Unlocking Potential
Cost Modeling Analysis

The costs for each of the areas outlined in the Unlocking Potential Plan were estimated using the following broad parameters:

1. Planned Service Expansion with all elements that inform costs, including specific services and types and goals or targets for numbers or percent of a group served.

2. Program Service Models Parameters. This includes staffing, staff compensation, and staff-child or staff-family ratios or caseloads.

3. Estimated eligibility and take-up rates, presuming that not all children or families may be eligible for a program, and that not all of those eligible may choose to or need to take-up a benefit or participate in a program.

4. Existing services, including the existing scope (i.e., reach or numbers served), existing per child or per-location costs, and variability of costs.

5. Gap between existing and planned services, including an estimate of unmet need and how planned services will expand upon existing services to meet the need.

ACNJ and the cost modeling consultants used a combination of census data/state data and information on existing service levels and cost for proposed maternal-infant health, child care, home visiting, and infant mental health in New Jersey and other states to estimate the components of planned service expansion.

Goal Area 1: High Quality Infant and Toddler Child Care

By 2023, 8,750 more infants and toddlers will participate in high-quality infant-toddler child care programs. Currently 3,533 infants and toddlers are enrolled in a high-quality program. Quality is defined as either a Grow NJ Kids rated center or an Early Head Start program.

1.1 By 2023 3,750 more infants and toddlers from low-income families receiving subsidy will participate in licensed, high-quality center-based or family child care. (Quality is defined as licensed/regulated and participating in the top tiers of Grow New Jersey Kids (GNJK)).

This represents a doubling of infants and toddlers receiving publicly supported early care and education in quality-rated programs from the current 3,533. Over three years, this will require an additional 1,250 new providers to be rated annually at a level 3 or higher. Given there are nearly 15,000 infants and toddlers in subsidized child care, **identifying and rating 3,750 (or one-quarter) who are high quality and likely to be rated highly should be achievable within existing resources**.

To achieve this policy objective *will require* concerted effort on the part of the state and its contracted organizations who perform the ratings to identify and triage among existing providers. It can (a) prioritize those who are most rating-ready and could benefit from the incentives of higher payments offered through tiered reimbursement; (b) assign those who will need a modest level of support in the first year to get the needed technical assistance or other supports be ready to be rated in years 2 and 3;

and (c) begin the process with those in need of more substantial investments (e.g. for facilities repairs) to be in a position to be rated by the second stage of the Pritzker initiative between 2023 and 2025.

As part of the strategy to get all centers and homes rated over time, the state's leadership should move toward requiring all child care providers participating in the subsidy program serving infants and toddlers be enrolled in GNJK as a condition of receiving subsidy and to be eligible for tiered reimbursement payments. Doing this could support making it so every provider is enrolled in GNJK is rated by a future date-certain, e.g. 2025.

1.2 Develop 2,000 more high-quality licensed child care slots for low-income infants and toddlers in child care centers and family child care homes.

At current payment rates for child care centers rated by Grow NJ Kids, we estimate that if 500 of the added slots were for infants 0 to 18 months, and 500 slots were for toddlers' care between 18 and 30 months the total annual costs **serving 1,000 more children in a mix of level 3- and level 4- rated providers would be $12 million annually**.

At current family child care payment rates, we estimate that if 500 of the added slots were for infants 0 to 18 months, and 500 slots were for toddlers' care between 18 and 30 months the total annual costs **serving 1,000 more children in a mix of level 3- and level 4- rated providers would be $8 million annually**.

1.3 Expand Early Head Start and Early Head Start-Child Care Partnership slots to serve 2,000 more infants and toddlers.

These new slots could be created either in response to new federal funding opportunities for EHS or EHS-CC Partnerships; a focused program that provides funding opportunities that encourages, incentivizes, and supports existing Head Start grantees' conversion of program slots for Early Head Start; or developing a state version of EHS-CC Partnerships by providing additional per child resources to Infant and Toddler center care providers, who enhanced their programs to meet EHS program standards. For example, if **programs were to receive a $3,000 per child supplement to improve program quality for 2,000 additional infants and toddlers this would amount to a $6 million annual cost.** Similarly, one could envision providing a similar level of one-time funding for conversion costs to convert some HS classrooms to meet infant and toddler Early Head Start licensing standards.

1.4 Improve the credentials and compensation for infant and toddler educators so that 1,000 additional low-income infants and toddlers will be cared for by a credentialed educator.

Roughly 200 educators, including a mix of those who would be serving infants (at a ratio of 1:4) and toddlers (at a ratio of 1:6), could become credentialed with an AA degree in early childhood education, particularly those with some credits. If candidates were provided two to three years of scholarship funding totaling $10,000 and provided a $5,000 annual increase in compensation upon achieving the credential this would cost **$2 million in one-time costs for scholarships and $1 million in annual costs for higher compensation to these educators.**

<u>**Total Investments Required to Meet Goal 1: Infant-Toddler Child Care.**</u> By 2023, $29.7 million in increased annual investments would be required to meet the objectives that together would mean 8,750 additional low-income children were receiving high-quality infant and toddler child care in the state.

Cost of New Investments in Child Care by Objectives

Infant Toddler Child Care Objectives	Increased # of Children in Quality Care	New Investment
Investment #1 – Increase number of current programs quality rated	3,750	Existing Resources
Investment #2- Increase availability of quality seats in centers	1,000	$12 Million
Investment #3 – Increase availability of quality seats in family child care homes	1,000	$ 8 Million
Investment #4 – Expand Early Head Start	2,000	$6 Million
Investment #5 – Improve infant-toddler educator credentials and compensation	1,000	$3 Million
State-level staffing costs for implementation and administration		$.7 Million
	8,750	$29.7 Million

Goal Area 2: High Quality Home Visiting

By 2023, 11,584 families with children younger than age three from low-income families will participate in a range of high-quality home visiting program services. This will be an increase of nearly 10,000 (9,867) families from the current estimated baseline of 1,717 participating and completing program services in the 3 MIECHV-supported evidence-based home visiting (EBHV) program models or EHS home-based program model.

2.1 Increasing by 2,685 the number of low-income families participating and completing one of the existing EBHV program models.

The first area of investment will be increased resources to strengthen existing services across the state's EBHV programs to meet the full level of current capacity and to retain many more families in programs to ensure they are benefiting fully from the programs. To achieve this, New Jersey will need to make new and concentrated efforts to achieve full utilization and enrollment in the current funded capacity for its 3 EBHV programs, identify what is leading to under-enrollment, and what steps and investments would support full utilization.

Baseline of Current Service Capacity Levels Considered High Quality - New Jersey has funded capacity to serve 4,755 children and families across the three evidence-based home visiting (EBHV) programs models: Nurse Family Partnership (NFP); Healthy Families America (HFA); and Parents As Teachers (PAT). In addition, there are 717 slots for funded enrollment in Existing Early Head Start Home-Based option. (EHS-HBO). The existing funded capacity is summarized in Table 1.

Table 1 – Existing Funded Capacity in Home Visitation Programs, New Jersey		
Program Model	**Total Funded Capacity**	**Average Monthly Enrollment**
Nurse Family Partnership (NFP);	1555	1279
Healthy Families America (HFA);	2052	1830
Parents As Teachers (PAT)	1148	825
Sub-total – State-administered (EBHV) Programs	4,755	3,934
Early Head Start Home-Based option. (EHS-HBO)	717	
Total Existing Home Visiting Services Capacity	**5,522**	

Sources: Data from NJ DCF for FY2019; 2019 EHS PIR data for funded capacity for EHS home-based option

Table 1 summarizes average monthly enrollment for the three EBHV programs from data provided by the NJ Department of Children and Families (DCF) for FY2019. This totaled 3,934, or about 800 (17 percent) less than the funded service capacity level for the state. The existing EBHV programs average monthly enrollment serving low-income families prenatally and with children younger than three is estimated to be 2,968 when one includes just those under age three in the programs[1] and enrollment for low-income families.[2]

One important contributing factor to the lower level of average monthly enrollment relative to funded capacity is that some of the program models may be under-resourced. Related to this, there is very high levels of attrition in families participating in the programs leading to many participating families being served for less than the program's full duration, with a high turnover in slots and many programs unable to fill the slot immediately.

Relative to the average funding levels for some of the program models, the average spending per family served in New Jersey is considerably below what other jurisdictions implementing these programs spend, and what reported program costs in other states and research studies of costs across program sites finds as average costs for the programs. Table 2 Indicates the total funding for the three EBHV program models implemented by local agencies across New Jersey.

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[1] An estimated 88 percent of services in the portfolio of 3 EBHV programs are for children 0 to 3

[2] Estimate that greater than 90 percent of EBHV families low-income based on NJ's MIECHV Annual Performance Reports for 2016,2017, 2018.

Table 2 – Existing Funded Capacity in Home Visitation Programs, New Jersey						
	Number of LIAs	Total Funded Capacity (Slots)	Average Monthly Enrollment	Total Grant Funding Across Program Sites	Funding Per Slot	Funding Per Family (For Average Monthly Enrollment)
Nurse Family Partnership	16	1555	1279	$7,230,036	$4,650	$5,653
Healthy Families America	21	2052	1830	$8,488,119	$4,137	$4,638
Parents As Teachers	21	1148	825	$3,774,129	$3,288	$4,575

- For the NFP program NJ DCF contracts with 16 local implementing agencies (LIAs) for NFP services across the state to serve a funded capacity of 1,555 families. The total funding under these contracts amounts to $7.2 million. This works out to an average cost per family for its funded enrollment of $4,650, and $5,653 per family for average monthly enrollment levels across programs. These per slot/per family served costs for NFP are well below the average cost per slot generally reported for NFP is $7000-$8700 annually.

- For the HFA program NJ DCF contracts with 21 local implementing agencies (LIAs) for HFA services across the state to serve a funded capacity of 2,052 families. The total funding under these contracts amounts to $8.5 million. This works out to an average cost per family for its funded enrollment of $4,137 and $4,638 per family for average monthly enrollment levels across programs. These per slot/per family served costs for HFA are below the average cost per slot generally reported for HFA, which is $4500-$6000 annually.

- For the PAT program NJ DCF contracts with 21 local implementing agencies (LIAs) for PAT services across the state to serve a funded capacity of 1,148 families. Total funding under these contracts amounts to 3.8 million - $3,288 for each family in its funded enrollment and $4,575 per family for average monthly enrollment levels. These per slot/per family served costs for PAT are similar to the average cost per slot generally reported for PAT, which is $2,500-$4000 annually.

The below average level of spending likely means that if programs' compensation levels required to support attracting and retaining high quality staff are insufficient, this could lead to lower quality services and higher staff attrition, which in turn contributes to higher attrition rates for participating families. To increase the number of families served in the EBHV models, and for the services to be high-quality so that staff turnover is reduced, and more families complete services, we estimate the cost of increasing the state's per family served at the current funded enrollment levels to the midpoint average costs found for other NFP and HFA programs. This would amount to $7.3 million in increased investment for current funded enrollment to achieve higher program participation and program completion so that an additional 2,635 families with children younger than three are receiving high-quality home visiting in the state.

We estimate $7.3 million in total annual investments to increase the per family spending levels for two of the three EBHV program models will be required. This could enable programs to enroll more families to get average monthly enrollment levels closer to the funded enrollment, and to improve rates of program completion closer to those found in the efficacy trial studies supporting the models' evidence of effectiveness.

2.2 Increasing by 1,000 the funded service capacity for the 3 major existing ongoing evidence-based home visiting (EBHV) program models (HFA, NFP, PAT) that the state manages.

For the second area of investment, expanding the funded service capacity for the existing evidence-based home visiting (EBHV) program models by 1,000 slots, we recommend an expansion that includes a mix of either 2 or 3 of the existing program models, and to target communities for expansion based on the levels of unmet needs in higher needs communities that have the capacity to successfully expand services in those communities. As initial steps, we would suggest a community by community level analysis of the level of program enrollment for the three program models across the communities where they are currently located. This analysis can identify programs with high participation levels (recent enrollment levels compared to funded enrollment levels), programs with substantial waitlists for particular program models, and low levels of program attrition.

For the cost estimation, we assume that half or more of the increased capacity could be used for expansion of the Nurse Family Partnership in existing and potentially new LIAs. There are currently 16 LIAs for NFP and 21 each for HFA and PAT. NFP also has the strongest base of research evidence supporting it. In addition, the 53 percent completion rate for NFP LIAs in New Jersey is a lower completion rate than what has been found in other states, it has a higher rate of completion than either HFA and PAT do in New Jersey. NFP also has demonstrated research supporting its use for particularly high needs family circumstances, including relatively young expectant mothers, those with at-risk pregnancies, experiencing poverty, unstable housing, as well as risk factors associated with a higher potential for child welfare involvement. Given the current priority focus on better birth outcomes for relatively disadvantaged expectant mothers, much of the expansion should be in new NFP slots.

We estimate the overall costs for a scenario where 60 percent (or 600) of the additional slots were in NFP and 40 percent (or 400) were HFA slots. Having the other 40 percent be a combination of HFA and PAT could also be possible, but given that more of the services by HFA LIAs reaches younger children under age three, and the program's LIAs have a slightly better record of successful program completion, we used a 40 percent HFA expansion for the cost calculation. **The total cost for the expansion of EBHV with this program mix would be a total increase of $7.3 million annually by 2023, with costs in the intervening years increasing at lower levels.**

Estimated Cost for Increased Enrollment in 2 or 3 EBHV Program Models*			
	Increase in L-I PN-3 Funded Enrollment	Estimated Overall Increase in Enrollment	Cost @ $7000 per slot
Investment # 2 – Add 1,000 Funded Capacity in High-Quality EBHV Program Services	1,000	**1,044**	$7.3 Million

2.3 Develop pilot expansions of a universal home visiting program across three to four of the state's highest need communities that enrolls 6,182 low-income families in the program.

The following cost estimates were based on utilizing the Family Connects program as the universal model. Family Connects provides initial home visits to families with newborns, conducts comprehensive assessment and connects families child development and family support services based on the needs identified in the assessment.

For the multi-site development and implementation of the Family Connects program model in higher need communities and counties we use per-family participation costs of $490, which a state agency planning (working with the Family Connects program developers) used for potential FC implementation in their budget analysis. We also use a higher average cost that the Ounce of Prevention indicated was the average cost in the initial years in a multiple county pilot implementation of the program in Illinois. Using the midpoint of the cost estimates for these possible lower and upper-bound costs per family served, we arrive at an overall cost estimate of $8.4 million annually at full implementation across these communities by 2023. We estimate that if these were targeted to the communities with the highest rates of low-income families, from a total of 11,241 families giving birth and participating in a universally offered Family Connects program in those communities, 6,182 or 55 percent of the total birth could be to low-income families.

Total Children Served in Family Connects (FC) and Level of New Investments Required by 2023				
Total FC L-I Families Funded Enrolled	Total FC Enrollment	Cost @ $490 per slot	Cost @ $1000 per slot	Midpoint
6,182	11,241	$5.5 million	$11.2 million	**$8.4 million**

Total Investments Required to Meet Goal 2: Home Visiting. By 2023, $25.3 million in increased annual investments would be required to meet the goals that together would mean 9,867 additional low income children were receiving high-quality home visiting services in the state.

Cost of New Investments in Home Visiting By Objective

Home Visiting Objectives	Increase in L-I PN-3 EBHV & FC Enrollment	New Investment
Investment #1 – Improve EBHVs for higher-quality outcomes and reaching full funded enrollment	2,685	$7.3 Million
Investment #2 – 1000 added EBHV capacity	1,000	$7.3 Million
Investment #3 - FC serves 6,182 L-I Families	6,182	$8.4 Million
State level training, administration and implementation costs		$2.3 Million
TOTAL	9,867	$25.3 Million

Goal Area 3: Infant Mental Health

By 2023, approximately 7,247 children under age three and their caregivers in New Jersey will receive high-quality, appropriate mental health supports and services. Baseline figures used to help determine cost estimates include:

- *Existing mental health consultation levels.* There are currently 2.5 FTE mental health consultants supporting child care programs in a pilot program in New Jersey, with the capacity to serve approximately 80 centers and 160-240 children per year. Early Head Start offers mental health consultation as part of its performance standards. In 2019, 2,993 children were enrolled in 97 Early Head Start centers in New Jersey. Each of the 23 Early Head Start grantees in the state has a mental health professional on staff who provides an average of 35 hours per month of early childhood mental health consultation (21% of time), or the equivalent of 5 FTE consultants. Consultation services are provided to teachers of 308 Early Head Start children.

- *Pediatric offices.* In 2017, there were approximately 2,294 pediatricians, or 115.6 per 100,000 children, in the state (865.2 children per pediatrician, with smaller panels than the national mean of 1,147.9 children per pediatrician), and it is unclear whether mental health consultation is available in pediatric settings.[3]

- *Referrals for additional mental health services.* Approximately 9% to 14% of children under age 6 experience an emotional or behavioral problem that may benefit from mental health supports and services, with rates higher among low-income children. For example, in Early Head Start, of the 308 children for whom caregivers received mental health consultation services, 27% (84) were referred for additional mental health services.

- *Children's System of Care (CSOC).* In 2018, CSOC served 245 children under age 4, and over 59,000 children aged 5 and older: 23,768 CMO; 17,751 FSO; 31,100 mobile response and stabilization; 33,725 intensive in-community/behavioral assistant; 3,090 in out-of-home treatment; and 1,342 substance use treatment.

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[3] https://www.abp.org/sites/abp/files/pdf/pediatricphysiciansworkforcedatabook2017-2018.pdf

- *Medicaid reimbursement rates for mental health services.* Forty-two percent of New Jersey's newborns, and 37 percent of the state's infants, toddlers, and preschoolers, are enrolled in Medicaid,[4] whose reimbursement levels for mental health services for family therapy are lower than that of private insurance (e.g., $98.82 vs. $132 for billing code 90847), and Medicaid does not cover parent-only visits, without the child present (billing code 90846, reimbursed at $162 in private insurance).

- *Early childhood specialists at Central Intake Offices.* There are currently 17 early childhood specialists serving the 21 Central Intake offices across New Jersey. Four EC specialists current hold an Endorsement.

- *Mental health professional supply and training*. In 2011-15, there were an estimated 7,576 psychologists and 20,356 social workers in New Jersey, or 106.4 and 285.9 per 100,000 working-age population.[5] In 2019, only 161 mental health professionals had specialized training in infant/toddler mental health, as indicated by receipt of a level of endorsement. Of these, 78% had Category I or II endorsements (Infant Family Associate, or Infant Family Specialists).

3.1 Expand the availability of infant mental health consultation services in a variety of settings.

Infant-Toddler Mental Health Consultants in Early Care and Education Settings. To reach a target of 425 (25% of the 1,700 centers statewide that serve infants and toddlers) with mental health consultation services, an estimated **$3.01 million annually** will be needed to support an additional 18 consultants and enhance the salary of existing consultants in the New Jersey pilot program and at Early Head Start. These estimated costs include direct costs for salaries (mental health consultants; supervisors; project coordinators; administrative assistants), indirect costs, research/evaluation costs, and state-level administrative costs.

Infant-Toddler Mental Health Consultants in Pediatric Settings. To reach a target of 200 pediatricians (25% of the estimated 802 pediatricians serving low-income infants and toddlers) with mental health consultation services, an estimated **$2.34 million annually** will be needed to support 12.5 consultants. These estimated costs include direct costs for salaries (mental health consultants; supervisors; project coordinators; administrative assistants), indirect costs, research/evaluation costs, and state-level administrative costs.

Early childhood specialists at Central Intake Offices to connect families to appropriate services in the community. To ensure each of the 21 Central Intake offices has access to an early childhood specialist would cost an estimated **$1.66 annually.**

3.2 Increase the availability of intensive mental health services for infants and toddlers and their families.
To reach a target of 2,785 children and their families annually with intensive infant mental health services will cost an estimated **$1.37 million annually** based on a 10 visit outpatient MH episode as reimbursed by private pay (8 child visits * $132 + 2 parent visits * $162) = $1380.

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[4] https://ccf.georgetown.edu/wp-content/uploads/2017/02/New-Jersey-Medicaid-CHIP-new-v1.pdf
[5] https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/state-profiles/newjersey-2018.pdf

Increasing and expanding Medicaid reimbursement rates for mental health services. Approximately 2,130 children under three and their parents (24% of those receiving consulting services) are assumed to be referred for more intensive mental health services and supports. For each parent-child dyad to receive 10 sessions total (8 family-focused and 2 parent-focused), we estimate a per dyad additional cost of $589 to provide parity between Medicaid and private insurance reimbursement, estimating a total cost of **$1.38 million annually** to increase Medicaid reimbursement rates[6] for children and expand to cover parent sessions.

3.3 Increase the supply of well-trained infant mental health professionals across the state.

Training in early childhood mental health. The new early childhood specialists at CI offices, the 30.5 new early childhood mental health consultants (at ECE and pediatric settings), and the clinical mental health professionals needed to provide more intensive mental health services to children, parents, and caregivers will require training specific in infant/toddler mental health. We recommend early childhood specialists be supported in obtaining a Level II Endorsement and that early childhood mental health consultants (the new consultants as well as existing consultants without endorsement training) be supported in receiving their Level III Endorsement. To meet the mental health service needs of the expected 2,130 children and their caregivers, we estimate approximately 116 additional clinical mental health professionals will require training in infant-toddler mental health, or an endorsement at Level IV (clinical). We estimate that initial (year 1) training costs will be higher than ongoing training costs in order to build an initial trained infant/toddler mental health workforce. We estimate[7] initial training costs across specialists, consultants, and clinicians to total $397,000 (year 1) and ongoing costs to be **$230,000 annually** which includes cost for a full time endorsement coordinator.

Total Investments Required to Meet the Goal 3: Infant Mental Health. By 2023, $10 million in increased annual investments would be required to meet the goals that together would mean 7,247 additional low- income children and their families were receiving mental health services in the state.

Cost of New Investments in Infant Mental Health By Objective

Infant Mental Health Objectives	Anticipated Number Children Served	New Investment
Investment #1 – Expand the availability of infant mental health consultation services	4,462	$7.01 Million
Investment #2 – Increase the availability of intensive mental health services	2,785	$2.75 Million
Investment #3 - Increase the supply of well-trained infant mental health professionals across the state		$230,000
	7,247	$10 Million

(Note: 10% state-level administration costs were built into each of the above estimates)

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[6] Note that New Jersey's FMAP rate is 50%.

[7] Note that training cost estimates do not include the costs of the 30 or more hours of training in infant-toddler mental health required to attain endorsement or for the required BA, MA, or doctoral degrees.

By 2023, 3,000 low- income women will have equitable access to maternal and infant care supports and services to ensure a healthy birth. This represents a new state initiative that is currently in the pilot phase.

4.1 Coordinate and align activities with the Healthy Women Healthy Families Initiative to ensure equitable maternal and infant care among women and children of all races and ethnicities.
To reach a target of 3,000 pregnant women annually with perinatal supports and services
will cost an estimated **$4.1 million annually** based on each mother receiving 3 prenatal visits, labor and delivery and 2 postnatal visits as well as access to childbirth classes and breastfeeding support groups at an estimated cost of 1,250 per mother. The cost also includes state-level training and administrative costs to implement the program.

Please note: The costs to implement the remaining objectives would be absorbed in existing resources.

Total Investments Required to Meet Goal 4: Maternal and Infant Health. By 2023, $4.1 million in increased annual investments would be required to meet the objectives that together would mean 3,000 additional low-income mothers receive high-quality maternal and infant care supports.

Cost of New Investments in Maternal Infant Health By Objective

Maternal-Infant Health Objectives	Anticipated Number Mothers Served	New Investment
Investment #1 – Expand the availability of infant mental health consultation services	3,000	$3.75 Million
State level training, administration and implementation costs		$375,000
	3,000	$4.1 Million

Goal Area 5: Systems Integration

By 2023, a system is in place to enable more low-income families with infants and toddlers to be connected to critical services to ensure healthy growth and development.

5.1 Strengthen the county-based Central Intake Hubs in their role as the system connection between families and critical maternal and child health and early childhood services.
To achieve this goal, the plan calls for enhancing, strengthening and fully financing the existing county-based Central Intake structure in order to more effectively assist families in navigating and accessing essential early childhood services across home visiting, child care, mental health and related maternal and infant health. These hubs will also assume an important accountability role to assure that targets for service are reached and impact is achieved in addition to identifying needs, gaps and opportunities within the county.

To strengthen the Central Intake Hub system, an estimated **$3M annually** would added to the current system resources to add 2 additional Central Intake Specialists and 2 additional Community Health workers at 7 Hub locations (425,000 X 7 Hubs). An additional $300,000 annually will be required for state level administration and implementation costs.

Please note: The costs to implement the remaining objectives would be absorbed in existing resources.

Total Investments Required to Meet Goal 5: Systems Integration. By 2023, $3.3 million in increased annual investments would be required to meet the objectives to ensure a system is in place to enable more low-income families with infants and toddlers are connected to critical services to ensure healthy growth and development.

Cost of New Investments in Systems Integration By Objective

Maternal-Infant Health Objectives	Anticipated Number Served	New Investment
Investment #1 – Strengthen existing Central Intake Hubs	28,864	$3 Million
State level training, administration and implementation costs		$300,000
	28,864	$3.3 Million

Total Cost of New Investments Per Child By Goals

Unlocking Potential Goals	# of Additional Low- Income Children To Be Served	New Investment	Cost Per Child Served
Goal #1 – Quality Infant Toddler Child Care	8,750	$29.7 Million	$3,394
Goal #2- Home Visiting	9,867	$25.3 Million	$2,564
Goal #3 – Infant Mental Health	7,247	$10 Million	$1,380
Goal #4 – Maternal-Infant Health	3,000	$4.1 Million	$1,366
Goal #5 – Systems Integration	28,864	$3.3 Million	$114
TOTAL	28,864	$72.4 Million	$2,508

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