	0.8	0.8	0.8	0.2	0.4	1.8	0.7
No response	4.7	4.5	6.3	4.2	5.2	2.9	4.3	3.2	5.0
Employment assistance services (percentage)									
I have heard of this (type of) program	62.8	69.1	76.6	66.9	72.9	65.9	66.0	77.0	67.5
My family has participated since the birth of my youngest child	3.2	8.3	9.1	12.7	7.2	1.2	6.0	5.4	5.8
My family has participated in the last 12 months	2.0	3.8	3.2	4.7	4.1	0.5	2.9	2.3	2.7
None of the responses apply	28.4	21.5	15.5	20.8	19.8	28.8	25.9	15.8	23.8
Prefer not to say	1.0	0.7	1.2	2.5	0.0	0.7	1.0	0.5	1.0
No response	7.8	8.7	6.7	9.7	7.2	4.6	7.1	6.8	7.8

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.13. Top Reasons for Not Participating in Cash and In-kind Assistance Programs

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Top reasons (percentage)									
I did not know about the program(s)/service(s).	21.3	13.7	12.4	16.0	16.4	19.0	18.8	9.7	17.4
I thought my child did not need or would not benefit from the program(s).	47.2	38.7	39.8	25.3	37.1	59.1	44.3	39.6	43.4
I thought my child or family would not qualify for the program(s).	42.0	43.3	37.8	34.7	41.6	43.8	43.2	34.6	41.4
My child or family did not qualify for the program(s).	38.1	41.9	46.9	48.0	48.1	32.6	38.0	53.0	41.0
It was too difficult to enroll in the program(s) (e.g., paperwork).	6.4	7.7	9.1	14.7	8.3	2.9	7.1	9.7	7.3
My family did not have transportation to participate in the program(s).	1.2	5.3	5.4	2.7	6.0	1.5	3.0	4.6	3.2
The distance to the program(s) was too far to travel.	0.9	4.6	3.7	3.1	4.4	0.7	1.7	5.5	2.4
I thought that others would think less of my family for using the program(s).	2.6	3.5	5.8	6.7	5.7	0.7	3.7	5.1	3.5
The hours of the program(s) did not fit my family's schedule	1.7	6.0	6.2	6.2	2.1	4.9	4.0	5.5	3.8
Other	4.7	3.2	4.6	3.1	1.6	0.7	1.8	1.4	4.3
Prefer not to say	2.4	2.1	1.2	5.3	5.5	1.0	3.3	4.1	2.1

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.14. Sources of Information about Early Childhood Care and Education Resources

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Top three most common ways respondent learns about early childhood care and education resources (percentage)									
Friends or family	79.2	76.0	75.5	75.3	78.4	79.1	79.6	70.7	77.6
Google Search	64.2	61.0	64.1	57.9	63.9	67.4	67.4	50.5	63.3
Facebook or other social media outlets	57.3	47.4	49.8	48.5	51.2	58.6	54.5	49.1	53.1
NH state run website	28.6	35.9	31.4	42.6	32.5	23.1	30.8	33.8	31.1
Local organization(s) in my community	16.0	18.8	10.6	22.6	13.2	13.9	13.3	23.9	15.5
211 New Hampshire	3.1	10.1	17.1	7.7	11.9	4.4	7.2	10.4	8.0
Organization(s) that is not specific to New Hampshire	1.0	1.4	0.4	2.1	0.3	1.2	0.8	1.8	1.0
Other	6.5	6.3	11.4	6.0	6.5	8.8	6.7	9.9	7.5

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.15. Experience with Finding Child Care and Early Learning Programs and Need for Nonstandard Care Hours

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Difficulty finding type of care or early learning program parent wanted for their youngest child's current or most recent enrollment (percentage distribution)									
No difficulty	36.9	38.4	41.2	52.7	38.1	30.5	37.1	38.8	37.7
Little difficulty	24.1	21.3	19.3	19.9	18.4	26.7	23.7	18.1	22.2
Some difficulty	20.2	28.3	29.6	17.1	28.1	28.6	26.0	25.6	26.2
A lot of difficulty	17.3	10.9	8.2	7.5	14.4	13.8	12.2	15.6	12.8
I did not find the child care or early learning program I wanted	0.9	0.4	1.2	1.4	0.7	0.3	0.5	1.9	0.7
Prefer not to say	0.6	0.8	0.4	1.4	0.4	0.0	0.5	0.0	0.4
Parent feels there are good choices for child care or early learning programs where they live (percentage distribution)									
Yes	63.3	66.0	67.3	65.4	58.3	70.7	69.0	47.8	64.9
No	25.4	27.3	29.2	25.2	31.1	23.9	22.0	46.9	26.7
Don't know	11.2	5.3	3.1	9.0	10.1	4.9	8.6	5.0	7.9
Prefer not to say	0.2	1.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5
Need for care for respondent or spouse to work or attend school in the evening, during the night, or on weekends (percentage)									
Need care for my children in the evenings	14.5	21.3	23.7	21.9	21.5	13.6	17.8	20.5	18.3
Need care for my children at nights	7.1	10.4	14.0	11.2	13.4	5.3	8.9	13.2	9.5
Need care for my children on the weekends	10.8	17.9	19.9	14.9	20.5	9.3	13.2	22.0	14.7
Do not need evening, nights, or weekend care	81.6	67.9	66.1	73.0	66.7	82.3	75.8	68.8	74.6

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.16. Experience with Child Care Gaps

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
There was a time in the past 12 months when could not find child care for a week or longer (percentage distribution)									
Yes	23.4	28.6	20.7	34.6	26.8	17.0	22.8	31.2	24.1
No	74.2	69.6	77.7	63.7	70.7	82.3	75.3	66.5	73.8
Prefer not to say	2.4	1.8	1.7	1.7	2.6	0.7	1.9	2.3	2.1
The top two reasons why could not find care at that time (percentage)									
Could not find a provider with a space	33.3	21.8	16.0	28.4	22.3	32.9	25.0	31.9	26.6
Could not find a provider with the quality I wanted	36.3	32.1	34.0	19.8	32.0	50.0	34.0	34.8	34.6
The available hours and locations did not fit my needs	30.4	30.8	44.0	25.9	36.9	35.7	29.8	43.5	33.1
Could not afford any of the care options	41.5	47.4	40.0	59.3	49.5	18.6	45.2	37.7	43.0
Could not afford the quality of care I wanted	28.1	25.6	26.0	33.3	25.2	21.4	29.3	20.3	27.0
Other	3.0	6.4	6.0	6.2	3.9	2.9	3.7	5.8	4.6
There was a time in the past 12 months when quit a job, school, or training activity or when unable to take a job or participate in education or training because of problems arranging child care (percentage distribution)									
Yes	16.2	23.7	17.4	23.1	22.7	12.6	18.0	19.8	18.3
No	82.6	75.6	82.6	75.6	76.6	87.4	81.2	79.3	80.8
Prefer not to say	1.2	0.7	0.0	1.3	0.8	0.0	0.8	0.9	0.8

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.17. Experience with Developmental Screening for Youngest Child

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Result of the most recent screening (percentage distribution)									
No concerns, my child is right where he/she should be	81.2	73.0	61.7	67.0	72.5	81.5	75.8	71.5	74.2
Concerns, and a rescreening in a few months was recommended	5.4	9.8	14.3	9.4	13.2	5.0	9.1	7.7	8.8
Concerns, and a referral was made to have further testing	10.7	15.3	23.3	20.8	13.2	13.1	14.4	16.2	15.1
Prefer not to say	2.7	1.8	0.8	2.8	1.1	0.5	0.8	4.6	2.0
If there were concerns, how concerns were addressed (percentage)									
Met with doctor	69.0	58.5	72.0	56.3	74.0	65.0	69.9	64.5	66.9
Met with child care provider	19.0	36.6	38.0	34.4	32.0	35.0	35.5	25.8	31.6
Received an email	4.8	9.8	12.0	6.3	16.0	5.0	12.9	0.0	9.0
Received a phone call	14.3	9.8	16.0	12.5	18.0	10.0	15.1	6.5	13.5
Other	28.6	22.0	10.0	25.0	12.0	25.0	19.4	19.4	19.5
Prefer not to say	0.0	0.0	2.0	0.0	0.0	2.5	1.1	0.0	0.8
If there were concerns, was the child referred for a specialized service (percentage distribution)									
Yes, but we chose not to pursue it	0.0	7.3	8.0	0.0	10.0	2.5	5.4	3.2	5.3
Yes, and we did pursue it	81.0	75.6	74.0	75.0	82.0	70.0	75.3	83.9	76.7
No	16.7	17.1	16.0	21.9	8.0	25.0	17.2	12.9	16.5
Don't know	2.4	0.0	0.0	0.0	0.0	2.5	1.1	0.0	0.8
Prefer not to say	0.0	0.0	2.0	3.1	0.0	0.0	1.1	0.0	0.8

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.18. Experience with Kindergarten Transition: Children in Kindergarten Fall 2018 and Fall 2019 Cohorts

Indicator	By Family Income			By Rural Status		Total
	Low	Middle	High	Nonrural	Rural	
Children who enrolled in kindergarten in 2018–2019 school year						
Options available prior to starting kindergarten (percentage)						
Online or written information about the kindergarten enrollment process	89.7	83.5	91.8	88.1	87.8	88.5
An information session about the kindergarten enrollment process	79.7	75.0	76.7	74.5	82.0	76.5
An information session about supporting your child through the transition	71.2	63.9	75.3	68.7	70.0	70.1
An opportunity for your child to visit the school prior to the start of the school year	91.4	70.5	87.7	82.4	78.0	82.2
An opportunity for your child to visit their kindergarten classroom prior to the start of the school year	87.7	62.9	84.9	77.7	69.4	76.9
A process, with your consent, that allows your child's child care or early learning program to share information about your child with their kindergarten program	68.4	51.0	56.2	54.6	59.2	56.8
Respondent is very satisfied or satisfied with... (percentage)						
Completeness of the information received	87.9	80.4	94.4	87.0	86.0	87.2
Timeliness of the information received	84.5	75.0	93.1	83.1	86.0	84.2
Transition activities participated in	84.2	67.0	87.5	80.4	71.4	79.3
Overall experience with kindergarten transition	86.0	72.9	90.3	82.4	82.0	82.8
Children who will enroll in kindergarten in 2019–2020 school year						
Options available prior to starting kindergarten (percentage)						
Online or written information about the kindergarten enrollment process	85.4	89.2	91.6	88.6	90.7	88.9
An information session about the kindergarten enrollment process	80.9	83.8	80.7	81.8	79.1	81.0
An information session about supporting your child through the transition	76.6	64.9	67.1	68.3	67.4	67.9
An opportunity for your child to visit the school prior to the start of the school year	83.7	76.7	85.5	82.0	83.3	82.0
An opportunity for your child to visit their kindergarten classroom prior to the start of the school year	80.4	71.6	74.7	73.9	76.2	74.4
A process, with your consent, that allows your child's child care or early learning program to share information about your child with their kindergarten program	53.2	55.4	42.2	47.9	53.5	49.5
Respondent is very satisfied or satisfied with... (percentage)						
Completeness of the information received	81.6	82.4	81.9	82.5	77.3	82.1
Timeliness of the information received	79.6	80.8	78.3	78.9	81.4	79.7
Transition activities participated in	71.4	69.9	74.4	71.3	75.0	72.2
Overall experience with kindergarten transition	63.8	77.5	79.3	75.6	72.7	74.5

SOURCE: Tabulations from PDG B–5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.19. Employment Status of Respondent and Spouse/Partner

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Current employment status (percentage distribution)									
Employed full time (35 + hours per week)	51.1	67.1	70.7	42.6	60.4	71.7	61.2	59.6	59.5
Employed part time (1–34 hours per week)	19.8	13.1	16.9	19.6	17.6	16.2	18.0	15.0	17.4
Not employed and looking for work	5.4	2.5	0.8	8.5	4.2	0.5	3.1	5.5	3.6
Not employed – full or part time student	1.2	0.7	1.2	3.8	0.3	0.2	0.8	1.8	1.1
Not employed – disabled	1.2	1.4	4.6	6.0	0.5	0.0	1.6	3.2	2.0
Not employed – retired	0.2	0.0	0.4	0.0	0.3	0.0	0.2	0.0	0.2
Other	19.6	14.5	5.4	18.7	16.6	10.9	14.5	13.2	15.2
Prefer not to say	1.6	0.7	0.0	0.9	0.3	0.5	0.6	1.8	1.0
For those married or with a partner, their current employment status (percentage distribution)									
Employed full time (35 + hours per week)	93.3	86.0	81.8	73.0	84.3	96.5	90.3	84.2	89.1
Employed part time (1–34 hours per week)	2.5	5.2	1.7	6.0	4.1	1.8	2.7	3.7	3.1
Not employed and looking for work	1.1	5.2	9.1	8.0	7.1	0.3	3.0	7.3	3.8
Not employed – full or part time student	0.4	0.0	0.0	1.0	0.0	0.0	0.3	0.0	0.2
Not employed – disabled	0.4	2.2	4.6	4.0	3.0	0.0	1.6	2.4	1.7
Not employed – retired	0.4	0.0	0.0	1.0	0.3	0.0	0.2	0.6	0.2
Other	1.9	1.3	2.8	7.0	1.2	1.5	1.9	1.8	1.9
Prefer not to say	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

SOURCE: Tabulations from PDG B–5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.20. Employment-related Benefits of Respondent and Spouse/Partner

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
For employed respondents, have access to following benefits (percentage)									
Flexible scheduling/work hours	60.1	59.6	60.1	64.4	60.2	60.7	59.1	62.8	60.0
Paid maternity/paternity leave	33.9	38.1	28.6	25.0	24.6	44.7	33.9	34.0	33.7
Unpaid maternity/paternity leave	49.5	29.4	27.6	32.6	30.4	46.7	38.5	37.2	38.5
Paid sick leave	67.9	66.1	67.5	57.6	62.6	76.4	68.2	63.5	67.3
Paid holidays	70.7	67.4	72.4	66.7	65.1	76.9	70.0	70.5	70.3
Paid vacations	68.7	62.8	64.0	60.6	56.1	76.4	65.0	67.9	65.9
Onsite child care at market rates	4.1	9.6	6.9	4.5	7.6	6.3	5.9	8.3	6.3
Onsite child care with employer-provided discount	7.5	14.7	11.3	8.3	19.0	4.8	8.4	17.9	10.4
Dependent Care Assistance Plan	15.0	19.7	24.1	8.3	16.3	24.5	18.6	19.2	18.6
For respondents with employed spouse/partner, they have access to following benefits (percentage)									
Flexible scheduling/work hours	42.9	55.9	43.6	39.1	40.9	53.1	47.4	40.8	46.3
Paid maternity/paternity leave	33.1	28.2	27.9	17.2	24.5	38.7	32.3	26.2	30.9
Unpaid maternity/paternity leave	30.2	21.3	16.4	15.6	23.0	28.3	25.9	22.3	25.4
Paid sick leave	73.3	72.3	69.3	59.4	67.9	77.9	73.5	68.5	72.3
Paid holidays	79.5	77.1	75.7	65.6	71.9	85.3	79.0	74.6	78.2
Paid vacations	81.9	78.2	72.1	70.3	74.1	85.0	79.7	78.5	79.1
Onsite child care at market rates	1.9	4.3	2.1	3.1	2.2	2.7	2.4	2.3	2.5
Onsite child care with employer-provided discount	1.9	3.2	4.3	1.6	4.0	1.9	3.1	1.5	2.7
Dependent Care Assistance Plan	8.3	11.2	19.3	3.1	6.6	16.1	11.5	8.5	11.1

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table B.21. Family Economic Circumstances

Indicator	By Age of Youngest Child			By Family Income			By Rural Status		Total
	Age 0, 1, 2	Age 3, 4	Age 5, 6	Low	Middle	High	Nonrural	Rural	
Currently living in a temporary residence or transitional housing (percentage distribution)									
Yes	3.1	8.6	7.1	6.0	10.1	1.2	4.8	7.2	5.4
No	96.2	91.0	92.5	92.8	89.7	98.8	94.8	91.4	94.1
Prefer not to say	0.7	0.4	0.4	1.3	0.3	0.0	0.4	1.4	0.6
Current annual family income (percentage distribution)									
\$0 to \$7,500	2.4	0.0	1.3	7.2	0.0	0.0	1.1	3.2	1.6
\$7,501 to \$15,000	2.6	2.5	3.3	12.7	0.0	0.0	1.9	5.4	2.7
\$15,001 to \$22,500	3.1	4.3	2.9	15.7	0.0	0.0	2.5	5.0	3.4
\$22,501 to \$30,000	5.2	3.6	5.0	22.0	0.0	0.0	3.7	7.2	4.7
\$30,001 to \$45,000	8.0	7.9	13.3	42.4	0.0	0.0	8.2	12.2	9.1
\$45,001 to \$60,000	9.0	12.9	9.2	0.0	28.4	0.0	9.2	13.6	10.0
\$60,001 to \$75,000	11.3	13.3	15.0	0.0	35.6	0.0	12.2	15.8	12.6
\$75,001 to \$90,000	10.9	16.9	12.5	0.0	36.1	0.0	13.5	11.3	12.8
\$90,001 or more	42.3	31.2	34.2	0.0	0.0	100.0	42.5	21.7	37.7
Prefer not to say	5.2	7.5	3.3	0.0	0.0	0.0	5.2	4.5	5.4
Respondent is fairly worried or very worried about: (percentage)									
Not being able to pay your family's monthly bills	27.3	33.2	32.8	56.2	35.8	10.7	27.5	39.1	30.0
Not having enough food for your family	12.2	16.4	20.1	32.6	17.8	2.7	13.4	22.0	15.0
Not being able to pay for routine health care costs for yourself and your family	20.6	28.2	28.2	41.6	32.4	8.6	22.9	30.7	24.3
Not being able to pay your health care bills	27.0	30.0	34.4	48.6	39.0	10.9	27.7	37.5	29.3
Not being able to pay your credit card bills	27.7	30.8	31.7	47.3	38.5	13.5	28.4	35.3	29.4
Not being able to pay your student loan bills	32.0	33.9	31.3	46.8	43.0	16.9	31.7	36.6	32.4
Not being able to pay your rent or mortgage	23.5	27.9	31.3	51.4	33.2	7.0	24.3	33.3	26.3
Not having enough money for retirement	53.4	52.5	59.7	68.8	64.7	40.0	53.0	63.6	54.5

SOURCE: Tabulations from PDG B-5 Family Survey.

NOTE: – = not applicable. Percentage distributions may not sum to 100 because of rounding. See Table B.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Appendix C. PDG B–5 System Workforce Survey Methods and Tabulations

A total of 316 individuals age 18 or older who reported working with children ages 0 to 5 or with families of children in this age range responded to the New Hampshire PDG B–5 System Workforce Survey. This count excludes 50 cases that either did not provide consent or who did not respond to any questions after providing consent. This appendix provides summary information about the characteristics of the survey respondents and a full set of tabulations from the PDG B–5 System Workforce Survey. See Appendix F for the survey instrument.

As noted in Chapter 2, some survey responses appeared to be suspicious. Suspect respondents were identified based on several defining characteristics: 1) IP addresses located outside of the New Hampshire, Maine, Vermont, or Massachusetts, 2) duplicate IP addresses, 3) email addresses comprised of random letter and number strings, 4) duplicate email addresses, 5) selection of all items options for questions with multiple-selection criteria, 6) nonsensical or repetitive responses to open-ended questions, and/or 7) lack of response to any item after consent. All respondents flagged as questionable were sent an email requesting a physical mailing address to receive the gift card. Data from the 261 respondents who did not provide a physical mailing address were purged from the survey.

Characteristics of Respondents

The survey asked respondents to provide basic demographic and economic information. These characteristics show the following:

- Respondents were predominantly female (90 percent), white (93 percent), not Latinx (87 percent), and with English as the home language (92 percent). The average age was 38, with about 60 percent under age 40. The predominant marital status was married/partnered (73 percent), with about 1 dependent child on average. (See Table C.2.)
- Nearly all respondents had at least some college, with a majority having a 4-year degree or higher (58 percent). Fourteen percent reported having a graduate or professional degree, 55 percent had an early childhood credential and 31 percent had a teaching certificate. (See Table C.4.)
- Compared with the other groups of respondents, teachers are somewhat more likely to be male. The leaders who responded are less diverse in terms of race-ethnicity; they are older and have fewer young dependents; they have more education (post-BA especially). Responding home visitors/family support workers (HV/FSW) tend to be similar to

leaders in many of their characteristics. Assisting teachers are both younger and older than respondents in the other roles. They are less likely to be married and they have fewer dependents; they also have lower educational attainment.

The survey asked respondents the type of position they held and the organization they worked. Other questions covered the ages of children that respondents work with, years of experience, and reasons for working in the field. From these question, we learn the following:

- Respondents represent varied positions among B–5 service providers. 49 respondents (15 percent) were in leadership roles as a director or executive director. The bulk of respondents (157 individuals or 48 percent) were teachers, assistant/associate teachers, or aids. Other positions with 10 or more respondents include home visitors (27 respondents), early intervention specialists (15 respondents), special education teachers (14 respondents), and various types of health care providers (21 respondents). (See Table C.1.)
- These members of the B–5 workforce represent a diverse set of programs. Most prevalent was private child care centers (108 respondents or 33 percent), followed by public school preschool or special education preschool programs (45 respondents), Head Start/Early Head Start programs (36 respondents), early childhood intervention programs (30 respondents), home visiting programs (28 respondents), and FRCs (14 respondents). (See Table C.3.)
- Respondents work with children across the B–5 continuum. Most common was working with preschool-age children (i.e., ages 3 to 5) (49 percent), but most worked with multiple age groups in their current role. About 11 percent reported working with children with special needs. (See Table C.3.)
- On average, respondents have worked about 7 years in their current program and 12 years in the early childhood field. About half of respondents have worked fewer than 5 years in their current program and 28 percent had worked fewer than 5 years in the field. (See Table C.4.)
- The most common “top” reasons respondents reported for working in the field is because it is “their chosen career or profession” (55 percent) and “it is a way to help children and families” (51 percent). Just 13 percent selected that it “was a step towards a related career” and only 11 percent stated it was “a way to earn money.” (See Table C.5.)

Tabulations

Tabulations were conducted for all respondents (316 cases) and for four subgroups based on the respondent’s position (275 cases). Based on the respondent’s current position (Q3), respondents were classified into the following four groups:

- **Program leaders.** Individuals who responded that they were a program director or executive director (48 respondents)
- **Teachers.** Individuals who responded that they were a head or lead teacher/caregiver, a teacher/caregiver, or a special education teacher (118 respondents)
- **Assistant teachers.** Individuals who responded that they were an associate teacher, assistant teacher, or aide (49 respondents)
- **Home visitors and family support workers.** Individuals who responded that they were an early intervention specialists, home visitor, case manager/case worker, social worker, or functional support/family support provider or specialist (60 respondents).

The distribution of the respondents by the four subgroups is shown in Table C.1, both for the total respondents and for the cases included in the subgroup analyses by position. Note that the tabulations by position, the percentages and percentage distributions for the subgroups will not be a weighted average of the results for all respondents because of the exclusion of 41 cases with positions that fall outside of the four groups defined above.

In Tables C.2 to C.17, results are shown for survey respondents disaggregated by the position, along with results for all respondents (recorded in the last column of each table). As indicated in the row labels, results are either percentage distributions (summing to 100 percent) when only one response was allowed or percentages when respondents could select all response options that applied. Note that some respondents did not complete the full survey or did not respond to specific survey items. Unless otherwise indicated, tabulations exclude cases with no response, either because of an incomplete survey or item nonresponse.

For the subgroup analyses, we have just under 50 leaders and assisting teachers, 60 home visitors/family support workers, and nearly 120 teachers. These are small groups; small differences across subgroups are likely not to be statistically significant. Further, we do not know how representative the respondents are of the overall early childhood workforce or of the subgroups of positions. Thus, all responses are representative only of the set of individuals who responded to the survey.

Table C.1. Distribution of Workforce Survey Respondents by Subgroup

Indicator	Number	Percentage Distribution: All Cases	Percentage Distribution: Cases in Four Position Groups
All respondents	316	100.0	100.0
By current position			
Program leaders (directors or executive directors)	48	15.2	17.5
Teachers	118	37.3	42.9
Head or lead teacher / caregiver	43	13.6	15.6
Teacher / caregiver	61	19.3	22.2
Special education teacher	14	4.4	5.1
Assistant teachers	49	15.5	17.8
Associate teacher	21	6.6	7.6
Assistant teacher	27	8.5	9.8
Aide	1	0.3	0.4
Home visitors/family support workers	60	19.0	21.8
Early intervention specialist	15	4.7	5.5
Home visitor	27	8.5	9.8
Case manager/case worker	3	0.9	1.1
Social worker	6	1.9	2.2
Functional support/family support provider/specialist	9	2.8	3.3
Other (not included in subgroup analysis)	41	13.0	–
Physician (e.g., pediatrician, general practitioner, internist)	1	0.3	–
Mental health/behavioral health provider	2	0.6	–
Oral health provider	0	0.0	–
Health outreach worker	0	0.0	–
Other health care provider, please specify:	17	5.4	–
Job counselor/trainer	0	0.0	–
Other	21	6.6	–

SOURCE: Tabulations from PDG B–5 Workforce Survey.

NOTE: – = group excluded from subgroup analysis. Percentage distributions may not sum to 100 because of rounding.

Table C.2. Characteristics of Respondents

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Respondent gender (percentage distribution)					
Male	4.9	15.8	4.3	3.6	9.6
Female	95.1	84.2	95.7	96.4	90.4
Respondent age group (percentage distribution)					
18 to 29	9.8	36.0	61.9	18.9	29.4
30 to 39	22.0	48.0	28.6	22.6	33.5
40 to 49	26.8	10.0	4.8	28.3	17.3
50 to 59	29.3	4.0	2.4	18.9	12.5
60 and older	2.0	2.4	11.3	5.9	7.4
Identify as Hispanic or Latinx (percentage distribution)					
Yes	0.0	21.4	17.0	10.9	13.1
No	100.0	78.6	83.0	89.1	86.9
Race (percentage distribution)					
White	97.6	89.3	89.4	100.0	93.1
Nonwhite	2.4	10.7	10.6	0.0	6.9
Primary language spoken at home (percentage distribution)					
English	95.0	86.6	97.9	96.4	91.7
Other	5.0	13.4	2.1	3.6	8.3
Marital status (percentage distribution)					
Single	19.5	17.9	31.9	16.7	21.4
Married or Domestic Partnership	75.6	79.5	63.8	70.4	72.8
Divorced	4.9	2.7	2.1	11.1	5.2
Separated	0.0	0.0	2.1	1.9	0.7
Number of dependents in the household (average)					
5 years or younger	0.29	0.54	0.47	0.36	0.42
Between 6 and 12 years old	0.31	0.34	0.28	0.62	0.38
Between 13 and 18 years old	0.29	0.27	0.04	0.40	0.26
Nonworking adults over age 18	0.40	0.63	0.64	0.22	0.45

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.3. Respondents' Program Type and Ages of Children Working With

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Type of program I (percentage distribution)					
Public school program (non-Head Start, e.g. Title I, locally funded, early childhood special education, or other public program)	4.3	27.1	10.2	1.7	13.7
Head Start/Early Head Start (community-based or school-based)	4.3	17.8	18.4	1.7	11.4
Private center (for-profit center, single center; for-profit center, multi-center; nonprofit center; religiously exempt center)	61.7	36.4	46.9	5.0	33.3
Licensed, voluntarily registered, or local ordinance approved family child care home or participant in a family child care home system	2.1	5.1	16.3	1.7	5.1
Early childhood intervention program	4.3	6.8	2.0	18.3	9.5
Home visiting program (may be part of a Family Resource Center)	2.1	0.0	2.0	41.7	8.9
Family Resource Center (other than home visiting program)	4.3	0.9	0.0	13.3	4.4
Area Agency	4.3	0.9	0.0	6.7	2.2
Child Protective Services agency	0.0	0.0	2.0	0.0	0.3
Pediatric practice	0.0	0.9	0.0	1.7	1.0
General medical practice or health center	2.1	0.0	0.0	0.0	0.3
Hospital or emergency room	0.0	0.9	0.0	0.0	0.3
Dental or other oral health practice	0.0	0.0	0.0	0.0	0.0
Mental health or behavioral health practice	4.3	0.9	0.0	0.0	1.0
Community Action Agency	0.0	0.9	2.0	5.0	2.9
Other state or local social services provider	0.0	0.0	0.0	1.7	0.6
Other	6.4	1.7	0.0	1.7	5.1
Ages of children work with most often (percentage)					13.7
Infants (under one year of age)	52.1	10.2	16.3	50.0	31.3
Young toddlers (12-30 months)	66.7	19.5	26.5	63.3	41.8
Older toddlers (31-35 months)	60.4	32.2	59.2	56.7	49.1
Preschoolers (ages 3 – 5)	77.1	66.1	40.8	51.7	61.1
School age children (kindergarten and older)	33.3	4.2	8.2	30.0	18.0
Children with disabilities or special needs, regardless of age	14.6	2.5	2.0	20.0	11.1
Other:	2.1	0.0	0.0	13.3	3.8

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.4. Highest Education, Credentials, and Experience of Respondents

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Highest education level (percentage distribution)					
0 – 11 years	0.0	0.0	0.0	0.0	0.0
High school graduate or GED/HSET	2.4	1.8	2.1	0.0	1.4
Some college with no degree	14.6	10.5	25.5	7.3	12.0
Associates (two-year) degree in early childhood education/child development	7.3	26.3	27.7	9.1	18.8
Associates (two-year) degree in another field	2.4	14.9	6.4	3.6	7.9
College (four-year) degree in early childhood education/child development	22.0	28.1	25.5	16.4	22.5
College (four-year) degree in another field	12.2	11.4	10.6	30.9	18.4
Some graduate or professional school with no degree	7.3	1.8	0.0	5.5	3.1
Graduate or professional degree	31.7	4.4	0.0	23.6	14.3
Other	0.0	0.9	2.1	3.6	1.7
Has specific credential (percentage)					
Early childhood credential	68.6	64.5	51.1	38.3	54.7
Teaching certificate	17.1	46.7	26.7	25.5	30.6
Teaching license	14.3	42.1	28.9	10.6	25.7
License as a registered nurse (RN), practical nurse (LPN) or vocational nurse	5.7	2.8	17.8	0.0	5.7
License as a clinical social worker (LCSW)	0.0	0.9	2.2	4.3	1.9
Other	5.7	0.9	2.2	29.8	11.3
None	14.3	4.7	8.9	17.0	10.9
Years of experience working with children ages 0 to 5 or their families (percentage distribution)					
Less than 5	6.7	27.5	68.9	19.3	27.9
5 to 9	15.6	37.3	17.8	35.1	26.9
10 to 14	17.8	15.7	6.7	15.8	13.1
15 to 24	28.9	12.8	4.4	22.8	18.3
25 or more	31.1	6.9	2.2	7.0	13.8
Years of experience in current program (percentage distribution)					
Less than 5	22.2	42.2	82.2	70.2	51.0
5 to 9	22.2	41.2	17.8	17.5	27.2
10 to 14	17.8	7.8	0.0	7.0	8.6
15 to 24	26.7	5.9	0.0	5.3	9.0
25 or more	11.1	2.9	0.0	0.0	4.1

SOURCE: Tabulations from PDG B–5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.5. Respondents' Top Two Reasons for Working in Early Childhood

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Top two reasons for working in early childhood (percentage)					
It is my chosen career or profession	77.1	55.9	40.8	41.7	54.4
It is a step towards a related career	6.3	14.4	24.5	8.3	12.7
It is a way to earn money	4.2	17.8	10.2	8.3	10.8
It is work I can do while my own children are young	4.2	13.6	16.3	8.3	10.1
It is a way to help families and children	60.4	37.3	40.8	73.3	50.6
I enjoy the work setting or environment	22.9	23.7	34.7	23.3	25.6
I like the people I work with	6.3	15.3	10.2	6.7	10.8
I don't feel I am qualified to do anything else	0.0	0.8	6.1	1.7	1.9
This was the only job available to me	2.1	2.5	0.0	0.0	1.9
Other:	2.1	2.5	0.0	1.7	2.8

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.6. Respondents' Hours per Week and Weeks per Year in Current Position, and Other Employment

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Months per year paid for this job (percentage distribution)					
Less than 9	0.0	7.2	4.9	1.8	3.6
9	2.2	7.2	9.8	1.8	5.7
10	4.4	43.3	36.6	7.0	23.1
11	0.0	3.1	0.0	0.0	1.4
12	93.5	39.2	48.8	89.5	66.2
Hours per week paid for this job (percentage distribution)					
Less than 30	6.5	8.0	4.7	23.2	11.2
30 to 34	4.4	10.0	14.0	7.1	9.8
35 to 39	8.7	23.0	30.2	26.8	23.9
40	54.4	43.0	46.5	41.1	43.9
41 or more	26.1	16.0	4.7	1.8	11.2
Work at any other jobs (percentage distribution)					
Yes	23.4	23.1	18.8	23.3	24.3
No	76.6	76.8	71.3	76.7	75.7
Among those with other jobs, hours per week usually worked in those jobs (percentage distribution)					
Less than 5	18.2	25.0	0.0	30.0	20.7
5 to 9	9.1	18.8	0.0	10.0	15.5
10 to 14	63.6	25.0	33.3	50.0	37.9
15 to 19	0.0	18.8	16.7	10.0	12.1
20 or more	9.1	12.5	50.0	0.0	13.8

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.7. Respondents' Pay and Benefits in Current Position

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Hourly pay before taxes and deductions (average dollars)	21.97	20.53	18.61	20.48	20.54
Annual pay before taxes and deductions (average dollars)	46,118	37,123	34,911	35,428	39,255
Program offers regular wage increases (percentage distribution)					
Yes, annually	38.3	41.5	38.8	10.0	33.7
Yes, when funding is available	40.4	49.2	38.8	41.7	44.8
No	19.2	6.8	12.2	33.3	14.9
I don't know	0.0	1.7	10.2	15.0	5.7
Not applicable	2.1	0.9	0.0	0.0	1.0
Has specific benefits through this job (percentage with benefit)					
Flexible scheduling	72.3	54.4	59.5	91.7	68.5
Paid retirement/pension plan	45.7	56.6	40.5	60.8	54.5
Paid maternity/paternity leave	28.9	57.1	48.6	31.8	44.0
Paid sick leave	75.6	65.4	53.7	87.0	73.3
Paid holidays	87.0	67.0	61.9	93.1	79.0
Paid vacations	78.7	65.0	55.8	89.5	74.7
Additional pay or other forms of compensation when you work more than 40 hours in a week	32.6	61.3	45.0	39.1	47.0
Paid planning/preparation time	64.3	61.2	45.0	75.6	63.6
Paid breaks	54.4	43.4	43.9	50.0	48.5
Paid time for professional development or continuing education	82.6	61.6	57.5	98.2	76.3
Discounted fee if your own child is enrolled in the program	60.0	58.0	48.7	31.0	52.0
Own children are in care at this program (percentage distribution)					
No, I don't have children	23.4	24.8	34.7	15.0	25.2
No, my program does not offer child care	6.4	6.8	18.4	38.3	17.2
No, my children don't need care	42.6	35.0	18.4	33.3	32.2
No, my children get care elsewhere	8.5	13.7	14.3	8.3	11.5
Yes	19.2	19.7	14.3	5.0	14.0

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.8. Respondents' Training and Professional Development Opportunities in Current Position

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Has specific training/professional development through this job (percentage with feature)					
Orientation for new staff that includes emergency, safety, and health procedures	95.5	69.0	69.4	87.9	78.9
Orientation for new staff that includes interaction with children and parents, discipline methods, appropriate activities	93.0	64.7	67.4	72.4	70.2
Periodic "refresher" training for emergency, safety, and health procedures	93.2	67.6	59.6	79.0	75.4
Some in-service training	97.7	73.2	71.1	94.6	83.7
Inservice training that is provided regularly by your program	79.1	61.1	56.8	73.5	67.7
Some staff meetings to handle administrative concerns	97.7	67.0	71.1	88.1	79.6
Monthly staff meetings that include staff development activities	68.2	47.8	52.2	84.8	61.5
Some professional resource materials on a variety of early childhood subjects that are available on premises	88.4	69.6	66.0	89.8	77.9
Good professional library containing current materials on a variety of early childhood subjects that is available on premises	66.7	57.4	56.8	75.9	64.2
Support for staff to attend courses, conferences or workshops that are not provided by the program	90.7	68.2	66.0	87.9	78.1
Can choose the type of professional development participates in (percentage distribution)					
Yes	95.5	87.3	93.9	81.4	89.0
No	4.6	12.7	6.1	18.6	11.0
Receives assistance with specific costs related to professional development (percentage with type of assistance)					
Assistance with tuition or registration fees	82.1	38.5	41.3	55.2	53.3
Reimbursement for travel expenses while engaging in professional development	51.3	49.5	43.5	79.3	57.4
Reimbursement for child care expenses while engaging in professional development	2.6	24.8	19.6	5.2	14.2
Release time to participate in professional development	69.2	30.3	13.0	62.1	43.9

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.9. Respondents' Professional Development Participation in Current Position and Assessment of Helpfulness

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Participated in specific professional development activities in last 12 months (percentage)					
Noncredit courses, seminars, or workshops that you attended in person	82.5	70.0	81.3	89.5	79.5
Noncredit online courses, seminars, or workshops	85.4	58.8	58.3	73.2	66.2
Credit-bearing college or university courses that you attended in person	7.3	46.4	66.0	13.0	32.5
Credit-bearing college/university online courses	15.0	54.0	71.7	17.0	39.8
Conferences where early childhood practitioners and/or researchers present their research	57.5	63.4	63.6	69.6	63.0
Observation visits to other early childhood programs	20.0	52.8	56.5	24.1	38.4
Coaching or mentoring as part of a formal arrangement	26.8	55.1	60.9	37.5	45.3
Participation in a network of professionals working with children (e.g., a learning community)	75.6	55.1	56.5	72.4	61.7
Rated specific activity (if participated) as helpful or very helpful (percentage)					
Noncredit courses, seminars, or workshops that you attended in person	83.9	47.3	50.0	86.7	61.9
Noncredit online courses, seminars, or workshops	63.6	55.1	44.8	71.9	71.3
Credit-bearing college or university courses that you attended in person	66.7	49.3	38.7	100.0	54.0
Credit-bearing college or university online courses	83.3	53.3	56.3	81.8	59.4
Conferences where early childhood practitioners and/or researchers present their research	91.3	51.2	40.0	84.9	69.5
Observation visits to other early childhood programs	100.0	55.3	40.7	73.3	62.9
Coaching or mentoring as part of a formal arrangement	100.0	47.8	29.6	93.8	61.6
Participation in a network of professionals working with children (e.g., a learning community)	82.1	50.0	56.7	94.1	71.3
Helpfulness of activities participated in to improve practice (percentage distribution)					
Not helpful	0.0	4.4	4.1	1.7	3.0
Somewhat helpful	30.0	40.0	34.7	15.5	32.1
Helpful	47.5	40.9	49.0	48.3	44.2
Very helpful	22.5	14.8	12.2	34.5	20.7

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.10. Respondents' Assessment of Barriers to Participation in Professional Development Activities in Current Position

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Barriers that limit participation in professional development activities (percentage selecting barrier)					
I don't have enough time	61.0	21.7	20.8	41.4	33.1
I do not have the pre-requisites (e.g., qualifications, experience, seniority).	7.3	17.4	20.8	1.7	11.7
There is no relevant professional development offered.	12.2	22.6	16.7	5.2	15.7
The activities I want to participate in are too expensive.	36.6	31.3	27.1	19.0	28.8
The activities I want to participate in are too far away or difficult to get to.	43.9	32.2	35.4	24.1	32.4
The activities I want to participate in conflict with my work schedule.	39.0	27.0	18.8	25.9	27.1
I am unable to find or pay for child care.	7.3	9.6	8.3	6.9	7.4
The activities I want to participate in are not provided in my primary language.	0.0	13.9	6.3	1.7	6.7
There are no incentives for participating in professional development.	4.9	10.4	14.6	10.3	9.7
The activities will not benefit me or my practice with children enough to justify the time and expense required.	14.6	6.1	4.2	6.9	7.0
Other (please specify):	7.3	3.5	4.2	6.9	5.7
No barriers prevent my participation.	9.8	6.1	6.3	17.2	10.0

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.11. Respondents' Opportunities for Promotion, Performance Feedback, Supervision, and Scheduling in Current Position

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Opportunities for promotion are available (percentage distribution)					
Yes	40.4	65.3	57.1	49.2	53.7
No	59.6	34.8	42.9	50.9	46.3
Understands steps required for promotion (percentage distribution)					
Yes	75.0	77.1	76.1	74.3	72.2
No	25.0	22.9	23.9	25.8	24.4
Has regular supervisory meetings (percentage distribution)					
Yes	70.7	63.2	61.2	79.3	67.2
No	29.3	36.8	38.8	20.7	32.8
Receives a formal review or feedback on performance at least once a year (percentage distribution)					
Yes	68.3	77.4	67.4	80.7	75.6
No	31.7	22.6	32.7	19.3	24.4
Program director or supervisor makes an effort to modify work schedule to meet respondent's personal needs (percentage distribution)					
Yes	90.2	64.0	77.6	93.1	78.8
No	9.8	36.0	22.5	6.9	21.2
Importance to respondent that program director or supervisor makes an effort to modify work schedule to meet respondent's personal needs (percentage distribution)					
Not important	2.5	7.0	4.1	0.0	4.1
Somewhat important	37.5	50.9	69.4	29.3	44.9
Very important	60.0	42.1	26.5	70.7	51.0

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.12. Respondents' Assessment Job Satisfaction and Other Aspects of Current Position

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Agree or strongly agree with specific statements (percentage)					
I feel prepared for the challenges of meeting the learning, social-emotional, and other developmental needs of young children and their families.	92.7	70.2	63.3	94.7	79.2
I have sufficient time to prepare for my work with young children and/or their families.	75.6	52.2	51.0	84.2	64.9
I have sufficient time to reflect on my work and improve my practice.	80.5	58.3	59.2	76.8	66.5
I am required to complete too much paperwork or documentation (including data collection).	62.5	48.7	25.0	56.1	47.7
I feel I am empowered to do my job to the best of my ability.	82.9	78.1	57.1	94.7	80.2
I have the support I need from supervisors or co-workers to do my job to the best of my ability.	87.8	73.7	67.4	91.2	80.5
My personal needs (comfort, safety, health, space to work and relax away from children) are met in this job.	78.1	58.8	63.3	93.0	72.9
My co-workers and I are treated with respect on a day-to-day basis.	90.2	68.4	53.1	96.4	77.1
I have the support I need in dealing with difficult situations that may involve coworkers, children, or parents.	95.1	67.5	63.3	91.2	78.2
I feel I have a voice in decision making about program operations.	90.2	59.3	59.2	66.7	68.3
I am often overwhelmed at work.	51.2	52.2	54.2	35.1	46.6
Overall, I am satisfied with my job.	92.7	75.4	71.4	93.0	82.9

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.13. Respondents' Future Professional Plans

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Where respondent sees themselves professionally in 2 to 4 years (percentage distribution)					
In the same position I am currently	63.4	48.3	22.9	53.6	50.3
In a different position at my current employer	7.3	18.4	16.7	23.2	15.5
In a similar position at a different employer	4.9	14.9	35.4	8.9	14.5
In a different position at a different employer	4.9	9.7	16.7	1.8	7.8
Working in a different career (i.e., outside of early childhood)	7.3	3.5	2.1	3.6	3.7
Retired	9.8	0.0	0.0	3.6	2.7
Other:	0.0	3.5	2.1	3.6	3.0
I don't know	2.4	1.8	4.2	1.8	2.4
Reasons for expecting to leave the current position (percentage)					
Not applicable—I plan to stay in my current position	63.9	45.0	17.8	49.0	45.8
I am looking for a different job opportunity at my current program.	0.0	14.4	22.2	6.1	10.6
I am looking for a different job opportunity in a different child care/early childhood program.	2.8	18.0	35.6	2.0	15.0
I am looking for a different job opportunity outside of early childhood.	5.6	13.5	20.0	10.2	11.7
I am retiring.	11.1	4.5	2.2	8.2	6.6
I am starting my own early childhood business or program.	2.8	3.6	2.2	2.0	2.9
The program I work for has money problems.	5.6	8.1	4.4	0.0	5.1
I am going back to school.	0.0	4.5	8.9	6.1	4.4
I want a higher paying job.	11.1	21.6	26.7	24.5	20.9
I want better benefits.	8.3	16.2	15.6	14.3	12.8
I want to be able to work a shorter work week.	11.1	4.5	8.9	0.0	5.9
I am leaving for health-related reasons or because of an injury.	0.0	0.9	0.0	2.0	0.7
I want a job that has more flexibility.	5.6	7.2	2.2	0.0	5.1
My child or children will be in school.	2.8	0.9	0.0	0.0	1.1

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.14. Earners, Household Income, and Receipt of Tax Credits/Benefits by Respondents

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Number of income earners in the household (percentage distribution)					
1	24.4	11.4	14.9	26.8	19.0
2	73.2	76.3	74.5	71.4	73.6
3	2.4	12.3	6.4	1.8	6.8
4	0.0	0.0	4.3	0.0	0.7
Total household income in 2018 calendar year (percentage distribution)					
\$7,501 to \$15,000	0.0	0.9	2.1	1.8	1.0
\$15,001 to \$22,500	0.0	2.6	14.6	1.8	3.8
\$22,501 to \$30,000	0.0	4.4	4.2	5.4	3.8
\$30,001 to \$45,000	9.8	8.8	27.1	10.7	13.3
\$45,001 to \$60,000	24.4	23.7	14.6	23.2	21.2
\$60,001 to \$75,000	12.2	27.2	8.3	14.3	17.1
\$75,001 to \$90,000	9.8	16.7	14.6	21.4	17.1
\$90,001 or more	39.0	10.5	6.3	17.9	16.7
Prefer not to say	4.9	5.3	8.3	3.6	6.1
Receives specific credits or subsidies (percentage)					
Earned Income Tax Credit	7.1	13.9	10.2	17.9	13.0
Child Tax Credit	7.1	13.9	20.4	25.0	17.7
Child Care Scholarship	0.0	18.3	26.5	3.6	12.0
Subsidized housing/Section 8	0.0	19.1	20.4	5.4	12.0
Fuel Assistance	0.0	21.7	14.3	3.6	12.0
New Hampshire Financial Assistance for Needy Families (FANF) (also known as Temporary Assistance for Needy Families or TANF)	0.0	9.6	6.1	1.8	5.0
New Hampshire Children's Health Insurance Program (CHIP)	4.8	13.0	12.2	10.7	9.7
Medicaid	2.4	28.7	16.3	10.7	16.3
Low Income Home Energy Assistance Program (LIHEAP)	0.0	5.2	6.1	0.0	3.3
SNAP (Supplemental Nutrition Assistance Program) benefits, also known as food stamps	0.0	1.7	10.2	3.6	3.0
Special Supplemental Nutrition Program for Women, Infants, and Children (also known as WIC)	2.4	6.1	4.1	3.6	4.0
School Reduced Breakfast and Lunch Program	0.0	12.2	6.1	3.6	6.0
Supplemental Security Income (SSI)	0.0	3.5	8.2	0.0	3.3
None of the above	83.3	24.3	28.6	51.8	43.3

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.15. Respondents' Health Insurance Coverage and Specific Assets

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Has health insurance (percentage distribution)					
Yes	87.8	88.5	87.8	91.1	89.2
No	12.2	11.5	12.2	8.9	10.8
Type of coverage for those with insurance (percentage distribution)					
Private insurance through my job	41.7	22.0	14.3	45.1	32.3
Private insurance through my spouse/partner's job	41.7	14.0	14.3	21.6	21.7
Private insurance purchased directly	8.3	18.0	11.9	13.7	12.9
Medicaid	2.8	29.0	23.8	7.8	17.1
Medicare	5.6	15.0	28.6	9.8	13.3
Military health care/VA	0.0	0.0	0.0	2.0	0.4
I don't know	0.0	2.0	7.1	0.0	2.3
Home is rented, owned, or something else (percentage distribution)					
Rent	26.8	28.1	34.7	39.3	31.3
Own	70.7	67.5	55.1	58.9	64.3
Other	2.4	4.4	10.2	1.8	4.4
Has a rainy day (or emergency) savings account balance (percentage distribution)					
Yes	51.2	65.5	65.3	59.5	60.4
No	48.8	34.5	34.7	40.8	39.6
Has a reliable vehicle (percentage distribution)					
Yes	97.6	76.8	68.8	94.6	84.3
No	2.4	23.2	31.3	5.5	15.7

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.16. Respondents' Employment and Financial Concerns and Participation in Financial Education

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Fairly worried or very worried about specific employment concerns (percentage)					
Having your hours cut back at work	2.6	46.7	51.1	9.3	27.9
Being laid off	2.6	39.3	36.2	7.3	23.5
Having your job benefits reduced	7.5	47.2	29.6	19.2	27.8
Not being to take time off when needed	31.7	50.9	40.4	18.2	34.9
Not getting a raise	29.0	42.7	54.4	51.8	42.3
Losing pay due to illness	26.8	41.1	43.8	27.3	33.9
Fairly worried or very worried about specific financial concerns (percentage)					
Not being able to pay your family's monthly bills	31.7	50.9	54.2	41.8	42.0
Not having enough food for your family	12.2	41.6	31.9	18.5	26.8
Not being able to pay for routine health care costs for yourself and your family	32.5	50.0	52.1	40.0	41.5
Not being able to pay your health care bills	36.6	47.3	52.2	47.3	41.8
Not being able to pay your credit card bills	23.7	45.3	45.2	36.5	34.2
Not being able to pay your student loan bills	48.3	47.1	54.6	41.3	38.1
Not being able to pay your rent or mortgage	23.7	45.5	55.1	34.0	36.6
Not having enough money for retirement	48.7	55.0	61.2	60.4	54.6
How secure respondent feels about current financial situation (percentage distribution)					
Very secure	17.1	18.6	10.2	17.9	18.2
Somewhat secure	48.8	54.9	55.1	46.4	50.7
Not that Secure	24.4	23.9	20.4	23.2	23.3
Not at all Secure	9.8	2.7	14.3	12.5	7.8
How confident respondent is that they could weather a financial crisis (percentage distribution)					
Very confident	4.9	16.7	18.4	8.9	13.1
Somewhat confident	41.5	47.4	51.0	35.7	45.5
Not that confident	41.5	30.7	16.3	32.1	29.3
Not at all confident	12.2	5.3	14.3	23.2	12.1
Ever participated in financial management/ financial literacy classes (percentage distribution)					
Yes	36.6	33.6	31.3	34.6	34.7
No	63.4	66.4	68.8	65.5	65.3
Ever participated in one-on-one financial counseling (percentage distribution)					
Yes	24.4	34.5	37.5	28.6	32.1
No	75.6	65.5	62.5	71.4	67.9

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Table C.17. Respondents' Priorities for Improving Early Childhood Programs and Services

Indicator	By Current Position				Total
	Program Leaders	Teachers	Asst. Teachers	HV/Family Support	
Top three choices for priorities for improving early childhood programs and services (percentage)					
Improve equitable access to early childhood programs and supports for vulnerable children and families.	41.5	41.2	35.4	47.3	41.4
Raise the quality of early childhood programs and services.	22.0	33.3	35.4	30.9	30.5
Enhance the coordination and continuity of services across early childhood services (within and beyond early childhood care and education).	34.1	46.5	45.8	32.7	41.7
Improve the working conditions of the early childhood workforce (e.g., time available for reflective practice).	36.6	39.5	27.1	36.4	34.9
Increase the compensation (salaries and benefits) of the early childhood workforce.	92.7	44.7	47.9	67.3	60.0
Increase professional development supports for the early childhood workforce.	17.1	24.6	20.8	21.8	25.4
Improve the quality of early childhood care and education facilities.	39.0	25.4	16.7	20.0	23.7
Other, please specify:	2.4	0.0	0.0	5.5	2.0

SOURCE: Tabulations from PDG B-5 Workforce Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding. See Table C.1 for the sample sizes for the subgroups and survey total. Cases with missing responses are excluded from the tabulations.

Appendix D. PDG B–5 System Kindergarten Teacher Survey Methods and Tabulations

The analysis of the New Hampshire PDG B–5 System Kindergarten Teacher Survey is based on responses from 209 individuals age 18 or older who reported teaching kindergarten during the 2018–2019 academic school year. Originally there were 256 cases, but through analysis, 12 cases were excluded that did not provide consent, 21 cases were excluded that provided questionable data, and 14 cases with little to no data were excluded for a total of 47 invalid or incomplete survey responses.²⁹ This appendix provides additional information about the characteristics of the Kindergarten Teacher Survey respondents and includes survey tabulations. See Appendix F for the survey instrument. Henry et al. (2020) provide additional methods details.

Characteristics of Respondents

The survey included questions to capture key characteristics of the survey respondents: demographic characteristics, professional background, and classroom context. Responses to these questions show the following characteristics and contextual factors:

- Overall, respondents were predominantly or exclusively female (96 percent), white (100 percent), and not Latinx (99 percent).
- All respondents reported teaching kindergarten during the 2018–2019 academic school year. The bulk of the teachers reported having more than 10 years of experience teaching in some capacity (36 percent reported teaching 11 to 19 years; 35 percent reported over 20 years of teaching). Of the years reported teaching kindergarten specifically, a quarter each reported teaching kindergarten for 11-19 years (24 percent) and 1-3 years (25 percent). Other respondents taught kindergarten for 4-5 years (19 percent), 6-10 years (18 percent), over 20 years (12 percent), and less than one year (less than 3 percent).
- Most teachers reported prior work experience in an early childhood environment other than a public school classroom such as center-based child care (34 percent), a private preschool (31 percent), a private or parochial school (14 percent), and a home child care

²⁹ The study team did not have access to a centralized list of kindergarten teachers in the 2018–2019 school year, nor a count of the number of potentially eligible kindergarten teacher survey respondents. Average daily kindergarten membership was about 10,800 students in the 2018–2019 school year. Assuming 18 students on average in each kindergarten classroom, we estimate a population of about 600 kindergarten teachers in that year. This suggests a response rate of about 35 percent (209 divided by 600).

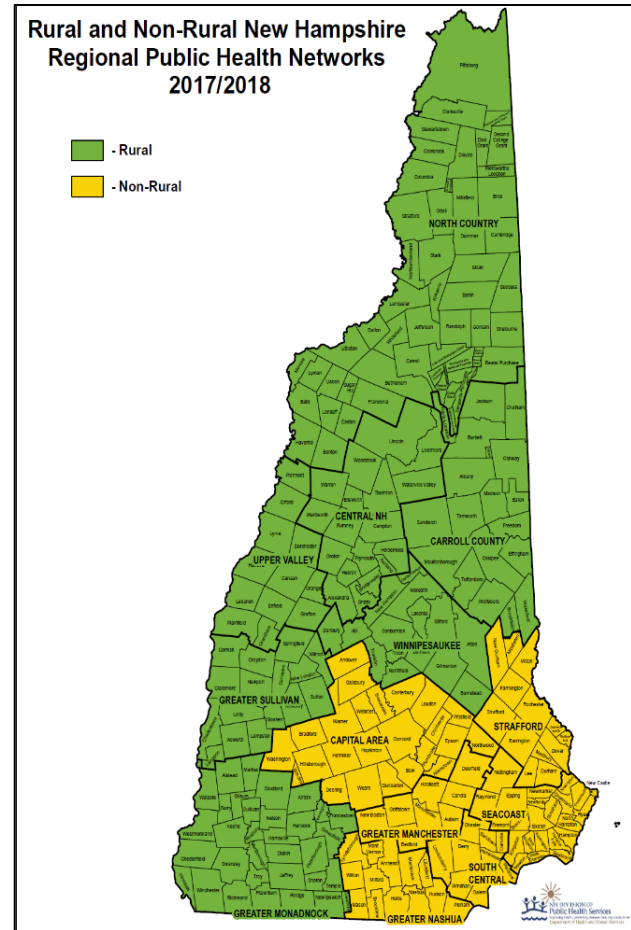
setting (12 percent), among other settings. Over 25 percent reported working only in a public-school classroom.

- Over half of the respondents held a New Hampshire Credentialing Endorsement in Elementary Education, either K–6 (31 percent) or K–8 (49 percent). About one in four respondents reported certification in Early Childhood Education (N–3), 7 percent in Early Childhood Special Education (N3), and 18 percent in General Special Education. These percentages reflect individuals with more than one endorsement.
- A plurality of respondents reported receiving their primary bachelor’s degree in elementary education (39 percent) while 28 percent reported an undergraduate degree in early childhood education (including Family Studies and Human Growth and Development Majors). Other responses included general Liberal Arts (13 percent), Science (13 percent), and “other” (unrelated) degree (8 percent).
- A majority (57 percent) of the teachers reported holding a master’s degree while 41 percent reported no master’s degree, and less than 2 percent reported current enrollment in a master’s program in elementary education.
- The primary discipline of master’s degrees was elementary education (68 percent), while 15 percent were early childhood education, 9 percent special education (including either early childhood or general special education), and 7 percent an “other” option.
- Teachers are not identified by name or school, but over 200 respondents provided the School Administrative Unit (SAU) in which they taught during the 2018–2019 school year. Fifty-five of the approximately 100 SAUs that offer kindergarten are represented in the sample. Respondents were located in all 10 counties.
- The majority of teachers taught kindergarten in a full-day program (84 percent); 16 percent reported teaching in half-day kindergarten programs, with a small number describing two sessions (morning and afternoon) or an on-site before- or after-care arrangement.
- The most typical class size for kindergarten teachers was 16 to 20 children (61 percent). 19 percent reported 11 to 15 children in a classroom, 11 percent had 21 to 25 children, 5 percent reported fewer than 10 children, and less than 5 percent reported more than 26 children in a classroom.

Summary and Tabulations

Tabulations from the PDG Kindergarten Survey are shown in the attached tables for all respondents and for two subgroups based on rural/nonrural status and district’s free and reduce price lunch eligibility rate. The subgroups are defined as follows (see Table D.1):

- **Rural Status.** Consistent with the definition adopted for the PDG Needs Assessment, respondents were classified into two groups based on the school district’s New Hampshire Regional Public Health Network’s designation of zip codes as rural (31 percent) or nonrural (69 percent).
- **Free and Reduced-Price Lunch (FRPL) eligibility.** Respondents were classified into one of two groups based on the school district’s percentage of students eligible for FRPL. The split was based on whether a school district was above the state average for FRPL eligibility, which is 27.16 percent. Districts were designated as above state FRPL average (districts that have more children who qualify, 50 percent) or below state FRPL average (districts that have fewer children that qualify, 50 percent).



In Tables D.2 to D.13, results are shown for survey respondents disaggregated by rural and FRPL eligibility status. The results for all respondents are recorded in the last column of each table. Unless noted in the table, results are either percentage distributions (summing to 100 percent) when only one response was allowed or percentages when respondents could select all response options that applied. Estimates by subgroups only include respondents for which district was provided, while the total includes all respondents. In addition, some respondents who completed the survey left responses to specific questions blank. Tabulations exclude cases with no response, either because of an incomplete survey or item nonresponse.

The summary that follows is organized by the two main themes relevant for the needs assessment: the kindergarten entry assessment process and kindergarten transition practices.

Findings: Kindergarten Entry Assessment Process

Overall Results

- Fifty-three percent of teachers used a formal screening or assessment tool upon kindergarten entry. Of those using a formal screening tool, 30 percent used PALS

(Phonological Awareness Literacy Screening), 12 percent used ASQ:SE (Ages & Stages Questionnaire: Social-Emotional), 9 percent used DIAL (Developmental Indicators for Assessment of Learning), 6 percent used ASQ (Ages & Stages Questionnaire) and 10 percent reported using “other” screening tools. Of those using a formal assessment tool, 5 percent used TS Gold (Teaching Strategies Gold), 5 percent used BSRA (Bracken School Readiness Assessment), 4 percent used Brigance, 3 percent used COR (Child Observation Record) and 2 percent used WSS (Work Sampling System) while 10 percent reported using “other” assessment tools.

- The majority of teachers (63 percent) reported screening children upon kindergarten entry using a checklist developed by the school, district, or teacher while 15.8 percent reported that they did not use a screening tool during the kindergarten entry process. In comparison, 17 percent reported using a nonstandardized assessment tool developed by their school, district or teacher and 30 percent reported not using a formal assessment tool during the kindergarten entry process. The most common domains of learning that were assessed included literacy, mathematics, fine motor development, and language development. Other domains (gross motor, approaches to learning, creative expression, social skills and emotional development) were reported as less frequently assessed or not assessed (social studies, science).
- More than half of the kindergarten teachers participated in the kindergarten entry assessment process with another staff member or as a member of a team, while 10 percent were solely responsible and 12 percent were not involved in the process at all.
- Entry assessment took place most often during registration days (57 percent) but were also conducted during the summer, the spring, before school or after school and could take more than 30 minutes (29 percent), between 16 and 30 minutes (39 percent), 11-15 minutes (23 percent) or less than 10 minutes (9 percent).
- Over half of the kindergarten teachers perceived their kindergarten entry assessment process as either “acceptable” (40 percent) or “good” (32 percent) with 13 percent rating their process as “very good”, 11 percent poor, and 4 percent very poor.
- Most teachers reported that the kindergarten entry assessment process did not affect their classroom schedule (34 percent) or only somewhat affected it (34 percent).

Differences by Rural Status

- Of the formal tools, nonrural districts were most likely to use the PALS (32 percent); the other most common option was a teacher-made/nonstandardized screening tool (30 percent).
- Rural districts were more likely to use a nonstandardized screening tool (e.g., teacher-made checklists, 55 percent) but more than a third of rural districts reported using either the ASQ:SE (25 percent) and/or ASQ (12 percent).

- Eighteen percent of nonrural districts reported not using a screening tool at all compared to 11 percent for rural districts.
- The BSRA was more widely used by teachers from rural districts (12 percent) than nonrural districts (less than 2 percent).

Differences by FRPL Eligibility Rate

- Teachers from school districts below the state average FRPL eligibility rate were less likely to use a formal screening tool (22 percent, compared to 10 percent in districts above the FRPL average) but those above and below the state average reported using teacher-developed checklists fairly equally (approximately 40 percent).
- Teachers from school districts above the state average FRPL eligibility rate were more likely to use the ASQ (8 percent) and/or the ASQ: SE (20 percent). Only 3 percent of teachers from districts below the state average used either screener.
- The PALS was more widely used by teachers from districts above the state average rate (39 percent, compared to 18 percent in districts below the state average).
- The DIAL was the only screening tool teachers from districts below the state average FRPL eligibility rate reported higher use compared with those in districts above the state average (13 percent vs 6 percent).
- Teachers from districts below the state average FRPL eligibility rate were less likely to report use of a formal assessment tool (37 percent) compared with teachers from districts above the state average (25 percent).

Findings: Kindergarten Transition Practices

Overall Results

- Almost all kindergarten teachers (95 percent) received some information about children and families prior to the school year, such as general information or Individualized Education Plan (IEP) records (both over 90 percent). Fewer received a family questionnaire (59 percent) or records from the ECCE setting, such as assessment data (38 percent).
- The majority of teachers reported building partnerships with families between 1 and 3 times prior to the start of the kindergarten year (80 percent) but 14 percent of teachers reported no contact with families during the kindergarten transition.
- Building partnerships with local child care programs occurred seldomly or only occasionally (65 percent). While more than 65 percent of children were reported to transition from a prior ECCE setting, 24 percent of teachers never had contact with the previous setting.

- Building partnerships with community-based settings such as mental health agencies and family resource centers was less common than with ECCE, with only 13 percent of teachers contacting settings for mutual referrals (29 percent), shared information (48 percent), shared resources (52 percent), or other purposes (38 percent).

Differences by Rural Status

- All kindergarten teachers reported receiving some general information about children and families before the school year began.
- There was a notable difference between the rural and nonrural districts regarding the use of family questionnaires: 79 percent of teachers in a rural district received a family questionnaire while only 50 percent received one in a nonrural setting.
- Just over 10 percent of teachers in nonrural settings reported not receiving any IEP data prior to the school year, whereas all teachers in the rural settings received this information.
- Generally, nonrural and rural districts were not connecting with community partners outside of ECCE. The few nonrural districts that were connecting with community partners did so by way of shared resources (57 percent in nonrural versus 43 percent in rural). Rural districts made those connections by way of mutual referrals (43 percent versus 21 percent in nonrural).

Differences by FRPL Eligibility Rate

- Teachers in districts below the state average FRPL eligibility rate generally received less information prior to kindergarten entry, with the exception of IEP records/special education information and ECCE program information (e.g., strengths/needs, likes/dislikes, approach to learning in classroom setting). These differences were fairly low, however, with the equivalent of only 3 to 5 more teachers receiving this information than in districts above the state average.
- Differences between the two subgroups were notable in the sources of transitional data: 45 percent of teachers in districts above the state average reported receiving ECCE program assessment results versus 29 percent of districts below the state average. Sixty-three percent of teachers in districts above the state average FRPL eligibility rate reported receiving data from family questionnaires versus 52 percent for teachers in districts below the state average.

Table D.1. Distribution of Teacher Survey Respondents by Subgroups

Indicator	Number	Percentage Distribution: All Cases	Percentage Distribution: Valid Cases
All respondents	209	100.0	100.0
By rural status			
Nonrural	140	67.0	69.0
Rural	63	30.1	31.0
Missing	6	2.9	--
By district FRPL rate			
Above state average	101	48.3	49.8
Below state average	102	48.8	50.2
No response	6	2.9	--

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

NOTE: -- = group excluded from subgroup analysis. Percentage distributions may not sum to 100 because of rounding.

Table D.2. Characteristics of Respondents

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Respondent gender (percentage distribution)					
Male	5.0	1.6	5.0	3.0	3.9
Female	95.0	98.4	95.0	97.0	96.1
Nonbinary/other	0.0	0.0	0.0	0.0	0.0
Prefer not to say	0.0	0.0	0.0	0.0	0.0
Identify as Hispanic or Latinx (percentage distribution)					
Yes	0.7	3.2	1.0	2.0	1.5
No	99.3	96.8	99.0	98.0	98.5
Race (percentage distribution)					
White	100.0	100.0	100.0	100.0	100.0
Nonwhite	0.0	0.0	0.0	0.0	0.0
District county (percentage distribution)					
Coos	0.0	100.0	0.0	100.0	4.4
Grafton	0.0	100.0	33.3	66.7	13.3
Carroll	0.0	100.0	0.0	100.0	2.9
Belknap	14.3	85.7	14.3	85.7	3.4
Sullivan	11.1	88.9	44.4	55.6	4.4
Merrimack	90.6	9.4	75.0	25.0	15.8
Strafford	100.0	0.0	21.4	78.6	13.8
Cheshire	0.0	100.0	0.0	100.0	2.0
Hillsborough	100.0	0.0	46.3	53.7	20.2
Rockingham	100.0	0.0	90.0	10.0	19.7

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

NOTE: — = not applicable. Percentage distributions may not sum to 100 because of rounding.

Table D.3. Teaching Experience

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Years teaching (percentage distribution)					
Less than 1 year	0.0	0.0	0.0	0.0	0.5
1-3 years	2.9	9.5	2.9	6.9	4.8
4-5 years	6.4	4.8	3.9	7.9	7.2
6-10 years	15.0	19.0	16.7	15.8	16.3
11-19 years	39.3	33.3	41.2	33.7	36.4
20+ years	36.4	33.3	35.3	35.6	34.9
Years teaching kindergarten (percentage distribution)					
Less than 1 year	0.7	4.8	1.0	3.0	2.9
1-3 years	28.6	19.0	25.5	25.7	25.0
4-5 years	18.6	19.0	16.7	20.8	18.8
6-10 years	16.4	20.6	18.6	16.8	17.8
11-19 years	25.0	22.2	32.4	15.8	24.0
20+ years	10.7	14.3	5.9	17.8	11.5
Early childhood education settings worked (percentage)					
Private preschool	27.3	37.7	27.6	33.7	30.8
Private/Parochial elementary school	12.9	16.4	16.3	11.6	14.1
Center-based childcare	30.3	41.0	31.6	35.8	33.8
Home/family-based childcare	9.8	14.8	8.2	14.7	12.1
Early Head Start/Head Start classroom	4.5	14.8	8.2	7.4	7.6
Laboratory school	10.6	9.8	8.2	12.6	10.1
Other	4.5	1.6	2.0	5.3	3.5
None	31.8	21.3	29.6	27.4	27.8

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding.

Table D.4. Respondent Education

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
NH credentialing endorsement (percentage)					
Early Childhood (N-3)	24.5	19.0	27.7	17.8	23.6
Early Childhood Special Education (N-3)	5.8	6.3	6.9	5.0	6.7
Elementary Education (K-6)	31.7	31.7	33.7	29.7	31.3
Elementary Education (K-8)	49.6	49.2	43.6	55.4	49.0
General Special Education	20.1	14.3	24.8	11.9	17.8
Other	7.9	7.9	10.9	5.0	7.7
Baccalaureate degree discipline (percentage)					
Early Childhood	28.6	26.4	31.8	24.2	27.9
Elementary Education	40.5	37.7	39.8	39.6	38.8
Liberal Arts	10.3	18.9	10.2	15.4	13.1
Science	11.1	17.0	11.4	14.3	12.6
Other	9.5	0.0	6.8	6.6	7.7
Master's degree (percentage distribution)					
Does not have a master's degree	38.6	47.6	29.4	53.5	41.3
Pursuing Master's degree	1.4	1.6	2.0	1.0	1.4
Has a master's degree	60.0	50.8	68.6	45.5	57.2
Master's degree discipline (percentage)					
Early Childhood	18.1	9.7	20.3	8.9	15.4
Elementary Education	62.7	80.6	55.1	86.7	68.4
Special Education	12.0	3.2	15.9	0.0	9.4
Other	7.2	6.5	8.7	4.4	6.8

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding.

Table D.5. Kindergarten Classroom Characteristics

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Program type (percentage distribution)					
Full-day	79.9	93.7	74.3	94.1	83.6
Half-day	18.7	6.3	23.8	5.9	15.5
Half-day with established before/aftercare	1.4	0.0	2.0	0.0	1.0
Number of students in the classroom (percentage distribution)					
Less than 10	0.0	14.3	1.0	7.9	4.9
11-15	17.3	22.2	21.8	15.8	19.4
16-20	66.2	50.8	63.4	59.4	60.7
21-25	12.2	7.9	9.9	11.9	10.7
26-30	2.2	4.8	1.0	5.0	2.9
More than 30	2.2	0.0	3.0	0.0	1.5

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding.

Table D.6. Number of Adults in Kindergarten Classroom

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Teachers (N)					
Mean	1.03	1.05	1.03	1.04	1.04
Standard deviation	(0.21)	(0.22)	(0.17)	(0.24)	(0.22)
Assistant teachers (N)					
Mean	0.23	0.22	0.32	0.13	0.17
Standard deviation	(0.42)	(0.55)	(0.54)	(0.33)	(0.48)
Paraprofessionals (N)					
Mean	0.82	0.72	0.78	0.80	0.80
Standard deviation	(0.77)	(0.81)	(0.66)	(0.90)	(0.80)
Volunteers (N)					
Mean	0.03	0.06	0.04	0.04	0.05
Standard deviation	(0.17)	(0.30)	(0.24)	(0.20)	(0.24)

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

Table D.7. Kindergarten Readiness Tools

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Formal screening or assessment used (percentage distribution)					
Yes	52.6	50.9	36.2	67.7	53.3
No	47.4	49.1	63.8	32.3	46.7
Screening tools (percentage)					
DIAL	7.5	14.0	12.8	6.3	9.2
ASQ	2.9	11.7	3.0	8.2	5.9
ASQ: SE	5.8	25.0	3.0	20.4	11.9
PALS	32.8	18.3	18.2	38.8	29.7
Nonstandard, teacher-created	30.7	55.0	36.4	39.8	37.1
None	18.2	11.7	22.2	10.2	15.8
Other	10.4	8.3	14.3	5.2	10.0
Assessment tools (percentage)					
TS Gold	3.0	8.6	4.3	5.2	4.6
WSS	1.5	3.4	2.1	2.1	2.0
BSRA	1.5	12.1	3.2	6.2	4.6
COR	2.3	3.4	2.1	3.1	3.1
Brigance	5.3	1.8	3.2	5.2	4.1
Nonstandard, teacher-created	15.8	22.8	17.0	18.8	17.4
None	30.8	31.0	37.2	24.7	30.1
Other	9.8	10.3	11.7	8.2	9.7
Rating of kindergarten entry process (percentage)					
Very Poor	4.6	1.8	6.5	1.1	3.7
Poor	13.1	7.1	12.9	9.7	11.0
Acceptable	41.5	39.3	30.1	51.6	40.3
Good	30.8	33.9	35.5	28.0	31.9
Very Good	10.0	17.9	15.1	9.7	13.1

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding.

Table D.8. Domains in Kindergarten Entry Assessment

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Domain in kindergarten entry assessment (percentage)					
Approaches to Learning	36.2	42.9	46.8	31.1	39.0
Literacy	97.9	85.7	95.2	93.2	92.9
Language	54.3	81.0	69.4	56.8	63.1
Mathematics	72.3	71.4	75.8	68.9	70.9
Science	1.1	0.0	1.6	0.0	0.7
Social Studies	0.0	0.0	0.0	0.0	0.0
Social Skills	38.3	42.9	48.4	32.4	40.4
Emotional Development	14.9	40.5	25.8	20.3	23.4
Creative Expression	8.5	4.8	11.3	4.1	9.2
Fine Motor Skills	64.9	83.3	74.2	67.6	70.9
Gross Motor Skills	27.7	69.0	41.9	39.2	41.1

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding.

Table D.9. Implementation of the Kindergarten Entry Assessment

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Responsible party for implementation (percentage)					
Kindergarten teacher	80.9	90.5	83.9	83.8	82.3
Curriculum specialist	9.6	11.9	14.5	6.8	11.3
Special education teacher/administrator	36.2	45.2	46.8	32.4	38.3
ESOL teacher	9.6	4.8	9.7	6.8	7.8
Reading/literacy specialist	51.1	28.6	43.5	44.6	43.3
Assessment team	18.1	31.0	22.6	21.6	22.0
SLP	19.1	31.0	30.6	16.2	22.0
OT/PT	13.8	28.6	24.2	13.5	17.7
School nurse	1.1	7.1	0.0	5.4	2.8
Guidance counselor	3.2	7.1	8.1	1.4	4.3
Title 1 coach/tutor	11.7	0.0	3.2	12.2	7.8
Time of assessment (percentage)					
During scheduled registration days	53.2	65.9	41.9	69.9	57.1
During a drop-in prior to the start year	24.5	19.5	17.7	27.4	22.9
After your typical school day	8.5	4.9	11.3	4.1	7.1
Before your typical school day	4.3	0.0	6.5	0.0	3.6
During the summer months	21.3	14.6	14.5	23.3	18.6
Beginning of school year during day	17.0	7.3	17.7	11.0	13.6
Spring prior to kindergarten	13.8	9.8	21.0	5.5	12.9
Other	6.4	9.8	8.1	6.8	7.9
Length of assessment (percentage distribution)					
Less than 5 minutes	2.2	2.6	3.4	1.4	2.2
5-10 minutes	6.5	7.7	5.1	8.2	6.6
11-15 minutes	25.8	15.4	25.4	20.5	23.4
16-30 minutes	36.6	46.2	28.8	47.9	39.4
30 + minutes	29.0	28.2	37.3	21.9	28.5
Impact on classroom schedule (percentage distribution)					
Not at all (1)	36.2	26.8	41.0	27.0	33.6
Somewhat	30.9	39.0	29.5	36.5	34.3
Moderately	20.2	12.2	16.4	18.9	17.1
Significantly (4)	12.8	22.0	13.21	17.6	15.0
Impact on classroom schedule					
Mean	2.10	2.29	2.02	2.27	2.14
Standard deviation	(1.04)	(1.10)	(1.06)	(1.05)	(1.05)

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding.

Table D.10. Content of Information Received about Children and Families

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Content of information received (percentage)					
General information	97.8	100.0	97.9	99.0	98.5
Information for children with an IEP	88.9	100.0	93.8	90.6	90.9
Child assessment results from an early childhood program the child attended	34.8	41.4	28.9	44.8	37.9
Other child information from an early childhood program the child attended	33.3	37.9	36.1	33.3	34.8
Family questionnaire	49.6	79.3	54.6	62.5	58.6
Other	5.9	6.9	5.2	7.3	6.1
No information received	0.0	0.0	0.0	0.0	0.0

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

Table D.11. Partnership Opportunities During Kindergarten Transition

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Number of partnership opportunities with families before or during the kindergarten transition process (percentage distribution)					
0	14.8	12.1	17.5	10.4	13.6
1-3	83.0	75.9	79.4	82.3	79.8
4-5	2.2	6.9	3.1	4.2	4.5
6 +	0.0	5.2	0.0	3.1	2.0
Degree to which partner with local child care programs regarding the transition to kindergarten (percentage distribution)					
Not at all	28.1	13.8	33.0	14.6	23.7
Seldom	37.8	25.9	40.2	28.1	33.8
Occasionally	28.1	37.9	20.6	41.7	31.3
To a considerable degree	5.2	13.8	5.2	10.4	8.1
Almost always	0.7	8.6	1.0	5.2	3.0

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding.

Table D.12. Children Transitioning from ECCE

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Percentage of children transitioning from ECCE					
Mean	69.8	62.4	76.8	57.9	66.8
Standard deviation	(23.7)	(23.4)	(20.5)	(23.3)	(24.5)

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

Table D.13. Community Agency Partnerships

Indicator	By Rural Status		By District FRPL Rate Relative to State Rate		Total
	Nonrural	Rural	Below	Above	
Utilization of partnerships					
Yes	12.7	13.8	8.2	17.9	12.7
No	87.3	86.2	91.8	82.1	87.3
Purpose of partnerships					
Mutual referrals	21.4	42.9	12.5	38.5	28.6
Share information (with family consent)	50.0	42.9	50.0	46.2	47.6
Share resources	57.1	42.9	50.0	53.8	52.4
Other	42.9	28.6	25.0	46.2	38.1

SOURCE: Tabulations from PDG B-5 Kindergarten Teacher Survey.

NOTE: Percentage distributions may not sum to 100 because of rounding.

Appendix E. Databases for New Hampshire B–5 Programs

Table E.1 provides a summary of the data systems for B–5 system programs identified in Chapter 2. The table illustrates the multiplicity of databases for B–5 programs in NHDHHS and NHDOE, although some programs do share a common database. For additional documentation of these databases, see Ridgeway and Anderson (2019).

Table E.1. Databases for New Hampshire B–5 Programs

DHHS Program/Function/ Business Entity	Data Collection or Reporting System
Office of the Commissioner	
Administrative Business Supports	
Legal & Regulatory Services	
Child Care Licensing Unit (CCLU)	MyLicenseOffice
Population Health	
Division of Public Health	
Population Health and Community Services	
Birth Conditions Program (with Special Medical Services & NH Family Voices)	Welligent
Maternal & Child Health: Community Collab's to Strengthen & Preserve Families	MS Excel & Word. UNH partner Grant
Maternal & Child Health: Early Hearing Detection and Intervention (EHDI)	Welligent
Maternal & Child Health: Injury Prevention	CDC NVRS passworded website
Maternal & Child Health: Pregnancy Risk Assess. Monitoring System (PRAMS)	PRAMS
Maternal Child & Health: Family Planning	JSI
Maternal Infant and Early Childhood Home Visiting Program (MIECHV)	Efforts to Outcomes online Database by Social Solutions
Newborn Screening	Blood Test System
NH Healthy Lives: Comprehensive Cancer Control Program	Keene State MS Excel.
Women, Infants and Children (WIC)	StarLINC
Public Health Protection	
Healthy Homes and Lead Poisoning Prevention Program (HHLPPP)	CDC Stellar System

DHHS Program/Function/ Business Entity	Data Collection or Reporting System
Division of Economic Health & Housing Stability	
Family Assistance	
Comprehensive Family Supports and Services (CFFS)	MS Excel Workbook
Supplemental Nutrition Assistance Program (SNAP)	New Heights
Children's Medicaid (CM)	New Heights
Temporary Assistance to Needy Families (TANF)	New Heights
Child Care Scholarship	New Heights
Housing Supports	
Permanent Supportive Housing	NH Homeless Management Information System (HMIS)
Family Shelters	HMIS
Child Support Services	
Child Support Program Title IV - D	New England Child Support Enforcement System (NECSSES)
Child Development & Head Start Collaboration	
Child Development	Professional registry
Child Care Aware (CCA Contractor): Child Care Scholarship	New Heights, Bridges, QRIS, CCA-America National Data System (NDS)
Head Start Collaboration Office	Office of Head Start: Program Information Report (PIR)
Current Quality Rating and Improvement System (QRIS)	Paper
Future QRIS System	Electronic database
Division for Behavioral Health	
Drug and Alcohol Services	
Specialty Substance Use Disorder (SUD) treatment: pregnant/parenting women	Web Information Technology System (WITS)
Community Based Mobile Crisis Team: Adverse Childhood Experiences (ACEs)	Hard Copy, Survey Monkey
Children's Mental Health	
Infant and Early Childhood Mental Health Plan	NA
Division of Long Term Supports & Services	
Elderly & Adult Services	
NH Family Caregiver Support Program	ServiceLink and MS Excel
Developmental Services	
Children's in-Home Support Waiver	NH Leads and/or BTS
Special Medical Services	
Family-Centered Early Support and Services (FCESS)	NH Leads data system
Special Medical Services, Title V (SMA)	SMS database created/managed by DOIT
Partners in Health (PIH)	PIH database created/managed by DOIT
Watch Me Grow (WVG)	MS Excel workbook

DHHS Program/Function/ Business Entity	Data Collection or Reporting System
Area Agency Family Support (He-M 519)	NH Leads
Division for Children, Youth & Families	
Family, Community & Program Support	
Strength to Succeed	MS Excel
Strength to Succeed: Partners data with Children's Mental Health Bureau	MS Excel (DCYF Data Steward)
Child Health Support	MS Excel (DCYF Data Steward)
Home Based Therapeutic (HBT)	MS Excel (DCYF Data Steward)
Individual Service Option (ISO)	MS Excel (DCYF Data Steward)

SOURCE: Ridgeway and Anderson (2019), Appendix C.

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