



# STATE OF BABIES YEARBOOK 2021





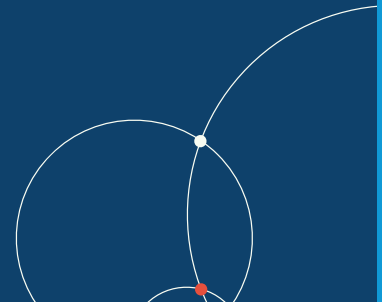


How do we ensure that every baby has the chance to grow and thrive? At ZERO TO THREE, we found this question more urgent than ever in this third edition of the *State of Babies Yearbook*. We present this report after a year in which all of us, but especially families with young children, have faced unprecedented challenges from the pandemic, its economic fallout and social isolation, and nationally visible incidents of racial injustice that resonated in our study of babies' lives in America. Last year, we explored the very different experiences of babies when viewed through an equity lens, finding early disparities among women and babies of color, babies growing up in families with low or modest income, and babies living in rural, non-metropolitan communities. This year, we show how those inequities that pre-existed COVID-19 illuminate the disparate economic and social impacts of the pandemic on families of color and those with low income [as we supplement our usual data sources with data from the Rapid Assessment of Pandemic Impact on Development in Early Childhood survey].

The *State of Babies Yearbook: 2021* and the expansive data at [www.stateofbabies.org](http://www.stateofbabies.org) make it easier for policymakers, advocates, and stakeholders to see the babies and families behind the numbers by digging deeper into the data and following the threads through their pandemic experiences. We believe the message stemming from families' challenges both before and during the pandemic will be clear to those who share our commitment to making the well-being of infants, toddlers, and their families a national priority. Now is the time for a bold, *national* agenda for our babies, a time when policymakers at all levels must seize the opportunity to lay durable foundations for the youngest among us to thrive.

We hope the *Yearbook* will both inform and inspire you in your work to help every baby have a strong start and the opportunity to reach their full potential.

Myra Jones-Taylor  
CHIEF POLICY OFFICER



The *State of Babies Yearbook: 2021* is part of ZERO TO THREE's *Think Babies*™. ZERO TO THREE created *Think Babies* to make the potential of every baby a national priority. When we *Think Babies* and invest in infants, toddlers, and their families, we ensure a strong future for us all. Learn more at [thinkbabies.org](http://thinkbabies.org).

ZERO TO THREE works to ensure all infants and toddlers benefit from the family and community connections critical to their well-being and development. Since 1977, the organization has advanced the proven power of nurturing relationships by transforming the science of early childhood into helpful resources, practical tools and responsive policies for millions of parents, professionals, and policymakers.

The data and indicator analysis in the *Yearbook* are powered by Child Trends, the nation's leading nonprofit research organization focused exclusively on improving the lives and prospects of children, youth, and their families. For 40 years, decision makers have relied on the organization's rigorous research, unbiased analyses, and clear communications to improve public policies and interventions that serve children and families.



**ZERO TO THREE**  
Early connections last a lifetime



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*Author Credit: Kim Keating, Patricia Cole, and Alexandra Schneider, with contributions from Mollyrose Schaffner.*

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**11.5  
million**

babies live in the  
United States.

# Executive Summary

**Telling the story of America’s babies is more important than ever. The *State of Babies Yearbook: 2021* shows that, even before the COVID-19 pandemic, the littlest among us did not have the supports they need to thrive.** It also shows that in America, racial and economic inequities start even before birth. An unacceptable number of infants and toddlers—2 in 5—lived in families whose income was inadequate to make ends meet. A concerning proportion, especially among babies of color, did not have preventive medical care, adequate household food security, or safe and stable housing. These shortcomings, visible in previous years, presaged the havoc wrought by the pandemic on families’ stability, and created conditions that could undermine babies’ development. The pandemic’s impacts were predictable and some avoidable. Yet, for decades, our nation has stood on the sidelines while families juggled meeting economic and child caring needs amidst threadbare systems of support and while families of color faced systemic barriers to economic security. Our nation’s lack of strong, permanent policies that recognize families’ dual roles of participating in the economy and nurturing their children weakened families’ ability to withstand the additional hardships imposed by the pandemic.

*Now is the time for national action to establish bold, durable policies that address deep-seated inequities and ensure all babies have the ingredients to thrive.*

The first 3 years of a child’s life shape every year that follows. During this period of rapid development, more than a million new brain connections form each second.<sup>1</sup> The strength of these connections will influence a child’s future success in school and life. Early adversities, often beginning prenatally, literally get under the skin, changing brains and bodies for a lifetime. Strong, supportive relationships with close caregivers can buffer young children from adversity’s effects. The pandemic’s widespread, intense effects clearly illustrate the chain reaction that hardship can have on families and their children’s development. As parents face the pressures of safeguarding their families from disease, economic uncertainty, and loss of child care, their levels of emotional distress rise, in turn leading to higher levels of emotional distress in their young children. The long-term ramifications of this extended period of distress on the healthy social-emotional and cognitive development of babies are of great concern. Supporting families is thus the key to strong early development and to recovering from the economic and social trauma of the pandemic. Unless we remedy the lack of key national and state policies that would broadly support family well-being, the adversity could have lasting effects on young children, their families, and our nation as we recover and rebuild.

Fundamental to the story of the *State of Babies* is its depiction of racial and economic injustice experienced by too many babies and their families. Unsurprisingly, *Yearbook* data reveal significant disparities across key indicators of well-being for babies of color (i.e., Black, Hispanic, American Indian/Alaska



Native, Hawaiian/Pacific Islander, and in some instances Asian) and babies in families with low-income (i.e., below 200 percent of the Federal Poverty Line [FPL]) that have only become more glaringly clear with the disproportionate impacts of COVID-19. Even among states with more positive averages, significant disparities exist in the opportunities to thrive available to babies and families of color, often driven by historical and structural inequalities rooted in racism. By nearly every measure, children living in families with low income and children of color faced the biggest obstacles even prior to COVID-19, such as crowded housing conditions, adverse early childhood experiences (ACEs), and limited access to quality child care. The current crisis has further exposed and exacerbated these disparities and structural barriers, which have harmful and life-altering effects that begin even before birth and can last a lifetime. Though the pandemic itself was unexpected, our long-term failure to support families with young children—particularly families with low income and families of color—and especially to reverse the effects from systemic racism virtually ensured that those who were already facing barriers would be disproportionately harmed by the pandemic and its economic fall-out.

The *State of Babies Yearbook* bridges the gap between science and policy with national and state-by-state data on the well-being of America’s babies. The 2021 edition of the *Yearbook* provides an in-depth look into the experience of our nation’s babies and their families and, importantly, substantial disparities and inequities in their experience when examined by race/ethnicity, income, and geographic setting. The 2021 *Yearbook* is augmented by national data collected through the University of Oregon’s Rapid Assessment of Pandemic Impact on Development in Early Childhood (RAPID-EC) Project during the pandemic to show how the crisis was affecting families with infants and toddlers.<sup>ii</sup> Policymakers and advocates can use the data to identify and advance policies that produce the near-term support and long-term stability babies and families need.

**As policymakers focus on recovery, science tells us what must rise to the top.** The greatest opportunity to influence a child’s success begins early—when our brains grow faster than any later point in life. All families want to give their children a strong start in life, but for too long our nation’s policies have not kept up with the reality of parenting today, the challenges that families with young children face, or the detrimental factors that rob many children of an equitable opportunity to reach their potential. As families look for solid ground in the devastating landscape created by the pandemic, the time to make every baby our national priority is now. The status quo before the pandemic fell far short, and there must be no going back. The Consolidated Appropriations Act, signed into law on December 27, 2020, and the American Rescue Plan, signed on March 11, 2021, have made a strong beginning, centering families’ needs and addressing the devastation they have experienced in the pandemic. But the story told in the *State of Babies Yearbook: 2021* about both the ingrained barriers families faced before the pandemic and the heightened challenges during the year-long crisis, points to the urgency of a national agenda of bold, durable policies that address deep-seated inequities and give every baby the ingredients to thrive. The *Yearbook* includes the elements of ZERO TO THREE’s national policy agenda, *Recovery Begins with Babies and Families: An Agenda for the Administration and the 117<sup>th</sup> Congress*.

*The story told in the State of Babies Yearbook: 2021 about both the ingrained barriers families faced before the pandemic and the heightened challenges during the year long crisis points to the urgency of a national agenda.*



ZERO TO THREE's policy framework, grounded in the science of early childhood development, promotes support for infants and toddlers' healthy development in three domains: Good Health, Strong Families, and Positive Early Learning Experiences. The *State of Babies Yearbook: 2021* uses this framework to outline what all babies need to thrive. Major findings in these domains include:



### **GOOD HEALTH:**

Despite some incremental progress in a few health indicators, the evidence of gross disparities—particularly for babies in families of color—in maternal health and birth outcomes, such as maternal and infant mortality, low birthweight, and prematurity, is strongest in this domain, beginning prenatally and requiring a robust response in national and state policies. Key concerns in the pandemic center on the drop in access to health care among children of color and in families with low income as well as the long-term impacts of high levels of emotional distress among both parents and children. Strong national policies should center on expanding health insurance coverage, embedding child development and family support in primary pediatric care, and building capacity in infant and early childhood mental health (IECMH).



### **STRONG FAMILIES:**

Although overall family resilience in the face of challenges was at positive levels (85 percent) pre-COVID-19, this and other indicators of family well-being show that families with low income struggle with challenges around basic needs, such as crowded housing and basic income supports, as well as ACEs. During the pandemic, many families with babies experienced a drop in income, especially families of color and those with low income. Household food insecurity grew and housing became more precarious, contributing to high levels of emotional distress. Strong national policies must build on the American Rescue Plan, creating permanent policies that promote economic security and ensure families can take paid time off. Supports to strengthen families must be expanded to provide a buoy in crisis and in calm.



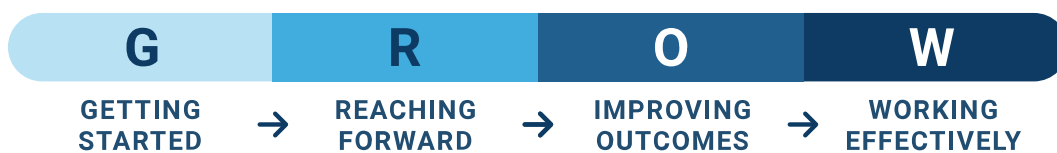
### **POSITIVE EARLY LEARNING EXPERIENCES:**

As a nation we continue to ignore the need to ensure our babies have quality early learning experiences that nourish their early development: From being read to every day, to securing a place in Early Head Start (EHS) or a subsidy for quality child care, to the basic quality floor states set for child care, babies need a greater investment in their foundational development. During the pandemic, the fragile structure for child care and supporting parents was rendered even more unstable. With stabilization funding for child care now in place through the American Rescue Plan, we must turn our sights to building a child care system that works for all, expanding EHS to provide comprehensive services to all eligible infants and toddlers and more pregnant women, and expanding early intervention services to reach more children and to prevent as well as address developmental delays and disabilities.

## Ensuring all babies have a strong foundation to GROW

All states have room to grow in how they support parents in nurturing the development of their young children. Although some states are more advanced than others, the addition of subgroup data makes clear that even states with the most positive environments for families with young children need to look inward and examine the equity of opportunity for every baby.


The *State of Babies Yearbook: 2021* continues to use a transparent ranking process to group states into one of four tiers to provide a quick snapshot of how states fare on selected indicators and domains. These tiers represent four groupings of states that are approximately equal in size and ordered from the highest to lowest performing. The following tiering symbols designate a given state's placement in one of the four tiers.



Because available indicators often do not tell us exactly what we need to know about how children and families are faring or how policies are reaching them, we are following a multiyear process of seeking new ways to describe these conditions. Accordingly, the 2021 *Yearbook* holds constant the indicators used to create the tiered rankings, allowing states to track progress more consistently until we have refined the indicators and can re-rank states based on a set of indicators that will remain stable over time.

We hope policymakers and advocates in the states will use this opportunity to really “see” their babies and focus on the children and families behind the numbers using the more extensive data in their profiles available on [stateofbabies.org](http://stateofbabies.org). In particular, communities can look at the data on subgroups together to forge a common understanding from which to start the conversations and actions that promote equity of access to the ingredients all babies need to thrive.

### STATE OF BABIES YEARBOOK 2021: OVERALL RANKINGS

<b>Working Effectively</b> 	Connecticut Delaware District of Columbia	Iowa Maryland Massachusetts	New Hampshire Oregon Pennsylvania	Rhode Island Vermont Washington
<b>Improving Outcomes</b> 	Alaska Colorado Idaho Kansas	Maine Minnesota Missouri	Montana Nebraska New Jersey	North Carolina Ohio Wisconsin
<b>Reaching Forward</b> 	California Florida Hawaii Illinois	Kentucky Michigan New York	North Dakota South Dakota Tennessee	Utah Virginia West Virginia
<b>Getting Started</b> 	Alabama Arizona Arkansas Georgia	Indiana Louisiana Mississippi	Nevada New Mexico Oklahoma	South Carolina Texas Wyoming



# The State of Babies Yearbook: 2021 in Context

In March 2020, the COVID-19 pandemic swept across the United States, shutting down critical social structures, such as child care and school systems, and key segments of the economy that heavily affected all families, but particularly those with young children. In the ensuing months, families have had to adapt to a new normal amidst widespread stay-at-home orders, increasing infection rates and death tolls, high unemployment rates, and an increased national focus on anti-Black racism and the racial justice movement. Although the pandemic's long-term effects on early childhood development cannot be fully assessed at this time, it is clear that families with young children have faced unprecedented challenges in the wake of the pandemic that create the conditions for detrimental impacts.



As could be predicted from current and past *State of Babies Yearbooks* data, the pandemic laid bare our nation's lack of systems and policies that equitably advance the stability of all families. Increasing levels of food insecurity, caregiver stress, and material hardship have placed many babies and toddlers at greater risk than ever before and may influence their chance of a strong start in life long after the pandemic is resolved. Equally predictable, these challenges are disproportionately affecting Black and Brown communities. Similarly, with as many as 2 in 5 (40.3 percent) of the nation's babies living in families with low income or in poverty prior to COVID, the pandemic placed in stark relief the need to ensure economic security for all families.

Initial federal relief measures, including the \$2 trillion Coronavirus Aid, Relief, and Economic Security (CARES) Act, enacted March 25, 2020, buffered the early economic impact of COVID-19 on families with young children. Provisions included \$600 per week in unemployment benefits, eviction protection, loan forgiveness, and other benefits that helped many families compensate for income and job loss. However, many families slipped into financial and material hardship, especially as several CARES benefits began to expire. The economic impacts of COVID-19 are of considerable concern to babies and toddlers, whose long-term health and well-being can be negatively affected by chronic stress and hardship. Nine months after the CARES Act, the Consolidated Appropriations Act, signed into law on December 27, 2020, and the American Rescue Plan, signed on March 11, 2021, brought much needed relief, centering families' needs and addressing the devastation they have experienced in the pandemic. But the ingrained barriers families faced before the pandemic and the heightened challenges during the year-long crisis make clear the urgency of a national agenda of bold, durable policies that address deep-seated inequities and give every baby the ingredients to thrive. ZERO TO THREE presents such an agenda in *Recovery Begins with Babies and Families: An Agenda for the Administration and the 117<sup>th</sup> Congress*<sup>iii</sup>, the components of which are included in the *Yearbook*, along with state opportunities for action.

## Economic Insecurity and Material Hardship: The Critical Role of Income in a Baby's Life

The findings of both the *State of Babies Yearbook: 2021* and RAPID-EC Project make evident the crisis of material hardship faced by far too many families with young children and the profound effects that economic insecurity has had on their well-being. Deep and long-standing economic inequity in America, including disparities in wealth due to structural racism, has and continues to be the central underlying factor beneath most of the struggles families face. Sadly, families with young children are more likely to have low income or to live in poverty, causing stress during their babies' critical years of foundational, rapid brain development. Research shows the timing of poverty matters tremendously for long-term development and child outcomes, with early childhood poverty being especially harmful to children's outcomes across cognitive, social, emotional and health domains.<sup>iv,v</sup> Studies, including the National Academies of Science, Engineering, and Medicine's *A Roadmap to Ending Child Poverty*, also show that increasing families' incomes during the early childhood years has lasting impacts on children's academic achievement and educational attainment.<sup>vi</sup>



Immediate efforts taken to assess and track the effects of the COVID-19 pandemic on families with young children include the pivotal work of the University of Oregon's Rapid Assessment of Pandemic Impact on Development in Early Childhood (RAPID-EC) Project<sup>vii</sup>, which was launched on April 6, 2020. Based in the University's Center for Translational Neuroscience, the RAPID-EC Project collects online survey responses from a nationally representative sample of 3,235 families with young children. Responses were collected on a weekly basis through the first 17 weeks of the pandemic, and the survey has since continued on a bi-weekly basis. Real-time data collected from families between April 6 and December 24, 2020, have been key in helping ZERO TO THREE understand the lived experiences of infants, toddlers, and their families throughout the ongoing pandemic. Within each domain of the 2021 *Yearbook*, we summarize findings from the RAPID-EC project that directly relate to Good Health, Strong Families, and Positive Early Learning Experiences.

An alarming 2 in 5 babies (40.3 percent) in America live in households with either low income (21.7 percent), meaning earnings between 100 and 199 percent of FPL or in poverty (18.6 percent), earning less than 100 percent of FPL. Equally troubling, a new demographic indicator included this year—“No Working Parents”—shows that 5 percent of infants and toddlers already were in families with parents who were disconnected

from the workforce, meaning their parent(s) had not worked any weeks in the past 12 months and the reasons for not working were not due to attending school. Among babies in families in poverty, as many as 1 in 5 (21 percent) lived with no working parents. These numbers preceded the spike in unemployment seen in the wake of the pandemic. Since the onset of the pandemic, babies have been particularly more likely to be in families impacted by the job losses due to shutdowns because the losses have been concentrated among lower wage jobs.

Even without a pandemic, babies in families with low household income struggle with challenges related to meeting basic needs, such as food insecurity and crowded housing; and they are more likely to experience ACEs. Over 35 percent of all families in the survey report difficulties paying for basic needs, and over 65 percent report financial problems during the pandemic. Nationally, 1 in 5 babies had already experienced at least one adverse event (e.g., exposure to violence, parental substance abuse) in their first 3 years; and the incidence of adversity is markedly higher, nearly 1 in 3 (30.6 percent) among babies in families with low income.

Data collected by the RAPID-EC project make clear that the implications of material hardship on families during COVID-19 have been manifold. Nearly 40 percent of all families in the survey reported that they were experiencing material hardship after CARES Act benefits expired. As would be expected, lower-income households have been hit the hardest. Food insecurity has been of particular concern during the pandemic, as the usual avenues of food assistance for children and families have been disrupted. And the economic downturn and job loss across income groups caused by the pandemic have increased the number of families who have found themselves eligible for food assistance. Many states have reported surges in Supplemental Nutrition Assistance Program (SNAP) applications during COVID<sup>viii</sup>, a further indication that food insecurity has only grown as an issue of great concern. Increased rates of material hardship compounded with worry about other factors give rise to higher

rates of parental stress, anxiety, and depression, which can impact child emotional well-being. Furthermore, parents struggling to make ends meet often are unable to dedicate time or resources to foster positive early learning experiences. The high cost of child care is burdensome for both married and single parent families in America. As a result of the pandemic, retaining access to and paying for child care becomes an even greater challenge. RAPID-EC findings also indicate that parents are forced to prioritize financial responsibilities and basic needs over engaging their young child in activities that boost early childhood learning and cognitive development.

Disruptions in child care have also had a domino effect on families with young children.<sup>ix</sup> During early stages of the pandemic, child care centers across the country shut down, requiring families to quickly find alternate child care solutions, especially if they were essential workers or had no paid leave. Child care accessibility and affordability have decreased, especially for families with low income who are already experiencing higher rates of financial and material hardship.



## Valuing the experience of all babies: Race, racism, and equity

Collectively, Black, Hispanic, American Indian/Alaska Native, and other people of color (including Asian, Hawaiian/Pacific Islander, and Multiple Race families) in America have been subjected to centuries of **institutionalized** and **interpersonal racism** that have limited equitable access to resources (e.g., quality health care, employment, and housing) that are fundamental to family stability and well-being. The consequences of these and other barriers manifest themselves in the additional challenges families in these historically marginalized communities face in their efforts to ensure their babies have every opportunity for healthy development during their critical early years and set them on the path to thrive in the years beyond.

Simply stated, race matters. For this reason, wherever possible, the *State of Babies Yearbook* disaggregates national and state averages on key indicators of child well-being to explore the data by race and ethnicity (in addition to income and urbanicity) to better identify disparities that warrant further examination and action. As the *State of Babies* data continue to indicate, and as reported in our 2020 brief, *Maternal and Child Health Inequities Emerge Even Before Birth*<sup>1</sup>, the negative consequences of racism begin early, with both immediate and potentially long-term effects on babies' development. Specifically, racism contributes to the deep disparities in health and well-being revealed in most of the *Yearbook's* indicators when examined by race and ethnicity. As reflected in the data, children of color face obstacles, such as living in families with low income or in poverty, low birthweight, unstable housing, and limited access to quality child care, at disproportionately higher rates than seen in the majority White population. And it is critical that the root causes of these harmful and potentially life-altering effects of these early inequities be identified in order for them to be successfully addressed.

The *State of Babies Yearbook: 2021* continues the focus on equity in the experiences and outcomes of babies and families that we explored in the 2020 edition. Our release of the 2021 *Yearbook* coincides with the broader national awakening to with the deeply rooted history of systemic racism that continues to negatively affect the lives of Black, Hispanic, and Native American families as well as other people of color. The *State of Babies Yearbook* aims to bridge the gap between science and policy with national and state-by-state data on the well-being of America's infants and toddlers. The data are clear: the state where a baby is born makes a big difference in their chance for a strong start in life. But location is only one factor in ensuring that our youngest children have a healthy start to life. Ensuring an equitable start for all babies requires understanding the influence of race, ethnicity, and racism in the lives of babies and families.

<sup>1</sup> ZERO TO THREE and Child Trends released the first version of the *Maternal and Child Health Inequities Emerge Even Before Birth*, which drew connections between the role of systemic racism and infant, toddler, and maternal outcomes, as a companion brief to the 2020 *Yearbook*. At the time of the current *Yearbook*, the brief is being updated using the latest data available and in several important ways continues to expand our efforts to equitably communicate data by race and ethnicity. The new version will be released in the spring of 2021.



## Our approach to reporting on equity

Working in collaboration with our data partners at Child Trends, we continue to improve on our efforts to communicate data by race and ethnicity in a manner that reflects a commitment to equity and the importance of all babies and families' experiences. Our focus in presenting data on disparities is not to present the experience of any group as the norm nor to imply lesser importance of the incidence of negative outcomes within the majority population of White babies and families. Rather our goal is to ensure that the experiences of all of OUR babies—particularly those in historically overburdened and under-resourced communities—are presented. Beginning with the 2021 *Yearbook*, when presenting race/ethnicity data our comparison of findings for each group is to the national average instead of to the majority population of White babies and families.

Most importantly, we continue to strive in presenting data on disparities to enable policymakers and advocates at the federal and state levels to do the following:

- identify where there is over-representation of babies of a particular race/ethnicity;

- explore the root causes of the inequities and disproportionality where they are revealed;
- examine any areas where disparities by race/ethnicity parallel disparities seen by income and/or urbanicity;
- determine the ways in which past and present policies and practices foster inequities; and
- develop policies that address, reduce, and ultimately eradicate disparities in disproportionately impacted groups as well as negative outcomes in all groups.

We encourage readers to identify such opportunities as they view the race/ethnicity data throughout the *Yearbook*.<sup>2</sup>

**Institutionalized racism** refers to policies, practices, and norms that limit access by race to societal opportunities, goods, and services. These policies, practices, or norms may be legalized, and may result in generational impacts.<sup>3</sup> An example of institutionalized racism is the practice of redlining in the 1950s where neighborhoods where the

*“The tragic fact remains true in this country: children’s outcomes are predicted by their demographic characteristics, the color of their skin, their family’s income bracket, and their home language. These inequities begin before birth and follow children into the early care and education (ECE) system, one of the first systems with which they interact.”*

*“The Children’s Equity Project”*

Meek, S., Iruka, I. U., Allen, R., Yazzie, D., Fernandez, V., Catherine, E., McIntosh, K., Gordon, L., Gilliam, W., Hemmeter, M. L., Blevins, D., & Powell, T. (2020). Fourteen priorities to dismantle systemic racism in early care and education. The Children’s Equity Project. Retrieved from: <https://childandfamilysuccess.asu.edu/cep>

<sup>2</sup> Additional guidance on equitable research and communication of data can be found in Child Trends’ publications, *How to Embed a Racial and Ethnic Equity Perspective in Research* and *Equitable Research Communication Guidelines*.

<sup>3</sup> <https://pdfs.semanticscholar.org/72d4/f329a003af893bdb548fa7fecdc0145fc01.pdf>

majority of residents were people of color were systematically denied access to home loans. The influence of redlining persists to this day, with formerly redlined districts continuing to experience economic inequality.<sup>b</sup>

**Interpersonal racism** refers to individual discriminatory actions toward others based on their race, as well as beliefs held by individuals about the abilities, experiences, or intentions of others according to their race.<sup>c</sup> For example, many White members of the medical field hold false beliefs about biological differences between Black and White patients, such as incorrectly believing Black patients do not experience as much pain as White patients and therefore do not need as much pain medication.<sup>d</sup>

**Anti-Black racism**<sup>e</sup> refers to the specific kind of racial prejudice directed toward Black people. Anti-Blackness devalues Blackness, while systematically marginalizing Black people, the issues that affect [them], and the institutions created to support [them]. The first form of anti-Blackness is overt racism, which is upheld by covert structural and systemic racism that categorically predetermines

the socioeconomic status of Blacks in this country. The second form of anti-Blackness is unethical disregard for Black people, as seen in the cases of police, or civilian, brutality against Black bodies.

**Disproportionality** refers to a group's representation in a particular category that exceeds expectations for that group, or differs substantially from the representation of others in that category.<sup>f</sup> An example of disproportionality is the higher incidence of Black and American Indian/Alaska Native babies' removal from home and entry into the child welfare system, as reported in the *State of Babies Yearbook: 2021*.

b <https://ncrc.org/holc/>

c <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446334/pdf/10936998.pdf>

d <https://www.pnas.org/content/113/16/4296>

e <https://www.bread.org/blog/reflection-anti-black-racism>

f <https://www.nasponline.org/resources-and-publications/resources-and-podcasts/diversity-and-social-justice/disproportionality#:~:text=Disproportionality%20refers%20to%20a%20group's,of%20others%20in%20that%20category>



A close-up photograph of a woman with dark hair, seen from the side, gently holding a baby. The woman's eyes are closed, and she has a peaceful expression. The baby, with dark curly hair, is wearing a white short-sleeved shirt and is looking down. The woman's hand is resting on the baby's head. The background is a soft, light blue color. On the left side of the page, there are decorative blue circles of varying sizes, some containing small colored dots (red, orange, purple) connected by thin lines.

# About the 2021 Yearbook

*Grounded in the science of early childhood development, ZERO TO THREE's policy framework identifies and promotes comprehensive policies in three domains that are essential for healthy development: Good Health, Strong Families, and Positive Early Learning Experiences.*

*State of Babies Yearbook* indicators in each domain examine child and family well-being, status and reach of programs and services, and the presence or absence of key policies that promote healthy development.



As in the first two editions of the *State of Babies Yearbook*, the 2021 *Yearbook* presents findings on the well-being of America’s babies and their families as last reported in key national datasets (e.g., U.S. Census Bureau population statistics and American Community Survey, and the National Survey of Children’s Health from the Health Resources and Services Administration’s Maternal and Child Health Bureau). Because these datasets are reported retrospectively—a majority based on data from 2019—they do not yet reflect the very consequential disruptions families experienced with the onset of the COVID-19 pandemic in 2020. Yet circumstances are such that the 2021 *Yearbook* is being released in the wake of the ongoing global COVID-19 pandemic, a once-in-a-century virus that since March 2020 has had both immediate and yet-to-be-determined negative impacts on our nation’s families—including those with young children. Although the long-term effects of the COVID-19 challenge are not yet fully known, the *Yearbook* would not be complete without acknowledging and addressing the pandemic’s widespread disruption of health, economic, and educational systems and the threats to healthy development and well-being it has already imposed on America’s babies. To fill in that picture, we have brought in real-time data from the RAPID-EC project, drawing connections between the conditions babies and families faced before the pandemic and its impact on their well-being during the crisis.

Given the serious nature of the ongoing pandemic and need for data on which policymakers, advocates, and all stakeholders in the lives of babies and families can take action, throughout the *Yearbook* we continue to shed light on indicators related to access to health care and deep disparities in maternal and child health; but we look even more deeply at indicators of economic security and material hardship that already threatened the strength and stability of families. This edition also focuses on child care and other key opportunities for early learning and early identification of delays—additional areas where the pandemic has had tremendous impact and increased the potential for long-term negative effects.

For all of the above reasons, the 2021 *Yearbook* includes:

- **A SHARPER FOCUS ON EQUITY.** As the nation grapples with deep-rooted racial and economic inequities, COVID-19 has, predictably, exacerbated disparities. It has never been more important or urgent to understand the vastly different challenges—even beyond national and state averages—faced by families in accessing education, employment, and health resources that promote family stability and well-being. We have deepened our emphasis on equity throughout the *Yearbook*, and present results disaggregated by race/ethnicity, family income, and urbanicity (i.e., urban or rural residency), whenever data allow. Beginning with indicator updates for the 2021 *Yearbook*, we are updating data for all racial and ethnic subgroups that each data source allows. We are now including estimates for American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Asian, and multiracial groups wherever possible instead of aggregating them into an “Other” category. Detailed views of subgroup data nationally and by state can be found on the [stateofbabies.org](https://stateofbabies.org) website.
- **PAIRING OF DATA AND RESPONSIVE POLICY RECOMMENDATIONS.** The challenge and opportunity before our national policymakers is to adopt robust, comprehensive child and family policies so our nation’s families will never again be set adrift, in crisis or in calm. Our nation will reap the rewards of such policies now and in the future. When families have what they need to thrive, our economy works. When policies embody equity—ensuring access to populations previously marginalized based on color, national origin, or family income—all children have opportunities to flourish and our society is strengthened. Throughout the *Yearbook* we assert the national policies and state opportunities required to meet this objective. These recommendations are based on ZERO TO THREE’s federal policy agenda, *Recovery Begins with Babies: An Agenda for the Administration and the 117<sup>th</sup> Congress*<sup>x</sup> as well as *Building for the Future: Strong Policies for Babies and Families*



After COVID-19,<sup>xi</sup> a comprehensive exploration of the impacts of the pandemic and the need for both immediate relief and durable policies.





- **RENEWED CALL FOR BETTER DATA COLLECTION.** To develop policies and direct resources where they are most needed, we continue to call for more comprehensive and consistent collection and reporting of disaggregated data by key subgroups at the federal, state, and local levels. It is particularly important that these efforts focus on identifying and addressing challenges in reporting on children and families in all racial and ethnic groups, especially those for which there has been under-reporting due to smaller population sizes. In the absence of full representation of all babies and families in the data our ability to fully address inequities will continue to be limited. It is equally important that increased funding be made available to enhance and ensure the annual availability of national datasets as well as to initiate and/or sustain research on current and future effects of the COVID-19 pandemic on babies and families. The importance of timely data has been made even clearer by the pandemic, and responsive research efforts, such as the RAPID-EC Project and Census Pulse Survey,<sup>xii</sup> offer pioneering models for providing the public real-time data.

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## What's new in 2021

- **NATIONAL PROFILE.** The 2021 *Yearbook* now includes a summary profile of all indicators for the nation as a whole, in addition to state-level profiles. Like the state profile, the national profile offers an easily accessible view of the demographics of America's babies and families and of how they are faring on key indicators of well-being for Good Health, Strong Families, and Positive Early Learning Experiences—collectively and by the subgroups of race/ethnicity, income, and urbanicity.
- **NEW INDICATORS.** The *Yearbook* includes six new indicators that allow more in-depth analyses and understanding of babies' and families' experiences and well-being. The new indicators provide additional information on the demographics of the families in which babies live, implementation of policies that protect and support mothers during pregnancy and postpartum, connection to a source of health care, and entry of babies into the child welfare system and their permanency outcomes. Table 1 outlines all new indicators. Findings on new and past indicators are instrumental in examining both equity and COVID-19 ramifications.

**TABLE 1. NEW INDICATORS IN THE 2021 YEARBOOK**

	<p><b>Demographics</b></p>	<ol style="list-style-type: none"> <li>1. No working parents</li> </ol>
	<p><b>Good Health</b></p>	<ol style="list-style-type: none"> <li>1. Postpartum extension of Medicaid coverage</li> <li>2. Pregnant worker protections</li> <li>3. Medical home</li> </ol>
	<p><b>Strong Families</b></p>	<ol style="list-style-type: none"> <li>1. Removed from home</li> <li>2. Permanency type achieved (reunification, adoption, relative, guardian)</li> </ol>
	<p><b>Positive Early Learning Experiences</b></p>	<ol style="list-style-type: none"> <li>1. No new indicators added in 2021</li> </ol>

- FURTHER ENHANCED WEBSITE.** The content and functionality of [stateofbabies.org](http://stateofbabies.org) have been expanded further to provide a richer picture of their own and other states' data. Specifically, we have added a more detailed view of the data by key subgroups (i.e., race/ethnicity, income, and metro/rural), wherever data are available. Additional enhancements include the ability to view state findings on individual indicators collectively. The website also includes topic-specific views of the data in three new sub-reports: *Babies in Families with Low Income*, *Material Hardship*, and *The Intersection Between Race/Ethnicity and Health*. The lived experience and voice of babies and families have also been added for the 2021 website in a new Stories feature.
- EXPANDED RESOURCES.** The *State of Babies Advocacy and Outreach Tools* have been updated to reflect new data from the 2021 *Yearbook*, including disaggregated data that allows users to look beyond averages that can mask significant disparities. The toolkit includes two sections: Advocacy Tools and Planning Tools. The suite of Advocacy Tools is designed to support users in communicating *Yearbook* results and leveraging those results to advocate for the policies and investments babies need to thrive. The Planning Tools provide a pathway for states to dig into the data to assess needs and opportunities for infants, toddlers, and families in their state and create a plan to move forward. Additional resources outlined in the report, such as *Building Strong Foundations: Advancing Comprehensive Policies for Infants, Toddlers, and Families*, describe strategies that policymakers can consider as they determine how to begin developing infant/toddler policies and include examples of states currently implementing each of the strategies.

## Ensuring all babies have a strong foundation to GROW

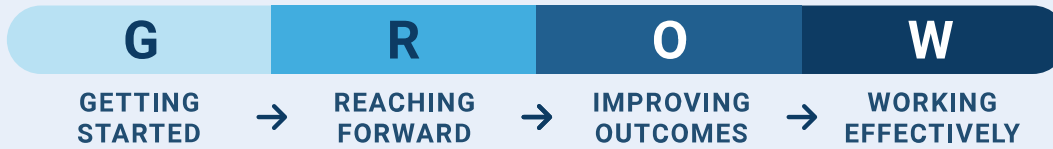
Comparing indicators across states and the District of Columbia makes clear that the state in which a baby lives can make a difference in whether they have a strong start and that all states have room to grow in how they support parents in nurturing the development of their young children. Some states are more advanced than others, but the addition of subgroup data makes clear that even states with the most positive environments for families with young children need to look inward and examine the equity of opportunity for every baby.

As in previous *Yearbook* editions, the *State of Babies Yearbook: 2021* provides a profile of each state and the District of Columbia's performance on key indicators in each of the three policy framework domains: Good Health, Strong

Families, and Positive Early Learning Experiences. A transparent ranking process is used to group states into one of four tiers to provide a quick snapshot of how states compare at both domain and indicator levels. The tiers represent four groupings of states that are approximately equal in size and ordered from highest to lowest performing. Because reaching a final set of indicators will take several years, the indicators on which tier placement is based continue to be held constant to the initial set of indicators ranked in the 2019 *Yearbook*. A detailed description of the ranking process is provided on page 148 and in Appendix C: Methodology.

The following tiering symbols are used in the state profiles and throughout the *Yearbook* to designate a given state's placement on the GROW scale.

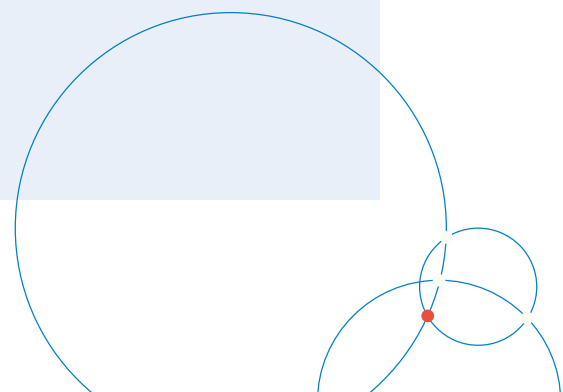




Individual state profiles and rankings are intended to be a catalyst for action—to move babies to the top of policy agendas and mobilize political and public will to make investments where they generate the greatest return over the lifetimes of today’s 11.5 million infants and toddlers, and those who will follow. We hope policymakers and advocates in the states will use this opportunity to really “see” their babies and focus on the children and families behind the numbers using the more extensive data in their profiles available on [stateofbabies.org](http://stateofbabies.org). In particular, communities can look at the data on subgroups together to forge a common understanding from which to start the conversations and actions that promote equity of access to the ingredients all babies need to thrive.

## STATE OF BABIES YEARBOOK 2021: OVERALL RANKINGS

<b>Working Effectively</b> <b>G R O W</b>	Connecticut Delaware District of Columbia	Iowa Maryland Massachusetts	New Hampshire Oregon Pennsylvania	Rhode Island Vermont Washington
<b>Improving Outcomes</b> <b>G R O W</b>	Alaska Colorado Idaho Kansas	Maine Minnesota Missouri	Montana Nebraska New Jersey	North Carolina Ohio Wisconsin
<b>Reaching Forward</b> <b>G R O W</b>	California Florida Hawaii Illinois	Kentucky Michigan New York	North Dakota South Dakota Tennessee	Utah Virginia West Virginia
<b>Getting Started</b> <b>G R O W</b>	Alabama Arizona Arkansas Georgia	Indiana Louisiana Mississippi	Nevada New Mexico Oklahoma	South Carolina Texas Wyoming

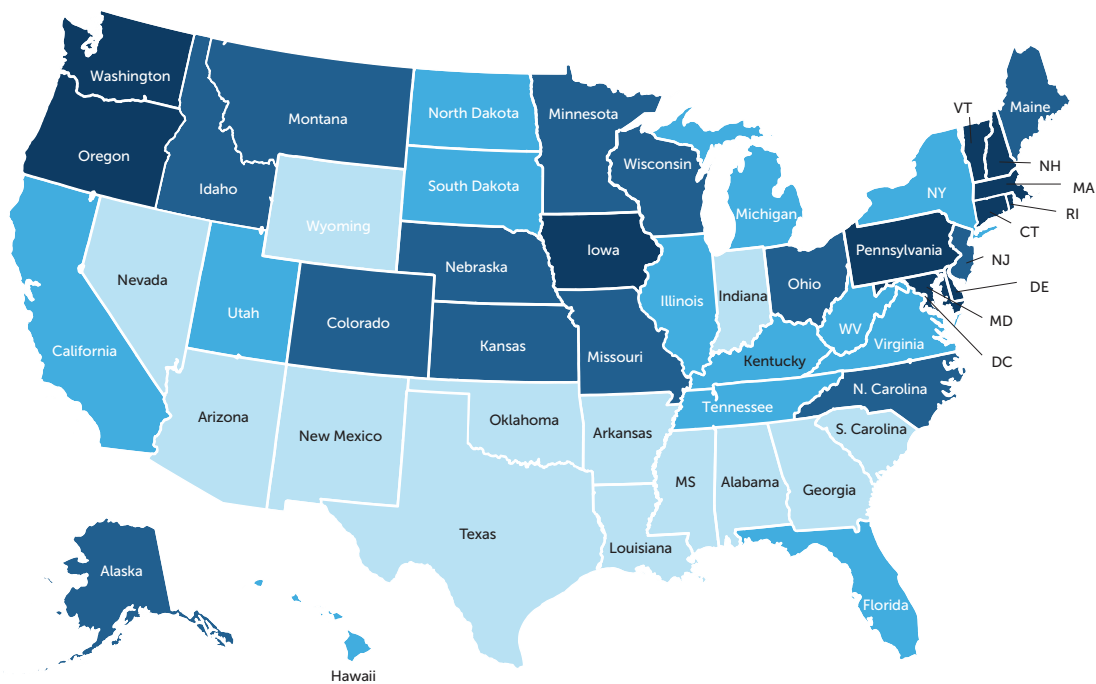





## HOW STATES COMPARE

Figure 1 presents a snapshot of how all 50 states and the District of Columbia compare to each other using the GROW tiers. Although ranking lends itself to quick distinctions across states, it is very important in interpreting a state's ranking to bear in mind that a state's indicators are not compared to a specific benchmark, but are placed in the context of all states' performance on that indicator as well as the national average. Therefore, all states, including those in higher tiers, have indicators on which they can improve. A lower overall rank should not obscure the fact that a state may have promising indicators within one or more domains which can reflect initiatives the state has undertaken to improve babies' outcomes. Even within states in higher tiers, subgroup data for children and families are likely to show different experiences on indicators of well-being, so all states must make a concerted effort to "see" all their babies and how different groups are faring. A detailed summary of each state's results by domain and indicator is provided in individual state profiles in the *Yearbook* and can be viewed at [stateofbabies.org](http://stateofbabies.org). Regional patterns in 2021 were similar to those seen in previous years. States in the Northeast and Northwest were more likely to score in the top two tiers of states across all three domains, as compared to states in the Southwest, Midwest, and South.

### STATE OF BABIES YEARBOOK: 2021: OVERALL RANKINGS Figure 1.





# The State of America's Babies

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## Demographics

*The portrait of the nation's babies and families requires policies and services that acknowledge and respond to their varying experiences and needs.*

The United States is home to 11.5 million babies who comprise 3.5 percent of the nation's population. This is a moderate decrease of approximately 218,000 babies from previous *Yearbook* editions. America's babies and parents are more diverse than at any other point in our nation's history.<sup>xiii</sup> They differ by race and ethnicity, income level, and geographic location, and are raised in a variety of family structures that reflect the characteristics of the society overall. *State of Babies Yearbook* findings continue to reflect this diversity.

Similar to previous years, 1 in 5 babies (20.5 percent) lives with a single parent, nearly 1 in 10 (8.4 percent) lives in grandparent-headed households, and nearly two thirds (62.9 percent) have mothers in the workforce. And a new demographic tracked in this edition of the *Yearbook* tells us that prior to the COVID-19 pandemic, as many as 5.3 percent of babies lived in families with no working parent. These demographic findings have substantial implications for designing and implementing policies and services that best meet the needs of our youngest children.

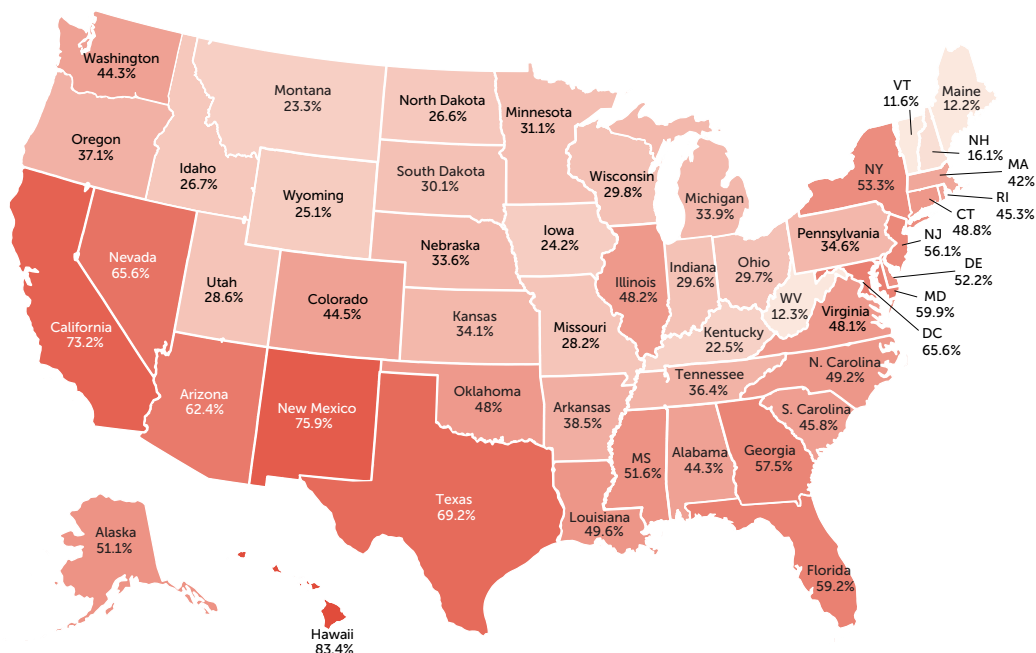
## The Importance of Equity

Opportunities to grow and flourish are not shared equally by the nation’s infants, toddlers, and families, reflecting past and present systemic barriers to critical resources, such as limited access to quality health care services, stable housing, reliable income and employment, and quality child care.<sup>xiv</sup> Although national- and state-level findings presented in the *Yearbook* provide an overall view of how babies and families are faring, a deeper understanding of the state of America’s babies can be gained only by examining the very different

experiences of key subgroups. This examination begins by taking a closer look by race/ethnicity, income, and urban/rural setting.

- RACE/ETHNICITY.** According to the 2020 U.S. Census Bureau Population Estimates, in 2019, half (50.3 percent) of America’s babies were children of color, continuing a trend that began in 2011. Specifically, 49.7 percent of babies were White, 26.0 percent Hispanic<sup>3</sup>, 13.7 percent Black, 4.8 percent Asian, 0.8 percent American Indian/Alaska Native, 0.2 percent Native Hawaiian/Pacific Islander, and 4.8 percent Multiple Races. As the result of the longstanding history of systemic racism and marginalization, Black, Hispanic, and American Indian/Alaska Native infants and toddlers are disproportionately at risk for poorer outcomes in all three domains of well-being reported in the *Yearbook*. The negative immediate and long-term consequences of early inequities are well documented in research. For this reason, for all indicators where data are available, we examine differences in outcomes by race and ethnicity. Figure 2 illustrates the wide variation in proportions of babies of color by state.

## 50% OF BABIES ARE CHILDREN OF COLOR Figure 2.



<sup>3</sup> Throughout the *State of Babies Yearbook*, we use the term “Hispanic” or “Latinx” in presenting data, in keeping with the ethnicity classification used in the data source.

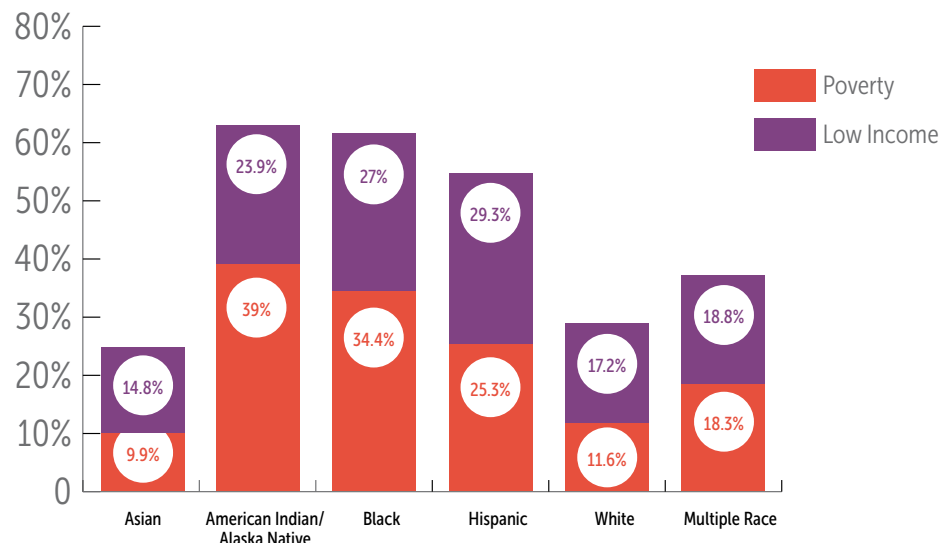
- INCOME.** Research shows that poverty at an early age can be especially harmful, affecting later achievement and employment.<sup>xv</sup> Yet babies are the age group most likely to live in families with low income and in poverty. As presented in Figure 3, prior to the COVID-19 pandemic, as many as 40 percent of infants and toddlers lived in families that earned less than 200 percent of the FPL (\$51,500 a year for a family of four in 2019) and did not have the financial resources to make ends meet. And nearly 1 in 5 (18.6 percent) of the nation’s 11.5 million babies were living in poverty (see Figure 4). Infants and toddlers represent only 3.5 percent of the nation’s population but 6 percent of those in poverty. Nearly 1 in 5 (18.6 percent) are in families that live below the poverty level that face even greater challenges meeting their basic needs. These 2021 *Yearbook* findings reflect what had been a slight downward trend from previous years, but still represent a very concerning proportion of young children in families that have difficulty making ends meet. The circumstances for babies are even more troublesome when these national averages are examined by race and ethnicity, where the persistent effects of long-standing systemic

racism are evident. Black, Hispanic, and Native American babies disproportionately live in families with low income—more than half of families in each of these groups.

Another powerful measure of the status of babies in the United States can be found in our poor standing among other developed nations. Between 2018 and 2019, the United States ranked 33rd for relative child poverty among 37 economically advanced countries, a drop from 32nd in the previous year.<sup>xvi</sup>

- POVERTY.** The percentages of babies in poverty (those living in families with household income less than 100 percent of the FPL) were highest among American Indian/Alaska Native (39 percent) and Black infants and toddlers (34.4 percent), both at or nearly double the national average of 18.6 percent. The poverty rate among Hispanic babies (25.3 percent) was also higher than the national average. In comparison, the percentages of babies in poverty were slightly below the national average for Multiple Race infants and toddlers (18.3 percent), and poverty among White (11.6 percent) and Asian (9.9 percent) babies was below the national average.

**BABIES IN FAMILIES WITH INCOME BELOW 200% FPL** Figure 3.

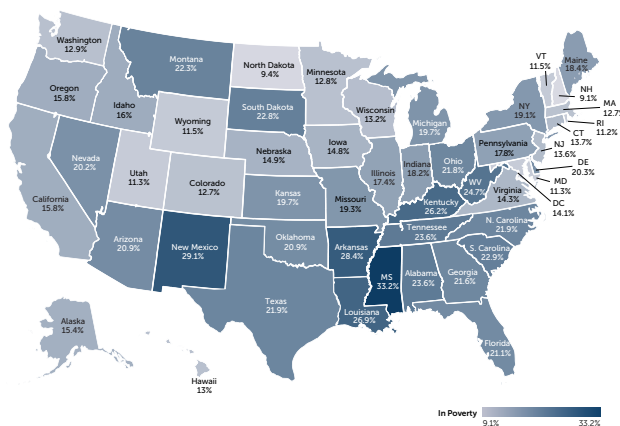


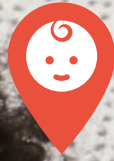
- **LOW INCOME.** The percentages of Hispanic (29.3 percent), Black (27 percent), and American Indian/Alaska Native (23.9 percent) babies in families with low income (meaning families with household income between 100 percent and 200 percent of the FPL) were above the national average of 21.7 percent, while the percentages for White (17.2 percent), Asian (14.8 percent), and Multiple Race (18.8 percent) babies were below the national average.
- **NO WORKING PARENTS.**
  - **Race**—The percentages of babies living in families with no working parent were higher than the national average of 5.3 percent for American Indian/Alaska Native (12 percent), Black (10 percent), Multiple Race (7 percent), Hispanic (6.2 percent), and Native Hawaiian/Pacific Islander (5.7 percent) babies, while the percentages for White (3.4 percent) and Asian (2.9 percent) were below the national average.
  - **Income**—The national average for families above low income with no working parents was 1 percent whereas 12 percent of families with low income had no

working parents.

- **Urbanicity**—On average, the percentage of babies living with no working parents was lower for families living in urban areas (5 percent) than for families living in rural areas (7 percent). The percentages of babies living with no working parents varied by state, ranging from less than 1 percent in Colorado, Delaware, Minnesota, New Hampshire, and Wisconsin to 20.1 percent in Alaska.
- **RURAL/URBAN.** In 2019, nearly 1 in 11 of America’s babies (8.5 percent) lived in a rural4 or “nonmetropolitan” area of the United States (see Figure 5). The experiences of children in rural families, including young children, are substantially different from children in urban or “metropolitan” areas, due in great part to more limited access to health care, education, and employment resources. As a result, rural babies have markedly higher risk of poverty, food insecurity, infant mortality, and birth to teen or single mothers as well as a higher incidence of disabilities.<sup>xvii</sup>

**1 IN 5 BABIES LIVES IN POVERTY**  
Figure 4.





# National Findings by Domain

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# Good Health

**Supporting babies' and mothers' physical and mental health provides the foundation for infants' lifelong physical, cognitive, emotional, and social well-being.** Babies' brains grow rapidly in the first years of life, and, in these early years, the brain works with other organs and organ systems to set the stage for subsequent development and health outcomes. The *Yearbook* examined indicators related to coverage and access to health care, maternal and infant health outcomes, food insecurity and nutrition support, and mental health. As with last year's report, concerning disparities in maternal and infant health outcomes, particularly for Black mothers and babies, point to the need for policies that help overcome generations of structural racism and promote access to responsive health care. Babies in families with low income and, where data are available, babies of color experience disparities in access to preventive well-baby care. Such disparities are important at any time, especially given the opportunity for pediatric care to be a gateway to developmental support for families, and call for urgent attention.



his past year, these disparities” proved to be a bellwether: in the pandemic, they clearly point to the more intense impacts on health care access, food security, and mental health experienced by families of color who have young children. The lack of permanent, comprehensive policies to (1) extend insurance coverage to more people; (2) ensure children have access to a medical home where developmental and family needs receive attention; and (3) support maternal, infant, and early childhood mental health added to this intensity and must be the path forward.

## AT A GLANCE: GOOD HEALTH BEFORE AND DURING COVID-19\*

Indicator	State of Babies Yearbook Pre-Covid	RAPID-EC During Covid
<b>Health Care</b>		
<b>Well-Child Visits</b>	<p>9% of infants and toddlers did not have a well-child visit in the previous year</p> <p>Babies in families with low income (12.2%) were more likely to miss a well-child visit in the previous year than babies in families with above low income (6.6%)</p>	<p>37.8% of families had missed a well-baby or child visit since the beginning of the pandemic</p> <p>Babies in families with low income (46.3%) were more likely to miss a well-child visit than babies in families with above low income (32.2%)</p> <p>Children with disabilities were more likely to miss a well-child visit (59.7%) compared to children without disabilities (46.5%)</p>
<b>Vaccinations</b>	<p>27.2% of babies had not completed recommended vaccinations in the previous year</p> <p>Babies in families with low income (33.4%) were more likely to have missed recommended vaccines compared to babies in families with above low income (21.1%)</p>	<p>18.1% of families reported that their children had missed a recommended vaccine since the start of the pandemic</p> <p>Babies in families with low income were more likely to miss a recommended vaccine (23.2%) compared to higher-income families (14.3%)</p> <p>Children with disabilities were more likely to miss a recommended vaccine (28.4%) compared to children without disabilities (17%)</p>
<b>Mental Health</b>		
<b>Moms</b>	<p>20% of mothers report less than optimal mental health</p> <p>White mothers reported this at a higher rate, 21.7%; Black mothers (19.7%), Hispanic mothers (17.4%), and Asian mothers (16.9%) reported this at rates lower than the average</p> <p>24.6% of mothers with low income reported less than optimal mental health compared with 17.6% of those above low income</p>	<p>Caregiver emotional distress increased early on, and though it gradually declined after that, it is still well above pre-pandemic levels</p> <p>Caregiver distress has remained especially high for families with low income, Black and Latinx families, single parent households, and households of children with disabilities</p> <p>Families report less emotional support and greater isolation</p>
<b>Young children</b>	No data available	<p>Child emotional distress, behavior issues increased early on, began to gradually decline, but remain well above pre-pandemic levels. Black and Latinx families, families with low income, and families with a child with a disability reported especially high rates of child fussiness and fearful/anxious behaviors</p>



Nutrition		
Food Insecurity	13.7% of families with babies had high food insecurity, an improvement from the previous year at 16%	26.8% of families reported high food insecurity during the pandemic, compared with 15% pre-COVIDc
	WIC receipt fell to 79.3% of eligible families from 85.9%, although Black and Hispanic families had higher than average participation rates	45.4% of families with low income reported high food insecurity, compared to 29.2% pre-COVID
		35.1% of Black families and 34.4% of Latinx families reported high food insecurity, compared to 21.4% and 19.2% pre-COVID

NOTES: RAPID-EC = Rapid Assessment of Pandemic Impact on Development in Early Childhood; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children

\* Data from the *State of Babies Yearbook: 2021* and the RAPID-EC Project are not directly comparable due to variation data sources and sample sizes; and are presented to give a general indication of conditions before and during COVID-19.

a Indicator of missed well-child visits is based on 1,223 caregiver responses from December 2020. Survey respondents were asked to report whether they had missed a well-child visit since the beginning of the pandemic.

b Indicator of missed recommended vaccine is based on 3,235 caregiver responses from December 2020. Survey respondents were asked to report whether they had missed a recommended vaccine since the beginning of the pandemic.

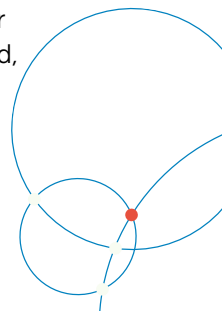
c Indicator of food insecurity was based on responses from 2,538 caregivers between the dates of August 11 and December 3, 2020 (weeks 19, 21, 23, 25, 27, 31, 33, and 35 of the survey).

Strengthening equitable access to integrated, affordable maternal, pediatric, and family health care is essential to meeting babies' and families' health and developmental needs. For parents, Medicaid expansion is key to expanding health coverage. Two more states adopted expansion since the 2020 *Yearbook*, bringing the total to 39. But in the pandemic year, with a greater risk of infection in people of color and with low income, coupled with widespread layoffs that increased the uninsured, closing the coverage gap has become more urgent. The ARP recognized this need by providing additional incentives for remaining states to adopt expansion.

Researchers have found that infants and toddlers with access to health coverage are more likely than their uninsured peers to see a doctor regularly and to receive preventive health care and treatments. Routine checkups and other preventive care, such as recommended vaccinations and screening for early detection of harmful risk factors, help prevent more costly health issues as children get older. Babies of color and in families with low income were less likely to have well-child visits and receive recommended vaccinations. They were also less likely to have a medical home where they received care. During the pandemic, preventive care use plummeted among these children, not only increasing the risk of

diseases such as measles, but also decreasing the opportunity for identifying developmental needs and emerging mental health problems of both babies and parents from the stress, isolation, and trauma of the pandemic.

Infants and toddlers also need positive relationships to support their healthy social-emotional development, in other words, to promote positive IECMH. Early caring and nurturing relationships thus are critical for positive cognitive development, which is intertwined with positive social-emotional development. The *Yearbook* includes a report of maternal mental health, where 1 in 5 mothers say they have less than optimal mental health. For mothers with low income, this rate is 1 in 4. White mothers have the highest rate of less than optimal mental health, while Black, Hispanic, and Asian mothers report rates below the average. No measures of mental health status are available for infants and toddlers. Yet, the impacts of emotional distress and its implications for long-term development are critical for understanding the potential fallout from the pandemic. As families have experienced economic upheaval, social isolation, increased caregiving needs, and material hardships, emotional distress for both adults and young children has risen. For some families, the early spike in distress subsided, but for families of color, the emotional toll has



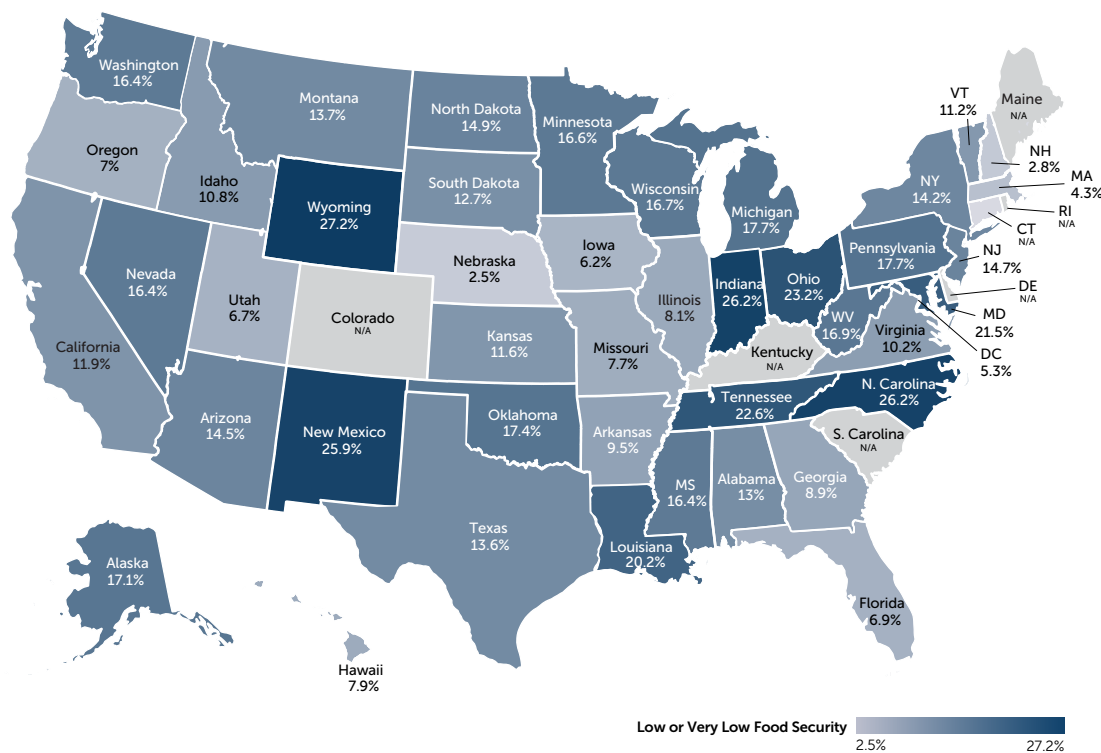
continued. Science tells us that some stress is tolerable for rapidly developing brains and bodies, but chronic, unrelenting stress can be toxic to the developing brain. The conditions of families with young children, which will be developed more in the Strong Families section, must raise alarms around the need for supportive policies, expanded services, and vigilance to detect both short and long-term effects. In particular, babies and their families may require access to IECMH services, such as maternal depression screening and interventions to support the parent-child relationship, detect mental health problems, or prevent them from taking root.

Equitable access to good nutrition during the prenatal period and first years of life is key to ensuring that babies receive the nourishment and care they need for a strong start in life. One of the bright spots in the pre-pandemic data was the

drop in households with babies experiencing low or very low food security, to 13.7 percent<sup>5</sup> at the time of the 2021 *Yearbook* from 16 percent in the previous edition. This positive trend was upended by the economic impact of the pandemic, where more than half of families with low income were food insecure and more than one quarter of all families reported high levels of food insecurity. In this context, the drop in eligible infants receiving Supplemental Nutrition for Women, Infants, and Children (WIC) reported in this year's *Yearbook* is even more concerning.

National data in the Good Health domain include indicators of maternal and child health, including health care coverage, prenatal care, birth outcomes, and receipt of recommended preventive care as well as food security, nutrition, and mental health. National averages and state counts in these areas indicate that infants and toddlers are

## FOOD INSECURITY



5 Food insecurity data for the 2021 *Yearbook* is sourced from the Current Population Survey, Food Supplement 2018. See Indicator Dictionary in Appendix B for details.

doing well or have made gains in areas such as high percentages completing routine medical visits, and vaccinations, and low percentages of low-income infants and toddlers who are uninsured. Policy indicators in this domain present the extent to which states have adopted policies through Medicaid that support maternal mental health and babies' social-emotional well-being, such as covering maternal depression screening in well-child visits, completing social-emotional screening of babies, and covering delivery of IECMH services in various settings. Gains in these areas are found in the number of states that have adopted Medicaid expansion and that allow, recommend, or require maternal depression screening. New indicators in 2021 provide information on the percentage of babies who have a medical home and the extent to which states' policies provide protections for pregnant workers.




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## Key findings

The 2021 *Yearbook* pre-COVID findings on indicators of Good Health reflect several areas in which babies and their families were showing improvements prior-to the pandemic and movement in policies that contribute to better outcomes, such as expanded access to health care coverage and preventive medical care services, an upward trend in vaccinations, and wider coverage of maternal and child mental health screenings. The importance of these services has only increased in the wake of the pandemic.

Good Health is the domain in which the most data are available by subgroup. Findings on several of the *Yearbook's* Good Health indicators offer a compelling look at differences in access to health care as well as health outcomes when the data are analyzed by race, income, and urbanicity. Findings in this area also reveal areas in which the intersection of factors (e.g., representation of a race/ethnicity in a rural area) or patterns across subgroups should be further explored. Significant challenges remain in maternal and child health, with notable disparities in the health of families of color and those with low household income.



*“The pandemic has made pregnancy anything but ordinary. We are worried about our family members, children, and selves getting sick. As I inch closer to my due date, still not vaccinated, I worry how different my postpartum experience will be knowing I won’t be surrounded by friends and family like I was last time. I hope that I’ll be okay, but I just don’t know.”*

*Allison, Strolling Thunder mom, VA*

Positive findings in this area include the following:

**MEDICAID EXPANSION.** Medicaid expansion improves parents’ access to care, and it has been associated with lower rates of infant mortality in states that adopted this policy. During the 2021 *Yearbook* period, growth was seen in the number of states that have implemented Medicaid expansion, with the addition of two states bringing the total to 39 at the time of the *Yearbook*.

**PREVENTIVE MEDICAL CARE (WELL-CHILD VISITS).** A high percentage of babies (91 percent) had received regularly scheduled preventive medical care in the past 12 months, as in the 2 previous years. A majority of babies in all states received preventive well child visits; however, rates ranged across states from 85.4 percent in New Mexico to 96.8 percent in Oregon. Subgroup analysis of babies who had received preventive medical care can be done by household income.

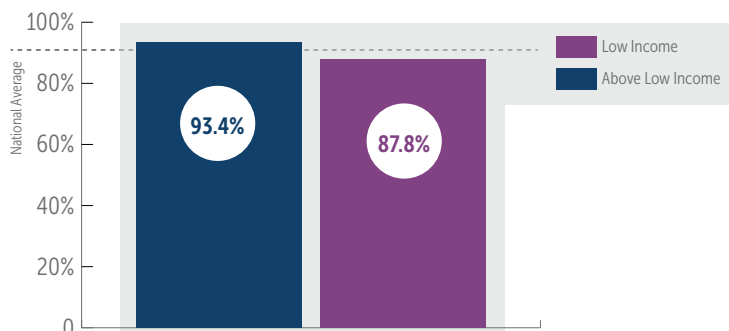
- **Income**—When compared by income, fewer families with low income (87.8 percent) reported that their baby had received a preventative medical visit in the previous year as compared to babies in families above low income (93.4 percent). At the state level, babies in families with low income ranged from 75.7 percent in Hawaii to 99.1 percent in New Jersey, while for families above low income state rates ranged from 84.3 percent in Mississippi to 100 percent in Maine. Results were mixed for the few states showing a significant difference between families with low income and families above

low income, with two states trending in the same way as the national data, and one state finding higher rates of medical visits for families with low income as compared to families above low income.

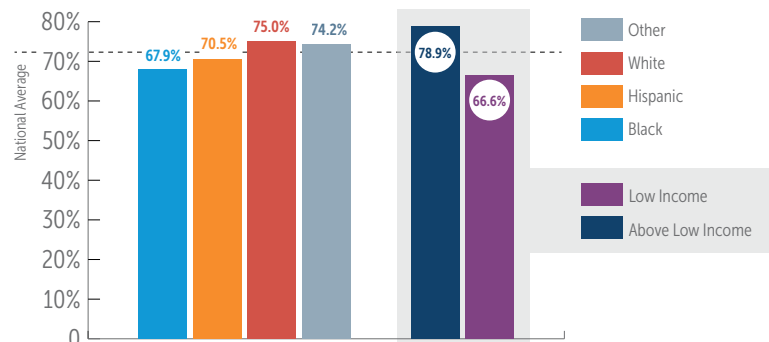
**VACCINATIONS.** The percentage of babies who completed vaccinations according to schedule was 72.8 percent, a small increase from previous years. Babies receiving recommended vaccinations varied by state, ranging from 61.6 percent in Montana to 83.7 percent in Connecticut. Vaccinations can be examined by race/ethnicity and income.

- **Race**—Nationally, the percentage of infants and toddlers receiving recommended vaccinations was higher than the national average of 72.8 percent for White (75 percent) babies and those identified as Other Race (74.2 percent). The proportions of Hispanic (70.5 percent) and Black (67.9 percent) babies who had received recommended vaccination were lower than the national average.
- **Income**—The percentage of infants/toddlers receiving recommended vaccinations was significantly lower for babies in families with low income (66.6 percent) compared to babies in families above low income (78.9 percent). Variation was also found across states in the percentage of babies in low-income families who had received vaccinations, ranging from 51.7 percent in Washington to 84.1 percent in Connecticut.

## Key Findings Well-Child Visits



## Key Findings Vaccinations



**MATERNAL DEPRESSION SCREENING.** The number of states with Medicaid plans that allow, recommend, or require maternal depression during well-child visits increased substantially from previous years to 43, with 6 new states now including this important screening in their plans.

**INFANT AND EARLY CHILDHOOD MENTAL HEALTH.** Although no update had been made to the IECMH indicators' data since the 2020 *Yearbook*, the number of states with Medicaid plans that cover social-emotional screening of young children (36 states) was as high as last reported. Similarly, nearly all states' Medicaid plans cover IECMH services provided in settings most accessible to families with young children, with 49 states covering IECMH services in the home, 46 states covering these services in pediatric/family medicine practices, and 34 states covering these services in early care and education settings.

Indicators of serious concern include those related to reliable access to health care, food insecurity, nutrition assistance, maternal health and birth outcomes, and mother's mental health.

**UNINSURED LOW-INCOME.** Despite coverage available through Medicaid and the Children's Health Insurance Program, 5.1 percent of low-income infants and toddlers still lack health insurance. This is a slight decline from the previous two *Yearbooks'* findings of 5.8 and 5.4 percent. Rates of uninsured babies in families with low income ranged from 0.1 percent in Vermont to 13.9 percent in North Dakota. Variation was also found when examined by race/ethnicity and urbanicity.

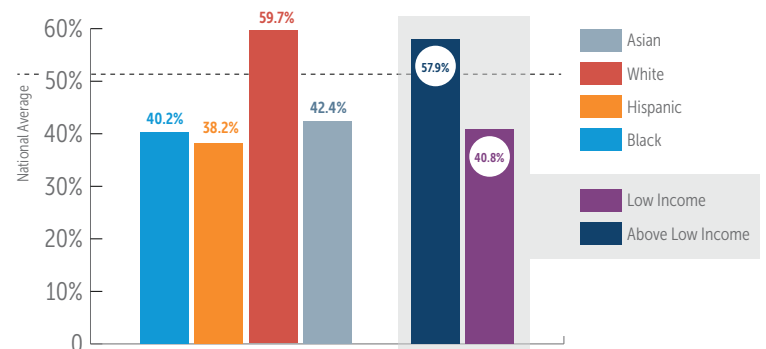
- **Race**—The incidence of babies in families with low income without health insurance was lower than the national average of 5.1 percent for Black (3.6 percent), Asian (5.0 percent), and Multiple Race (3.4 percent) babies. Most notably, the percentage of American Indian/Alaska Native babies (12.5 percent) in families with low income without health insurance was more than double the national average. The rates of White (5.7 percent) and Hispanic (5.5 percent) babies who were uninsured were also above the national average.

- **Urbanicity**—The percentage of uninsured babies in families with low income was higher in rural areas (6.8 percent) than for babies in urban areas (4.8 percent).

**MEDICAL HOME.** A new indicator in 2021, Medical Home, reveals that only half (51 percent) of infants and toddlers had a medical home (i.e., a consistent medical provider or practice) from whom they received coordinated, ongoing, comprehensive care. While in the states the rates varied from 43.8 percent in California to 63.6 percent in New Hampshire, most states reported approximately half of parents report their babies have a medical home. This indicator could be analyzed by race/ethnicity and income; and showed significant differences in both areas.

- **Race**—Nationally, the percentage of White parents (59.7 percent) reporting that their baby had a medical home was above the national average of 51 percent. Asian (42.4 percent), Black (40.2 percent), and Hispanic (38.2 percent) parents reporting that their baby had a medical home was less than the national average. Due to small sample sizes, all state data was suppressed or unreliable; however, the few states reporting significant race/ethnicity differences also reflected the national trend.
- **Income**—The average number of parents with low income (40.8 percent) reporting that their child had a medical home was significantly less than for families above low income (57.9 percent). Due to small sample sizes, most

**Key Findings Medical Home**



of the state estimates for families with low income were either unreliable or suppressed, however, roughly half of states reported higher rates of access to a medical home from higher income groups. Among families with low income, having a medical home ranged from 25.3 percent in Illinois to 64.8 percent in Colorado.

**FOOD INSECURITY.** The percentage of households with babies who experienced food insecurity had decreased before the pandemic to 13.7 percent of infants and toddlers compared to approximately 16 percent in the previous two *Yearbooks*. However, the rate of babies experiencing this challenge to their basic needs remains concerning and is an area in which the pandemic has had devastating effects. Although subgroup analyses are not available for this indicator, variations can be reported across states and ranged from 2.5 percent of households with babies in Nebraska to 27.2 percent in Wyoming experiencing food insecurity.

**WIC COVERAGE.** A notable decline was found in the reach of WIC coverage, with participation of eligible infants falling to 79.3 percent from 85.9 percent reported in the 2020 *Yearbook*. This drop is particularly concerning given the increased food insecurity in households with young children during the pandemic. State level data were not available for this indicator. At the national level, subgroup data were available by race/ethnicity.

- **Race**—The percentage of eligible infants covered by WIC was higher than the national average of 79.3 percent for Black<sup>6</sup> (100 percent) and Hispanic (84.1 percent) infants. The proportions of White (63.9 percent) and Other Race (71.9 percent) eligible babies covered by WIC were lower than the national average.

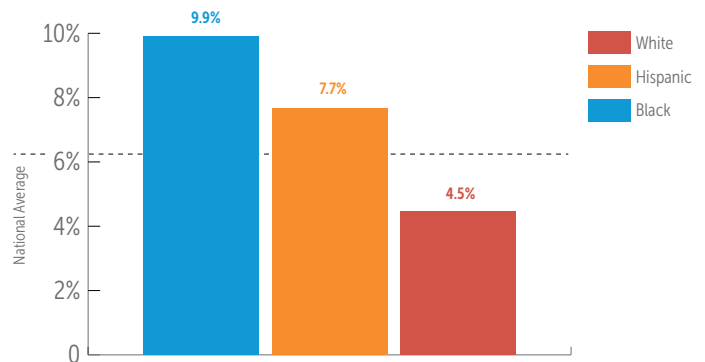
**LATE OR NO PRENATAL CARE.** Nationally, the percentage of women receiving late or no

prenatal care was 6.2 percent. Rates of women receiving late or no prenatal care varied across states, ranging from 1.7 percent in Rhode Island to 11.3 percent in New Mexico. This indicator of maternal health was analyzed by race/ethnicity and by urbanicity.

- **Race**—The percentage of White women (4.5 percent) receiving late or no prenatal care was lower than the national average of 6.2 percent. The proportions of Black (9.9 percent) and Hispanic (7.7 percent) women receiving late or no prenatal care were higher than the national average.
- **Urbanicity**—Nationally, the percentage of women in rural areas receiving late or no prenatal care was 6.6 percent, which was higher than the national average of 6.2 percent. State differences in the percentage of women in rural areas receiving late or no prenatal care ranged from 2.3 percent in Vermont to 13.7 percent in Arizona. In comparison, the percentage of women in urban areas receiving late or no prenatal care (6.2 percent) was the same as the national average; and variation across states for women in urban areas ranged from 1.3 percent receiving late or no prenatal care in Vermont to 11.0 percent in Hawaii.

**MATERNAL MORTALITY.** As reported in the 2020

### Key Findings Late or No Prenatal Care



6 The estimated coverage rate exceeded 100 percent for Black-Only Non-Hispanic infants. This is likely a result of sampling variability in the Current Population Survey's Annual Social and Economic Supplement data used to estimate the number of infants eligible for WIC (denominator of the rate). The lower-bound range of the 95-percent confidence intervals surrounding the rate was below 100 percent.

*Yearbook*, the nation's maternal and infant mortality rates are particularly concerning and are higher than rates found in other industrialized countries. Maternal mortality continued to occur at a rate of 17.4 deaths per 100,000 live births nationally. Differences in states' definitions and reporting practices continue to prevent reporting in the *Yearbook* of maternal mortality rates at the state level. Examination of this indicator is possible by race/ethnicity for only three groups (White, Hispanic, and Black mothers). However, analysis of the available data show that deep disparities persist.

- **Race**—Nationally, the maternal mortality rates for White (14.9) and Hispanic (11.8) mothers were lower than the national average of 17.4 deaths per 100,000 live births. The maternal mortality rate for Black mothers (37.3) continued to be alarming at more than twice the national average.

**NEGATIVE BIRTH OUTCOMES.** Negative birth outcomes persist and are unchanged from previous *Yearbook* findings. As many as 1 in 10 babies (10 percent) are born preterm and 1 in 12 (8.3 percent) are born at low birthweights, which can jeopardize development. The 2021 *Yearbook* data and subgroup analyses make clear that significant racial disparities persist on both of these critical indicators of infant health.

- **PRETERM BIRTHS.** Nationally, the percentage of infants born preterm was unchanged from the previous year at 10 percent. The rates of preterm births varied by state, ranging from 7.8 percent in Oregon to 14.2 percent in Mississippi. Subgroup analyses of preterm births could be conducted by race/ethnicity and by urbanicity.

**Race**—The percentages Hispanic (9.7 percent) and White infants (9.1 percent) who were born preterm were similar to, but slightly less, than the national average of 10 percent. In comparison, nearly 1 in 7 Black infants (14.1 percent) were born preterm.

**Urbanicity**—Nationally, little variation was found in preterm births in urban and rural areas. However, the percentage of infants



in rural areas (10.3 percent) who were born preterm was higher by a small margin than the national average of 10 percent. At the state level, the percentages of infants in rural areas born preterm ranged from 5.7 percent in Massachusetts to 14.6 percent in Mississippi. The rate of preterm births for infants in urban areas was the same as the national average, with differences across states ranging from 7.2 percent in Vermont to 13.9 percent in Mississippi.

**LOW BIRTHWEIGHT.** One in 12 infants (8.3 percent) were born at low birthweight, nationally, with the rates of low birthweight ranging across states from 5.9 percent in Alaska to 12.1 percent in Mississippi.

- **Race**—The percentages of Hispanic (7.5 percent) and White (6.9 percent) infants born at low birthweight were below the national average of 8.3 percent. The incidence of low birthweight was markedly higher than the national average for Black infants (14.1 percent), approaching nearly twice the national rate and affecting 1 in 7 Black babies.
- **Urbanicity**—The proportions of infants born at low birthweight were similar for babies in rural and urban areas. Low birthweight rates for

both urban and rural babies were the same as the national average at 8.3 percent. However, substantial differences were found between states. The percentages of infants born at low birthweight ranged from 6.3 percent in Alaska to 11.7 percent in Mississippi in urban areas and from 4.8 percent in Massachusetts to 12.5 percent in Mississippi for babies in rural areas.

**INFANT MORTALITY.** Although infant mortality is more consistently reported than maternal mortality, the rate remained high and was virtually unchanged from previous years. Nationally, the infant mortality rate was 5.7 deaths per 1,000 live births at the time of this *Yearbook*, compared to 5.8 and 5.9 reported in the 2020 and 2019 *Yearbooks*, respectively. Infant mortality rates continued to vary widely across states and ranged from 3.6 per 1,000 live births in New Hampshire to an alarming 8.3 in Mississippi. Examination of this indicator is possible only by race/ethnicity, where deep disparities persist.

- **Race**—The infant mortality rates for White (4.8) and Hispanic (5.0) babies were lower than the national average of 5.7 deaths per 1,000 live births. The infant mortality rate for Black babies (11.1) continued to be twice as high as the national average, and the rate for American Indian/Alaska Native babies (8.4) was also markedly higher.

**MOTHERS' MENTAL HEALTH.** Mothers reporting less than optimal mental health remained high, with 1 in 5 mothers of infants and toddlers (20.3 percent) rating their own mental health as worse than "excellent" or "very good." This was similar to the finding of 19.8 percent reported in the 2020 *Yearbook* and a decrease from 22 percent reported in the 2019 *Yearbook*. Variation across states ranged from 1 in 8 mothers (11.8 percent) reporting less than optimal mental health in the District of Columbia to almost 1 in 3 mothers (31.4 percent) in Ohio. When examined by race and income the following differences were found:





- **Race**—Nationally, 21.7 percent of White mothers of infants and toddlers reported less than optimal mental health, which is higher than the national average of 20.3 percent. The rates were below the national average for Black (19.7 percent), Hispanic (17.4 percent), and Asian (16.9 percent) mothers.
- **Income**—The average number of mothers of infants or toddlers with low income (24.6 percent) reporting less than optimal mental health was significantly higher than reported by mothers above low-income (17.6 percent).

Subdomain	Indicator	Description	2019 Yearbook	2020 Yearbook	2021 Yearbook
Health Care Access/ Affordability	Eligibility limit (% FPL) for pregnant women in Medicaid	Income cutoff (percent of the FPL) for Medicaid eligibility for pregnant women (median)	200	200	200
	Medicaid expansion state	State adopted Medicaid expansion under the Affordable Care Act	34 states	37 states	39 states
	Uninsured low-income infants/toddlers	Percentage of low-income infants/toddlers who are uninsured	5.8%	5.4%	5.1%
	● Medical home (NEW)	Percentage of infants/toddlers who received coordinated, ongoing, comprehensive care within a medical home	--	--	50.9%
	● Extension of Medicaid coverage for pregnant women postpartum (NEW)	State efforts to extend Medicaid coverage beyond 60 days postpartum	--	--	45 states—No law beyond mandatory 60 days; 5 states—Law covering either (a) some women but not all, or (b) all women but for less than 1 year; 1 state—Law covering all women for 1 year postpartum
Food Security	Low or very low food security	Percentage of households with infants/toddlers experiencing low or very low food security	16.5%	15.9%	13.7%
Nutrition	Infants ever breastfed	Percentage of infants ever breastfed a	83.2%	82.9%	83.6%
	Infants breastfed at 6 months	Percentage of infants breastfed at 6 months a	57.6%	54.6%	55.1%
	WIC coverage	Percentage of eligible infants who participated in WIC	--	85.9%	79.3%
	High weight-for-length among WIC recipients	Percentage of WIC recipients ages 3-23 months who have high weight-for-length	--	Available at state level only	Available at state level only

Subdomain	Indicator	Description	2019 Yearbook	2020 Yearbook	2021 Yearbook
Maternal Health	Maternal mortality rate	Number of pregnancy-related deaths per 100,000 live births	--	17	17
	Late or no prenatal care received	Percentage of women receiving late or no prenatal care	6.2%	6.2%	6.2%
	State Medicaid policy for maternal depression screening in well-child visits	State Medicaid policy requires, recommends, or allows maternal depression screenings during well-child visits a	36 states	37 states	43 states
	Mothers reporting less than optimal mental health	Percentage of mothers of infants/toddlers rating their mental health as worse than "excellent" or "very good"	22.0%	19.8%	20.3%
	Pregnant worker protections (NEW)	Protections or accommodations are set in place for pregnant working people	--	--	31 states (3–state employees only; 23 – state and private with limitations; 5–all employees)
Child Health	Infant mortality rate	Deaths per 1,000 live births	5.9	5.8	5.7
	Low birth weight	Percentage of babies with low birth weight	8.2%	8.3%	8.3%
	Preterm birth	Percentage of babies born preterm	--	10.0%	10.0%
	Preventive medical care received	Percentage of infants/toddlers who had a preventive medical visit in the past year a	90.7%	91.1%	91.1%
	Preventive dental care received	Percentage of infants/toddlers who had a preventive dental visit in the past year a	30.0%	31.9%	32.9%
	Received recommended vaccines	Percentage of infants/toddlers receiving the recommended doses of DTaP, polio, MMR, Hib, HepB, varicella and PCV vaccines by ages 19 through 35 months	70.7%	70.4%	72.79%

Subdomain	Indicator	Description	2019 Yearbook	2020 Yearbook	2021 Yearbook
Infant and Early Childhood Mental Health <sup>b</sup>	Medicaid plan covers social-emotional screening for young children	State Medicaid plan covers social-emotional screening for young children (birth–6 years old) with a tool specifically designed for this purpose	41 states	43 states	43 states
	Medicaid plan covers IECMH services—at home	Medicaid plan covers services in home settings	46 states	49 states	49 states
	Medicaid plan covers IECMH services—in medical settings	Medicaid plan covers services in pediatric/family medicine practices	45 states	46 states	46 states
	Medicaid plan covers IECMH services—in ECE settings	Medicaid plan covers services in early care and education program settings	34 states	34 states	34 states

● New indicator in 2021

NOTES: ECE = Early childhood education; FPL = Federal Poverty Level; IECMH = infant and early childhood mental health; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children

a Due to changes in data reporting and/or changes to the methods for calculating this indicator, we caution against directly comparing estimates from the 2019 Yearbook and the 2020 and 2021 Yearbooks. For a more detailed discussion, see the indicators and methodological appendices.

b The Infant Early Childhood Mental Health Medicaid Survey was completed by two additional states in the survey administration reported in the 2020 Yearbook than in the 2019 Yearbook. Therefore, increases from the 2020 Yearbook may be real or may be a result of the increase in survey coverage. No updates to the data were available for the 2021 Yearbook.



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## Effects of COVID-19 pandemic on Good Health

The COVID-19 pandemic has given rise to a wide array of factors that threaten babies and toddlers' chances at a healthy start in life. Specifically, increases in child and caregiver emotional distress, disruptions in preventive care, and increases in food insecurity have the potential to negatively impact babies and toddlers' physical and social-emotional health in the long term.

### SOCIAL-EMOTIONAL HEALTH

Developmental research confirms that early years are crucial to the developing brain. Prolonged stressful early life experiences can permanently impact children's brain and biological systems, increasing the risk of learning difficulties and lifelong health problems such as obesity and heart disease.<sup>xviii</sup> Furthermore, caregiver and child mental health are linked. Higher rates of caregiver anxiety, depression, and stress can directly increase young children's emotional distress.<sup>xix</sup>

Caregivers reported an immediate increase in emotional distress at the beginning of the pandemic, which coincided with an increase in child emotional distress and behavioral problems. Overall, child and caregiver mental health has improved since the pandemic began, but this trend is not present in certain subgroups. Caregiver stress and child behavior problems have remained especially high in lower-income households, Black, and Latinx households, as well as in single-parent homes<sup>xx</sup> and households of children with disabilities.<sup>xxi</sup> Emotional support can serve as an important buffer against emotional distress in young children,<sup>xxii</sup> but families are reporting lower levels of emotional support and higher levels of loneliness than before the pandemic. The RAPID-EC report also shows higher rates of family conflict across households with young children compared to pre-pandemic levels.<sup>xxiii</sup> This is particularly concerning given that the pandemic has eliminated many of the typical pathways by which cases of abuse and neglect are reported and the



social systems of support that reduce the effects of child maltreatment.

### PREVENTIVE CARE

COVID-19's impact on health care is also significant. Many preventive health measures for young children have been compromised during the pandemic, especially for lower income households and Black and Latinx households. According to the RAPID-EC data, 37.8 percent of families sampled have missed a well-baby or well-child visit since the start of the pandemic, a rate that is worryingly more than three times higher than pre-pandemic levels. Well-child visits are an essential part of good health, giving physicians the chance to screen for early issues with development, child and caregiver mental health, physical safety, and child-caregiver relationships. Young children also receive vital vaccinations against deadly childhood illnesses during these visits. Among the families surveyed in RAPID-EC,

18.1 percent reported that their children had missed a recommended vaccine since the start of the pandemic, which reveals an increased risk for outbreaks in childhood illnesses like hepatitis, measles, and whooping cough. In particular, the rate of 16-month-old children with a measles vaccination fell from 72 percent in March 2020 to 62.4 percent in August 2020.<sup>xxiv</sup> Prior to the pandemic, measles was already on the rise, and the lower rate of vaccinations due to both COVID-19 and the anti-vaccination movement has increased the risk of a future outbreak.

Subgroup analysis of the RAPID-EC data further reveals that babies and toddlers of color, children with disabilities, and those in families with low incomes are disproportionately missing well-child visits and accompanying vaccines. The percentage of Black and Latinx babies missing well-child visits and recommended vaccines is significantly higher than both the national average and the rate of White babies missing the same types of preventive care (see Figure 6). Young children with disabilities were more likely than children without disabilities to miss preventive visits at key milestone ages of 12 and 24 months.<sup>xxv</sup> Families with low income were also more likely than middle- and high-income households to miss check-ups and vaccinations,

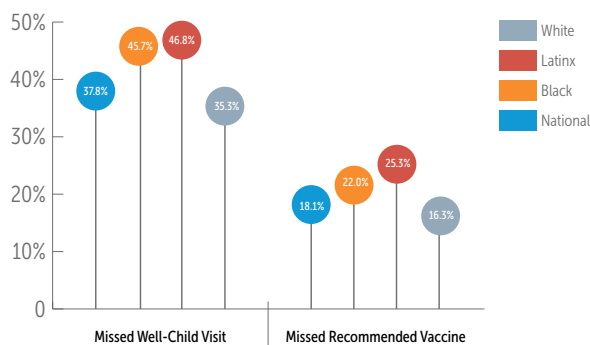
reporting concerns about cost and significantly more challenges finding care for other family members necessary to attend doctor visits (see Figure 7).

## FOOD INSECURITY

Although the *State of Babies Yearbook* classifies food insecurity under its Good Health domain, the pandemic's spiraling effects have made it clear that access to food is a basic needs support that is heavily linked to home environment. Food insecurity is one of the strongest drivers of caregiver anxiety, depression, and stress in lower-income households,<sup>xxvi</sup> which presents a concern for babies and toddlers in these households.

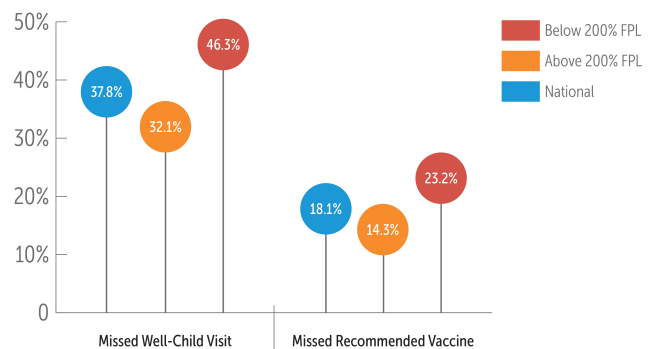
Households with children were already 1.5 times more likely to be food insecure before the pandemic compared to households without children,<sup>xxvii</sup> but the uptick in unemployment and loss of free food streams such as public-school meals has only exacerbated this existing inequality. While food insecurity has increased overall for families with babies and toddlers, this is especially evident among households with low income (see Figure 8) and Black and Latinx households (see Figure 9).

**COVID-19 Disruptions in Preventive Health by Race/Ethnicity** Figure 6.



NOTE: Figure data based on self-reported missed vaccines from the RAPID-EC survey.

**COVID-19 Disruptions in Preventive Health by Income Level** Figure 7.



NOTE: FPL = Federal Poverty Level; Figure data based on self-reported missed vaccines from the RAPID-EC survey.

The state of food insecurity paints a worrisome picture for our nation’s babies and toddlers, for whom adverse early life experiences can be detrimental to development. Numerous non-profit organizations, school districts, and volunteers have mobilized across the country to meet the growing food needs during the pandemic, but young children are still at risk. Grocery prices have risen from pre-pandemic levels, and need at food pantries and demand for SNAP benefits increased significantly, especially since vital CARES Act benefits expired at the end of July. One helpful support from the federal level has been allowing states to add the value of school meals when schools are in remote learning—and, more recently, meals in early learning settings—to family SNAP benefits. The Consolidated Appropriations Act, signed into law on December 27, 2020, and the American Rescue Plan, passed March 6, 2021, have provided additional federal support for families with young children. Although the RAPID-EC data included in this report does not reflect financial hardship and food insecurity after December 2020, these economic supports, which include an enhanced child credit and paid family and medical leave, have taken a step in the right direction of supporting families and promoting healthy development.

## A path forward: Ensuring the physical and social-emotional health of babies and families through policy

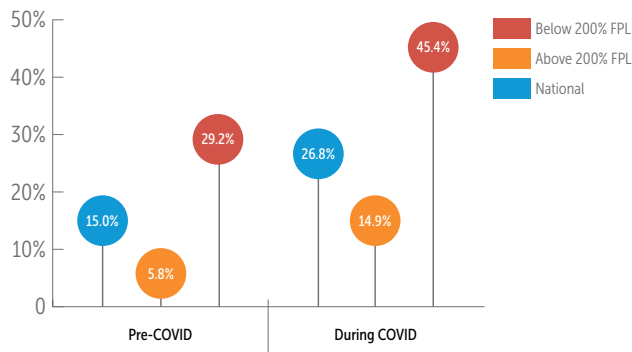
Federal and state policymakers can strengthen babies’ early foundations by improving the continuum of services that promote early childhood health and mental health, as well as targeted interventions for infants and toddlers who face barriers to receiving care.

**EXTEND MEDICAID COVERAGE FOR MOTHERS AND BABIES.** Medicaid, together with the Children’s Health Insurance Program (CHIP), covers about 45 percent of children under 6 years old and almost three quarters of young children living in or near poverty.<sup>xxviii</sup> States determine whom they will cover and the types of services that may be reimbursed, so the federal policy sets the floor in terms of coverage. Medicaid requires that all states provide the comprehensive approach of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

These health programs are a gateway for a range of critical health and developmental services that can help mitigate the effect of ACEs and chronic, unrelenting stress. Medicaid Expansion, where

### Food Insecurity by Income Level

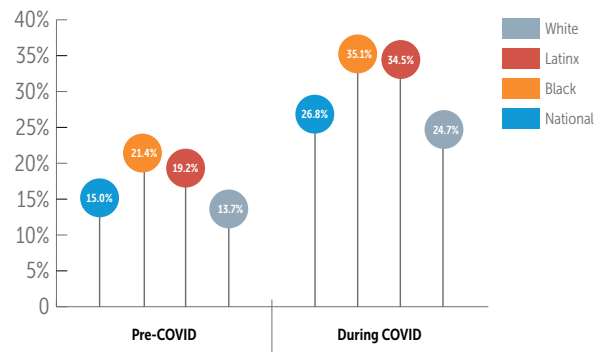
Figure 8.



NOTE: FPL = Federal Poverty Level; High food insecurity was calculated based on the aggregated responses of survey questions relating to food insecurity. Figure data based on caregiver responses from the RAPID-EC survey between August 11 and December 3, 2020 (weeks 19 through 35 of the survey).

### Food Insecurity by Race/Ethnicity

Figure 9.



NOTE: High food insecurity was calculated based on the aggregated responses of survey questions relating to food insecurity. Figure data based on caregiver responses from the RAPID-EC survey between August 11 and December 3, 2020 (weeks 19 through 35 of the survey).



*“My husband has a pre-existing condition. [When he was] hospitalized in October of 2020, it resulted in several challenges that were exacerbated by the pandemic. Unable to invite another individual in our home to care for our child and having to nurse my husband back to health was also quite difficult.”*

*Eliza, Strolling Thunder mom, SC*

adopted, has helped make health care more of a family affair by improving the mental and physical health of parents and creating a welcome mat effect so more eligible children have been enrolled.<sup>xxix</sup> However, several changes to Medicaid could enhance maternal and infant health as well as the role of primary care in prevention and promoting strong development:

- mandating Medicaid coverage for women through 12 months postpartum (which the ARP made an option to states) and promoting coverage of approaches such as doulas;
- ensuring coverage of IECMH services under the child’s Medicaid number that include multigenerational/dyadic therapies for babies and caregivers on the basis of child diagnosis, parent diagnosis, or other indicators of need, even in the absence of a child’s diagnosis;
- mandating Medicaid coverage and continuous enrollment for all children until 3 years old, and;
- requiring a certain percentage of Medicaid funding to be used for health promotion and prevention, including addressing the social determinants of health, and promoting use of EPSDT to monitor and address developmental and mental health needs.

**State Opportunity:** States should adopt the option provided in the recently enacted American Rescue Plan to extend Medicaid and CHIP postpartum coverage to 12 months. States that have not adopted Medicaid expansion can now receive incentives to do so. States can also specify in their Medicaid plans that multigenerational mental health therapies for babies and caregivers are covered based on the children’s eligibility.

**TRANSFORM PEDIATRIC CARE TO SUPPORT EARLY DEVELOPMENT.** Pediatric primary care is a universal touchpoint that reaches almost every baby, toddler, and young child in the

nation. We can transform the pediatric setting into a family-centered support by adding a child development specialist to the primary care team, an approach pioneered by ZERO TO THREE's HealthySteps program, driving better developmental trajectories and outcomes for young children and caregivers. Adding such a specialist should be part of expanding the reach of medical homes as well as a strategy to continue support to families in times of crisis such as the COVID-19 pandemic.

**State Opportunity:** States can incorporate a child development specialist in pediatric primary care into their maternal and child health approaches, using financing strategies such as Medicaid to sustain the approach.

#### **EXPAND FOOD AND NUTRITION BENEFITS.**

Food insecurity mounts in households with children and infants, toddlers, and pregnant women need access to affordable nutrition foods to ensure proper health and development. Nutrition assistance programs reduce food insecurity by helping people purchase healthy food they might not otherwise be able to afford, thereby increasing healthy eating. SNAP and WIC are two federal programs that work to support families

with young children in purchasing nutritious foods. SNAP not only protects families from both hardship and hunger but has been proven to be a cost-effective investment for the federal government. It is estimated that every \$1 increase in SNAP benefits can generate \$1.54 in economic activity.<sup>xxx</sup> Beyond the ability to purchase food, WIC provides nutrition education, breastfeeding support, and referrals to health care and social services for millions of families—playing a crucial role in improving lifetime health for women and young children. Greater investments in SNAP and WIC could change the trajectory of health and development for millions of families across the country. The federal government can do this by:

- boosting SNAP and WIC benefits to both improve the health and well-being of families and stimulate the economy; and
- eliminating cumbersome barriers to accessing SNAP and WIC and increasing program flexibilities. Eligibility and technology barriers are troublesome for families struggling to meet their basic needs. Focusing on modernizing WIC (as we have seen with SNAP) will allow for more flexibility in families' purchasing power and will allow for greater use of benefits.





**State Opportunity:** Given the national drop in WIC participation and participation disparities across states, increasing outreach to eligible families is an important state undertaking. WIC can also be a platform for parenting and other family support services.

**INCREASE THE CAPACITY TO SUPPORT STRONG IECMH:** How young children feel about themselves and relate to others are at the core of all learning and development. Our nation must build the infrastructure and means to promote and address the foundational mental health needs of young children. Such an infrastructure would:

- infuse all early childhood settings, such as pediatric care, child care, and home visiting, with an understanding of IECMH and skills to promote positive social-emotional development and seek support from IECMH professionals to address behavioral health concerns;
- develop a diverse, equitably supported, and highly skilled IECMH clinical workforce by establishing IECMH Centers of Excellence and clinical leadership programs to address mental health needs of infants and toddlers, especially the effects of trauma and other ACES. Such IECMH expertise should be infused in state child welfare systems to support babies and families who have experienced trauma; and
- consistently apply the science of IECMH with the widespread use of developmentally appropriate treatment approaches, practices, and tools. Promoting the use of evidence-based multigenerational/dyadic therapies, as well as developmentally appropriate assessment instruments and the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5™) to assess, diagnose, and treat mental health disorders in young children will help fill a critical gap.



*“It’s concerning to me that my baby only has virtual doctor visits. I feel like she is not getting the attention or quality of care she would have been receiving pre-Covid. Visits are done hastily. We have had doctor’s visits where they have failed to mention important information to us.”*

*RAPID-EC Respondent, MA*

**State opportunity:** States could specifically include the mental health needs of infants and toddlers in their state mental health plans for funding under the Mental Health Block Grant; invest in developing the IECMH workforce; and specify Medicaid and CHIP reimbursement for the use of DC:0–5, developmentally appropriate assessment instruments, and multigenerational/dyadic therapies for young children.

**PROVIDE REASONABLE ACCOMMODATIONS FOR PREGNANT WORKERS.** Healthy pregnancies are the critical first step in helping babies to grow, thrive, and reach their optimal potential. Today, more pregnant women are in the workforce than ever before, and they are working later into their pregnancies. Supporting working women in maintaining healthy pregnancies is critical to reducing premature births and infant mortality, and it lays a strong foundation for a baby’s long-term development. Some women—especially those in physically demanding jobs—will have a medical need for a temporary, job-related accommodation,

such as assistance with heavy lifting or additional bathroom breaks, in order to maintain a healthy pregnancy. Yet, often, employers will refuse to provide the pregnant worker with the necessary accommodation, leaving her to choose between protecting her job or her health and the health of her baby. Federal- and state-level actions to ensure the health of pregnant women and their babies should include:

- passage of the Pregnant Workers Fairness Act, which would make unlawful any states’ employment practices that discriminate against making reasonable accommodations for qualified employees affected by pregnancy, childbirth, or related medical conditions.

**State Opportunity:** States can enact robust policies, especially in the absence of a federal statute, that require employers’ pregnant worker protection plans to be applicable to the general public, including private and state employees.





# Strong Families

Young children develop in the context of their families, where stability, safety, and supportive relationships nurture their growth. The indicators in this domain examine this family context, including well-being, economic resources, and physical environment, as well as the experience of infants and toddlers in the child welfare system. Although the *Yearbook* shows some improvement in several indicators on average, babies in families with low income and babies of color often had greater challenges to family and child well-being and secure environments. These factors could be sources of chronic stress in any time, but lower levels of economic and social resilience and vulnerabilities to material hardships created a risk for greater impacts from the COVID-19 crisis among some families. The high proportion of babies in families with low income—2 in 5 babies—meant their families were harder hit as pandemic job loss was disproportionately concentrated among younger workers who are likely to work in jobs with low wages.<sup>xxxii</sup>



he proportion of Black and Hispanic babies and those with low income in crowded housing pre-COVID signaled precarious housing arrangements that could lead to spread of the disease and vulnerability to eviction. Lower levels of resilience in these families pre-COVID provide an inkling of the high levels of emotional distress that they would experience in the pandemic. These risks were realized as the pandemic rolled on, and the majority of families surveyed by the RAPID-EC project reported material and psychological difficulties. Yet, the pandemic only exacerbated existing areas of concern, often with weak or nonexistent policies to fall back on. This devastating impact on families has exposed the need for durable long-term policies to promote greater economic security, ability to meet basic needs, and family support.

### AT A GLANCE: STRONG FAMILIES BEFORE & DURING COVID-19

INDICATOR	State of Babies Yearbook PRE-COVID	RAPID-EC DURING COVID
Income	<p>Many babies experience low income:</p> <p>2 in 5 (40%) babies lived in families with low income</p> <p>62.9 percent of American Indian/Alaska Native babies; 24.7 of Asian babies; 61.4% of Black babies; 54.6% of Hispanic babies; 37.1% of multiple race babies; 28.8% White babies</p>	<p>Families with low income, families of color felt greater economic impact</p> <p>More than half of families with low income pre-pandemic lost income during the pandemic; 37.4% of higher income families also experienced income loss<sup>a</sup></p> <p>Middle- and higher-income Black and Latinx households have experienced material hardship at a higher rate compared to White households of similar pre-pandemic income</p>



<p><b>Housing</b></p>	<p>Crowding indicates precarious housing</p> <p>16% of babies lived in crowded housing</p> <p>Native American babies, 25.3%; Asian babies, 23.5%; Black babies, 18.8%; Hispanic babies, 28.4%; Multiple race babies, 11.6%; Other race babies, 16%; White babies, 7.8%</p> <p>24.7% of babies in families with low income; 8.1% in families above low income</p>	<p>Families less likely to afford basic needs</p> <p>12.5% of families reported being unable to afford the full amount of their rent or mortgage<sup>b</sup></p> <p>17% of families reported being unable to pay the full amount for utilities</p> <p>36.5% of families reported difficulty paying for basic needs like food, housing, medical care, and heating</p> <p>Black and Latinx households, and households with low income were significantly more likely to have difficulty affording basic needs</p>
<p><b>Resilience vs. Emotional Distress</b></p>	<p>Differences in reported resilience</p> <p>Overall, families with babies showed a high level of resilience</p> <p>Families with low income and Black families were less likely to describe themselves as resilient</p>	<p>Stress increased more for some groups</p> <p>Caregiver and child stress increased for all populations during the pandemic, and remain high</p> <p>Families with low income, single parent homes, and families of children with disabilities continue to experience especially high stress levels</p> <p>Black and Latinx families, families with low income, and families of a child with a disability reported especially high rates of child behavior problems</p>

\* Data from the *State of Babies Yearbook: 2021* and the RAPID-EC Project are not directly comparable due to variation data sources and sample sizes; and are presented to give a general indication of conditions before and during COVID-19.

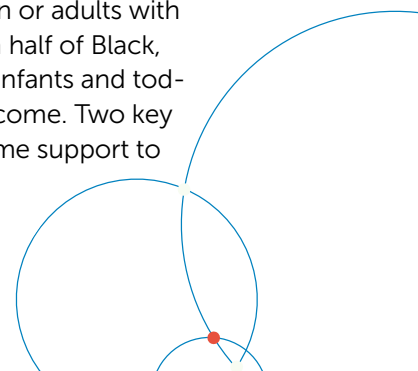
<sup>a</sup>The income loss indicator was based on caregiver responses between April 27 through December 21, 2020 (weeks 3 through 37 of the survey). Income loss was self-reported.

<sup>b</sup>Material hardship indicators (housing, utilities, basic needs) are based on responses from 2,538 caregivers between August 11 and December 21, 2020 (weeks 19, 21, 23, 25, 27, 31, 33, and 37 of the survey). Experiences of material hardship were self-reported.

For babies, the family is central to their well-being, starting with the unhurried time they need with their parents to form healthy attachments. Nurturing and responsive relationships offer both immediate and long-term benefits, fostering trust, positive social-emotional development, and the capacity to form strong relationships in the future. All families benefit from parenting supports, and many—particularly those challenged by economic instability—require access to additional resources that help them meet their children’s needs. *Yearbook* indicators of state family support policies include home visiting, paid family leave, and paid sick time. The *Yearbook* touches on family well-being by looking at resilience. Most families with babies report high resilience, meaning that when faced with a problem they are able

to talk together about what to do, work together to solve problems, know they have strengths to draw on, and stay hopeful even in difficult times. Yet, families of color and those with low income are less likely to report high resilience. Similarly, infants and toddlers of color and in families with low income are more likely to experience ACEs.


A key aspect of the Strong Families domain is economic security and the ability to meet basic needs. Prior to the pandemic, parents of young children were already more likely to live in poverty than adults without children or adults with school-age children. More than half of Black, Hispanic, and Native American infants and toddlers live in families with low income. Two key federal tax credits provide income support to



low-income working parents: the Earned Income Tax Credit (EITC) and the Child Tax Credit (CTC). ARP enhanced both of these policies, with the Child Tax Credit expansion particularly benefiting families with young children. The EITC is available to income-eligible working parents and is intended to incentivize work and offset federal tax burdens.<sup>xxxii</sup> ARP extended it temporarily to childless adults. The effects of both tax credits are particularly significant for young children and lifting families out of poverty. The CTC enhancement which provides a fully refundable credit of \$3,600 per young child will have and even, by some estimates cutting child poverty by 40 percent. Improving the economic status of young children is associated with improvement in their immediate well-being as well as the benefits of better health, education, employment, and earnings as adults.<sup>xxxiii</sup> Policy indicators in this domain present the extent to which states support families with young children through employment and tax policies, such as Temporary Assistance for Needy Families (TANF) work exemption and child tax credits.

Families with young children face many challenges that threaten their abilities to meet their children's basic needs and provide the stable physical environments required for optimal development. This can have both immediate and long-term effects. For example, infants and toddlers are uniquely sensitive to challenges in their environments, such as housing instability and crowded housing, that can jeopardize development. Adversities experienced early in life—such as hunger, abuse, neglect, or household instability—can create stress that undermines lifelong development.<sup>xxxiv</sup> Chronic stress experienced in early childhood, such as that caused by extreme poverty or abuse and neglect, can be toxic to the developing brain and may lead to problems with self-regulation, lags in cognitive and social-emotional development, and chronic health problems in adulthood. However, caring relationships with trusted caregivers can buffer babies' exposure to adverse events and mitigate long-term negative effects.

Another group of indicators focus on the experiences of infants and toddlers in the child welfare system. Infants and toddlers are the age group



*“The pandemic has made pregnancy anything but ordinary. We are worried about our family members, children, and selves getting sick. As I inch closer to my due date, still not vaccinated, I worry how different my postpartum experience will be knowing I won’t be surrounded by friends and family like I was last time. I hope that I’ll be okay, but I just don’t know.”*

*Allison, Strolling Thunder mom, VA*



most vulnerable to abuse and neglect, and they experience the highest rates of maltreatment.<sup>xxxv</sup> Yet, too few families receive early support that could prevent the circumstances that increase the risk for maltreatment, the most frequent form of which is neglect. Infants and toddlers who have experienced maltreatment frequently experience delays in their social-emotional and cognitive development, making prevention and early intervention efforts especially important.<sup>xxxvi</sup> Foster care practices not attuned to early development can compound these problems. Placement in foster care means a sudden disruption in caregiving, further jeopardizing a very young child's well-being. In losing their primary caregiver, a baby experiences profound loss and fear that can overwhelm their ability to cope. This traumatic stress, in turn, negatively impacts the developing brain and all development and learning to follow. Child welfare systems should be responsive to the needs of very young children in their policies and practices, but seldom are.<sup>xxxvii</sup> The *Yearbook* examines maltreatment rates and the length of time babies spend in foster care, where the vast majority stay for more than a year—a very significant portion of the life of a child under age 3. By orienting its approach around the science of early childhood development and the impact of intergenerational trauma, ZERO TO THREE's Infant Toddler Court Program achieves permanency in less than a year for almost all of the babies whose families are supported by a court team, with less than 1 percent experiencing a recurrence of maltreatment.<sup>xxxviii, xxxix</sup> New indicators in this domain round out this picture with the number of babies who are removed from home due to maltreatment and the types of permanency achieved when children exited from foster care.

Finally, examining key indicators in the next section reveals a concerning pattern in which children and families of color and those with low income consistently are doing worse than the national average. Children and families of color face numerous challenges stemming from racism—such as housing policies that have limited where Black families could live—that impact their everyday life. These challenges are exacerbated even more for children and families with

low income. Structural reasons leading to lower earnings mean Black and Hispanic families often have less ability to take advantage of policies such as unpaid family leave and also are less likely to work in jobs where paid leave is available. The lack of policies and supports to promote equity in family resources and well-being left families of color more vulnerable to the extreme impacts of the pandemic, which even families with higher incomes experienced, in contrast to their White counterparts. These disparate experiences underscore the need for long-term, permanent policies designed to address these disparities by race, ethnicity, and income. Such policies include the provision of safe and stable housing, family-friendly employer policies, such as paid sick and family medical leave; economic support for families with low income; and tax credits that benefit families with young children.

## Key findings

The 2021 *Yearbook* findings in the Strong Families domain indicate areas in which babies and their families as a whole were doing well prior to the pandemic, such as sustained family resilience and downward trends in unsafe neighborhoods and ACEs. Yet even where overall indicators are positive, Black and Hispanic families and those with low income tend to have experiences that are worse than the national average. Moreover, indicators where such disparities emerge are warning signals that the pandemic threatens to undermine these families' well-being and their children's development. Little movement occurred in states' implementation of policies that allow families time to care for their babies and themselves through paid sick and family medical leave or to offset the costs of raising a young child.

## INDICATORS OF FAMILY AND CHILD WELL-BEING

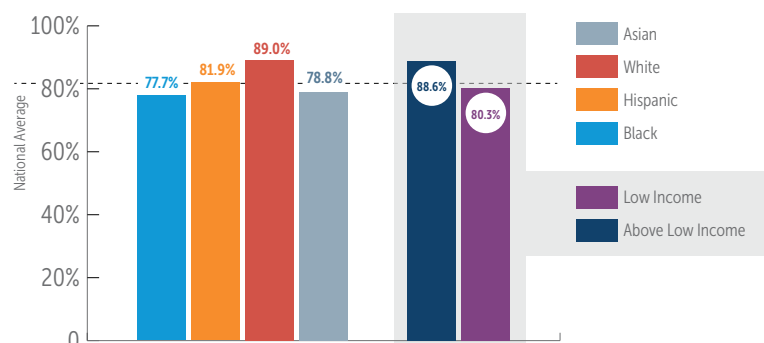
**FAMILY RESILIENCE.** Most families with an infant or toddler (85.3 percent) reported a favorable level of resilience, a very slight increase from

85.2 percent in the 2020 *Yearbook*. This indicator continued to be a sign that overall families were feeling able to bounce back when faced with adversity. Family resilience ranged across states, from 79.7 percent in Arizona to 91.7 percent in Illinois. Differences are also found when resilience is examined by subgroup.

- **Race**—The percentage of parents with babies reporting resilience was higher than the national average (85.3 percent) for White parents (89 percent). This was the only race/ethnicity above the national average. The rates of resilience were below the national average for Hispanic (81.9 percent), Asian (78.8 percent), and Black (77.7 percent) parents.
- **Income**—The percentages of parents reporting resilience were higher for parents above low income (88.6 percent) than parents with low income (80.3 percent).

**ADVERSE CHILDHOOD EXPERIENCES.** Exposure to unmanageable stress can interfere with the normal development of the body's neurological, endocrine, and immune systems, leading to increased susceptibility to disease. Because their brains are developing rapidly, infants and toddlers are especially vulnerable, and the damage may be long-lasting.<sup>x1</sup> Estimates of ACEs in the *State of Babies Yearbook* are based on the National Survey of Children's Health. Survey items asked parents to indicate whether their child had ever experienced one or more of the following: economic hardship, divorce/separation of parent, death of a parent, a parent who served time in jail, witness to

## Key Findings Family Resilience





domestic violence, victim of or witness to neighborhood violence, lived with someone who was mentally ill or suicidal, lived with someone with an alcohol/drug problem, or was treated or judged unfairly because of race/ethnicity.

One in 5 babies (20.7 percent) nationally has already had at least one ACE (e.g., witnessing or experiencing violence or abuse, or living in a home where there is substance abuse) and nearly 1 in 12 (7.7 percent) has experienced two or more. Each of these findings reflect a small decline from previous years. The incidence of one ACE ranged across states from 13 percent of babies in Illinois to 27.7 percent in Oklahoma; and from 1.8 percent in Maryland to 17.6 percent in Oklahoma for two or more adverse experiences. Differences were stark in the experiences of babies when examined by race and income.

- Race**—Nationally, the percentages of Black (26.4 percent) and Hispanic (24.8 percent) infants and toddlers reported as having had one adverse experience were higher than the national average of 20.7 percent. The percentages of Asian (18.0 percent) and White (17.6 percent) babies reported as having one ACE were lower than the national average. Similarly, the percentages of babies with two or more ACEs were higher than the national average of 7.7 percent among Black (13.0 percent) and Hispanic (9.3 percent) babies; and the percentages were lower than the national average among White (5.8 percent) and Asian (1.0 percent) babies.

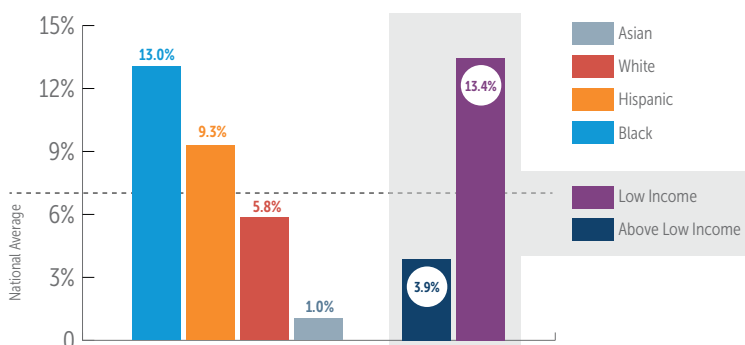
- Income**—On average, infants and toddlers in families with low income (30.6 percent) were twice as likely to have one ACE than those above low-income (14 percent). Babies in families with low income (13.4 percent) were 4 times as likely to have two or more ACEs than those in families above low-income (3.9 percent).

## INDICATORS OF PHYSICAL ENVIRONMENT

**MOBILITY.** A relatively low percentage of babies, 2.6 percent, experienced housing instability in the form of frequent moves. We defined mobility as having moved three or more times since birth, a more stringent definition than is sometimes used. This was a slight decrease from 2.7 percent reported in the 2020 *Yearbook*. Frequent moves can disrupt many aspects of families' lives, including their connections with social support networks and formal services such as child care that advance early learning. Mobility in the states ranged from 0.0 percent in Connecticut to 8.2 percent in New Mexico. Analyses by subgroup showed differences by race/ethnicity and income.

- Race**—The percentages of Hispanic (3.3 percent) and Asian (3.0 percent) families reporting mobility were higher than the national average of 2.6 percent. Rates of mobility were lower than the national average for Black (2.5 percent) and White (2.3 percent) families.
- Income**—Nationally, families with low income (3.7 percent) were twice as likely to report housing instability than those above low-income (1.9 percent).

### Key Findings 2+ Adverse Experiences



**CROWDED HOUSING.** Prior to COVID-19, nearly 1 in 6 babies (15.5 percent) were living in crowded housing, an alarming finding that is unchanged from the previous *Yearbook* reports. It presages concerns about the spread of COVID-19 in homes where numerous people live in close quarters. In homes where families are crowded, parents are less responsive to infants and toddlers and are

more likely to use punitive discipline.<sup>xii</sup> Crowding has also been associated with children’s health problems, including respiratory conditions, injuries, and infectious diseases, and with young children’s food insecurity.<sup>xiii</sup> Wide variation was found among states, with rates ranging from 6.6 percent in West Virginia to 28.3 percent in California. Subgroup data available for this indicator showed substantial differences by race/ethnicity, income, and urbanicity.

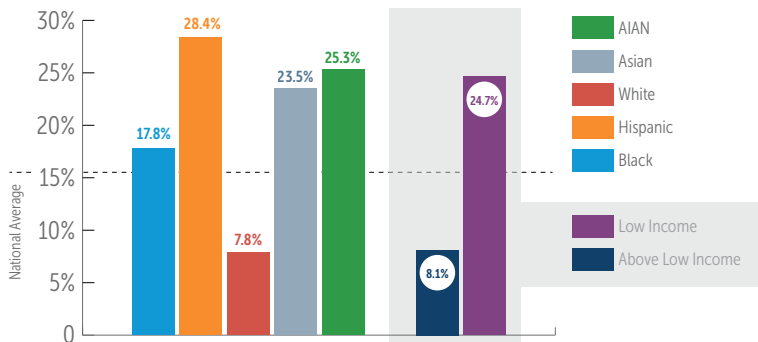
- **Race**—Nationally, a significantly higher percentage of Hispanic (28.4 percent), American Indian/Alaska Native (25.3 percent), and Asian (23.5 percent) babies lived in crowded housing than the national average of 15.5 percent. The percentages of Black (17.8 percent) and Other Race (16 percent) babies living in crowded housing were also above the national average. The percentages of Multiple Races (11.6 percent) and White (7.8 percent) babies living in crowded housing were lower than the national average.
- **Income**—In all 50 states and the District of Columbia, a significantly higher percentage of babies in families with low income lived in crowded housing than those in families above low-income. The percentage of babies in families with low income (24.7 percent) living in crowded housing was 3 times higher than for babies in families above low-income (8.1 percent). In looking at variation between states for babies in families with low income, the percentage living in crowded housing ranged from 9.9 percent in West Virginia to 44.9 percent in California.



*“My husband had 6 weeks of paid leave when I had our son. I had a rough birth experience and he tended to me and bonded with our son in a way we both feel would have been impossible without him home those first few weeks. Now that I am expecting my second child and seeing the continued disproportionate rate for maternal mortality for Black women, raising awareness is even more important to our family.”*

*Allison, Strolling Thunder mom, VA*

### Key Findings Crowded Housing



- **Urbanicity**—Nationally, a significantly higher percentage of infants and toddlers living in urban areas (16.5 percent) were in crowded housing than babies living in rural areas (12.2 percent). The percentage of babies living in crowded housing varied widely by state. In urban areas, rates ranged from 6.5 percent in Maine to 28.5 percent in California. In rural areas, rates ranged from 4.4 percent in Connecticut to 40 percent in Alaska.

**UNSAFE NEIGHBORHOODS.** Nationally, 4.9 percent of parents of infants and toddlers reported living in neighborhoods that are not safe, a continued decrease from previous *Yearbooks*. Living in unsafe neighborhoods ranged from 1.1 percent in Iowa to 11.0 percent in New Mexico. While nationally there was a decline, when examined by sub-group, differences were found by race/ethnicity and even greater variation was found by income.

- **Race**—The percentages of Black (7.5 percent) and Hispanic (6.1 percent) parents reporting unsafe neighborhoods was higher than the national average of 4.9 percent. Asian (4.4 percent) and White (3.9 percent) parents reported lower percentages of living in unsafe neighborhoods than the national average.
- **Income**—Parents in families with low income reported living in unsafe neighborhoods (6.7 percent) at nearly twice the rate of parents above low-income (3.7 percent). The rates of parents with low income reporting unsafe neighborhoods ranged from less than 1 percent in Georgia to 18.2 percent in New Jersey.

Despite the incremental improvements noted above, several areas of serious concern were present for babies and families.

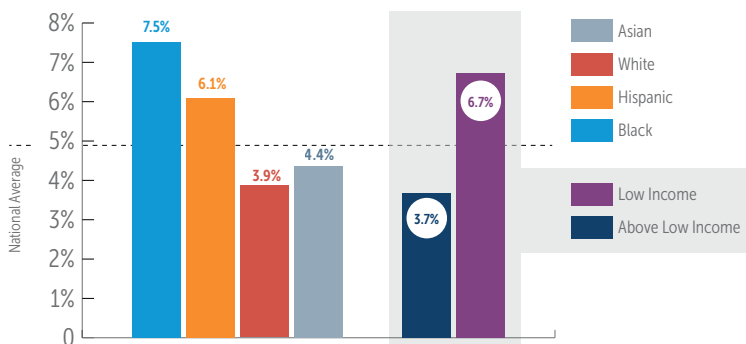
## BABIES IN THE CHILD WELFARE SYSTEM

Several indicators in the *Yearbook's* Strong Families domain address the disturbing reality that infants and toddlers are the age group most likely to experience abuse and neglect, which often results in removal from their parents' custody and entry into the foster care system. These indicators include rates of maltreatment, removals from home, the amount of time babies spend in out-of-home placement, the proportion of babies who achieve permanency, and the types of permanency achieved.

Racial disparities are widespread in child welfare, as Black and American Indian/Alaska Native children come to the attention of the child welfare system—often for reasons classified as neglect but that are the result of poverty such as poor housing conditions—and are placed in foster care at rates disproportionate to their share of the population. This pattern holds true in many states where data were available, including similar outcomes for Hispanic children in some cases. The disproportionality of children of color in the child welfare system often stems from over-surveillance in communities where these families live. Racial bias also contributes to over-reporting of families of color to child protective services and has been shown to impact the decisions of child welfare caseworkers in making a determination of abuse or neglect. Research has found that Black children are 15 percent more likely than White children to be involved in a substantiated child welfare case despite no differences in incidences of maltreatment and when controlling for poverty, and Black families are less likely compared to White families to be offered in-home family preservation services.<sup>xliii</sup>

Despite the higher rates of substantiation and removals among babies of color, the *State of Babies Yearbook: 2021* findings show that once in the system, White, Hispanic, and Multiple Race

### Key Findings Unsafe Neighborhoods



infants and toddlers are more likely than babies in other race groups to remain in out-of-home placements for more than a year. One possible explanation for the longer period out-of-home is that their entry into the system is more likely to be due to more severe circumstances than neglect, such as abuse and drug addiction.

**MALTREATMENT.** Maltreatment of infants and toddlers, meaning abuse or neglect, accounts for more than a quarter of all substantiated maltreatment incidents.<sup>xiv</sup> By far, the most prevalent form of maltreatment is neglect: “the absence of sufficient attention, responsiveness, and protection that are appropriate to the ages and needs of a child.”<sup>xiv</sup> Child maltreatment is influenced by a number of factors, including poor knowledge of child development, substance abuse, other forms of domestic violence, and mental illness. Although maltreatment occurs in families at all economic levels, abuse and neglect are more commonly reported, and therefore substantiated, in families that are economically disadvantaged.

Although subgroup analyses could not be done of maltreatment data, 2021 *Yearbook* findings

show the national rate of maltreatment of babies (16.4 per 1,000 infants and toddlers) was virtually unchanged from the rates reported in the 2020 and 2019 *Yearbooks*—15.9 and 16.0, respectively. Rates of maltreatment of infants and toddlers varied widely across states, ranging from 2.0 per 1,000 babies in Pennsylvania to 42.1 in Kentucky.

**REMOVED FROM HOME.** Removal of babies from their home due to maltreatment is a new indicator in the 2021 *Yearbook*. Nationally, the rate of removals was 7.1 per 1,000 infants and toddlers. Removal rates varied by state, ranging from 2.5 per 1,000 babies in Virginia to 24.6 in West Virginia. Analyses of removals could be completed by race and showed stark differences. However, not all race comparisons could be made due to the large number of states where data by race/ethnicity were not available.

- **Race**—The proportion of babies removed from home and placed in foster care was markedly higher than the national average of 7.1 per 1,000 for American Indian/Alaska Native babies (20.7) and above the national average for Multiple Race (11.3), Native



Hawaiian/Pacific Islander (10.7), and (Black (10.4) babies. White (6.5) and Hispanic (5.3) babies were removed at rates lower than the national average, with a substantially lower rate for Asian babies (0.7).

**DURATION OF OUT-OF-HOME PLACEMENT.** At the national level, only 1 in 5 babies (18.7 percent) in out-of-home placement exited foster care in less than 12 months, which was a small decrease from 20.2 percent reported in the 2020 *Yearbook*. This means that the vast majority of infants and toddlers in foster care remain there for more than a year—a large proportion of their total lifespan by age 3. The state that was doing the best job of limiting the time in care for babies still had almost 60 percent of these young children in care after a year. The percentage of children in out-of-home placement who exited care in less than 12 months varied by state, ranging from 4.5 percent in Illinois to 40.6 percent in Colorado. Differences on this indicator can be analyzed by race/ethnicity; however, not all race comparisons could be made due to high levels of missing data by race from states.

- **Race**—The percentage of babies in out-of-home placement who were in care for less than 12 months was higher than the national average for Asian (27.5 percent), Native Hawaiian/Pacific Islander (27 percent), and Black (19.9 percent) babies. These shorter stays in care were slightly below the national average for Hispanic (18.4 percent), White (18.2 percent) and Multiple Race (16.9 percent) babies.

**TYPES OF PERMANENCY ACHIEVED.** As reported in previous *Yearbook* editions, nearly all (98.8 percent) infants and toddlers exiting foster care achieved permanency. The 2021 *Yearbook* findings provide an additional view of the types of permanency babies achieved. The largest proportion of babies exiting care are reunified (48.1 percent) or adopted (34.6 percent); fewer babies achieve permanency with a guardian (8.3 percent) or relative (7.8 percent). Although there are high levels of missing data by race from states, differences in the types of permanency achieved could be determined for some races.

- **Race**

**Reunification.** The percentages of babies who were reunified with their families were higher than the national average of 48.1 percent for Asian (60.9 percent), Native Hawaiian/Pacific Islander (60.9 percent), Hispanic (52 percent), American Indian/Alaska Native (49.6 percent) and Black (49.5 percent) babies. The percentages of babies reunified were less than the national average for Multiple Race (46.6 percent) and White (45.2 percent) babies. Overall, rates of reunification varied by state, ranging from 24.7 percent in Delaware to 71.1 percent in New Mexico.

**Adoption.** The percentages of babies exiting foster care who were adopted were higher than the national average of 34.6 percent for White (37.2 percent), Multiple Race (37.2 percent), and Hispanic (34.8 percent) babies. The percentages of babies adopted were lower than the national average for Black (29.7 percent), Asian (27.7 percent), Native Hawaiian/Pacific Islander (27.3 percent), and American Indian/Alaska Native (23.8 percent) babies. Overall, rates of adoption ranged widely across states from 11 percent in Wyoming to 58.9 percent in Delaware.

**Guardian.** The percentages of babies exiting foster care who were placed permanently with a guardian were higher than the national average of 8.3 percent for American Indian/Alaska Native (13.2 percent), Black (10.2 percent), White (9.3 percent), and Hispanic (8.9 percent) babies. The percentages of babies placed with a guardian were lower than the national average for White (7.4 percent), Multiple Race (7.1 percent), and Asian (4.8 percent) babies. Data for guardian placement were not available for Native Hawaiian/Pacific Islander babies. Rates of placement with a guardian ranged widely across states from 1.6 percent of babies exiting care in New Jersey to 24.1 percent in Texas.

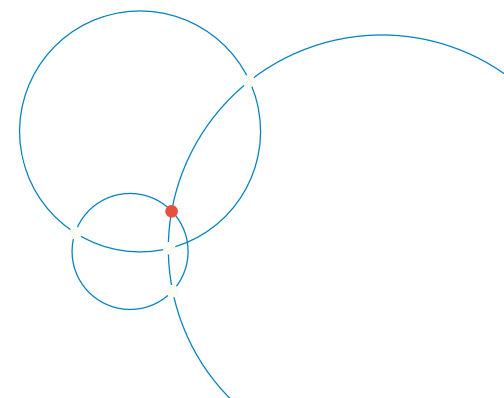
**Relative.** The percentages of babies exiting foster care who were placed permanently with a relative were higher than the national average of 7.8 percent for White (9.3 percent), Black (9.2 percent), and Multiple Race (7.9 percent) babies. The percentages of babies placed with a relative were substantially lower than the national average for Hispanic (3.6 percent), Asian (3.2 percent), and American Indian/Alaska

Native (2.9 percent) babies. Data for relative placement were not available for Native Hawaiian/Pacific Islander babies. Rates of placement with a relative ranged widely across states from 1.3 percent of babies exiting care in Illinois to 47.4 percent in Kentucky; however, it is noteworthy that information on this type of permanency was not available from as many as 25 states.

Subdomain	Indicator	Description	2019 Yearbook	2020 Yearbook	2021 Yearbook
Basic Needs Support	TANF benefits receipt among families in poverty	Percentage of families with infants/toddlers living below 100% of the FPL that receive TANF benefits <sup>a</sup>	20.6%	21.7%	21.7%
	Housing instability	Percentage of infants/toddlers who have moved three or more times since birth <sup>a</sup>	2.5%	2.7%	2.6%
	Crowded housing	Percentage of infants/toddlers who live in crowded housing	15.6%	15.5%	15.5%
	Unsafe neighborhoods	Percentage of infants/toddlers living in unsafe neighborhoods, as reported by parents <sup>a</sup>	6.3%	5.8%	4.9%



Subdomain	Indicator	Description	2019 Yearbook	2020 Yearbook	2021 Yearbook
Child Welfare	Family resilience	Percentage of families with infants/toddlers who report "family resilience" <sup>a</sup>	82.6%	85.2%	85.3%
	ACEs—1	Percentage of infants/toddlers who have experienced one ACE <sup>a</sup>	21.9%	22.4%	20.7%
	ACEs—2 or more	Percentage of infants/toddlers who have experienced two or more ACE <sup>a</sup>	8.3%	8.6%	7.74%
	Infant/toddler maltreatment rate	Maltreatment rate per 1,000 infants/toddlers <sup>a,b</sup>	16.0	15.9	16.4
	● Removed from home	Number per 1,000 infants/toddlers who have been removed from home and placed in foster care			7.1
	Time in out-of-home placement	Percentage of infants/toddlers who exited foster care in less than 12 months	--	20.2%	18.65%
	Permanency	Percentage of infants/toddlers exiting foster care who achieve permanency <sup>b</sup>	98.4%	98.6%	98.8%
	● Permanency – Adopted	Percentage of infants/toddlers exiting foster care who are adopted	--	--	34.6%
	● Permanency – Reunified	Percentage of infants/toddlers exiting foster care who are reunified			48.1%
	● Permanency – Guardian	Percentage of infants/toddlers exiting foster care who are placed with a guardian			8.3%
	● Permanency – Relative	Percentage of infants/toddlers exiting foster care who are placed with a relative			7.8%
Home Visiting	Potential home visiting beneficiaries served	Percentage of infants/toddlers who could benefit from evidence-based home visiting and are receiving those services	1.9%	1.9%	2.0%



Subdomain	Indicator	Description	2019 Yearbook	2020 Yearbook	2021 Yearbook
Supportive Policies	Paid sick time that covers care for child	State requires employers to provide paid sick days that cover care for child (Y/N)	11 states	11 states	12 states
	Paid family leave	State has a paid family leave program (Y/N)	7 states	9 states	10 states
	TANF work exemption	Single-parent head of unit is exempt from work-related activity if caring for a child under 12 months old (Y/N)	--	24 states	79.3%
	State CTC	State has CTC	--	24 states	Available at state level only
	State EITC	State has an EITC	--		

● New indicator in 2021

NOTES: ACE = adverse childhood experiences; CTC = child tax credit; EITC = earned income tax credit; TANF = Temporary Assistance to Needy Families

<sup>a</sup> Due to changes in data reporting and/or changes to the methods for calculating this indicator, we caution against directly comparing estimates from the 2019 Yearbook and the 2020 and 2021 Yearbooks. For a more detailed discussion, see the indicators and methodological appendices.

<sup>b</sup> This indicator appears in the *State of Babies Yearbook* domain tables only, because of concerns about its data quality (see Appendix C for more information). It is included in the rankings, to be consistent with the initial *State of Babies Yearbook: 2019*.

## Effects of COVID-19 pandemic on Strong Families

The economic effects of COVID-19 have placed an extraordinary burden on families with young children, as caregivers struggle with job and income loss, reduced accessibility to ECE and health care, and basic needs insecurity. As noted previously, *State of Babies* indicators showed families with infants and toddlers who are families of color or with low income already had high levels of economic insecurity, crowded housing, and food insecurity, and rated their mental health and resilience lower. The pandemic has exacerbated existing inequalities, many of which reflect the effects of structural racism. The prevalence of financial and material hardship places babies and toddlers at considerable risk, as stressful early life

experiences that are chronic and unrelenting can have lasting effects on brain and socioemotional development.

Although the CARES Act's enhanced unemployment benefits and eviction moratorium buffered early economic fallout of the pandemic, many families slipped into financial hardship when those benefits expired. As of December 2020, 66.2 percent of RAPID-EC respondents reported that they were experiencing financial problems, and 36.5 percent reported difficulty paying for basic needs (e.g., food, housing, and utilities).<sup>7</sup> Job loss and income loss have increased significantly during the pandemic. Among families with young children, since the pandemic began 42.2 percent have experienced a decrease in income,<sup>8</sup> 33.9 percent experienced a decrease in employment,<sup>9</sup> and 26.6 percent were unemployed, temporarily

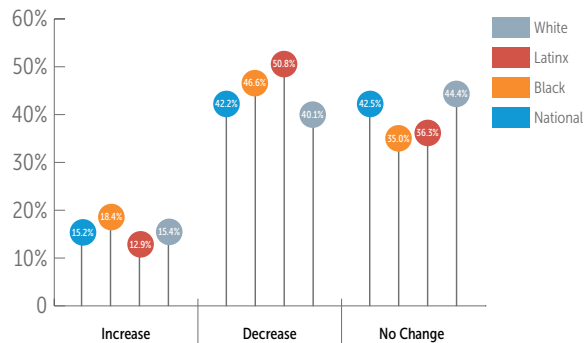
7 Financial problems and basic needs insecurity were based on the full sample of 6,720 families from the RAPID-EC survey.

8 Indicator was based on RAPID-EC responses from weeks 3 through 37 of the survey. This corresponds to responses between April 27 through December 21, 2020.

9 Indicator was based on RAPID-EC responses from weeks 3 through 25 of the survey. This corresponds to responses between April 27 through September 28, 2020.

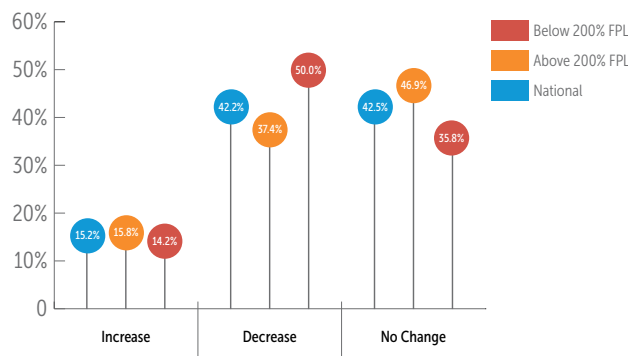


## Household Pandemic Income Change by Race/Ethnicity Figure 10.



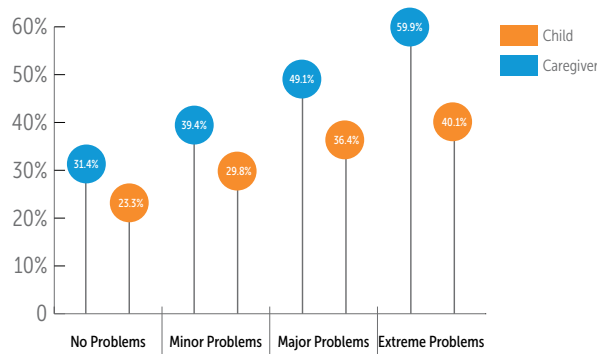
NOTE: Figure data based on the full sample of 6,720 families from the RAPID-EC survey between April 6 and December 24, 2020. Changes in income were self-reported by survey respondents.

## Income Change During COVID by Income Level Figure 11.



NOTE: FPL = Federal Poverty Level; Figure data based on the full sample of 6,720 families from the RAPID-EC survey between April 6 and December 24, 2020. Changes in income were self-reported by survey respondents.

## Emotional Distress by Level of Financial Hardship Figure 12.



NOTE: Data on financial problems and caregiver/child distress were based on the full sample of 6,720 families from the RAPID-EC survey between April 6 and December 24, 2020. Emotional distress scores were calculated based on aggregated responses. Financial hardship was self-reported.

out of work, or furloughed as of December 2020.<sup>10</sup>

Subgroup analysis of the RAPID-EC data further reveals that Black, Latinx, and low-income households have been impacted the most when it comes to financial problems, job loss, and basic needs insecurity (see Figures 10 and 11). For middle- and high-income households, experiences of material hardship are disaggregated by race and ethnicity. Structural inequalities and a pandemic that disproportionately affects Black and Brown communities have caused middle- and higher-income Black and Latinx households to experience material hardship at a higher rate compared to White households of similar pre-pandemic income.<sup>xlvi</sup>

Caregiver rates of stress, anxiety, and depression have risen during the pandemic, which may be partially accounted for by difficult decisions about returning to work, putting children in child care arrangements that feel unsafe, and balancing responsibilities at home. RAPID-EC data show a linear relationship between household level of financial hardship and emotional distress, among both caregivers and babies and toddlers. (See Figure 12).

## A way forward: Addressing family strengths and challenges through policy

All families need support in tackling the tough yet rewarding job of raising and nurturing children. Strong family policies at both the national and state levels support both the caregiving and economic functions of the family as well as fostering caring communities. Policies also can promote equitable support for all families, by promoting economic security and broad community


10 Indicator was based on RAPID-EC responses from weeks 3 through 37 of the survey. This corresponds to responses between April 27 through December 21, 2020.

supports that reverse the disproportionate involvement with the child welfare system that families of color experience. Strong national policies are the most effective way to ensure that all families have economic protections and supports, but state policies can amplify such policies or fill the gap when they do not exist.

**ENACT COMPREHENSIVE NATIONAL PAID LEAVE POLICIES.** Comprehensive paid family and medical leave, such as proposed in the FAMILY Act, promotes bonding between parents and babies, and it enables workers to care for their own and family members' extended health needs. Paid sick days, such as proposed in the Healthy Families Act, allow all workers to earn time to address short-term care needs for themselves or their ill child or family member, and to obtain preventive care. At the time of the 2021 *Yearbook*, only 10 states had enacted paid family medical leave (an increase of only 1 state from the previous year) and 12 states required employers to provide paid sick days that cover care for child (1 state more than in the 2020 *Yearbook*).

**State Opportunity:** In the absence of national paid leave policies, some states have moved ahead with their own initiatives. States can continue this progress, working to enact policies or improve those they already have. If national policies are enacted, states can work to provide enhanced benefits to families.

**BUILD AN EQUITABLE ECONOMIC BASE.** Families need a range of national policies that bolster economic security when children are young and their development most sensitive to economic want. Families need a minimum wage of \$15 per hour, a universal child allowance—such as the enhanced young child tax credit—and new approaches such as “baby bonds” to help close the racial wealth gap. The American Rescue Plan included a year of an enhanced, fully refundable child tax credit with a higher payment for young children. Such financial support translates to stable housing, food on the table, access to medicine, and reduced stress at home, all of which play a critical role in creating an environment ideally suited to



*“A big challenge has been] being able to expect what’s coming and prepare for it. Keeping our fridge stocked has been more difficult. Teaching my daughter about things has become harder, utilities have become more due to weather and lack of finances to fix our household. My daughter’s progress in her development is a major concern right now.”*

*RAPIC-EC Survey Respondent, NV.*



child development. State policies can augment support. As reported in the *Yearbook*, 30 states offer an EITC to families with children and as few as 6 states have a CTC, with both figures being unchanged from the 2020 *Yearbook*.

**State Opportunity:** States often have parallel policies that can exceed federal policy, as with the current minimum wage, or enhance federal supports, such as state EITC or CTC. They can work toward improving families' economic security in a variety of ways.

**CREATE COMMUNITIES THAT REINFORCE FAMILY STRENGTHS.** Create a robust new federal funding stream to help communities design strategies and implement services and supports to address the social determinants of health, giving every family a place to turn for support as they nurture their young children's development. Such support helps families form protective factors that buffer babies and young children from intolerable stresses that can derail their development. We spend billions separating families and placing children in foster care, perpetuating institutionalized

racism and inequities, while investing almost nothing in prevention. It is time to create a continuum of parent and family support services.

**State Opportunity:** Although federal funding for flexible, comprehensive support for families is limited, states can work to pool funds, draw down funds for sources such as Medicaid, or use Family First Prevention Services Act funds to build a community infrastructure that reaches all families with support that will be welcomed.

**ENSURE FAMILIES' ABILITY TO ACCESS AND SUSTAIN SAFE, STABLE, AND AFFORDABLE HOUSING.** Safe and stable housing is a basic necessity for everyone and is particularly important for infants and toddlers. Babies reap particular developmental benefits from having a safe and stable place to call home. Stable housing supports family well-being and lower stress levels, setting the stage for nurturing parenting. However, many families struggle with the high cost of housing, causing them to move frequently, live in crowded housing or unsafe neighborhoods, or experience homelessness—all of which deprive young children of a stable environment needed to thrive. While the robust rental assistance funding in the ARP will help address the risk of eviction during the pandemic, federal housing assistance continues to fall short of the overall need, and the number of households with children receiving rental assistance has declined over time.

**State Opportunity:** While most funding for housing comes directly from the federal government, states have the opportunity to direct and target state funds in a way that can best meet the needs of households with young children. States can target funds to pregnant women, or households with young children to address this ongoing issue. States should ensure families with young children benefit from pandemic housing assistance.

**TRANSFORM CHILD WELFARE INTO A FAMILY-FOCUSED, TRAUMA-INFORMED “CHILD WELL-BEING SYSTEM.”** Transforming the child welfare system by applying the science of early childhood development and adopting trauma-responsive and healing-centered policies and practices can help courts and communities keep families intact and thriving. The Strengthening America’s Families Act would build on promising work spreading across the country, where states and communities forge judicial and child welfare partnerships in infant-toddler court teams that drive equity in family support and outcomes. The act also would create a framework for effectively implementing preventive services under the Family First Prevention Services Act.

**State Opportunity:** As states seek to improve child welfare and implement Family First, they can adopt a developmental framework to transform child welfare into a community-driven, trauma-responsive system to better support infants and toddlers and their families who come to the attention of the child welfare system.





# Positive Early Learning Experiences

Infants and toddlers learn through interactions with the significant adults in their lives and active exploration of enriching environments. This section includes indicators related to parent-child interactions as well as three formal systems that support early development and learning as well as parents' work: child care, EHS, and early intervention. Overall, the early childhood landscape is one of scarcity, with a dearth of unhurried time for parent-child interactions, assistance for families who cannot afford the high cost of care, seats in the comprehensive EHS program, and screening and services for the many infants and toddlers with experiences that create a greater risk for developmental delays. COVID-19 impacted all of these early childhood professionals and programs, but none so hard as child care. The *Yearbook*, augmented by other sources, shows that infant-toddler child care has been both prohibitively expensive for families and woefully undercompensated for providers.

## AT A GLANCE: EARLY LEARNING BEFORE & DURING COVID-19

INDICATOR	State of Babies Yearbook PRE-COVID	RAPID-EC DURING COVID
<b>Developmental Screening</b>	<p>Low rates of developmental screening</p> <ul style="list-style-type: none"> <li>• 33% of infants and toddlers receive a developmental screening</li> <li>• 26.2% of Asian babies; 27.2% of Black babies ; 27.9% of Hispanic babies; 35.7% of White babies</li> <li>• 27% of babies in families with low income; 36% in above low income</li> <li>• Babies in families with low income and babies of color are less likely to have well-child visits or a medical home, where screenings often occur (see Good Health)</li> </ul>	<p>Fewer opportunities for screening:</p> <ul style="list-style-type: none"> <li>• 37.8% of families had missed a well-baby or child visit since the beginning of the pandemic</li> <li>• 45.7% of Black families and 46.8% of Latinx families reported missing a well-child visit</li> <li>• Children with disabilities were more likely to miss well-child visits (59.7%), especially at key milestone dates of 12 and 24 months</li> </ul>
<b>Child Care</b>	<p>A system not working for families</p> <ul style="list-style-type: none"> <li>• Cost of care is prohibitive: state range for two-parent, single parent</li> <li>• Families above low income eligible for subsidy in only 6 states</li> <li>• Only 4% of low- and moderate-income families receive a subsidy</li> <li>• Parents and providers struggle with the economics</li> </ul>	<p>A destabilized system</p> <ul style="list-style-type: none"> <li>• Families' use of nonparental child care plummeted at the beginning of the pandemic, and while it has increased gradually, there were declines that roughly followed periods of worsening infection rates</li> <li>• Use of nonparental child care remains well below pre-pandemic levels, particularly for households with low income</li> <li>• 18.3% of families with low income and 28.4% of families with higher income reported difficulty paying for child care during the pandemic<sup>a</sup></li> </ul>
<b>Early Intervention</b>	<p>Few states serve children at risk for delays</p> <ul style="list-style-type: none"> <li>• An average of 6.8% of infants and toddlers receive early intervention services</li> <li>• In states that provide services to "at risk" children, this can range up to 19.2%</li> <li>• Only 6 states serve children at risk for delays</li> </ul>	<p>Fewer services, higher distress levels</p> <ul style="list-style-type: none"> <li>• Children with special needs are receiving fewer services and their families have less social support</li> <li>• Caregivers report sustained, higher levels of emotional distress</li> <li>• Children have been experiencing more mental health problems</li> </ul>

NOTES: ECE = early childhood education; RAPID-EC = Rapid Assessment of Pandemic Impact on Development in Early Childhood

\* Data from the *State of Babies Yearbook: 2021* and the RAPID-EC Project are not directly comparable due to variation data sources and sample sizes; and are presented to give a general indication of conditions before and during COVID-19.

<sup>a</sup> Indicator is based on the full RAPID-EC sample of 6,720 caregivers between April 6 and December 24, 2020.



The pandemic upended the fragile early learning system, resulting in care settings becoming even more scarce and unaffordable when families looked to return their children to these programs. The end result is that pre-COVID-19, families and providers struggled with the precarious economics of child care, and the pandemic has intensified that struggle, leaving a system in disarray. With \$50 billion to rescue child care flowing out to states, the nation's attention must turn to creating a high-quality, affordable child care system, funded as the public good it is, that supports and appropriately compensates early educators and caregivers who provide the quality care children and families need.

The quality of infant and toddlers' early learning experiences at home and in other care settings can impact their cognitive and social-emotional development, as well as early literacy. High-quality early childhood care can strengthen parents' interactions with their children in the home learning environment and support parents' ability to go to work or attend school. Equitable access to high-quality care across factors like race, ethnicity, and income ensures all infants and toddlers have the opportunity for optimal development; however, disparities in access to high-quality care remain across many states and communities in the United States. Investments in comprehensive ECE, starting at birth, are a powerful and cost-effective way to mitigate the negative consequences that poverty has on child development and later opportunity in adulthood.<sup>xlvii</sup> Recent economic analysis shows that high-quality care from birth to age 5 yields a return on investment of 13 percent per annum in the form of better outcomes in education, earnings, and health.<sup>xlviii</sup>

The *Yearbook* includes two indicators of adult-child interaction supporting early language; reading to babies every day; and talking, singing, or telling stories every day. Language and literacy skills begin developing at birth and are fostered by parents and caregivers. Long before they are able to read, infants and toddlers develop literacy skills and an awareness of language.<sup>xlix</sup> Because language development is fundamental to many areas of learning, skills developed early in life help set the stage for later school success. By reading aloud to their young children, parents help them acquire the skills they will need to be ready for school.<sup>l</sup> Young children who are regularly read to have a larger vocabulary; higher levels of phonological, letter name, and sound awareness; and better success at decoding words.<sup>li</sup> Overall, few

babies are being read to every day. While more are hearing talking, singing, or stories, a sizeable group of babies are not receiving these interactions. There are differences by race and ethnicity as well as income, which could reflect several factors, such as less available time, greater stress, as well as cultural factors or a lack of understanding that even very young infants benefit from hearing language and the close contact these activities bring. If many parents pre-COVID already were not having frequent interactions with their babies that promote early language and literacy, during the pandemic they have been hard-pressed to balance work and caregiving. While opportunities for being with young children increased, parental stress and the need to support remote learning of older children may have prevented more of these interactions from occurring.



Second only to the nurturing experiences within the immediate family, ECE is the context in which early childhood development most frequently unfolds, starting in infancy.<sup>liii</sup> Parents of children under 3 years old are more likely to use informal child care (provided by friends, family, or neighbors) than formal child care.<sup>liiii</sup> The *Yearbook* includes several indicators related to the ability to afford child care, assistance provided, and the floor states place on quality. The implications of these indicators have been explored more fully in a separate brief, *The State of Child Care for Babies: The Need to Do Better for Our Youngest Children*.<sup>liv</sup> Cost is a major barrier for families with babies, even those with moderate income, yet only about 4 percent of families who need help paying for care receive direct assistance to do so. Some gains are found in the number of states with income eligibility criteria above 200 percent FPL for child care subsidies, and the number of states that reimburse center-based child care at or above the 75th percentile of current market rates. ECE settings have a dual role, helping parents work but also shaping the foundational brain development of the early years. Quality of care matters. Most states set a floor in their regulatory frameworks for infant-toddler care quality too low to ensure babies have the opportunities for one-on-one interactions with skilled early childhood educators they need to grow socially, emotionally, and cognitively. Because parents shoulder the bulk of paying for ECE, supplemented by the low wages of providers, the precarious economics of child care has always been a challenge to expanding access, ensuring appropriate compensation for educators who do highly skilled work, and improving quality.

When the pandemic began, many child care programs shut down at the same time as families' need for care plummeted. The hazards of the precarious nature of child care financing quickly became apparent. Even when programs remained open or have since reopened, reduced capacity meant programs struggle to remain viable. Parents' situations also varied, because of shifting preferences or need. Parents with different income levels have had very different experiences. The use of nonparental care by families with low



income and those with above low income both plummeted as the pandemic began, but families with low income have barely come back. Help for providers and families is included in the American Rescue Plan, but the pandemic experience has laid bare both the fragility of the current system *and* the vital role it has played in supporting the nation's productivity and economy. The need is clear for a strong, comprehensive child care system that meets the needs of both parents and children, with implications for the strength of the economy now and in the future.

The federal EHS program was created to help minimize the disparities caused by poverty by supporting the healthy development of expectant mothers and their infants and toddlers in families with income below the poverty line. The 2021 *Yearbook* shows only 11 percent of babies and toddlers who are eligible for EHS are currently being served. While this would appear to be a positive increase from 7 percent in previous years, this increase is related to the drop in the number of children who are income eligible. The number of slots funded for EHS actually has decreased. EHS weathered the pandemic because it is part of a system that ensured the program and its staff





were financially supported throughout. It could play a key role in helping families recover from their stressful economic and social ordeal, but its funding level allows it to reach only a small fraction of income-eligible children. As EHS expands, keeping its original mission of supporting the early development of children in overburdened, under-resourced families is imperative. EHS should not be expanded in a way that requires a work test that would exclude pregnant women and children in families disconnected from the workforce. The new demographic indicator shows 5 percent of all babies, but 21 percent of babies in poverty, are in families with no adult working. Those young children in the income-eligible group for EHS would benefit greatly from developmental support and should not be excluded from services.

Early identification of developmental delays and intervention are critical during the rapid growth of babies in the first 3 years. The *Yearbook* includes a cluster of indicators around developmental screening and Part C/Early Intervention services. State averages indicate that infants and toddlers as a whole have made small gains in developmental screenings, but still less than a third receive a

screening. Disparities emerge for children of color and with low income, who are at greater risk for delays. Children who receive a developmental screening are more likely to have delays identified, be referred for early intervention, and be determined eligible for early intervention services.<sup>lv</sup> For this reason, the American Academy of Pediatrics recommends that children receive developmental screening from their physicians at least three times before their third birthday. It is difficult to interpret the percentage of children receiving early intervention services, which has remained stable over several years. Because the *Yearbook* shows concerning rates of conditions that create risk for developmental delays, such as preterm birth, living in crowded housing, high rates of maltreatment, and multiple ACEs—more prevalent in children of color and those in families with low income—monitoring the development of these infants and toddlers is an important prevention measure. Even as early intervention service providers worked hard to continue supporting the infants and toddlers already identified as having developmental delays and disabilities, the pandemic exacerbated the conditions, including mental health issues, that could undermine future development. Yet, only six states have elected to serve an “at risk” category of children, to catch and address those risks before they develop into something more serious.

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## Key findings

The 2021 *Yearbook* findings in the Positive Early Learning Experiences domain reflect many areas in which, even prior to the pandemic, the early childhood system was not sufficiently supporting families in meeting the early learning needs of their infants and toddlers. Importantly, access to affordable, high-quality learning environments continues to be a limiting factor for most of America’s families, and it was disproportionately out of reach for families of color and those with low income. Limited progress was shown on key indicators in this domain and declines were found in others, such as receipt of Individuals with Disabilities in Education (IDEA) Part C services for babies with disabilities, that continued to leave

families without the comprehensive policies and services required to ensure optimal early learning.

Findings in this domain showed modest gains. Several key indicators continued to be of concern, particularly those related to supporting early literacy, early identification of developmental delays and intervention, and the quality of care for infants and toddlers.

## PARENT-CHILD LANGUAGE INTERACTIONS

**PARENT READS TO BABY EVERY DAY.** Despite the importance of reading, nationally, only 37.2 percent of parents reported reading to their infant or toddler every day. This finding was virtually unchanged from the percentages reported in the two previous *Yearbooks*. In looking across states, the proportion of parents who report reading to their baby daily ranged from 27.1 percent in Georgia to 57.8 percent in Vermont. In a majority of states, fewer than half of their parents read to their infant or toddler daily. Notable differences were found on this indicator when examined by race/ethnicity and income.

- **Race**—Nationally, the percentage of White parents (45 percent) who reported reading to their baby daily was above the national average of 37.2 percent. The proportions of Asian (36.9 percent), Black (24 percent), and Hispanic (23.4 percent) parents who reported reading to their baby daily were lower than the national average.

- **Income**—The proportion of parents with low income (27.6 percent) who reported reading to their infant or toddler every day was about two thirds the number for families above low-income (43.8 percent). Due to small sample sizes at the state level, most of the state estimates for families with low income were either unreliable or suppressed. However, states reporting differences by income also reflected the national trend. Among families with low income, state rates of reading ranged from 16.1 percent in California to 58.7 percent in Vermont.

**PARENT SINGS OR TELLS STORIES TO BABY EVERY DAY.** Nationally, more than half (57.4 percent) of parents sing or tell stories to their infant or toddler every day. Within the states, rates ranged from 47.6 percent in Texas to 72.3 percent in Alaska. The majority of states reported that more than half of parents sing or tell stories to their infant or toddler every day.

- **Race**—Nationally, the percentage of White parents (64.5 percent) who reported singing or telling stories to their baby every day was above the national average of 57.4 percent. The proportions of Asian (46.1 percent), Hispanic (45.9 percent), and Black (45.4 percent) parents who reported singing or telling stories daily were similar and lower than the national average.



- **Income**—Nationally, the average number of parents with low income (49.0 percent) who reported singing or telling stories to their children every day was about three quarters the number of families above low-income (63.0 percent). Due to small sample sizes, most of the state estimates for families with low income were either unreliable or suppressed, however, all differences were also in the same direction among states with significant differences. Among families with low income, state rates of singing or telling stories every day ranged from 30.3 percent in Texas to 76.1 percent in Alaska.

## EARLY INTERVENTION INDICATORS

**LIMITED REACH OF EARLY INTERVENTION TO IDENTIFY AND ADDRESS DEVELOPMENTAL DELAYS.** 2021 *Yearbook* findings show the timeliness and receipt of IDEA Part C services continues to be inadequate, despite the rapid pace of development babies experience in the first 3 years. Notably, only six states include children at risk for disabilities as eligible for IDEA Part C services or report that they serve them.

**DEVELOPMENTAL SCREENING.** Nationally, only 1 in 3 (32.5 percent) infants and toddlers from 9 through 35 months old received a developmental screening in the past year. This finding reflects a continuation of the slight incremental increases found in the previous 2 years; and when examined by subgroup, substantial disparities remain. Rates of developmental screening ranged from 20.9 percent in Louisiana to 56.6 percent in Oregon. Three quarters of states reported screening rates below 37.6 percent.

- **Race**—Nationally, the percentage of White parents (35.7 percent) reporting that their infants and toddlers had received a developmental screening in the past year was higher than the national average of 32.5 percent. Hispanic (27.9 percent), Black (27.2 percent), and Asian (26.1 percent) parents reporting that their child had received a developmental screening in the past year

were similar and lower than the national average.

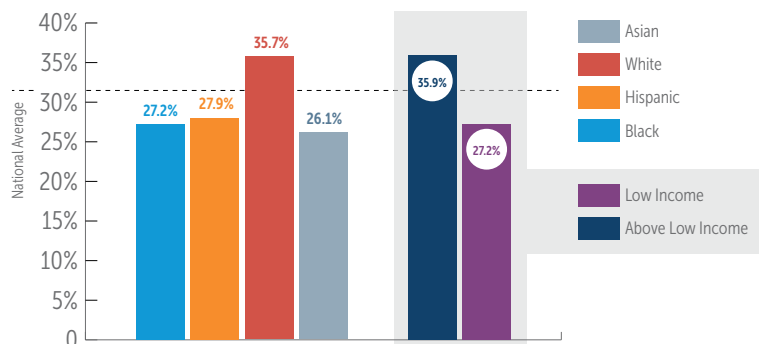
- **Income**—Nationally, the average number parents with low income (27.2 percent) reporting that their child had received a developmental screening in the past year was significantly less than the number of families above low income (35.9 percent). Due to small sample sizes, most of the state estimates for families with low income were either unreliable or suppressed, however, among states with significant differences, all differences also showed lower rates of screening for families with low income. Among families with low income, state rates of developmental screening ranged from 12.2 percent in New Hampshire to 51 percent in Oregon.

**INFANTS/TODDLERS RECEIVING IDEA PART C SERVICES.** Although subgroup data are not available for this indicator, the number of infants and toddlers with disabilities from birth to 2 years old who received early intervention services under IDEA Part C during the most recent 12-month period was virtually unchanged at 6.8 percent, up from 6.4 percent in the previous year.

## CHILD CARE INDICATORS

**ASSISTANCE PAYING FOR CHILD CARE.** The Child Care and Development Block Grant (CCDBG) is the major source of child care subsidies for families with low income, setting overall

### Key Findings Developmental Screening





policy that gives states flexibility in determining how to administer the program. Total funding comes from both appropriations and mandatory funds, sometimes referred to as the Child Care and Development Fund (CCDF). Funding has never been adequate to reach families eligible under the federal limit of 85 percent of state median income, so states generally set lower levels. Even so, very few families qualify. Yet, the cost of infant-toddler care is high, and many more families with low or moderate income could still use help paying for the care that takes such a big bite out of family budgets.

- At the time of the 2021 *Yearbook*, only 16 states set their income eligibility levels for child care subsidies—assistance for families with low income—above 200 percent of the FPL. However, this represented an increase of three states over the previous year.
- Only 4.2 percent of infants and toddlers in families with incomes equal to or below 150 percent of the state median income receive a child care subsidy, a level relatively unchanged over the last 3 years.

**LOW FLOOR FOR QUALITY CHILD CARE STANDARDS.** States do not share the same definitions of what constitutes a floor for quality care for

infants and toddlers, as established by regulations. They have different requirements for staff education and qualifications, the number of babies that can be cared for as a group, and the number of babies that can be cared for by one adult. Since the 2020 edition, the *Yearbook* has used the Head Start Program Performance Standards for EHS as a benchmark on which to compare states' requirements and standards for center-based child care for infants and toddlers. The EHS evaluation found that programs implementing these standards early and thoroughly had the broadest pattern of effects for children.<sup>lvi</sup> Although no updates to the data were available for the 2021 *Yearbook*, the findings remain concerning because they indicate states are less likely to meet or exceed EHS quality standards for babies after they reach 1 year old. These and other *State of Babies* data related to child care are explored more fully in *The State of Child Care for Babies: The Need to Do Better for Our Youngest Children*.<sup>lvii</sup>

- **More states have adult–child ratios that meet or exceed the standards set by EHS (one adult for every four infants and toddlers) for infants than for older babies.** 35 states meet or exceed the standard for children at age 11 months, 14 states at 19 months, and 2 states at 30 months. Among these states, 21 meet or exceed the standard for one of the ages (infants), 12 states achieve it for two ages (infants and 1-year-olds), and two states achieve it for all three ages, including 2-year-olds.
- **More states have group size requirements that meet or exceed the standards set by EHS (eight infants or toddlers in a group) for infants than for older babies.** 23 states meet or exceed the requirement for one of the ages (infants), 7 states achieve it for two ages (infants and toddlers), and only 1 state achieves it for all three ages.
- **Only six states require teachers of infants and toddlers to have either a child development associate (CDA) credential or state equivalent.** In fact, a vast majority—45 states—require no credential beyond a high school diploma.

These requirements fall short of EHS's requirement that teachers have a minimum of a CDA or comparable credential, with training or course work in early childhood development with a focus on infant/toddler development.

- Thirty states have adopted an infant/toddler professional credential, a component of early childhood workforce development that recognizes providers' achievement of the specialized knowledge and skills required to provide high-quality care for babies.

**QUALITY IMPROVEMENT FUNDS.** Even if regulatory requirements do not demand quality, states still can work to improve services. In addition to an overall quality improvement set-aside,

states must use 3 percent of their CCDF funds to improve the quality of services for infants and toddlers. States have used those funds to make significant program improvements, although these advances are not necessarily reflected in the *Yearbook* indicators. Improvements include increasing reimbursement rates for infants and toddlers, expanding access to subsidies to more families (12 states focused specifically on infants and toddlers), and implementing family-friendly eligibility policies that help ensure continuity of care for very young children.

- Thirty-four states planned to allocate more funding for quality improvement activities related to infants and toddlers, although it was unclear if these amounts were over and above the required infant-toddler set-aside.<sup>lviii</sup>



Subdomain	Indicator	Description	2019 Yearbook	2020 Yearbook	2021 Yearbook
Early Care and Education Opportunities	Parent reads to baby every day	Percent of parents who report reading to their infants/toddlers every day <sup>a</sup>	38.2%	37.8%	37.2%
	Parent sings to baby every day	Percent of parents who report singing songs or telling stories to their infants/toddlers every day <sup>a</sup>	56.4%	57.6%	57.3%
	% income-eligible infants/toddlers with EHS access	Percent of infants/toddlers below 100% of the FPL with access to EHS	7.0%	7.0%	11.0%
	Cost of care, as % of income, married families	Average state cost of center-based infant care as a percentage of median income for married families	Not available at national level	Not available at national level	Not available at national level
	Cost of care, as % of income, single parents	Average state cost of center-based infant care as a percentage of median income for single parents	Not available at national level	Not available at national level	Not available at national level
	Families above 200% of FPL eligible for child care subsidy	Income eligibility level for child care subsidy above 200% of the FPL	12 states	13 states	16 states
Child Care Quality	Low/moderate income infants/toddlers in CCDF-funded care	Percent of infants/toddlers with family incomes equal to or below 150% of the state median income who are receiving a child care subsidy	4.2%	4.2%	4.2%
	Allocated CCDBG funds	State allocated new CCDBG funds to invest in infant-toddler care		34 states	34 states
	Group size	Whether group size requirements meet or exceed the standards set by EHS at 11 months, 19 months, and 30 months old (value 0–3)	--	23 states <sup>c</sup>	7.74%
	Adult/child ratio	Whether adult–child ratio meet or exceed the standards set by EHS at 11 months, 19 months, and 30 months old (value 0–3)	--	35 states <sup>d</sup>	30 states
	Teacher qualifications	Level of teacher qualification required by the state, for teachers of 11-month-olds, 19-month-olds, and 30-month-olds across five categories: no credential beyond high school degree; CDA or state equivalent; Specific infant/toddler credential or CDA with infant/toddler credential; associate’s degree; Bachelor’s degree (value 3–15)	--	6 States—CDA/state equivalent	7.1
	Infant/toddler professional credential	State has adopted an infant/toddler credential	--	30 states	30 states
	State reimburses center-based child care	State reimburses center-based child care at or above the 75th percentile of current market rates		1 state	4 states

Subdomain	Indicator	Description	2019 Yearbook	2020 Yearbook	2021 Yearbook
Early Intervention and Prevention Services	Developmental Screening	Percentage of infants/toddlers, 9 through 35 months old, who received a developmental screening using a parent-completed tool in the past year	30.4%	31.1%	32.5%
	Delay	Percent of infants/toddlers with moderate/severe developmental delay <sup>a,b</sup>	1.1%	1.0%	1.1%
	At-risk children included in Part C eligibility definition	State includes "at-risk" children as eligible for IDEA Part C services	--	5 states	6 states
	Percent of infants/toddlers receiving IDEA Part C services	Percent of infants/toddlers receiving IDEA Part C services	3.1%	6.4% <sup>e</sup>	6.8% <sup>e</sup>
	Timeliness of Part C services	Percent of eligible infants and toddlers required to have an initial IFSP meeting who had the meeting within 45 days	--	Not available at national level	Not available at national level

NOTES: CDA = Child Development Associate degree; EHS = Early Head Start; CCDBG = Child Care Development Block Grant; CCDF = Child Care Development Fund; FPL = Federal Poverty Level; IDEA = Individuals With Disabilities in Education Act

<sup>a</sup> Due to changes in data reporting and/or changes to the methods for calculating this indicator, we caution against directly comparing estimates from the 2019 Yearbook and the 2020 and 2021 Yearbooks. For a more detailed discussion, see the indicators and methodological appendices (Appendix B and Appendix C).

<sup>b</sup> This indicator appears in the *State of Babies Yearbook* domain tables only, because of concerns about its data quality (see Appendices B and C for more information). It is included in the rankings, to be consistent with the initial *State of Babies Yearbook: 2019*.

<sup>c</sup> 23 states meet or exceed the requirement for one of the ages (infants), 7 states achieve it for two ages (infants and toddlers), and only 1 state achieves it for all three ages.

<sup>d</sup> 21 states meet or exceed the standard for one of the ages (infants), 12 states achieve it for two ages (infants and one-year-olds), and 2 states achieve it for all three ages, including 2-year-olds.

<sup>e</sup> Beginning with the 2020 calculation, cumulative count for most recent 12-month period is used, whereas snapshot was used for 2019.

## Effects of COVID-19 pandemic on Positive Early Learning Experiences

The fallout of COVID-19 and its resulting economic shutdown have made child care's importance for child and family success increasingly evident. More than half the families in the RAPID-EC survey reported using some form of nonparental child care for their infant or toddler prior to the pandemic. That number dropped to around 23 percent in early May when child care centers across the country shut down, requiring some families to quickly find alternate child care solutions. Specifically, household use of center-based child care declined from 52.9 percent

pre-COVID to 27 percent in May 2020. Additional safety precautions such as regular sanitation of high-touch surfaces, social distancing, and contact tracing have allowed some child care centers to reopen during the pandemic. However, many have struggled to remain open due to the increased cost of implementing public health measures, insufficient federal aid, and lower revenue from operating at limited capacity. Nearly 4.5 million child care seats risk being lost permanently, which threatens a US child care system that was already struggling to meet family needs prior to the pandemic.<sup>lix</sup> Even before this loss, child care deserts existed, particularly in rural communities and communities of largely middle-income or Latinx populations.<sup>lx</sup>

## CHILD CARE

According to RAPID-EC data, overall household use of nonparental child care gradually increased after plummeting at the start of the pandemic. However, a combination of job loss, reduced child care affordability, and safety concerns have kept nonparental child care use well below pre-pandemic levels, particularly for families with low income. Trends in nonparental child care use also unsurprisingly followed national COVID-19 spread data, with child care use dropping around weeks that coincided with the beginning of the second and third waves of the pandemic (see Figure 13).<sup>lxvi</sup>

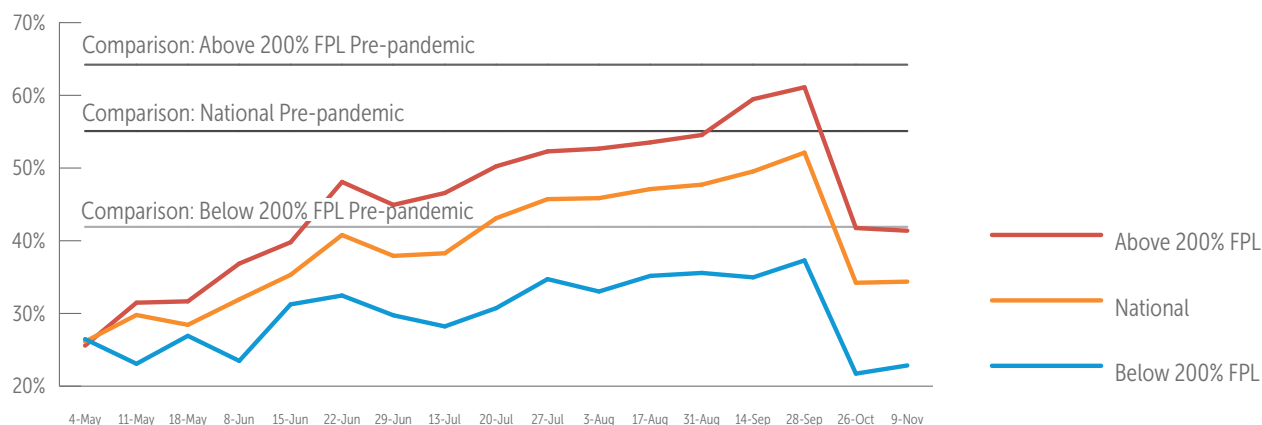
Unlike families of higher income, families with low income's use of nonparental child care was lower in October 2020 than it was in May 2020. This slower rate of return to nonparental child care among households with low income coincides with higher rates of unemployment and job loss compared to higher income families. In many families, pandemic-related unemployment has decreased need for nonparental child care. While decreased child care affordability may have also prevented families with low income from returning to pre-pandemic child care arrangements, only 18.3 percent of families with low income reported difficulty paying for childcare since the pandemic had started, compared to 28.4 percent of middle- and high-income families, a

likely result of household differences in child care subsidy eligibility.

Across all families, caregivers have been forced to make difficult decisions between delaying their return to work in order to care for young children and placing children in child care settings that feel unsafe. A study from the US Chamber of Commerce Foundation found that 50 percent of parents who had not returned to work by October cited child care as a reason they had not returned.<sup>lxvii</sup> According to RAPID-EC data, 82.6 percent of caregivers who were unable to work due to losing child care during the pandemic were not approved for unemployment benefits. Working mothers are disproportionately bearing the responsibility of child care, and are nearly three times as likely as men not to be working due to child care demands.<sup>lxviii</sup> Parents who do work from home are struggling to care for children while balancing responsibilities to support their family financially and manage older children's remote schooling, often with little outside help. Families are significantly less likely to use center-based or home-based child care compared to before the pandemic, and there has been a rise in use of friends and family members as sources of child care (see Figure 14).

Increasing concern about child care arrangements and financial security have the potential

**Nonparental Child Care Use During COVID-19** Figure 13.



NOTE: FPL = Federal Poverty Level; Figure includes data collected between May 4 and November 9, 2020. Caregivers reported whether they had used nonparental child care in the last week.



to negatively impact young children’s early social-emotional development and well-being, as caregiver stress rises. Single-parent and low-income households have been particularly impacted, and report higher rates of emotional distress and child distress.<sup>lxiv</sup>

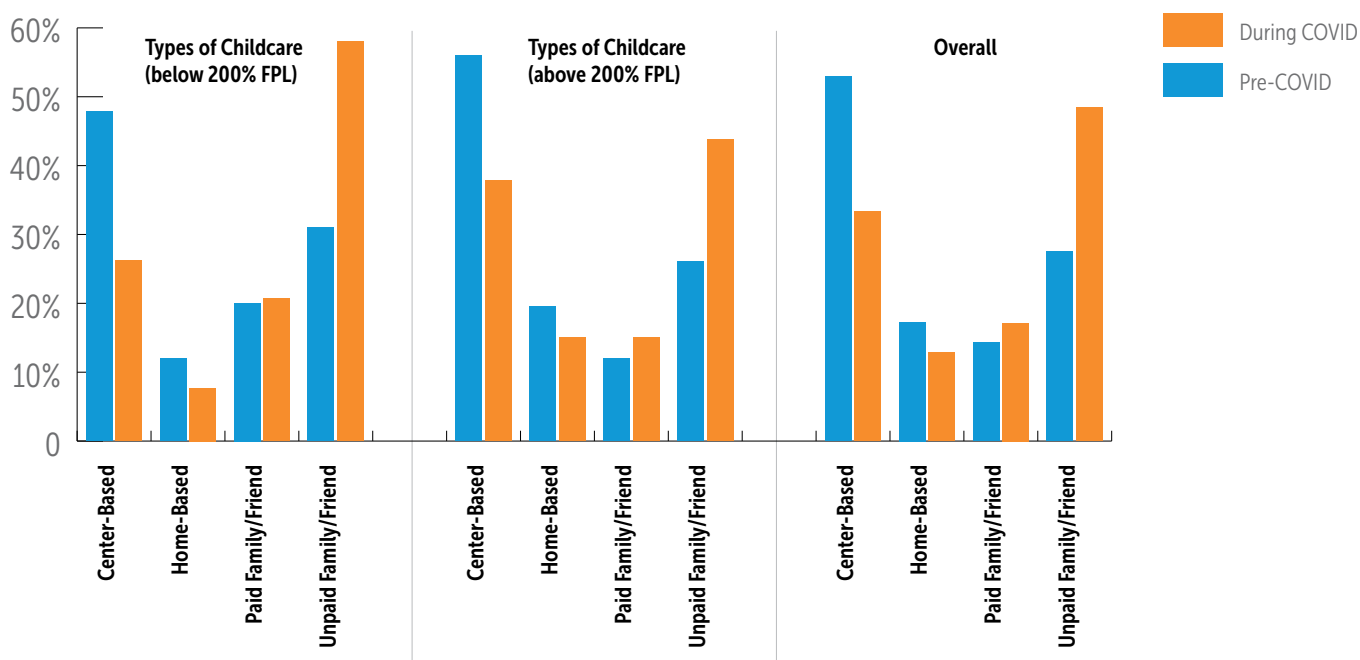
## EARLY LEARNING AND DEVELOPMENT

Shelter-at-home orders and social distancing measures have reduced babies and toddlers’ opportunities to engage in positive early learning experiences outside the home and increased many babies’ exposure to adverse early experiences. Early years matter most in shaping the foundation for later learning and development, and exploration and play are essential parts of those early years. The pandemic has decreased babies and toddlers’ time spent interacting with other children and practicing key social skills like sharing and working with a group. Some early child care providers have noticed delays in speech and language, which is likely a result of reduced socialization outside the home. The continued focus on social distancing and mask-wearing has made many young children hyper-aware of their surroundings, making it difficult for them to engage in relaxed

play.<sup>lxv</sup> While strong caregiver relationships are vital for babies and toddlers, caregivers of young children are experiencing new responsibilities and higher levels of stress that impact their ability to engage in positive early learning experiences at home. Babies and toddlers are at risk of being left behind as caregivers balance competing responsibilities of finances, child care, and managing older children’s remote schooling.<sup>lxvi</sup>

While it is unclear whether the social and developmental effects of the pandemic will be long-lasting, decades of research show that adverse early life experiences and chronic stress can have long-term negative consequences on health, learning, and development. For many families, the pandemic has worsened multiple factors that contribute to adverse childhood experiences, including food and basic needs insecurity, household stress, and rates of domestic abuse and neglect,<sup>lxvii</sup> especially for families with low income. When children have been exposed to one or a combination of these adverse experiences for a prolonged period of time, they may develop toxic stress, which has serious consequences for brain and biological development.<sup>lxviii</sup> Numerous studies also show disparities that arise early on continue to widen in later years, and the pandemic has exacerbated

**Non-Parental Childcare** Figure 14.



many existing inequities. Access to high-quality child care has been seen to buffer the later academic achievement gaps between low-income and higher-income children,<sup>11</sup> but the pandemic has also contributed to a large decrease in the number of families using nonparental child care,<sup>11</sup> particularly among families whose children could most benefit from these services.

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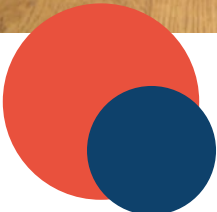
## A way forward: Strengthening early care and learning through policy

**Sustain child care and build the world-class system families deserve:** As a key foundation for a strong economy, child care is a public good. The ARP has made a robust investment in sustaining the child care system decimated by COVID-19. To rebuild, we need a comprehensive child care program that places quality child care within reach of all working families, particularly those with low and moderate income, and appropriately compensates and supports the child care workforce for their highly skilled work in nurturing early development. The Child Care for Working Families Act would increase the number of children and families served, assure quality services and promote equitable early learning opportunities.

**State Opportunity:** As states move to stabilize child care providers hard hit by the pandemic, they should adopt strategies that create a foundation for an improved system in the future. These include increasing the use of contracts to ensure all types of providers as well as families can count on financing that preserves capacity. They should be particularly attentive to ensuring that child care programs that serve the most under resourced and overburdened families, many of whom are families of color, have the resources to reopen, remain open, or pay back debts they incurred to stay open and that they are creating the conditions to alleviate child care deserts as rebuilding begins. States should also be sensitive to the range of family preferences in types of care and increase the availability of mechanisms, such as staffed family child care networks, shared services models, resource and referral agencies, and Infant-Toddler Specialist networks that can support and stabilize all provider types. States should also look to increase reimbursement rates for all providers, to ensure those providers serving families receiving subsidies have the increased resources they need to continue serving families safely and effectively, while also supporting increased pay and benefits for early

11 Caregivers who had reported using nonparental child care were asked which type of child care they were currently using for their children. Care options were (1) any type of paid or unpaid center-based childcare, such as pre-school, daycare center, public pre-kindergarten, Head Start, or faith-based nursery school, do not include kindergarten; (2) At least five hours of unpaid care by a relative, friend or neighbor; (3) At least five hours of paid care by a relative, friend or neighbor; (4) At least 5 hours of paid care from a home-based childcare provider, including home-based care where the provider is paid to care for your child even if you are not making the payment





*“My partner had a significant pay cut and I will have to return to work which is difficult on many levels. Child care in Boston is very expensive, and is now even harder to find due to new COVID-19 precautions. The supply is much smaller than the demand, and many families are turning to in-home care such as nannies, which we cannot afford.”*

*RAPID-EC Survey Respondent, MA*

educators who are serving as a foundational piece of our economic infrastructure. Finally, in response to the traumatic impact the pandemic has had on babies and toddlers and their families, states should look to set up systems of infant and early childhood mental health consultation to help providers better promote the social and emotional development of the children in their care.

**Fully fund Early Head Start as a beacon of hope:**

As more families are challenged by the sharp economic downturn, this effective early development and family support program should be empowered to reach all eligible infants and toddlers as well as serve significantly more pregnant people. Early Head Start (EHS) is the only federal program dedicated to comprehensively promoting healthy child and family development for pregnant people, infants, and toddlers living in families with incomes below the poverty line. Its effectiveness is supported by program performance standards that are a benchmark toward which other early childhood programs should strive.

In recent years, federal funds have been set aside expressly for expanding EHS, but the program should receive substantial funding increases to put it on a trajectory to reach full funding. Some expansion has come through Early Head Start-Child Care Partnerships to help infuse quality into child care programs, an option that should continue to be available to meet local needs.

Where community needs call for more infant-toddler services, programs should be encouraged to convert funded Head Start slots to Early Head Start openings. The conversion process must ensure programs have time to meet infant-toddler standards and are ready to provide appropriate services for the youngest children.

Although its grants flow directly to local communities, EHS can be a model for state investment to address the needs of babies and families facing the greatest challenges. In addition, nine states supplement EHS enrollment, although usually



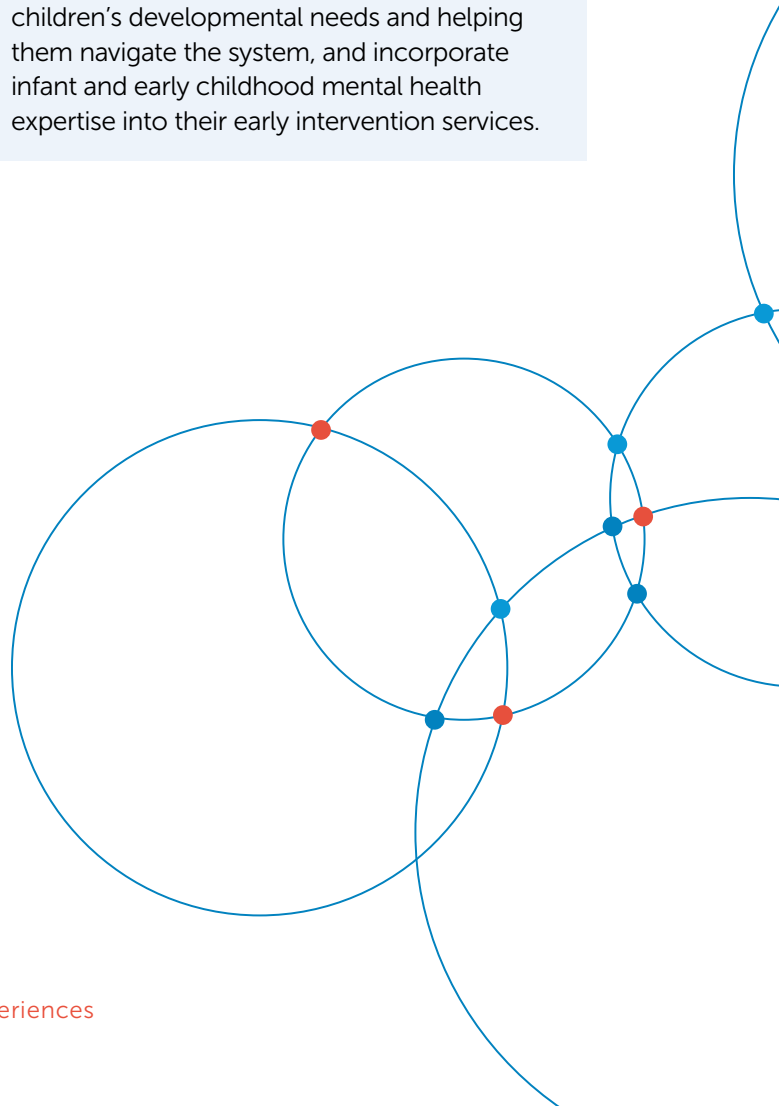
in small numbers. Fourteen states use Maternal, Infant, and Early Childhood Home Visiting program funds for the EHS home-based model.<sup>bx</sup>

**State Opportunity:** States can invest in expanding EHS as a proven comprehensive approach to support families and early development, starting prenatally, using state funds or by leveraging permissible federal funds. They could use the robust pandemic child care relief funds to support or establish child care programs meeting EHS standards for families experiencing economic and social distress to address their children’s developmental needs as they seek to return to work.

**Expand Early Intervention (EI) as an essential part of the early care and learning system:** The federal funding structure for EI services through Part C of IDEA should enable states to fully meet

the developmental needs of infants and toddlers, including developmental screening and follow-up; helping families navigate the system; expanding the EI workforce and ensuring adequate reimbursement; ensuring coverage for more children who are at risk or could benefit from services; and incorporating more infant and early childhood mental health expertise and services. As noted above, only 6 states include “at-risk” children as eligible for IDEA Part C services, an increase of 1 state from the previous reporting period.

**State Opportunity:** States can consider including children at risk for developmental delays in their eligible population to ensure early intervention can be a preventive service, especially if they have concerning levels in *Yearbook* indicators related to risk for developmental delays. They also can work to expand developmental and social-emotional screening for more children, expand outreach to parents to assist them in understanding their children’s developmental needs and helping them navigate the system, and incorporate infant and early childhood mental health expertise into their early intervention services.





# Future Directions for the State of Babies *Yearbook*

As noted in the inaugural *State of Babies Yearbook: 2019*, we have continued to refine the indicators and expand the policies tracked. As became clear when ZERO TO THREE and Child Trends embarked on this initiative 3 years ago, the breadth of the policy domains that influence development and the lack of some key data points meant that finding the strongest set of core indicators would of necessity be an iterative process. We began by identifying an aspirational set of indicators about babies and families, then assembling the best available, readily accessible data on the most important areas.



Enhancements in the *State of Babies Yearbook: 2021* reflect our continuing efforts to establish a stable set of data points that provide the most comprehensive picture of America's babies. Our objective in modifying or adding indicators is to ensure they are most useful to policymakers and advocates in spurring action and tracking policies over time to support young children and their families. This year, the *Yearbook* state profiles and website have been further enhanced to include additional new indicators of child well-being and policy; the ability to view disaggregated data by subgroup (i.e., race/ethnicity, income, and urbanicity) for all indicators where data are available; and new sub-report views of the data for 3 key topics – *The Intersection Between Race/Ethnicity and Health*, *Babies in Families with Low Income*, and *Material Hardship*. To provide continuity for states in cross-country comparisons while we go through this multiyear refinement process, *State of Babies* continues to hold constant the indicators that are the basis for states' tier determinations, using only the initial 2019 indicators.

We continue to examine options for the best way to support states and advocates in exploring the well-being of infants, toddlers, and families—and welcome input from stakeholders. To fully mine the data available at the federal and state levels requires both time and creativity. New datasets may become available, enabling easier access to useful data points. Exploring using available data to create new indicators can help us get closer to the conditions we really need to know about over time. Therefore, we have laid out a plan to reach a more stable set of indicators.

We hope states will continue to use this period to focus, not on their tier ranking, but on their own babies. They should use the deeper story gleaned from this year's expanded views of the data to get closer to the babies and families who are behind the numbers. In short, the story should not be about "pride of state." It should be about the babies.



## STATE OF BABIES MILESTONES

**Holding State Tiering Process Constant:** Each year of the roadmap will bring changes to indicators as we work through this iterative process to find the best combination of indicators to tell the story of babies and families across and within states. To avoid constant reranking that would make it difficult for states to understand their relative position, we decided to continue using the 2019 indicators to create the GROW tiers until we have identified the stable set of indicators that will be tracked over time. States will be able to see how Indicators added in those years compare to national averages and in what tier they fall.

**Using this opportunity to “see” your state’s babies:** The state tiers are a helpful at-a-glance way to see where your state’s babies stand. But by themselves, they are more about the state itself than the babies and families behind the numbers. During these years when indicators are refined or added, state policymakers and advocates should focus on the people represented by the numbers, in particular, using the data on race/ethnicity, income, and urbanicity to identify disparities, have conversations about equity and what it takes to achieve equitable access to the ingredients babies need to thrive, and craft more tailored actions in the state and its communities.

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### About the selected indicators

#### THE SELECTION PROCESS

The indicators used for the *State of Babies Yearbook* are objective measures of progress across three domains: Good Health, Strong Families, and Positive Early Learning Experiences. While there are many measures we might have included in each of these domains, in the 2021 *Yearbook*, as we did for 2019 and 2020, we limited our selection to those indicators that meet three criteria:

- They draw from a reliable, ongoing source that yields data for all 50 states.

#### YEAR 1

##### STATE OF BABIES YEARBOOK: 2019

Select indicators of child and family well-being and key policies; create national overview and state profiles; create method of comparing where babies in states stand.

#### YEAR 2

##### STATE OF BABIES YEARBOOK: 2020

Refine 2019 indicators, filling gaps and rounding out policy indicators based on *Building Strong Foundations*; disaggregate data by race/ethnicity, income, and urbanicity; retain 2019 tiered ranking indicators for continuity.

#### YEAR 3

##### STATE OF BABIES YEARBOOK: 2021

Adjust indicators; continue subgroup disaggregation; explore collecting data directly from states; retain 2019 tiered ranking indicators to assure continuity.

#### YEAR 4

##### STATE OF BABIES YEARBOOK: 2022

Refine any state data collection; obtain input from stakeholders on core indicators and method of state comparison; select final core indicators and revise state rankings.

## DOMAIN

### Subdomain Topics Covered by the Selected Indicators

#### GOOD HEALTH

- Health Care Access/Affordability
- Food Security
- Nutrition
- Maternal Health
- Child Health
- Infant/Toddler Mental Health
- Child Health
- Infant/Toddler Mental Health

#### STRONG FAMILIES

- Basic Needs Support
- Child Welfare
- Home Visiting
- Supportive Policies/Paid Leave

#### POSITIVE EARLY LEARNING EXPERIENCES

- Early Care and Education Opportunities
- Child Care Quality
- Early Intervention and Prevention Services

- They are of central importance to the domain, either because they directly measure a component of well-being or are policy choices strongly linked to well-being.
- They can be readily understood by a broad audience.

The resulting set of 60 indicators address the following topics, by domain and subdomain:

In making our selection of indicators for the inaugural *State of Babies Yearbook: 2019, ZERO TO THREE* and Child Trends reviewed potential indicators and obtained input from a panel of experts in the field.

As new data become available, we continue to refine indicators and incorporate additional indicators. In the second edition of the report, we added more than a dozen additional policy indicators. In this third edition, we have added four additional indicators focusing on the Good Health and Strong Families domains. See the Indicator Dictionary in Appendix B for a list of changes to indicators between reports and the full list of indicators.

Note that many of the indicators here are inter-related within and across the three domains of Good Health, Strong Families, and Positive Early Learning Experiences. We discourage users from focusing on any single indicator in isolation. For instance, when it comes to child care, access, affordability, and quality are three dynamically related legs of a stool. All states struggle with the trade-offs that come with policies that emphasize one or more of these at the expense of the others.

To round out the policy indicators, we turned to the framework created by ZERO TO THREE and the Center for Law and Social Policy in *Building Strong Foundations: Advancing Comprehensive Policies for infants, Toddlers, and Families*, a project that laid out a core set of policies to advance the well-being of very young children and their families. We added indicators that determined the absence or presence in states of key policies identified in that framework as forming the basis of





strong support for early development and thriving families. A matrix that crosswalks the 13 core policy areas with the *State of Babies Yearbook: 2021* indicators is provided in Appendix D.

In making our final selection, ZERO TO THREE and Child Trends again obtained input from a panel of experts in the field. Panelists also provided feedback on our approach to ranking states. We know some important topics are absent here, especially measures of positive social-emotional development. In these cases, we still have to acknowledge that available data do not meet our criteria. Other topics may have to wait until improvements are made in measures used to collect data about young children. As noted in the 2020 *Yearbook*, the *State of Babies Yearbook: 2019* was a starting place, and we intend to continue to refine indicators in future editions and consider creative ways to measure state policies.

## SUBGROUP ANALYSES

We have deepened our emphasis on equity throughout the *Yearbook*, and present results disaggregated by race/ethnicity, urbanicity, and

family income, wherever data allow. Beginning with indicator updates for the 2021 *Yearbook*, we are presenting data for all of the racial and ethnic subgroups that each data source allows. We are now including estimates for American Indian/Alaska Native, Native Hawaiian and Pacific Islander, and multiracial groups wherever possible instead of aggregating them into an “Other” category.

## CAUTIONS FOR INTERPRETATION OF THE DATA

Across indicators, we have suppressed estimates that are based on a small number of infants and toddlers. For indicators based on survey data, we suppress estimates based on less than 30 survey respondents. Additionally, estimates using data from the Adoption and Foster Care Analysis and Reporting System are suppressed if the numerator has less than 10 respondents to protect children’s identity. We have also flagged estimates as unreliable when estimates are unstable—when their 95 percent confidence interval is larger than 20 percentage points—or when all respondents are in one category (e.g., the state has a rate of 100 percent or 0 percent). It is especially important to use caution when interpreting the subgroup analyses. As we present more subgroup data, our estimates are based on fewer survey respondents. Readers should also use caution when comparing estimates across states and across time with these flags. Please see the Indicator Dictionary in Appendix B for details on each indicator.

## THE STATE RANKING PROCESS

We developed a transparent ranking process to facilitate users’ understanding of how states fare on the selected indicators and policy domains. The ranking process follows three steps: rescaling the indicators, calculating domain scores, and calculating the state’s overall ranking. To facilitate the comparison of rankings across years, this process has remained stable over time. Indicators added since the inaugural edition of the *Yearbook* are not included in the calculation of the rankings.



**RESCALING THE INDICATORS.** Because indicators vary in their units of measurement, as well as in the range of values observed across the states, their values are standardized—that is, mathematically transformed to facilitate comparisons across indicators and across states.

The performance of each state on a given indicator is compared with the highest and lowest values, to create a score ranging from 0 to 100<sup>12</sup>:

$$\text{Score (Rescaled Value)} = \frac{[(\text{Observed Value} - \text{Lowest Value}) / (\text{Highest Value} - \text{Lowest Value})] \times 100}$$

For indicators (such as low birthweight) where higher scores mark less desirable outcomes, we adjust the directionality before calculating the score, so that higher scores consistently mark more desirable outcomes, while lower scores are less desirable. For example, the percentage of births with low birthweight was changed to percentage of births that are *not* low birthweight before computing the score. With this adjustment, higher values are more desirable for all indicators.

Policy indicators with “yes” or “no” values (e.g., whether the state has expanded Medicaid), are grouped within a domain, and we compute a composite index measuring the percentage of policies a state has enacted. For example, we counted the number of affirmative scores related to the states’ provision of mental health services at home, at pediatric/family practices, and at ECE programs, and expressed the total as a percentage of the possible maximum (three, in this example). The one exception to this rule is the indicator “Medicaid allows maternal depression screening in well-child visits,” for which we created a scale from 1 to 4, with scores depending on whether

such screening was “not covered,” “allowed,” “recommended,” or “required.” These values were then transformed to a 0 to 100 scale, as with the other indicators.

**CALCULATING DOMAIN SCORES.** To create state-level composite scores for each of the three domains (Good Health, Strong Families, and Positive Early Learning Experiences), we simply used an unweighted average of the scores of the component indicators for that domain. Likewise, to compute overall state scores, we used an unweighted average of the domain-level scores.

**ASSIGNING STATES TO TIERS.** Once the state-level data for each indicator were re-scaled to scores ranging from 0 to 100, we divided the re-scaled data into four tiers to show a state’s performance on each indicator relative to other states, overall, and by domain. These tiers, also referred to as quartiles, represent four roughly equal-size groupings of states, ordered from lowest-performing, to next-to-lowest-, to next-to-highest-, to highest-performing. We use the tiering symbols throughout the *Yearbook* to designate a given state’s placement in one of the four tiers.

In contrast to individualized state rankings (ranging from 1 to 51), this approach emphasizes that differences between any two states can be relatively minor and/or not statistically significant, and all states have room for improvement. Since most of the indicators are based on survey data, minor differences between states may be within the standard error intrinsic to sample designs. We experimented with different numbers of tiers and found that using four groups yielded statistically significant differences on most of the indicators among states’ scores falling in the middle of each group.

<sup>12</sup> We used a “min-max” scaling procedure, based on the indicators’ maximum and minimum values. We chose this method over Z-scores (another standardization method), as its interpretation is more transparent.

**IMPROVE DATA COLLECTION.** We know that not all important measures of infant and toddler well-being are included in the *Yearbook*. In some cases, their absence reflects the fact that current data collection systems did not provide the consistent state-level information required for the *State of Babies Yearbook: 2019*; in other cases, valid measurement strategies have yet to be identified. Policymakers and advocates can work together to strengthen the country's data infrastructure concerning infants and toddlers.

**COLLABORATE.** Use information about the progress being made in the states to foster sharing of information among states, create opportunities to learn from one other's experiences (challenges and successes), and develop ongoing connections. States are often incubators for innovative ideas. Their experiences can show others which policy strategies are effective, and which are not.



# Giving Advocates the Tools to Connect Data to Policy

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ZERO TO THREE has created several tools to assist policymakers, advocates, and other stakeholders in using the *State of Babies Yearbook*.



- The **State Profile Navigator** <https://stateofbabies.org/StateProfileNavigator> allows groups to take the first steps in analyzing the data in the State Profiles.
- The **State of Babies Yearbook: 2021 Advocacy and Outreach Tools** (<https://stateofbabies.org/take-action>) provides stakeholders the resources they need to use the *Yearbook* as a lever to advocate for improved policies and programs, including key messages and talking points, sample e-mails, social media posts and graphics, as well as many other resources to use in telling the story of babies in a state.

**Think Babies** ([thinkbabies.org](http://thinkbabies.org)) provides opportunities for stakeholders to use data to advocate for policies that ensure all babies and their families have Good Health, Strong Families, and Positive Early Learning Experiences.

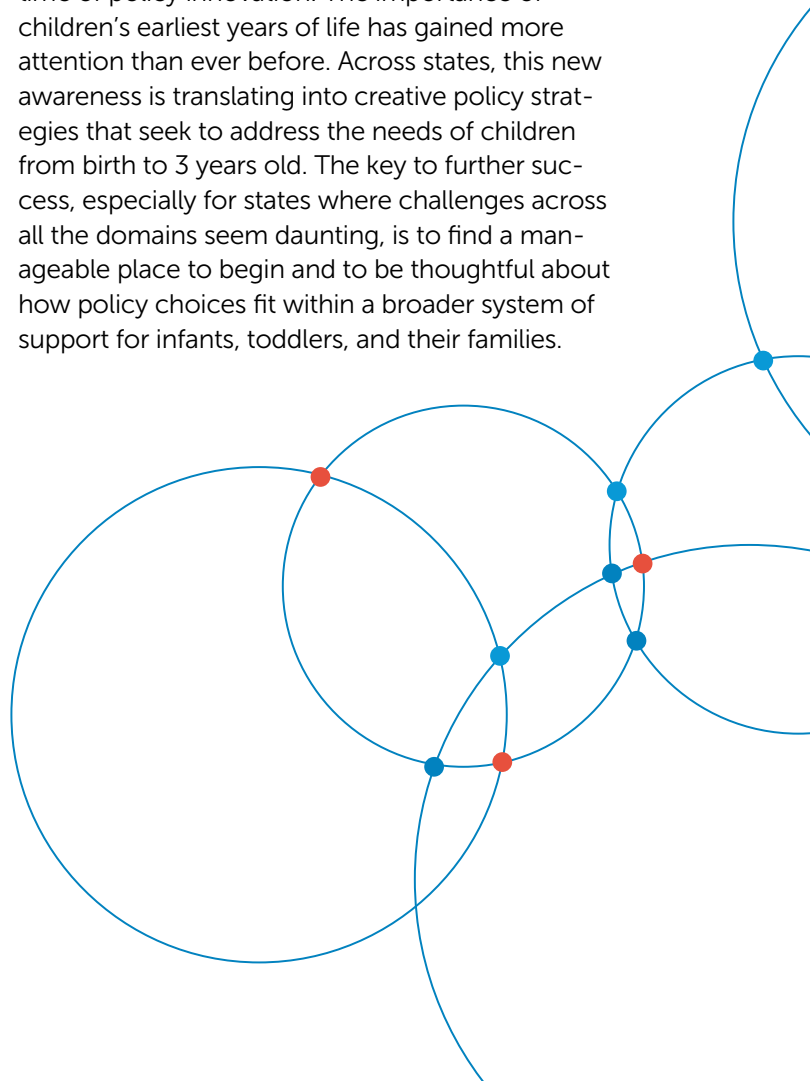
In addition, the following resources describe strategies that policymakers can consider as they determine how to begin developing infant/toddler policies and include examples of states currently implementing each of the strategies.

- **A Place to Get Started: Innovation in State Infant and Toddler Policies Building Strong Foundations: Advancing Comprehensive Policies for Infants, Toddlers, and Families** Using the four-part framework in *Building Strong Foundations*, a joint publication of ZERO TO THREE and the Center for Law and Social Policy, to guide the work, the ZERO TO THREE state policy team supports public-private teams in participating states to develop/refine and make progress on a statewide infant/toddler policy agenda.
- **Innovation in Cross-System Collaboration to Better Support Babies** Case studies and a companion brief to share examples of how states are connecting systems to collaboratively meet the needs of babies, young children, and families.

- **IECMH** This webinar and policy brief, created by ZERO TO THREE and Manatt Health, highlight what states can and should be doing to advance IECMH.
- **Advancing State Policies for Infants and Toddlers: Lessons Learned From Three States**
- **Voices for Babies: Elevating Family and Provider Stories** This resource highlights how ZERO TO THREE Think Babies™ State Partners include and elevate family and frontline voices to move policy.

In addition, the ZERO TO THREE State Initiatives Collection (<https://www.zerotothree.org/resources/states>) highlights innovative state policies and initiatives that affect infants, toddlers, and their families. It provides many examples of how states are tackling the policy priorities identified in the *Yearbook*.

For the early childhood field, this is an exciting time of policy innovation. The importance of children's earliest years of life has gained more attention than ever before. Across states, this new awareness is translating into creative policy strategies that seek to address the needs of children from birth to 3 years old. The key to further success, especially for states where challenges across all the domains seem daunting, is to find a manageable place to begin and to be thoughtful about how policy choices fit within a broader system of support for infants, toddlers, and their families.



## Resources

### **STATE OF BABIES YEARBOOK: 2021** <https://stateofbabies.org>

Visit the website to learn more about the *State of Babies*, download a full copy of the *Yearbook*, view and download State Profiles, obtain a copy of the companion brief, *Promising Approaches at Work in States*, and take action using the *State of Babies Yearbook: 2020 Advocacy and Outreach Tools*.

### **STATE OF BABIES YEARBOOK: 2020 ADVOCACY AND OUTREACH TOOLS** <https://stateofbabies.org/take-action>

Resources provided in the Toolkit (e.g., talking points, sample social media posts, templates for letters and e-mails, and graphics) are designed to help advocates use the *State of Babies Yearbook* to call on their federal, state, and local policymakers to Think Babies and work to improve outcomes for babies and families.

### **BRIEF: MATERNAL AND CHILD HEALTH INEQUITIES EMERGE BEFORE BIRTH** <https://stateofbabies.org/MaternalandChildHealthInequitiesBrief>

This companion brief to the *State of Babies Yearbook: 2020* addresses serious inequities in maternal health and birth outcomes, when health data are disaggregated and examined by race and ethnicity.

### **PROMISING APPROACHES AT WORK IN STATES** <https://stateofbabies.org/PromisingApproachesinStates>

This companion brief to the *State of Babies Yearbook: 2019* highlights a variety of states for their initiatives that address the challenges they face in ensuring infants and toddlers have the greatest opportunity to thrive.

### **STATE PROFILE NAVIGATOR** <https://stateofbabies.org/StateProfileNavigator>

The State Profile Navigator allows groups to take the first steps in analyzing the data in the State Profiles.

### **THINK BABIES** [thinkbabies.org](http://thinkbabies.org)

*Think Babies* is a call to action for federal and state policymakers to prioritize the needs of infants, toddlers, and their families and invest in our future, providing stakeholders opportunities to use data to advocate for policies that ensure all babies and their families have good health, strong families, and positive early learning experiences. <http://www.thinkbabies.org>

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## Appendix A. Summary of Indicator Values

Good Health				
Subdomain	Indicator	National Average/ Policy Count	Range	Summary
Health Care Access/ Affordability	Income cutoff (percent of the FPL) for Medicaid eligibility for pregnant women (median)	200%	138% (ID, LA, OK, SD) – 380% (IA)	24 states > 200%
	State adopted Medicaid expansion under the Affordable Care Act	39 states	--	--
	Percentage of low-income infants/toddlers who are uninsured	5.1%	0.1% (VT) – 13.9% (ND)	3 states > 10%
	Percentage of infants/toddlers who received coordinated, ongoing, comprehensive care within a medical home	50.9%	43.8% (CA) – 63.6% (NH)	35 states > 50%
	State efforts to extend Medicaid coverage beyond 60 days postpartum	<ul style="list-style-type: none"> <li>• 45 states—No law beyond mandatory 60 days</li> <li>• 5 states—Law covering either (a) some women but not all, or (b) all women but for less than 1 year</li> <li>• 1 state—Law covering all women for 1 year postpartum</li> </ul>	--	--
Food Security	Percent of households with infants/toddlers experiencing low or very low food security	13.7%	2.5% (NE) – 27.2% (WY)	18 states > 15%
Nutrition	Percentage of infants ever breastfed	83.6%	64.7% (MS) – 92.9% (OR)	11 states < 80%
	Percentage of infants breastfed at six months	55.1%	37.5% (WV) – 70% (WA)	13 states < 50%
	Percent of eligible infants who participated in WIC	79.3%	44.6% (NH) – 100% (MS, MD)	30 states < 80%
	Percent of WIC recipients ages 3-23 months who have high weight-for-length	Not Available at national level	6.1% (CO) – 18.2% (SD)	7 states < 10%

Maternal Health	Number of pregnancy-related deaths per 100,000 live births	17	Available at national level only	--
	Percent of women receiving late or no prenatal care	6.2%	1.7% (RI) – 11.3% (NM)	2 states > 10%
	State Medicaid policy requires, recommends, or allows maternal depression screenings during well-child visits	37 States	--	--
	Percentage of mothers of infants/toddlers rating their mental health as worse than “excellent” or “very good”	19.8%	11.8% (DC) – 31.4% (OH)	18 states < 20%
	Protections or accommodations are set in place for pregnant working people	31 states (3–state employees only; 23 – state and private with limitations; 5–all employees)	--	--
Child Health	Deaths per 1,000 live births	5.7	3.6 (NH) – 8.3 (MS)	8 states ≥ 7
	Percent of babies with low birthweight	8.3%	5.9% (AK) – 12.1% (MS)	4 states > 10%
	Percent of babies born preterm	10.0%	7.8% (OR) – 14.3% (MS)	23 states > 10%
	Percent of infants/toddlers who had a preventive medical visit in the past year	91.1%	85.4% (NM) – 96.8% (OR)	17 states < 90%
	Percent of infants/toddlers who had a preventive dental visit in the past year	32.9%	16.9% (IL) – 51.8% (WA)	9 states < 25%
	Percentage of infants/toddlers receiving the recommended doses of DTaP, polio, MMR, Hib, HepB, varicella and PCV vaccines by ages 19 through 35 months	72.79%	61.6% (MT) – 83.7% (CT)	13 states < 70%
Infant and Early Childhood Mental Health	State Medicaid plan covers social-emotional screening for young children (ages 0-6) with a tool specifically designed for this purpose	43 States	--	--
	Medicaid plan covers services in home settings	49 States	--	--
	Medicaid plan covers services in pediatric/family medicine practices	46 States	--	--
	Medicaid plan covers services in early care and education program settings	34 States	--	--

Strong Families				
Subdomain	Indicator	National Average/ Policy Count	Range	Summary
Basic Needs Support	Percentage of families with infants/toddlers living below 100% of the federal poverty line that receive TANF benefits	21.7%	2.7% (ID) – 88.2% (DC)	40 states < 30%
	Percentage of infants/toddlers who have moved three or more times since birth	2.6%	Less than 1% (DE, CT, MD, MA, NE, NH, OH, DC) – 8.2% (NM)	13 states > 5%
	Percentage of infants/toddlers who live in crowded housing	15.5%	6.6% (WV) – 28.3% (CA)	37 states > 10%
Child Welfare	Percentage of infants/toddlers living in unsafe neighborhoods, as reported by parents	4.9%	1.1% (IA) – 11% (NM)	4 states > 10%
	Percentage of families with infants/toddlers who report “family resilience”	85.3%	79.7% (AZ) – 91.7% (IL)	50 states > 80%
	Percentage of infants/toddlers who have experienced one adverse childhood experience	20.7%	12.9% (IL) – 27.7% (OK)	25 states > 20%
	Percentage of infants/toddlers who have experienced two or more adverse childhood experiences	7.74%	1.8% (MD) – 17.6% (OK)	1 state > 15%
	Maltreatment rate per 1,000 infants/toddlers	16.4	1.98 (PA) – 41.19 (KY)	19 states > 20
	Number per 1,000 infants/toddlers who have been removed from home and placed in foster care	7.1	2.54 (VA) – 24.58 (WV)	16 states > 10
	Percentage of infants/toddlers who spent one year or more in out-of-home placement	18.65%	4.5% (IL) – 40.6% (CO)	14 states > 25%
	Percentage of infants/toddlers exiting foster care who achieve permanency	98.8%	84.1% (SD) – 100% (DC, ME, NH)	3 states < 95%
	Percentage of infants/toddlers exiting foster care who are adopted	34.6%	11% (WY) – 58.9% (DE)	16 states < 25%
	Percentage of infants/toddlers exiting foster care who are reunified	48.1%	24.7% (DE) – 71.2% (NM)	1 state < 25%
	Percentage of infants/toddlers exiting foster care who are placed with a guardian	8.3%	1.6% (NJ) – 24.1% (TX)	43 states < 25%
	Percentage of infants/toddlers exiting foster care who are placed with a relative	7.8%	1.3% (IL) – 47.3% (KY)	20 states < 25%

Home Visiting	Percent of infants/toddlers who could benefit from evidence-based home visiting and are receiving those services	2.0%	Less than 1% (UT, TX, TN, NV, MS, GA, AL) – 6.7% (RI)	4 states > 5%
Supportive Policies	State requires employers to provide paid sick days that cover care for child (Y/N)	12 states	--	--
	State has a paid family leave program (Y/N)	10 states	--	--
	Single-parent head of unit is exempt from work-related activity if caring for a child under 12 months old (Y/N)	24 states (11 of which exempt for a single child only)	--	--
	State has a child tax credit	6 states	--	--
	State has an earned income tax credit	30 states	--	--

Positive Early Learning Experiences				
Subdomain	Indicator	National Average/ Policy Count	Range	Summary
Early Care and Education Opportunities	Percent of parents who report reading to their infants/toddlers every day	37.2%	27.1% (GA) – 57.8% (VT)	4 states > 50%
	Percent of parents who report singing songs or telling stories to their infants/toddlers every day	57.3%	47.6% (TX) – 72.3% (AK)	49 states > 50%
	Percent of infants/toddlers below 100% of the federal poverty line with access to Early Head Start	11.0%	5% (SC, NV) – 31% (DC)	31 states > 10%
	Average state cost of center-based infant care as a percentage of median income for married families	Not available at national level	7.6% (MS) – 17.5% (CA)	7 states > 15%
	Average state cost of center-based infant care as a percentage of median income for single parents	Not available at national level	29.3% (MS) – 93.8% (DC)	10 states > 50%
	Income eligibility level for child care subsidy above 200% of the federal poverty line	16 states	--	--
	Percent of infants/toddlers with family incomes equal to or below 150% of the state median income who are receiving a child care subsidy	4.2%	1.8% (CA) – 9.6% (NM)	17 states > 5%
	State allocated new Child Care and Development Block Grant (CCDBG) funds to invest in infant-toddler care	34 states	--	--

Child Care Quality	Whether group size requirements meet or exceed the standards set by Early Head Start at age 11 months, 19 months, and 30 months (value 0-3)	23 states  (16 states for one age group, 6 states for two age groups, 1 for three age groups)	--	--
	Whether adult/child ratio meet or exceed the standards set by Early Head Start at age 11 months, 19 months, and 30 months (value 0-3)	35 states  (21 states for one age group, 12 states for two age groups, 2 states for three age groups)	--	--
	Level of teacher qualification required by the state, for teachers of 11-month-olds, 19-month-olds, and 30-month-olds across five categories: no credential beyond high school degree; CDA or state equivalent; Specific infant/toddler credential or CDA with infant/toddler credential; Associate's degree; Bachelor's degree (value 3-15)	6 States—CDA/state equivalent  (45 States—No credential beyond high school)	--	--
	State has adopted an infant/toddler credential	30 states	--	--
	State reimburses center-based child care at or above the 75th percentile of current market rates	4 states	--	--
Early Intervention and Prevention Services	Percent of infants/toddlers, ages 9 through 35 months, who received a developmental screening using a parent-completed tool in the past year	32.5%	20.9% (LA) – 56.6% (OR)	40 states < 40%
	Percent of infants/toddlers with moderate/severe developmental delay	1.1%	Less than 0.25% (6 states) – 4.2% (IL)	11 states > 2%
	State includes “at-risk” children as eligible for IDEA Part C services	6 states	--	--
	Percent of infants/toddlers receiving IDEA Part C services	6.8%	1.9% (AR) – 19.2% (MA)	43 states < 10%
	Percent of eligible infants and toddlers required to have an initial IFSP meeting who had the meeting within 45 days	Not available at national level	82.1% (DE) – 100% (CT, IL, NC, NH, SD)	12 states < 95%

# Appendix B. *State of Babies Yearbook: 2021* Indicator Dictionary

## Good Health

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### *Income cutoff (percentage of the federal poverty line) for Medicaid eligibility for pregnant women*

Caring well for infants and toddlers begins with prenatal care. Medicaid/Children's Health Insurance Program (CHIP) helps women from lower-income households pay for health services that help ensure a healthy pregnancy and birth. States have flexibility to set income thresholds for eligibility; these are expressed as a percentage of the federal poverty line (FPL).

The data here reflect Medicaid rules in effect as of January 2020, as reported by the Kaiser Family Foundation.

Source: Kaiser Family Foundation. (2020). *Medicaid and CHIP eligibility, enrollment, and cost sharing policies as of January 2020: Findings from a 50-state survey*. Retrieved July 2020 from <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/#table2>

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### *Pregnant workers protection*

The Pregnancy Discrimination Act of 1978 (PDA) established a law for pregnant people to be treated and be provided with the same benefits as non-pregnant workers. Without these protections and accommodations set in place, many pregnant workers may find themselves having to leave their jobs or work under non-accommodating conditions (e.g., unable to sit or take rest).<sup>1</sup> However, despite the PDA of 1978, many soon-to-be parents still found themselves facing workplace discrimination. To combat this, various states have taken the effort to ensure pregnant workers have the protections and accommodations they need to promote healthy pregnancies and ensure inclusiveness of the pregnant workers in the workforce.

This is a new indicator for the *State of Babies Yearbook: 2021*. The data reflect laws passed by states that require employers to provide protections and accommodations to pregnant workers. These data are as of September 2020, reported by the National Partnership for Women and Families.

"None" was assigned to states that did not have any protection plans set in place. "State level" protection was assigned to states that specifically referenced protections or accommodations for pregnant workers that were considered "state" or "county" employees. States were classified as having protections for state employees only if the terms "state employers," "county," or "municipal employees" were used. The category "limited" was assigned to states that offer protections for state employees and private employees with exceptions (this would include states that have any employer size limit for eligibility, including "one or more" employees). "All employee" protection was assigned to states with protection plans applicable to the general public, including private and state employees.

1 National Partnership for Women & Families. (2019). The pregnant workers fairness act fact sheet. Retrieved November 2020 from <https://www.nationalpartnership.org/our-work/resources/economic-justice/pregnancy-discrimination/fact-sheet-pwfa.pdf>

Source: National Partnership for Women and Families. (2020). *Reasonable accommodations for pregnant workers: State and local laws*. Retrieved September 2020 from <https://www.nationalpartnership.org/our-work/resources/economic-justice/pregnancy-discrimination/reasonable-accommodations-for-pregnant-workers-state-laws.pdf>

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### **State adopted Medicaid expansion under the Affordable Care Act**

States with expanded Medicaid eligibility bring more children and families into the share of the population who have health insurance. Expanded Medicaid coverage has been shown to improve children's use of preventive care,<sup>2</sup> reduce infant mortality,<sup>3</sup> lower families' out-of-pocket medical expenditures,<sup>4</sup> reduce the amount of their unpaid medical bills,<sup>5</sup> and bring down the poverty rate.<sup>6</sup>

Medicaid expansion status for each state is based on the Kaiser Family Foundation's tracking and analysis of state activity. States' decisions about adopting Medicaid expansion are recorded as of February 2020. States that have adopted but not yet implemented Medicaid expansion are listed as Medicaid expansion states. Additional state-specific notes are provided in the source information.

Source: Kaiser Family Foundation. (2020). *Status of state action on the Medicaid expansion decisions: Interactive table*. Retrieved August 2020 from <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

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### **Percentage of low-income infants/toddlers who are uninsured**

Health insurance is an important financial backstop for families. An infant or toddler with a serious injury or illness can incur medical expenses that are overwhelming, particularly for families with low incomes. While health insurance coverage for this age group is nearly universal, some groups of children are still uncovered, and enrolling them may require special outreach efforts to close this gap.

The denominator for this indicator is the number of children ages 0-2 living below 200 percent of the federal poverty line. The numerator is the number of these children who do not have health insurance at the time of the interview.

This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: Survey respondents, who are likely the infant/toddler's parents or caregivers, report the infant or toddler's race and ethnicity. Respondents can select one or more of the following groups: White, Black or African American, American Indian or Alaska Native, Asian Indian, Japanese, Chinese, Korean, Filipino, Vietnamese, other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, other Pacific Islander, and/or some other race. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, and other Hispanic are coded as Hispanic, regardless of response to the race item. We then group the remaining non-Hispanic respondents into the following race categories for analyses: Non-Hispanic White,

2 Venkataramani, M., Pollack, C. E., & Roberts, E. T. (2017). Spillover effects of adult Medicaid expansions on children's use of preventive services. *Pediatrics*, 140(6), e20170953.

3 Bhatt, C. & Beck-Sagué, C. M. (2018). Medicaid expansion and infant mortality in the United States. *Research and Practice, American Journal of Public Health*, 108(4), 565-567. <https://doi.org/10.2105/AJPH.2017.304218>

4 Brevoort, K., Grodzicki, D., & Hackmann, M. B. (2017). Medicaid and financial health. NBER Working Paper No. 24002. National Bureau of Economic Research.

5 Abramowitz, J. (2020). The effect of state Medicaid expansions on medical out-of-pocket expenditures. *Medical Care Research and Review*, 77(1), 19-33

6 Remler, D. K. Korenman, S. D., & Hyson, R. T. (2017). Estimating the effects of health insurance and other social programs on poverty under the Affordable Care Act. *Health Affairs*, 36(10). <https://doi.org/10.1377/hlthaff.2017.0331>



Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian, Non-Hispanic Other, and Non-Hispanic multiple races. *Urbanicity*: Urban residence is defined as living within a metropolitan area. Metropolitan areas include central/principal cities, metro areas outside of central/principal cities, and metro areas with central/principal city status indeterminable. Rural residence is defined as living in non-metropolitan areas. Non-metropolitan areas are areas outside of metropolitan areas. Cases whose metropolitan status is indeterminable or mixed are excluded from the urbanicity subgroup analysis.

Source: Ruggles, S., Flood, S., Goeken, R., Grover, J., Meyer, E., Pacas, J., & Sobek, M. (2020). *American Community Survey 2018, five-year estimates*. (IPUMS USA: Version 10.0) [Data set]. IPUMS. <https://doi.org/10.18128/D010.V10.1>

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### **Percentage of households with infants/toddlers experiencing low or very low food security**

A lack of sufficient nutritious food is associated with a number of serious health, behavior, and cognitive deficits in children. Children living with food insecurity have poorer health than children who are in food-secure households.<sup>7</sup> Infants who experience food insecurity are more likely to perform poorly on tests of cognitive development.<sup>8</sup> For infants and toddlers, even mild levels of food insecurity may result in developmental deficits during this period of rapid brain growth.<sup>9</sup>

The denominator for this indicator is the number of households with one or more children ages 0–2. The numerator is the number of these households that experienced low or very low food security (not child- or adult-specific), as determined by survey responses.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S. & Warren, J. R. (2020). Current population survey, food security supplement 2018. (Integrated Public Use Microdata Series, Current Population Survey: Version 7.0). [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

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### **Percentage of infants who are ever breastfed, breastfed at 6 months**

Breastfeeding conveys advantages to both infants and their mothers. For young children, breastfeeding is associated with numerous benefits, including reduced rates of disease, overweight, and obesity. Breastfeeding is also associated with positive outcomes for the breastfeeding parent, including reduced rates of breast and ovarian cancers.<sup>10</sup> The skin-to-skin contact in breastfeeding improves oxytocin levels and breastfeeding parents report higher rates of attachment.<sup>11</sup> Experts recommend that babies are breastfed throughout the first year of life.

For the percentage of infants who are ever breastfed, the denominator is the number of toddlers ages 19–35 months in 2018. The numerator is the number of that group who were ever breastfed, according to parent's report.

7 Coleman-Jensen, A., McFall, W., & Nord, M. (2013). *Food insecurity in households with children: Prevalence, severity, and household characteristics, 2010–11*. U.S. Department of Agriculture, Economic Research Service. [https://www.ers.usda.gov/webdocs/publications/eib113/37672\\_eib-113.pdf](https://www.ers.usda.gov/webdocs/publications/eib113/37672_eib-113.pdf)

8 Zaslow, M., Bronte-Tinkew, J., Capps, R., Horowitz, A., Moore, K. A., & Weinstein, D. (2009). Food security during infancy: Implications for attachment and mental proficiency in toddlerhood. *Maternal and Child Health Journal*, 13(1), 66–80.

9 Rose-Jacobs, R., Black, M. M., Casey P. H., Cook, J. T., Cutts, D. B., Chilton, M., Heeren, T., Levenson, S. M., Meyers, A. F., & Frank, D. A. (2008). Household food insecurity: Associations with at-risk infant and toddler development. *Pediatrics*, 121(1), 65–72.

10 Office on Women's Health (OWH) (2019). *Making the decision to breastfeed*. <https://www.womenshealth.gov/breastfeeding/making-decision-breastfeed>

11 Health Services and Resources Administration (2020). *Understanding breastfeeding benefits*. <https://mchb.hrsa.gov/maternal-child-health-topics/understanding-breastfeeding-benefits>

For the percentage of infants breastfed at 6 months, the denominator is the number of toddlers ages 19-35 months in 2018. The numerator is the number of that group who were breastfed for any amount of time at six months of age, according to mother's report.

For the *State of Babies Yearbook: 2021* and the *State of Babies Yearbook: 2020*, we calculated data based on the National Immunization Survey (NIS), whereas for the *State of Babies Yearbook: 2019*, information was obtained from the CDC Breastfeeding Report Card. For both indicators, the NIS estimates presented may not line up with estimates published by the CDC, as the published estimates are based on a birth cohort. The public-use data does not have the information needed to calculate birth cohort estimates.

This indicator can be disaggregated by race/ethnicity and income. *Race/ethnicity*: Survey respondents, who are likely the child's parent or caregiver, reported the toddler's race. The public-use file includes the following categories: Hispanic, non-Hispanic White, non-Hispanic Black, and non-Hispanic other. The non-Hispanic other category includes Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, other races, and multiple races. These are the race/ethnicity categories presented with the indicator; however, the other and multiple race categories are very limited as they are an amalgamation of many different cultures. *Income*: NIS reports family income-to-poverty ratios based on family income, number of persons in the household, number of children in the household, and the 2017 Census poverty thresholds. Families with an income-to-poverty ratio less than 2 are considered low-income. Those with values greater than 2 are considered "not low-income."

Source: U.S. Department of Health and Human Services (DHHS) National Center for Immunization and Respiratory Diseases (2020). *The 2018 National Immunization Survey – Child*. [Data set]. Atlanta, GA: Centers for Disease Control and Prevention. <http://www.cdc.gov/vaccines/imz-managers/nis/datasets.html>

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### **State Medicaid policy requires, recommends, or allows maternal depression screening during well-child visits**

A young child's visit for pediatric care is an opportune time to screen for parental depression, which can have detrimental effects on caregiving and the well-being of both the parent and the child. Recent federal guidance<sup>12</sup> allows states to include screening for maternal depression as part of a well-child visit, and limited treatment for depressed mothers, within the context of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid program for children.

The National Academy for State Health Policy's website states that this information is based on state Medicaid websites and direct communication with state Medicaid officials, as of February 2020. States were listed as 1 if they require maternal depression screening during well-child visits, listed as 2 if they recommend screening, listed as 3 if they allow screening, and listed as 4 if no policy is in place about this maternal depression screening requirement.

Source: National Academy for State Health Policy. (2020). *Medicaid policies for maternal depression screening during well-child visits, by state*. Retrieved September 2020 from <https://healthychild.nashp.org/wp-content/uploads/2020/03/Mat-Depression-Screen-chart-3.20.20.pdf>

12 Center for Medicaid & CHIP Services. (2016). Maternal depression screening and treatment: A critical role for Medicaid in the care of mothers and children. Informational Bulletin. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf>

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### Late or no prenatal care

Pregnant people who receive no prenatal care, or whose care begins only in the last trimester of pregnancy, are more likely to have infants with health problems. Pregnant folks who do not receive prenatal care are three times more likely to give birth to a low-weight baby, and their baby is five times more likely to die.<sup>13</sup> In addition to receiving care early, frequency and timing of prenatal care are also important, especially for effective responses to specific maternal risk factors.<sup>14</sup>

Data for this indicator for the *State of Babies Yearbook: 2019* came from a report published by the National Center for Health Statistics, *Timing and Adequacy of Prenatal Care in the United States, 2016*. This report had not been updated at the time of publication of the *State of Babies Yearbook: 2020*. Data for the 2020 edition came directly from the CDC Wonder database. The indicator denominator is the total number of births with non-missing prenatal care information. The numerator is the number of those births where prenatal care began during the third trimester of pregnancy or not at all. There is no update for this indicator for the *State of Babies Yearbook: 2021*.

This indicator can be disaggregated by the birthing parent's race/ethnicity and urbanicity. *Race/ethnicity*: The included subgroups are Non-Hispanic Black, Non-Hispanic White, and Hispanic of all races. *Urbanicity*: CDC Wonder classifies each mother as living in a metro or non-metro area according to 2013 designations. The metro (urban) group includes counties in these categories: large central metro, large fringe metro, medium metro, and small metro. The non-metro (rural) group includes counties in these categories: micropolitan (non-metro) and noncore (non-metro).

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics. (September 2019). *Nativity public-use data 2018*. CDC WONDER Online Database. Retrieved October 2019 from <http://wonder.cdc.gov/nativity-expanded-current.html>

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### Percentage of mothers of infants/toddlers who rate their mental health as worse than “excellent” or “very good”

The links between parental mental health—particularly depression—and child well-being are well established in research.<sup>15</sup> The negative effects of maternal depression can begin prenatally.<sup>16</sup> Parents who are depressed are less likely to engage in the kinds of reciprocal social interplay that is so important to the healthy development of infants and toddlers.<sup>17</sup> Untreated depression in mothers or fathers is also associated with greater risk for delays in cognitive and motor development,<sup>18</sup> child maltreatment,<sup>19</sup> and neglect-

13 Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. (undated). *Prenatal services*. <http://www.mchb.hrsa.gov/programs/womeninfants/prenatal.htm>

14 Alexander, G.R., & Kotelchuck, M. (2001). Assessing the role and effectiveness of prenatal care: History, challenges, and directions for future research. *Public Health Reports*, 116(4), 306-16.

15 Chester, A., Schmit, S., Alker, J., & Golden, O. (2016). *Medicaid expansion promotes children's development and family success by treating maternal depression*. Georgetown University Health Policy Institute, Center for Children and Families. <https://ccf.georgetown.edu/wp-content/uploads/2016/07/Maternal-Depression-4.pdf>

16 Oberlander, T. F., Papsdorf, M., Brain, U. M., Misri, S., Ross, C., & Grunau, R. E. (2010). Prenatal effects of selective serotonin reuptake inhibitors antidepressants, serotonin transporter promoter genotype (SLC6A4), and maternal mood on child behavior at 3 years of age. *Archives of Pediatrics & Adolescent Medicine*, 164(5), 444-451.

17 Hops, H. (1995). Age- and gender-specific effects of parental depression: A commentary. *Developmental Psychology*, 31(3), 428-431.

18 Petterson, S.M. & Albers, A.B. (2001). Effects of poverty and maternal depression on early child development. *Child Development*, 72(6), 1794-1813.

19 Administration for Children and Families. (2007). Depression among caregivers of young children reported for child maltreatment. National Survey of Child and Adolescent Well-Being: Research Brief No. 13. [www.acf.hhs.gov/programs/opre/abuse\\_neglect/nscaw/reports/depression\\_caregivers/depression\\_caregivers.pdf](http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/depression_caregivers/depression_caregivers.pdf)

ful parenting practices.<sup>20</sup> Several intervention models are effective in treating parents' depression.<sup>21</sup>

This indicator summarizes the mental or emotional health status of the child's biological, step, adoptive, or foster mother. The denominator is children ages 0-2 who live with their biological, step, adoptive, or foster mother. The numerator is the number of those children whose mothers rate their mental/emotional health status as "good," "fair," or "poor." Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016-2018) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 2020 report, which were based on two years of NSCH data (2016-2017), or the 2019 report, which were based on 2016 data. They should be considered improved estimates, not new estimates, that can be compared directly to the 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and household income. *Race/ethnicity*: The child's race/ethnicity is reported by their caregiver, and the included subgroups are Hispanic of all races, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American Indian or Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016-2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as "not low-income."

Sources: Child and Adolescent Health Measurement Initiative. (2017). 2016 National Survey of Children's Health (NSCH) Stata constructed data set. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). 2017 National Survey of Children's Health (NSCH) Stata constructed data set. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). 2018 National Survey of Children's Health (NSCH) Stata constructed data set. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

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### **Percentage of infants/toddlers who had a preventive medical care visit in the past year.**

Preventive medical care (also known as "well-child care") is a critical opportunity to detect a developmental delay or disability, so that early treatment can reduce its impact on both the child and family.<sup>22</sup> Well-child visits also allow medical providers to promote behaviors conducive to healthy development, and

20 Chung, E. K., McCollum, K. F., Elo, I. T., & Culhane, J. F. (2004). Maternal depressive symptoms and infant health practices among low-income women. *Electronic article. Pediatrics*, 113(6), e523-e529.

21 Goodman, S. H. & Garber, J. (2017). Evidence-based interventions for depressed mothers and their young children. *Child Development*, 88(2), 368-377.

22 American Academy of Pediatrics. (2002). Developmental surveillance and screening of infants and young children. *Pediatrics*, 109(1), 144-145.

to share advice with the parents of infants and toddlers. For example, physician guidance increases the likelihood that parents will read to their child, or that a child will be breastfed.<sup>23</sup>

The denominator is children ages 0-2, and the numerator is those children who had one or more preventive medical visits in the past 12 months. Estimates in the *State of Babies Yearbook: 2021* are based on the 2016-17 combined National Survey of Children's Health (NSCH) and are the same as in the *State of Babies Yearbook: 2020*. These results are more reliable than the results presented in the *State of Babies Yearbook: 2019* report, which were based on the 2016 NSCH. This should be considered an improved estimate, not a new estimate that can be compared directly to the 2016 estimate. The estimates have not been updated to include 2018 data due to a change in item language in the 2018 NSCH restricting comparability to previous years. This also precludes adding subgroup analyses by race and ethnicity.

This indicator can be disaggregated by household income. NSCH derives household income-to-poverty ratios based on family income. Missing values were imputed by the Census Bureau, and the single imputation version provided in the combined 2016-2017 data file is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as "not low-income."

Source: Child and Adolescent Health Measurement Initiative. (2019). *2016-17 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved September 10, 2019 from [www.childhealthdata.org](http://www.childhealthdata.org)

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### **Percentage of infants/toddlers who had a preventive dental care visit in the past year.**

Early childhood tooth decay can be damaging to developing primary teeth,<sup>24</sup> and can negatively affect child oral health quality of life,<sup>25</sup> increase experience of dental pain, and negatively impact school performance.<sup>26</sup> The denominator is children ages 1-2, and the numerator is those children who ever had one or more preventive dental visits. Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016-2018) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 2020 report, which were based on two years of NSCH data (2016-2017), or the 2019 report, which were based on 2016 data. They should be considered improved estimates, not new estimates that can be compared directly to the 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and household income. *Race/ethnicity*: The child's race/ethnicity is reported by their caregiver, and the included subgroups are Hispanic of all races, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American

23 Young, K. T., Davis, K., Schoen, C., & Parker, S. (1998). Listening to parents. A national survey of parents with young children. *Archives of Pediatric and Adolescent Medicine*, 152(3), 255-262.

24 US Department of Health and Human Services. (2020). *Oral health in America: A report of the surgeon general*. US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health. Retrieved December 2020 from <https://www.nidcr.nih.gov/sites/default/files/2017-10/hck10cv.%40www.surgeon.fullrpt.pdf>

25 Filstrup, S. L., Briskie, D., Da Fonseca, M., Lawrence, L., Wandera, A., & Inglehart, M. R. (2003). Early childhood caries and quality of life: child and parent perspectives. *Pediatric dentistry*, 25(5), 431-440. [https://www.researchgate.net/profile/Marita\\_Inglehart/publication/8980934\\_Early\\_childhood\\_caries\\_and\\_quality\\_of\\_life\\_Child\\_and\\_parent\\_perspectives/links/56792e2c08aeaf87ed8afd72.pdf](https://www.researchgate.net/profile/Marita_Inglehart/publication/8980934_Early_childhood_caries_and_quality_of_life_Child_and_parent_perspectives/links/56792e2c08aeaf87ed8afd72.pdf)

26 Jackson, S. L., Vann Jr, W. F., Kotch, J. B., Pahel, B. T., & Lee, J. Y. (2011). Impact of poor oral health on children's school attendance and performance. *American Journal of Public Health*, 101(10), 1900-1906. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC322359/>

Indian or Alaska Native, Hawaiian or Pacific Islander, and some “Other” and “Two or More Races” categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016–2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as “not low-income.”

Sources: Child and Adolescent Health Measurement Initiative. (2017). 2016 National Survey of Children’s Health (NSCH) Stata constructed data set. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). 2017 National Survey of Children’s Health (NSCH) Stata constructed data set. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). 2018 National Survey of Children’s Health (NSCH) Stata constructed data set. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

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### **Percentage of infants/toddlers who received coordinated, ongoing, comprehensive care within a medical home.**

This indicator is new for the *State of Babies Yearbook: 2021*. The American Academy of Pediatrics defines a medical home as a health care model that is “accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.”<sup>27</sup> Having a medical home is associated with improved health outcomes and healthy behaviors, as well as decreased sick and emergency room visits for children without special healthcare needs.<sup>28</sup> Medical homes are also linked to better health status and increases to family functioning for children with special health care needs.<sup>29</sup>

The denominator is children ages 0–2. The numerator is children ages 0–2 whose parents affirmed the following items: their child has a personal doctor or nurse, a usual source for sick care, family-centered care, no problems getting needed referrals (if applicable) and effective care coordination when needed (if applicable). Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016–2018) combined sample of the National Survey of Children’s Health (NSCH).

This indicator can be disaggregated by race/ethnicity and household income. *Race/ethnicity*: The child’s race/ethnicity is reported by their caregiver, and the included subgroups are Hispanic of all races,

27 National Resource Center for Patient/Family-Centered Medical Home. (2020). *What is a medical home?* <https://medicalhomeinfo.aap.org/overview/Pages/Whatisthemedicalhome.aspx>

28 Long, W. E., Bauchner, H., Sege, R. D., Cabral, H. J., & Garg, A. (2012). The value of the medical home for children without special health care needs. *Pediatrics*, 129(1), 87–98. [https://pediatrics.aappublications.org/content/129/1/87?ijkey=9ab7a63be22b823793d6c92ad721129ebf98c0fe&keytype=tf\\_ipsecsha](https://pediatrics.aappublications.org/content/129/1/87?ijkey=9ab7a63be22b823793d6c92ad721129ebf98c0fe&keytype=tf_ipsecsha)

29 Homer, C. J., Klatka, K., Romm, D., Kuhlthau, K., Bloom, S., Newacheck, P., Van Cleave, J. & Perrin, J. M. (2008). A review of the evidence for the medical home for children with special health care needs. *Pediatrics*, 122(4), e922–e937. [https://pediatrics.aappublications.org/content/122/4/e922?ijkey=809ac017f019f-89122cb130b06716342cf7c08ab&keytype=tf\\_ipsecsha](https://pediatrics.aappublications.org/content/122/4/e922?ijkey=809ac017f019f-89122cb130b06716342cf7c08ab&keytype=tf_ipsecsha)

Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American Indian or Alaska Native, Hawaiian or Pacific Islander, and some “Other” and “Two or More Races” categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016–2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as “not low-income.”

Sources: Child and Adolescent Health Measurement Initiative. (2017). *2016 National Survey of Children’s Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). *2017 National Survey of Children’s Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). *2018 National Survey of Children’s Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

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### Percentage of babies with low birthweight (less than 5.5 pounds)

Low birthweight (less than 5.5 pounds) is strongly associated with poor developmental outcomes, beginning in infancy but extending into adult life.<sup>30</sup> Low weight is often associated with pre-term delivery, but can occur also with full-term births. Research points to a number of factors that can contribute to the likelihood of low weight at birth, including smoking during pregnancy; low weight gain during pregnancy, or low pre-pregnancy weight; and the pregnant parent’s stress during pregnancy.<sup>31</sup> The National Center for Health Statistics defines low birth weight as a weight of less than 2,500 grams, or 5 pounds and 8 ounces.

This indicator does not have an update for the *State of Babies Yearbook: 2021*, as new data were not available in time to be included. Data for the *State of Babies Yearbook: 2020* were calculated using data from CDC Wonder, whereas data from the inaugural yearbook came from a published report. The denominator is the total number of all births whose weight is known, and the numerator is the number of those babies with low birthweight.

This indicator can be disaggregated by mother’s race/ethnicity and urbanicity. *Race/ethnicity*: The included subgroups are Non-Hispanic Black, Non-Hispanic White, and Hispanic of all races. *Urbanicity*: CDC Wonder classifies mothers as living in a metro (urban) or non-metro (rural) area according to 2013 designations. The metro group includes counties in these categories: large central metro, large fringe

30 Reichman, N. (2005). Low birth weight and school readiness. In School readiness: Closing racial and ethnic gaps. *The Future of Children*, 15(1), 91-116. [https://www.princeton.edu/futureofchildren/publications/docs/15\\_01\\_FullJournal.pdf](https://www.princeton.edu/futureofchildren/publications/docs/15_01_FullJournal.pdf)

31 Ricketts, S. A., Murray, E. K., & Schwalberg, R. (2005). Reducing low birthweight by resolving risks: Results from Colorado’s Prenatal Plus Program. *American Journal Public Health*, 57(11),1952-1957.

metro, medium metro, and small metro. The non-metro group includes counties in these categories: micropolitan (non-metro) and noncore (non-metro).

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics. (September 2019). *Nativity public-use data 2018*. CDC WONDER Online Database. Retrieved October 2019 from <http://wonder.cdc.gov/nativity-expanded-current.html>

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### Percentage of babies born preterm (before 37 completed weeks of gestation)

Preterm births are the second leading cause of death among children younger than five.<sup>32</sup> The percentage of babies born preterm can be reduced through early intervention. The most effective interventions at improving infant survival rates are those that support the pregnant parent right before, during, and after the pregnancy. These can ensure that complications often associated with preterm delivery, such as infection, neurological challenges, and lung immaturity, are treated early.<sup>33</sup>

The data for this indicator have not been updated for the *State of Babies Yearbook: 2021*, as new data were not available in time to be included. The numerator is the number of infants born preterm, which is defined by the CDC as births before 37 completed weeks of gestation. The denominator is the total number of infants whose gestation duration is known.

This indicator can be disaggregated by the pregnant parent's race/ethnicity and urbanicity. *Race/ethnicity*: The included subgroups are Non-Hispanic Black, Non-Hispanic White, and Hispanic of all races. *Urbanicity*: CDC Wonder classifies each pregnant parent as living in a metro (urban) or non-metro area according to 2013 designations. The metro group includes counties in these categories: large central metro, large fringe metro, medium metro, and small metro. The non-metro group includes counties in these categories: micropolitan (non-metro) and noncore (non-metro).

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics. (September 2019). *Nativity public-use data 2018*. CDC WONDER Online Database. Retrieved October 2019 from <http://wonder.cdc.gov/nativity-expanded-current.html>

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### Infant mortality rate (deaths per 1,000 live births)

Children are much more likely to die during the first year of life than they are at older ages. Infant deaths can reflect underlying problems, such as barriers to accessing prenatal care, living in violent neighborhoods, or circumstances that challenge parents' ability to adequately supervise their young children. They can also highlight inequities: for example, in access to health care or safe places to play, or exposure to environmental toxins. Among infants, the leading causes of death include congenital and chromosomal abnormalities, problems related to short gestation and low birthweight, and sudden infant death syndrome (SIDS).<sup>34</sup>

The Centers for Disease Control and Prevention (CDC) website reports the infant mortality rate as the

32 World Health Organization. (2015). WHO recommendations on interventions to improve preterm birth outcomes. [https://www.who.int/reproductivehealth/publications/maternal\\_perinatal\\_health/preterm-birth-guideline/en/](https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/preterm-birth-guideline/en/)

33 *Ibid.*

34 Kochanek, K. D., Murphy, S. L., Xu, J., & Tejada-Vera, B. (2016). Deaths: Final data for 2014. *National Vital Statistics Reports*, 65(4). National Center for Health Statistics. Tables 3-4. Available at [http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65\\_04.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf)



number of infant deaths per 1,000 live births. The estimates for the *State of Babies Yearbook 2021* reflect data from 2018, with the exception of the District of Columbia, which has data from 2017.

This indicator can be disaggregated by mother's race/ethnicity. Subgroup data reflect years 2015–2017, and have not been updated since the *State of Babies Yearbook: 2020*. The included subgroups are non-Hispanic White, non-Hispanic Black, American Indian or Alaska Native, Asian or Pacific Islander, and Hispanics of all races.

Sources: Centers for Disease Control and Prevention. (2018). *Infant Mortality Rates by State [Interactive Map]*. Retrieved July 2020 from [https://www.cdc.gov/nchs/pressroom/sosmap/infant\\_mortality\\_rates/infant\\_mortality.htm](https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm)

Centers for Disease Control and Prevention. (2018). *Stats of the District of Columbia*. Retrieved July 2020 from <https://www.cdc.gov/nchs/pressroom/states/dc/dc.htm>

Xu, J., Murphy, S.L., Kochanek, K.D., & Arias, E. (2020). *Mortality in the United States, 2018*. National Center for Health Statistics. Data Brief. No. 355. Retrieved December 2020 from <https://www.cdc.gov/nchs/data/databriefs/db355-h.pdf>

Subgroup source: Centers for Disease Control and Prevention (2019). Infant mortality in the United States, 2017: Data from the period linked birth/infant death file. *National Vital Statistics Reports* 68(10). Retrieved October 2019 from [https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68\\_10\\_tables-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_10_tables-508.pdf)

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### **Maternal mortality rate (pregnancy-related deaths per 100,000 live births)**

Maternal mortality can be defined as the death of a mother that takes place during pregnancy, childbirth or post-partum.<sup>35</sup> A mother's death is detrimental to the development of the newborn child, and poses a great hardship to the affected household.

This indicator for the *State of Babies Yearbook: 2021* is reported at the national level only, as with the *State of Babies Yearbook: 2020* because the Centers for Disease Control and Prevention (CDC) do not recommend comparing state-level estimates. The *State of Babies Yearbook: 2021* data reflect a new methodology, recently adopted by the CDC (to be called 2018 method), for coding maternal deaths, that is not comparable with previous year's data. This new 2018 method was adopted to mitigate errors that were revealed with the reporting of maternal deaths (e.g., overreporting of maternal deaths among older women). Data reflect maternal mortality in 2018.

This indicator can be disaggregated by mother's race/ethnicity at the national level only. The subgroups reported are Non-Hispanic Black, Non-Hispanic White, and Hispanic of all races. The subgroups for American Indian & Alaska Native, Asian/Pacific Islander, multiracial groups, and other races were not available for the *State of Babies Yearbook: 2021*.

Source: Centers for Disease Control and Prevention. (2020). *Maternal mortality by state, 2018*. Retrieved July 2020 from: <https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf>

Subgroup source: Hoyert, D. & Minino, A. (2020). *Maternal mortality in the United States: Changes in coding, publication, and data release, 2018*. National Vital Statistics Reports. Retrieved July 2020 from: <https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr69-02-508.pdf>

35 MacDorman, M. F., Declercq, E., Cabral, H., & Morton, C. (2016). Is the United States maternal mortality rate increasing? Disentangling trends from measurement issues Short title: US Maternal Mortality Trends. *Obstetrics and gynecology*, 128(3), 447.

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### **Percentage of infants/toddlers receiving the recommended doses of DTaP, polio, MMR, Hib, HepB, varicella and PCV vaccines by age 19 through 35 months**

Vaccines are important for infants and toddlers, because many of the diseases vaccines prevent are more common, and more deadly, at this age. Vaccination protects not only the child who receives the vaccine, but also others in the child's community, including those who, for health reasons, cannot be vaccinated. The Centers for Disease Control and Prevention (CDC) recommends four doses of the diphtheria, tetanus, and pertussis (DTaP) vaccine, three or more doses of polio vaccine, one or more doses of the measles-mumps-rubella (MMR) vaccine, three or more doses of the *Haemophilus influenzae* type b (Hib) vaccine (or, for certain brands, four or more doses), the hepatitis B vaccine, and the varicella (chicken pox) vaccine.

The estimates reported here are from 2018. Technical notes on vaccine abbreviations, dose definitions and vaccine series for the National Immunization Survey (NIS) surveillance tables are available at: <https://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tech-notes.html>.

The numerator is the number of toddlers ages 19-35 months who received the recommended doses of DTaP, polio, MMR, Hib, HepB, varicella and PCV vaccines. The denominator is the number of toddlers ages 19-35 months.

This indicator can be disaggregated by race/ethnicity and income, when data are analyzed from the National Immunization Survey. *Race/ethnicity*: Survey respondents reported the toddler's race. The public-use file includes the following categories: Hispanic, non-Hispanic White, non-Hispanic Black, and non-Hispanic other. The non-Hispanic other category includes Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, other races, and multiple races. These are the race/ethnicity categories presented with the indicator; however, the other and multiple race categories are very limited as they are an amalgamation of many different cultures. *Income*: NIS reports income-to-poverty ratios based on family income, number of persons in the household, number of children in the household, and the 2017 Census poverty thresholds. Families with an income-to-poverty ratio less than 2 are considered low-income. Those with values greater than 2 are considered "not low-income."

Source: U.S. Department of Health and Human Services (DHHS). National Center for Immunization and Respiratory Diseases (2020). *The 2018 National Immunization Survey – Child* [Data set]. Atlanta, GA: Centers for Disease Control and Prevention. Retrieved from <http://www.cdc.gov/vaccines/imz-managers/nis/datasets.html>

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### **State Medicaid plan covers social-emotional screening for young children (ages 0 through 6 years) with a tool specifically designed for this purpose**

Because young children's social-emotional development is so critical to their present well-being, as well as their later success, an accurate assessment of their status in this area is important.<sup>36</sup> Health care providers should use an instrument that identifies young children at risk of behavioral health problems, specifically, not just a general developmental screening.

A survey administered by The National Center for Children in Poverty asked Medicaid officials if the state's Medicaid plan covers social-emotional screening for children ages 0-6 years with a tool specifically

36 Paschall, K., Moore, K. A., Pina, G., & Anderson, S. (2020). *Comparing the National Outcome Measure of Healthy and Ready to Learn with Other Well-Being and School Readiness Measures*. Child Trends. [https://www.childtrends.org/wp-content/uploads/2020/03/NOMMeasurement\\_ChildTrends\\_April2020.pdf](https://www.childtrends.org/wp-content/uploads/2020/03/NOMMeasurement_ChildTrends_April2020.pdf)

designed for the purpose of identifying young children who may need further evaluation for social-emotional and behavioral difficulties.

The data for this indicator have not been updated for the *State of Babies Yearbook: 2021*, and reflect the 2018 estimates used in the *State of Babies Yearbook: 2020*.

Source: Smith, S., Granja, M. R., Nguyen, U. T., & Rajani, K. (2018). *How states use Medicaid to cover key infant and early childhood mental health services: Results of a 50-state survey (2018 Update)*. National Center for Children in Poverty. Retrieved from [http://www.nccp.org/publications/pdf/text\\_1211.pdf](http://www.nccp.org/publications/pdf/text_1211.pdf)

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### **Medicaid plan covers infant and early childhood mental health services**

Mental health concerns arising during the first years of life can develop into serious problems if not identified and treated promptly.<sup>37</sup> Families with low incomes may not be able to afford these services unless they are covered by Medicaid. Ideally, a state's Medicaid plan covers infant and early childhood mental health (I-ECMH) services in any of the following settings: home, pediatric/family medicine practices, and early care and education programs.

This indicator has no update for the *State of Babies Yearbook: 2021*. A survey administered by The National Center for Children in Poverty asked Medicaid officials if the state's Medicaid plan covers services to address a child's mental health needs in the child's home, early care and education settings, and pediatric or family medicine settings. The estimates used here are from 2018. Georgia's Medicaid only covers mental health services for children ages 4 and older.

Source: Smith, S., Granja, M. R., Nguyen, U. T., & Rajani, K. (2018). *How states use Medicaid to cover key infant and early childhood mental health services: Results of a 50-state survey (2018 Update)*. National Center for Children in Poverty. Retrieved from [http://www.nccp.org/publications/pdf/text\\_1211.pdf](http://www.nccp.org/publications/pdf/text_1211.pdf)

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### **Percentage of eligible infants who participated in WIC**

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federal grant program that provides services to women and children, from pregnancy through the time the child reaches the age of five years. A woman's or infant's eligibility to participate in WIC is based on the caregiver's income, as well as the child's medical or dietary status.<sup>38</sup> Participating in WIC is associated with lower levels of infant mortality, better cognitive development for the child as well as more nutritious diets.<sup>39</sup>

The estimates reported in the *State of Babies Yearbook: 2021* reflect 2017 data. This indicator was new for the *State of Babies Yearbook: 2020*. Results for U.S. territories are included in the total for the United States. The estimated coverage rates exceed 100 percent for infants in Maryland and Mississippi. This is likely a result of sampling variability in the CPS-ASEC survey data used to estimate the number of eligible

37 Clinton, J., Feller, A. F., Williams, R. C. (2016). The importance of infant mental health. *Pediatrics and Child Health* 21(5), 239-241. doi: [10.1093/pch/21.5.239](https://doi.org/10.1093/pch/21.5.239)

38 Black, M. M., Cutts, D. B., Frank, D. A., Geppert, J., Skalicky, A., Levenson, S., Casey, P. H., Berkowitz, C., Zaldivar, N., Cook, J. T., Meyers, A. F., Herren, T., & Children's Sentinel Nutritional Assessment Program Study Group. F. (2004). Special Supplemental Nutrition Program for Women, Infants, and Children participation and infants' growth and health: A multisite surveillance study. *Pediatrics*, 114(1), 169-176.

39 Carlson, S., & Neuberger, Z. (2017). WIC Works: Addressing the Nutrition and Health Needs of Low-Income Families for 40 Years. Center on Budget and Policy Priorities. <https://www.cbpp.org/sites/default/files/atoms/files/5-4-15fa.pdf>

individuals in those states (the denominator for the rate). The lower bound of the 95-percent confidence interval surrounding these rates is less than 100 percent.

Source: USDA Food and Nutrition Service. (2020). *WIC 2017 eligibility and coverage rates*. USDA Food and Nutrition Service. Retrieved August 2020 from <https://www.fns.usda.gov/wic-2017-eligibility-and-coverage-rates>

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### **Percentage of WIC recipients, age 3-23 months, who have high weight-for-length**

While obesity is not typically measured among very young children, it is important to monitor infant and child growth over time and identify any abnormalities in the child's development that may arise.<sup>40</sup>

The American Academy of Pediatrics recommends using the weight-for-length growth standards to assess the nutritional status of children younger than two.<sup>41</sup> These standards have been recognized internationally in efforts to prevent child malnutrition and obesity.<sup>42</sup>

This indicator has no update for the *State of Babies Yearbook: 2021* and was new for the *State of Babies Yearbook: 2020*. The estimates are from 2016. High weight-for-length is defined as  $\geq 2$  standard deviations above the sex- and age-specific median in the World Health Organization (WHO) growth standards. Weight is measured to the nearest one-quarter pound, and length to the nearest one-eighth inch, using an infant measuring board according to CDC surveillance standards. Children with missing values of sex, weight, or length, or who had a length outside the range in the WHO growth standards (45–110 cm) were excluded. In addition, children with biologically implausible values were excluded from analyses. State estimates do not include data from WIC agencies in Indian Tribal Organizations (ITOs).

This indicator can be disaggregated by race/ethnicity. The included subgroups are American Indian/Alaska native, Asian/Pacific Islander, non-Hispanic Black, Hispanic, and non-Hispanic White.

Source: Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. (2019). *Data, Trend and Maps [online]*. Retrieved October 2019 from <https://www.cdc.gov/nccd-php/dnpao/data-trends-maps/index.html>

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### **State efforts to extend Medicaid coverage beyond 60 days postpartum**

The postpartum stage (after delivery) is an important period of time both for the parent who carried the child and newborn baby. Parents can face a variety of health challenges postpartum including depression, anxiety, pain, and any other complication that may have taken place during childbirth. Medicaid coverage is a way for parents to receive financial support as it relates to their pregnancy and the postpartum period. However, coverage gaps can leave many folks in need of support during a very vulnerable time of their lives. While states provide pregnant people with Medicaid benefits, only some states extend eligibility beyond the nationally mandated 60 days postpartum.<sup>43</sup>

40 Center for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. (2015). *Growth Chart Training: Using WHO Growth Charts*. Retrieved from: [https://www.cdc.gov/nccdphp/dnpao/growthcharts/who/using/assessing\\_growth.htm](https://www.cdc.gov/nccdphp/dnpao/growthcharts/who/using/assessing_growth.htm)

41 Daniels, S. R., & Hassink, S. G. (2015). The role of the pediatrician in primary prevention of obesity. *Pediatrics*, 136(1), e275-e292

42 De Onis, M., & Onyango, A. W. (2008). WHO child growth standards. *Lancet*, 371(9608), 204-204.

43 Ranji, U., Gomez, I., & Salganicoff, A. (2019). *Expanding postpartum Medicaid coverage*. Washington DC: Henry J. Kaiser Family Foundation Issue Brief.

This is a new indicator for the *State of Babies Yearbook: 2021*. The data source organized states into categories describing the current status of state efforts to extend Medicaid coverage to pregnant people beyond 60 days postpartum. Those categories included “enacted” if the state passed a bill and/or had money included in the state budget but was not yet implementing the policy and “implemented” if the state was currently providing some form of extended postpartum coverage.

For the specific categorization and coding, if a bill was introduced but not enacted it was categorized as a 0. If the bill was enacted or implemented, it was categorized as a 1 if any health or population restrictions were listed, or as a 2 if the bill was fully implemented and serving all pregnant people for at least one year.

Source: The American College of Obstetricians and Gynecologists. (2020). *Policy priorities-Extend postpartum Medicaid coverage*. The American College of Obstetricians and Gynecologists. Retrieved September 2020 from <https://www.acog.org/advocacy/policy-priorities/extend-postpartum-medicaid-coverage>

## Strong Families

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### *Housing insecurity (percentage of infants/toddlers who have moved three or more times since birth)*

The stability of housing—as measured by the frequency of residential moves—plays a role in young children’s well-being. Frequent moves can disrupt many aspects of families’ lives, including their connections with social support networks and formal services such as child care. High rates of moving may also be indicative of economic insecurity and parents’ tenuous hold on employment.

The denominator is the number of children ages 0-2. The numerator is those who moved to a new address three or more times since they were born, as reported by parents. Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016-2018) combined sample of the National Survey of Children’s Health (NSCH). These results are more reliable than the results presented in the 2020 report, which were based on two years of NSCH data (2016-2017), or the 2019 report, which were based on 2016 data. They should be considered improved estimates, not new estimates that can be compared directly to the 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by household income and race/ethnicity. *Race/ethnicity*: The child’s race/ethnicity is reported by their caregiver, and included subgroups are Hispanic of all races, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American Indian or Alaska Native, Hawaiian or Pacific Islander, and some “Other” and “Two or More Races” categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016-2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as “not low-income.”

Sources: Child and Adolescent Health Measurement Initiative. (2017). *2016 National Survey of Children’s Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). *2017 National Survey of Children’s Health (NSCH) Stata constructed data set*.

Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). *2018 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

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### **Crowded housing (percentage of infants/toddlers who live in crowded housing)**

Overcrowded living conditions can also be associated with negative outcomes. In homes where families are crowded, parents may have fewer opportunities to be adequately responsive to infants and toddlers, and more likely to use punitive discipline.<sup>44</sup> Crowding has also been associated with children's health problems, including respiratory conditions, injuries, and infectious diseases, and with young children's food insecurity.<sup>45</sup>

The denominator is the total number of children ages 0–2. The numerator is the number of those children who live in homes with more than two household members per bedroom, or, if no bedrooms, more than one person per room. Data reflect 2014–2018.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity*: Survey respondents (typically parents) report the infant or toddler's race and ethnicity. Respondents can select one or more of the following groups: White, Black or African American, American Indian or Alaska Native, Asian Indian, Japanese, Chinese, Korean, Filipino, Vietnamese, other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, other Pacific Islander, and/or some other race. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, and other Hispanic are coded as Hispanic, regardless of response to the race item. We then group the remaining non-Hispanic respondents into the following race categories for analyses: Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian, Non-Hispanic Other, and Non-Hispanic multiple races. *Income*: ACS reports family income as a percentage of poverty thresholds. The poverty threshold is based on both total family income and the size of the family, the number of people who are children, and the age of the householder. Infants and toddlers are considered to live in low-income families if this percentage is less than 200. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the poverty threshold for their family. *Urbanicity*: Metropolitan (urban) areas include central/principal cities, metro areas outside of central/principal cities, and metro areas with central/principal city status indeterminable. Non-metropolitan (rural) areas are areas outside of metropolitan areas. Cases whose metropolitan status is indeterminable or mixed are excluded from the urbanicity subgroup analysis.

Source: Ruggles, S., Flood, S., Goeken, R., Grover, J., Meyer, E., Pacas, J., & Sobek, M. (2020). *American Community Survey 2018, five-year estimates*. (IPUMS USA: Version 10.0) [Data set]. IPUMS. <https://doi.org/10.18128/D010.V10.1>

44 Evans, G. (2006). Child development and the physical environment. *Annual Review of Psychology*, 57, 423-451.

45 Cutts, D. B., Meyers, A. F., Black, M. M., Casey, P. H., Chilton, M., Cook, J. T., Geppert, J., Ettinger de Cuba, S., Heeren, T., Coleman, S., Rose-Jacobs, R., & Frank, D. A. (2011). U.S. housing insecurity and the health of very young children. *American Journal of Public Health*, 101(8), 1508-1514.

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### **Maltreatment rate per 1,000 infants/toddlers**

Infants and toddlers are the age group most likely to suffer abuse and neglect, accounting for more than a quarter of all substantiated incidents.<sup>46</sup> By far, the most prevalent form of maltreatment is neglect, defined as “the absence of sufficient attention, responsiveness, and protection that are appropriate to the ages and needs of a child.”<sup>47</sup> Child maltreatment is influenced by a number of factors, including inadequate access to education about child development, substance abuse, other forms of domestic violence, and mental illness. Although maltreatment occurs in families at all economic levels, abuse—and especially neglect—are more common in economically disadvantaged families than in families with higher incomes.<sup>48</sup> Note that the data source for this indicator is agency-confirmed reports, which are likely to underestimate the actual prevalence of maltreatment.

For the *State of Babies Yearbook: 2021*, the numerator is the number of unique maltreatment victims under 1, age 1, and age 2 as reported in the Child Maltreatment 2018 report. The denominator is the total number of children of the same ages, according to the Child Maltreatment 2018 report. This calculation is consistent with that from the *State of Babies Yearbook: 2020*. However, for the *State of Babies Yearbook: 2019*, information on the total number of children ages 0-2 was based on Census Bureau population estimates, rather than data in the Child Maltreatment report.

Use caution when comparing this indicator across states, as states’ child welfare systems vary significantly.

Sources: U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau. (2020). *Child Maltreatment 2018*. Retrieved July 2020 from <https://www.acf.hhs.gov/cb/resource/child-maltreatment-2018>

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### **Percentage of infants/toddlers living in unsafe neighborhoods, as reported by parents**

Living in neighborhoods that are unsafe can be a source of stress and may pose threats—through violence or pollutants—to physical well-being. Neighborhoods that are unsafe are associated with high rates of infant mortality and low birthweight, child abuse and neglect, and poor motor and social development among young children.<sup>49</sup> Parents in these neighborhoods may restrict children’s opportunities for outdoor play out of concern for safety.<sup>50</sup>

The indicator denominator is children ages 0-2. The numerator is those children whose parents disagree somewhat or definitely that their children are safe in the neighborhood.

Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016-2018) combined sample of the National Survey of Children’s Health (NSCH). These results are more reliable than the results

46 U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2018). *Child maltreatment 2016*. U.S. Government Printing Office. Retrieved from <http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2016>

47 National Center on the Developing Child. (2012). *The science of neglect: The persistent absence of responsive care disrupts the developing brain*. Working Paper 12. National Center on the Developing Child. <http://www.developingchild.harvard.edu>

48 Slack, K. S., Holl, J. L., McDaniel, M., Yoo, J., & Bolger, K. (2004). Understanding the risks of child neglect: An exploration of poverty and parenting characteristics. *Child Maltreatment*, 9(4), 395-408.

49 To, T., Cadarette, S. M., & Liu, Y. (2001). Biological, social, and environmental correlates of preschool development. *Child Care Health & Development*, 27(2), 187-200.

50 Beets, M. W. & Foley, J. T. (2008). Association of father involvement and neighborhood quality with kindergarteners’ physical activity: A multilevel structural equation model. *American Journal of Health Promotion*, 22(3), 195-203.

presented in the 2020 report, which were based on two years of NSCH data (2016-2017), or the 2019 report, which were based on 2016 data. They should be considered improved estimates, not new estimates that can be compared directly to the 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and household income. *Race/ethnicity*: The child's race/ethnicity is reported by their caregiver, and included subgroups are Hispanic of all races, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American Indian or Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016-2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as "not low-income."

Sources: Child and Adolescent Health Measurement Initiative. (2017). *2016 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). *2017 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). *2018 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

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### **Percentage of families with infants/toddlers who report "family resilience"**

How families cope with challenges can make a difference in their overall well-being. Children who learn that families can solve problems together, participate in decision-making, and reduce conflict gain valuable skills related to planning, communication, managing emotions, and optimism that can improve their chances of being resilient when encountering their own challenges.<sup>51</sup>

The indicator denominator is the number of children ages 0-2. The numerator is those children whose parent responded to the question "When your family faces problems, how often are you likely to do each of the following?" with the responses "most of the time" or "all of the time" to the question all four family resilience items. The four items are (a) talk together about what to do, (b) work together to solve our problems, (c) know we have strengths to draw on, and (d) stay hopeful even in difficult times. Response options for each item are none of the time, some of the time, most of the time, or all of the time.

51 Moore, K. A., Bethell, C. D., Murphey, D. A., Martin, M. C., & Beltz, M. (2017). *Flourishing from the start: What is it and how can it be measured?* Child Trends. <https://www.childtrends.org/wp-content/uploads/2017/03/2017-16FlourishingFromTheStart-1.pdf>



Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016-2018) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 2020 report, which were based on two years of NSCH data (2016-2017), or the 2019 report, which were based on 2016 data. They should be considered improved estimates, not new estimates that can be compared directly to the 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and household income. *Race/ethnicity*: The child's race/ethnicity is reported by their caregiver, and the included subgroups are Hispanic of all races, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American Indian or Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016-2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as "not low-income."

Sources: Child and Adolescent Health Measurement Initiative. (2017). *2016 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). *2017 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). *2018 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

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### **Percentage of infants/toddlers who have experienced one adverse childhood experiences; two or more adverse childhood experiences**

Exposure to unmanageable stress can interfere with the normal development of the body's neurological, endocrine, and immune systems, leading to increased susceptibility to disease. Because their brains are developing rapidly, infants and toddlers are especially vulnerable, and the damage may be long-lasting.<sup>52</sup> Survey items asked parents to indicate whether their child had ever experienced one or more of the following: economic hardship, divorce/separation of parent, death of a parent, a parent who served time in jail, being a witness to domestic violence, being a victim of or witness to neighborhood violence, living with someone who was mentally ill or suicidal, living with someone with an alcohol/drug problem, or being treated or judged unfairly due to race/ethnicity.

52 Shonkoff, J. P., Garner, A. S., the Committee on psychosocial aspects of child and family health, Committee on early childhood adoption and dependent care, & Section on developmental and behavioral pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129, e232-e246. Doi:10.1542/peds.2011-2663

The denominator is children ages 0-2. The numerators are all children ages 0-2 whose parent reports one adverse experience or two or more adverse childhood experiences (ACEs), respectively. There are nine ACE items: hard to get by on family's income; parent or guardian divorced or separated; parent or guardian died; parent or guardian served time in jail; saw or heard parents or adults slap, hit, kick, punch one another in the home; was a victim of violence or witnessed violence in neighborhood; lived with anyone who was mentally ill, suicidal, or severely depressed; lived with anyone who had a problem with alcohol or drugs; and treated or judged unfairly due to race/ethnicity. A response of "somewhat often" or "very often" to the question "How often has it been very hard to get by on your family's income?" was coded as an adverse childhood experience. The remaining survey items are dichotomous Yes/No response options, with "Yes" coded as an ACE. The wording of the economic hardship item was changed in the 2018 NSCH. Data for that item is no longer comparable to earlier version of the NSCH, however, the composite measure may continue to be compared.<sup>53</sup> Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016-2018) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 2020 report, which were based on two years of NSCH data (2016-2017), or the 2019 report, which were based on 2016 data. They should be considered improved estimates, not new estimates that can be compared directly to the 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and household income. *Race/ethnicity*: The child's race/ethnicity is reported by their caregiver, and the included subgroups are Hispanic of all races, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American Indian or Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016-2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as "not low-income."

Sources: Child and Adolescent Health Measurement Initiative. (2017). *2016 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). *2017 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). *2018 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

53 Child and Adolescent Health Measurement Initiative (CAHMI) (2019). *2017-2018 National Survey of Children's Health (2 years combined data set): Child and family health measures, national performance and outcome measures, and subgroups, STATA codebook, Version 1.0*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org)

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### **Number of infants/toddlers who have been removed from home and placed in foster care, per 1,000**

Unstable conditions at home can cause infants and toddlers to be placed in out-of-home care.

This indicator is new for the *State of Babies Yearbook: 2021*. The denominator is the number of infants and toddlers ages 0-2 in the population in 2019, according to U.S. Census population estimates. The numerator is the number of infants and toddlers who were removed from home and placed in foster care in FFY 2019. This fraction is then translated into a rate per 1,000 infants and toddlers.

This indicator can be disaggregated by race/ethnicity. Classification of infants and toddlers into racial and ethnic groups may vary from state to state, but typically a caseworker enters this information into the database. The included subgroups are non-Hispanic American Indian/Alaska native, non-Hispanic Asian, non-Hispanic Black, non-Hispanic Hawaiian/other Pacific Islander, Hispanic (of any race), non-Hispanic multi-racial, and non-Hispanic White.

Sources: Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U. S. Department of Health and Human Services (2020). Adoption and Foster Care Analysis and Reporting System (AFCARS), Foster Care File 2019 [Data set]. National Data Archive on Child Abuse and Neglect. <https://doi.org/10.34681/7424-0J56>

U.S. Census Bureau, Population Division. (2020). *Annual state resident population estimates for 6 race groups (5 race alone groups and two or more races) by age, sex, and Hispanic origin: April 1, 2010 to July 1, 2019*. <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

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### **Percentage of infants/toddlers in out-of-home placement who exited care in less than 12 months**

The U.S. Department of Health and Human Services recognizes four ways a young child can exit the child welfare system: through reunification with the parents or caregivers, legal adoption, placement with other relative(s), or through a placement with a non-relative legal guardian(s).<sup>54</sup> The Adoption and Safe Families Act of 1997 (ASFA) was passed to ensure timely permanency and placement for children in the child welfare system.

This indicator was new for the *State of Babies Yearbook: 2020*. For the *State of Babies Yearbook: 2021*, the denominator is all infants and toddlers ages 0-2 who entered care in 2018, and who either left care by 2019 or was also in the dataset for 2019. The numerator is the number of infants and toddlers in this cohort who exited care in less than 12 months.

This indicator can be disaggregated by race/ethnicity. Classification of infants and toddlers into racial and ethnic groups may vary from state to state, but typically a caseworker enters this information into the database. The included subgroups are non-Hispanic American Indian/Alaska native, non-Hispanic Asian, non-Hispanic Black, non-Hispanic Hawaiian/other Pacific Islander, Hispanic (of any race), non-Hispanic multi-racial, and non-Hispanic White.

Sources: Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U. S. Department of Health and Human Services (2019). Adoption and Foster Care Analysis and Reporting System (AFCARS), Foster Care File 2018 [Data set]. National Data Archive on Child Abuse and Neglect. <https://doi.org/10.34681/7424-0J56>

54 U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau. (2005). *Child welfare outcomes 2002-2005: Report to Congress prepared by the Children's Bureau (ACYF, ACF) of the U.S. Department of Health and Human Services*. Retrieved from <http://www.acf.hhs.gov/programs/cb/pubs/cwo05/index.htm>.

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**Percentage of infants/toddlers exiting foster care who achieve permanency; and, of these, the percentage reunified, placed with guardian, placed with non-guardian relative, and adopted**

Young children fare best when they experience stable and consistent caregiving. Most often, that is with their own parents; other relatives may be a next-best alternative. If care by a relative is not feasible, then loving adoptive parents can provide a permanent home. Multiple temporary placements, by contrast, can disrupt a young child’s sense of trust and security and contribute to emotional and behavioral problems.<sup>55</sup>

For the percentage of infants/toddlers exiting foster care who achieve permanency, the denominator is children exiting foster care during the fiscal year who are ages 0-2 at the time of exit. The numerator is those children of that group who achieve permanency. Permanency is defined as reunification with the parent, termination of parental rights (TPR) and adoption, guardianship with a permanent guardian, or guardianship with a “fit and willing relative” while remaining in the legal custody of the state. Data reflect the 2019 federal fiscal year. Our analysis of the FFY 2019 data limited this indicator to children who exited within the FFY. Previous analyses (for the *State of Babies Yearbook: 2019 and 2020*) included all children with a discharge reason, and a small portion may have exited shortly after the end of the FFY.

For the percentage of infants/toddlers exiting foster care who are reunified, the denominator is children exiting foster care during fiscal year who are ages 0-2 at the time of exit who achieve permanency. The numerator is children exiting foster care during fiscal year who are ages 0-2 at the time of exit who are reunified with the parent.

For the percentage of infants/toddlers exiting foster care who are placed with a guardian, the denominator is children exiting foster care during fiscal year who are ages 0-2 at the time of exit who achieve permanency. The numerator is children exiting foster care during fiscal year who are ages 0-2 at the time of exit who are placed with a guardian.

For the percentage of infants/toddlers exiting foster care who are placed with a relative, the denominator is children exiting foster care during fiscal year who are ages 0-2 at the time of exit who achieve permanency. The numerator is children exiting foster care during fiscal year who are ages 0-2 at the time of exit who are placed with a relative.

For the percentage of infants/toddlers exiting foster care who are adopted, the denominator is children exiting foster care during fiscal year who are ages 0-2 at the time of exit who achieve permanency. The numerator is children exiting foster care during fiscal year who are ages 0-2 at the time of exit who are adopted.

Use caution when interpreting this group of indicators, as states’ child welfare systems can vary significantly.

These indicators can be disaggregated by race/ethnicity. Classification of infants and toddlers into racial

55 Wulczyn, F., Ernst, M., & Fisher, P. (2011). *Who are the infants in out-of-home care? An epidemiological and developmental snapshot*. Chapin Hall Issue Brief. Retrieved from [https://fcda.chapinhall.org/wp-content/uploads/2012/10/2011\\_infants\\_issue-brief.pdf](https://fcda.chapinhall.org/wp-content/uploads/2012/10/2011_infants_issue-brief.pdf)

and ethnic groups may vary from state to state, but typically a caseworker enters this information into the database. The included subgroups are non-Hispanic American Indian/Alaska native, non-Hispanic Asian, non-Hispanic Black, non-Hispanic Hawaiian/other Pacific Islander, Hispanic (of any race), non-Hispanic multi-racial, and non-Hispanic White.

Source: Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U. S. Department of Health and Human Services (2020). Adoption and Foster Care Analysis and Reporting System (AFCARS), Foster Care File 2019 [Data set]. National Data Archive on Child Abuse and Neglect. <https://doi.org/10.34681/7424-0J56>

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### **Percentage of infants/toddlers who could benefit from evidence-based home visiting services and are receiving those services**

Home visiting is a two-generation approach to serving the varied needs of families with an infant or toddler. Trained home visitors teach parents about milestones of early development and other appropriate expectations for very young children, and help parents promote good health and keep their homes safe for babies and toddlers, use effective parenting practices, and access additional resources within their communities. A number of home visiting programs have been shown to be effective at improving one or more aspects of family well-being.<sup>56</sup> Yet, in most communities, the need for home visiting services far outpaces current capacity.<sup>57</sup>

The denominator is the number of children ages 0-2 who could benefit from home visiting according to the source document, which is calculated as the total number of children ages 0-2 based on the American Community Survey. The numerator is calculated by multiplying the total number of children who received home visiting by the percentage of children who receive home visiting who are ages 0-2. The national total was calculated from the data provided in the National Home Visiting Resource Center National Profile, which included children served in the tribal and US territory communities. All of the other state data were pulled from each individual state profile, also located on the National Home Visiting Resource Center website. Data reflect 2018 values.

Source: National Home Visiting Resource Center. (2019). *2019 Home visiting yearbook - State profile information*. Arlington, VA: James Bell Associates and the Urban Institute. Retrieved September 2020 from <https://nhvrc.org/yearbook/2020-yearbook/state-tribal-landscape/>

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### **State requires employers to provide paid sick days that cover care for child**

Parents should not have to give up pay to care for a sick child. To attract and retain a capable workforce, employers need to acknowledge that their employees have multiple responsibilities.

This indicator reports whether or not the state has a policy covering paid sick time for the care of family members that includes care for children, as reported by the National Partnership for Women and Families. The data reflect state paid sick days, as of April 2020.

56 Sama-Miller, E., Akers, L., Mraz-Esposito, A., Zukiewicz, M., Avellar, S., Paulsell, D., & Del Grosso, P. (2018). *Home visiting evidence of effectiveness review: Executive summary*. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. [https://www.acf.hhs.gov/sites/default/files/opre/homvee\\_executive\\_summary\\_2018\\_508.pdf](https://www.acf.hhs.gov/sites/default/files/opre/homvee_executive_summary_2018_508.pdf)

57 National Home Visiting Resource Center. (2017). *2017 Home visiting yearbook*. [https://www.nhvrc.org/wp-content/uploads/NHVRC\\_Yearbook\\_2017\\_Final.pdf](https://www.nhvrc.org/wp-content/uploads/NHVRC_Yearbook_2017_Final.pdf)

Source: National Partnership for Women and Families. (2020). *Paid sick days - State and district statutes*. Retrieved July 2020 from <https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-sick-days/paid-sick-days-statutes.pdf>

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### **State has a paid family leave program**

Nearly alone among all the world's nations, the United States has no federal paid family leave policy. Therefore, states must lead the way. Family leave is used primarily to care for a newborn child, but also to meet other exceptional caregiving needs, such as for an older, disabled, or chronically ill relative, or a newly adopted child. In addition to economic benefits for families, paid family leave promotes parent-infant bonding, can increase the likelihood of breastfeeding, lessen the likelihood of maternal depression, promote fathers' involvement in childrearing, increase mothers' attachment to the labor force, and reduce reliance on public assistance.<sup>58</sup>

The National Partnership for Women and Families (NPWF) produced a table summarizing state paid family and medical leave insurance laws, as of August 2019. NPWF uses the term "family leave" to mean time off to care for another person in the family, such as a newborn or newly adopted child, child, spouse, or parent with a serious health condition. Policies that have been enacted but not yet taken effect are included.

Source: National Partnership for Women and Families. (2019). *State paid family and medical leave insurance laws*. Retrieved from <http://www.nationalpartnership.org/research-library/work-family/paid-leave/state-paid-family-leave-laws.pdf>

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### **Percentage of families with infants/toddlers living below 100 percent of the federal poverty line that receive TANF benefits**

The Temporary Aid to Needy Families program (TANF) was designed to help lower income families with minor children with cash assistance, particularly while parents are seeking employment. However, states are allowed to spend TANF funds for a variety of other activities (for example, administrative costs, child care and pre-K programs, child welfare services, and work support activities) in addition to directly supporting families. Nationwide, only about one in four families living in poverty receives any TANF benefits, and the amount those families receive is often insufficient to lift them out of poverty.<sup>59</sup>

This indicator has no update for the *State of Babies Yearbook: 2021*. The numerator for this indicator is the number of TANF-receiving families whose youngest child was younger than three in Fiscal Year 2018. The denominator is the number of families whose youngest child is younger than three, and have incomes below the federal poverty level, based on estimates from the 2019 Current Population Survey, which spans from March 2018- February 2019.

Sources: U.S. Department of Health and Human Services Administration for Children & Families Office of Family Assistance. (2019). *Characteristics and financial circumstances of TANF recipients, fiscal year 2018* [Tables]. Retrieved from <https://www.acf.hhs.gov/ofa/resource/characteristics-and-financial-circumstances-of-tanf-recipients-fiscal-year-2018> Flood, S., King, M., Rodgers, R., Ruggles, S., & Warren, J. R. (2019). *Current population survey 2019*. (IPUMS, Version 6.0) [Data set]. IPUMS. Retrieved from <https://doi.org/10.18128/D030.V6.0>

58 Schulte, B., Durana, A., Stout, B., & Moyer, J. (2017). *Paid family leave: How much time is enough?* New America. Retrieved from <https://www.newamerica.org/better-life-lab/reports/paid-family-leave-how-much-time-enough/>

59 Floyd, I., Pavetti, L., & Schott, L. (2017). *TANF reaching few poor families*. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/family-income-support/tanf-reaching-few-poor-families>

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### TANF work exemption for single parents of infants

The Temporary Aid to Needy Families program (TANF) was designed to help poor families with minor children with cash assistance, particularly while parents are seeking employment. However, states are allowed to spend TANF funds for a variety of other activities (for example, administrative costs, child care and pre-K programs, child welfare services, and work support activities) in addition to directly supporting families.

Certain work-related activities are required in order for each state to meet the annual work participation rates, which are determined by the federal government.<sup>60</sup> States can determine exemptions that can be made for single-parent unit households with different household circumstances.

This indicator has no update for the *State of Babies Yearbook:2021*, as updated data on TANF were not available. This indicator was new for the *State of Babies Yearbook: 2020*. It documents, as of July 2018, whether a state exempts a single parent “head of unit” over 21 years of age, caring for an infant, from TANF work-related activity if caring for a child less than 12 months old. The source document contains details about the duration and conditions for exemptions. A superscript indicates that the exemption is only valid for a single child.

Source: Goehring, B., Heffernan, C., Minton, S., & Giannarelli, L. (2019). *Welfare rules databook: State TANF policies as of July 2018*. OPRE Report 2019-83. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved September 2019 from [https://www.acf.hhs.gov/sites/default/files/opre/2018\\_welfare\\_rules\\_databook\\_final\\_08\\_07\\_2019\\_508.pdf](https://www.acf.hhs.gov/sites/default/files/opre/2018_welfare_rules_databook_final_08_07_2019_508.pdf)

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### State offers a child tax credit

The Child Tax Credit (CTC) is a federal program for parents with low and moderate earnings.<sup>61</sup> For a child to be eligible, the parent must answer certain qualifying questions regarding the child’s age, relationship to the parent, support, dependency, citizenship, and residence. Because the CTC serves middle-income and most upper-middle income families, in addition to low- and moderate-income families, more families are able to receive this tax credit than families under the Earned Income Tax Credit (EITC). By providing families up to \$1,000 for each child under 17, and by raising the amount of the credit as earnings increase (up to a threshold), the CTC helps to pay for the cost of raising children.<sup>62</sup> Research suggests that families receiving a larger refundable tax credit have children who do better in school, have a higher chance of going to a university, and will likely earn more as adults.<sup>63</sup> Some states have also implemented a child tax credit to complement the federal CTC.

60 Goehring, B., Heffernan, C., Minton, S., & Giannarelli, L. (2019). *Welfare rules databook: State TANF policies as of July 2018*. OPRE Report 2019-83. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved September 2019 from [https://www.acf.hhs.gov/sites/default/files/opre/2018\\_welfare\\_rules\\_databook\\_final\\_08\\_07\\_2019\\_508.pdf](https://www.acf.hhs.gov/sites/default/files/opre/2018_welfare_rules_databook_final_08_07_2019_508.pdf)

61 Tax Credits for Workers and Their Families (2018). *State Tax Credits*. Retrieved September 2019 from <http://www.taxcreditsforworkersandfamilies.org/state-tax-credits/>

62 Marr, C., Huang, C. C., Sherman, A., & Debot, B. (2015). *EITC and Child Tax Credit promote work, reduce poverty, and support children’s development, research finds*. Center on Budget and Policy Priorities. <https://www.cbpp.org/sites/default/files/atoms/files/6-26-12tax.pdf>

63 Marr, C., Huang, C. C., Sherman, A., & Debot, B. (2015). *EITC and Child Tax Credit promote work, reduce poverty, and support children’s development, research finds*. Center on Budget and Policy Priorities. <https://www.cbpp.org/sites/default/files/atoms/files/6-26-12tax.pdf>

This indicator has no update for the *State of Babies Yearbook: 2021*, as the data source has not been updated. Data are current as of 2019. This indicator was new for the *State of Babies Yearbook: 2020* and documents whether a state offers a child tax credit. Details on states' child tax credits, including their amounts and their eligibility requirements are available in the source document.

Source: Tax Credits for Workers and Their Families (2019). *State Tax Credits*. Retrieved September 2020 from <http://www.taxcreditsforworkersandfamilies.org/state-tax-credits/>

Note: Although the source above lists the website was updated in 2019, data are unchanged for the *State of Babies Yearbook: 2021*.

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### **State offers an earned income tax credit**

The federal Earned Income Tax Credit (EITC) is a federal tax credit for working people with low and moderate earnings. The EITC provides workers with a tax credit that is applied to some or all of a worker's federal tax obligation, and thus can serve as a supplemental source of income.<sup>64</sup> The EITC is currently targeted towards workers who are raising children, with eligibility depending on the worker's income, marital status, and number of children.

State Earned Income Tax Credits provide an additional benefit to families by reducing their state income tax liability.<sup>65</sup>

Research has found that children who are beneficiaries of greater state or federal EITCs obtain better test scores, compared to similar families who are receiving lesser amounts. Additionally, college enrollment was greater in states that offered refundable tax credits similar to the federal program.<sup>66</sup>

For this indicator, states were counted as having the policy if states had enacted a law regarding EITC, even if it has not yet gone into effect. Data are as of March 2020. This indicator uses a different source for the *State of Babies Yearbook: 2021*, from the Center on Budget and Policy Priorities. The data for the *State of Babies Yearbook: 2020* were from Tax Credits for Workers and Their Families.

Source: Williams, E., Waxman, S., & Legendre J. (2020). *States can adopt or expand earned income tax credits to build a stronger future economy*. Washington, DC: Center on Budget and Policy Priorities. <https://www.cbpp.org/research/state-budget-and-tax/policy-basics-state-earned-income-tax-credits>

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## **Positive Early Learning Experiences**

### **Percentage of parents who report reading to their infants/toddlers every day**

Long before they are able to read, infants and toddlers develop literacy skills and an awareness of

64 Tax Credits for Workers and Their Families (2018). *State tax credits*. Tax Credits for Workers and Their Families. <http://www.taxcreditsforworkersandfamilies.org/state-tax-credits/>

65 National Conference of State Legislatures. (2019). *Tax credits for working families: Earned Income Tax Credit (EITC)*. National Conference of State Legislatures. <https://www.ncsl.org/research/labor-and-employment/earned-income-tax-credits-for-working-families.aspx>

66 Marr, C., Huang, C. C., Sherman, A., & Debot, B. (2015). *EITC and Child Tax Credit promote work, reduce poverty, and support children's development, research finds*. Center on Budget and Policy Priorities. <https://www.cbpp.org/sites/default/files/atoms/files/6-26-12tax.pdf>



language.<sup>67</sup> Since language development is fundamental to many areas of learning, skills developed early in life help set the stage for later school success. By reading aloud to their young children, parents help them acquire the skills they will need to be ready for school.<sup>68</sup> Young children who are regularly read to have a larger vocabulary; higher levels of phonological, letter name, and sound awareness; and better success at decoding words.<sup>69</sup>

The denominator for this indicator is all children ages 0-2. The numerator is those whose family members report reading to them every day.

Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016-2018) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 2020 report, which were based on two years of NSCH data (2016-2017), or the 2019 report, which were based on 2016 data. They should be considered improved estimates, not new estimates that can be compared directly to the 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and household income. *Race/ethnicity*: The child's race/ethnicity is reported by their caregiver, and the included subgroups are Hispanic of all races, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American Indian or Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016-2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as "not low-income."

Sources: Child and Adolescent Health Measurement Initiative. (2017). *2016 National Survey of Children's Health (NSCH) State constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). *2017 National Survey of Children's Health (NSCH) State constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). *2018 National Survey of Children's Health (NSCH) State constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

67 National Research Council. (1999). *Starting out right: A guide to promoting children's reading success*. The National Academies Press. <https://doi.org/10.17226/6014>

68 Raikes, H., Pan, B.A., Luze, G.J., Tamis-LeMonda, C.S., Brooks-Gunn, J., Constantine, J., Tarullo, L.B., Raikes, H.A., & Rodriguez, E. (2006). Mother-child bookreading in low-income families: Correlates and outcomes during the first three years of life. *Child Development*, 77(4), 924-953.

69 Burgess, S. R., Hecht, S. A., & Lonigan, C. J. (2002). Relations of the home literacy environment (HLE) to the development of reading-related abilities: A one-year longitudinal study. *Reading Research Quarterly*, 37(4), 408-426

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### **Percentage of parents who report singing songs or telling stories to their infants/toddlers every day**

Reading is not the only way parents can promote their young child's language development. Singing songs and telling stories are language-rich activities that are also typically rich in cultural traditions, thus contributing to a child's positive identity. Important features of many songs and stories are repetition, internal structure, and multiple perspectives—all features that help children develop the skills that underlie school success. Not all parents are comfortable with reading or have the appropriate materials, so encouraging parents to use songs and stories to nurture their child's language development is a smart strategy.

The indicator denominator is all children ages 0-2. The numerator is those whose family members report singing or telling stories to them every day.

Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016-2018) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 2020 report, which were based on two years of NSCH data (2016-2017), or the 2019 report, which were based on 2016 data. They should be considered improved estimates, not new estimates that can be compared directly to the 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and household income. *Race/ethnicity*: The child's race/ethnicity is reported by their caregiver, and the included subgroups are Hispanic of all races, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American Indian or Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016-2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as "not low-income."

Sources: Child and Adolescent Health Measurement Initiative. (2017). *2016 National Survey of Children's Health (NSCH) State constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). *2017 National Survey of Children's Health (NSCH) State constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). *2018 National Survey of Children's Health (NSCH) State constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

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### **Percentage of infants/toddlers below 100 percent of the federal poverty line with access to Early Head Start**

Early Head Start (EHS) is a comprehensive child development and family support program for infants, toddlers, and pregnant women in poor families. Apart from family income, each EHS program sets its own eligibility criteria, targeting their services to best meet the needs of families and children in their

community. Services may be delivered in centers, family child care homes, or individual family homes.<sup>70</sup> A recent study found that, among families participating in EHS, children had enhanced cognitive development, attention, and engagement; their parents had less stress and family conflict, and were more likely to be responsive, warm, and supportive. EHS families had lower rates of subsequent child maltreatment than those in a control group.<sup>71</sup>

The National Head Start Association reports the percentage of eligible children ages 0–2 who had access to Early Head Start during 2018 fiscal year. The denominator for this indicator is the number of children ages 0–2 below 100 percent of the federal poverty line, according to the 2018 U.S. Census Bureau’s Current Population Survey, Annual Social and Economic Supplement. The numerator is total funded EHS slots, based on the 2019 Head Start Program Information Report. This percentage does not account for eligibility criteria beyond income.

Source: National Head Start Association (2020). *Access to Head Start in the United States state-by-state fact sheets*. Retrieved July 2020 from <https://www.nhsa.org/national-head-start-fact-sheets>

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### **Average state cost of center-based infant care as a percentage of median income for married families/ single parents**

Providing care for infants and toddlers is more expensive than for older children, because higher adult-child ratios are required, and additional costs are associated with maintaining appropriate hygiene around diapering, bottle feeding, bedding, and so on. Parents can pay more than \$20,000 per year for center-based infant care, depending on where they live.<sup>72</sup> The new federal standard is that families should spend no more than 7 percent of their income for child care.<sup>73</sup>

The calculation of cost of care for single parents is consistent with the *State of Babies Yearbook: 2019* but relies on more recent data. The denominator is the median income for single-parent families based on the 2017 U.S. Census Bureau’s American Community Survey, five-year estimates. Unless otherwise indicated, the numerator is the 2018 annual cost of center-based infant care, based on the Child Care Aware of America’s January 2019 survey of Child Care Resource and Referral State Networks. Due to data availability, the numerators for New Jersey, South Carolina, Wyoming, and Alabama are from the 2017 market rate survey, and the numerators for Pennsylvania and Mississippi are from the 2016 market survey. Data from market rate surveys prior to 2018 are adjusted for inflation.

The calculation of cost of care for married parents is consistent with the *State of Babies Yearbook: 2020* but relies on more recent data. The denominator is the median income for married-couple families based on the 2017 U.S. Census Bureau’s American Community Survey, five-year estimates. Unless otherwise indicated, the numerator is the 2018 annual cost of center-based infant care, based on the Child Care

70 Early Head Start National Resource Center. <http://www.ehsnrc.org/ChildEligible.htm>

71 Green, B. L., Ayoub, C., Bartlett, J. D., Furrer, C., Cohen, R. C., Buttita, K., Von Ende, A., Koepp, A., Regalbutto, E., & Sanders, M. B. (2018). *How Early Head Start prevents child maltreatment*. Child Trends. Retrieved from <https://www.childtrends.org/publications/how-early-head-start-prevents-child-maltreatment>

72 Child Care Aware of America. (2019). *The U.S. and the high cost of child care: 2019*. Retrieved from [https://cdn2.hubspot.net/hubfs/3957809/2019%20Price%20of%20Care%20State%20Sheets/Final-TheUSandtheHighPriceofChildCare-Appendices.pdf?\\_\\_hssc=122076244.2.1605543695491&\\_\\_hstc=122076244.abdbe2aa1098f4ba8bffad2689acb4371602611682546.1605025891932.1605543695491.6&\\_\\_hsfp=3629513924&hsCtaTracking=b84e60b8-da54-4971-9364-7d5667e1a1b7%7C0be5fe22-5bef-4e54-908a-f95a653d2b14](https://cdn2.hubspot.net/hubfs/3957809/2019%20Price%20of%20Care%20State%20Sheets/Final-TheUSandtheHighPriceofChildCare-Appendices.pdf?__hssc=122076244.2.1605543695491&__hstc=122076244.abdbe2aa1098f4ba8bffad2689acb4371602611682546.1605025891932.1605543695491.6&__hsfp=3629513924&hsCtaTracking=b84e60b8-da54-4971-9364-7d5667e1a1b7%7C0be5fe22-5bef-4e54-908a-f95a653d2b14)

73 Department of Health and Human Services, *Child Care and Development Fund (CCDF) Program*; Proposed Rule, 80 Fed. Reg. 80466–80582 (December 24, 2015)

Aware of America's January 2019 survey of Child Care Resource and Referral State Networks. Due to data availability, the numerators for New Jersey, South Carolina, Wyoming, and Alabama are from the 2017 market rate survey, and the numerators for Pennsylvania and Mississippi are from the 2016 market survey. Data from market rate surveys prior to 2018 are adjusted for inflation.

Sources: Child Care Aware of America (2019). *2018 Appendices: The US and the high price of child care*. <https://info.childcareaware.org/download-price-of-care-extras?submissionGuid=8b6a0a23-af7f-4dfd-8b0c-c5f3196c230b>

Child Care Aware of America (2019). *Child care in America: 2019 state fact sheets*. Retrieved August 26, 2020 from <https://www.child-careaware.org/our-issues/research/the-us-and-the-high-price-of-child-care-2019/>

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### **Income eligibility level for child care subsidy is at or above 200 percent of the federal poverty line**

Families in every state need an income at least twice the federal poverty line to meet basic needs for food, housing, child care, transportation, and health care. In states with a lower income threshold for subsidy eligibility, families with an infant or toddler cannot afford care without sacrificing other essentials.<sup>74</sup>

The National Women's Law Center reports the income eligibility limits for a child care subsidy as a percentage of the 2019 federal poverty level for a family of three, or \$21,330 a year. The data source reflects policies as of February 2019. Eligibility limits that are equal to or above 200 percent of the federal poverty line are coded as "yes," and eligibility limits that are less than 200 percent of the federal poverty line are coded as "no." In Texas and Virginia, counties set their income limits and the median eligibility limit, so it is not possible to compute this indicator for these states.

Source: Schulman, K. (2019). *Early progress: State child care assistance policies 2019*. National Women's Law Center. Retrieved July 2020 from: <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2019/11/NWLC-State-Child-Care-Assistance-Policies-2019-final.pdf>

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### **Percent of infants/toddlers with family incomes equal to or below 150 percent of the state median income who are receiving a child care subsidy**

The federal Child Care and Development Fund (CCDF) is the primary source of financing for states' child care subsidy programs. States set their own eligibility requirements. Even in the most generous states, however, various barriers (including waiting lists or frozen intake, high family copayments, and low reimbursement rates for care providers) restrict access to these programs.<sup>75</sup>

The denominator for this indicator is the number of children ages 0-2 with family incomes less than or equal to 150 percent of the state median income. To calculate the denominator, we followed the following steps: a) obtained the state median incomes for 4-person families, by state, from the Federal Register; b) multiplied those numbers by 1.5 to get 150 percent of the state median income for 4-person families; c) calculated 150 percent of the state median income for families of different configurations, using the conversion provided in a table footnote in the Federal Register; d) applied to each respondent in the 2019 1-year American Community Survey (ACS) the appropriate 150 percent of state median income threshold, based on their state and family size; e) flagged respondents whose family income was less than or equal

74 Schulman, K. (2018). *Overdue for investment: State child care assistance policies, 2018*. National Women's Law Center. <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2018/11/NWLC-State-Child-Care-Assistance-Policies-2018.pdf>

75 Ibid.

to this threshold; f) exported the weighted number of children ages 0-2 with these flags. The numerator is the number of children ages 0-2 who received CCDF-funded care in Fiscal Year 2018 (based on estimates from the Administration for Children and Families Office of Child Care).

Sources: Administration for Children and Families, Office of Child Care. (n.d.). FY 2018 CCDF Data Tables (Preliminary). Retrieved September 2020 from <https://www.acf.hhs.gov/occ/resource/fy-2018-ccdf-data-tables-preliminary>

Administration for Children and Families, Office of Community Services. (2020). The Low-Income Home Energy Assistance Program IM 2020-02 state median income estimates for optional use in FY 2020 and mandatory use in FY 2021. Retrieved October 2020 from <https://www.acf.hhs.gov/ocs/resource/liheap-im-2020-02-state-median-income-estimates-for-optional-use-fy2020-and-mandatory-use-fy2021>

Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2020). *American Community Survey 2019, one-year estimates*. (IPUMS USA: Version 10.0) [Data set]. IPUMS. <https://doi.org/10.18128/D010.V10.0>

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### **The state has adopted a professional credential for infant/toddler teachers**

The quality of a child's care and education depends on the care environment and the interactions that take place there. A professional credential can expose a teacher to a greater variety of knowledge and skills, which in turn benefit the classroom where the child spends most of the day.<sup>76</sup>

This indicator has not had an update since it was originally included in the *State of Babies Yearbook: 2020*. This indicator denotes whether a state has adopted a professional credential for infant and toddler teachers. Note that there is not a consensus definition of appropriate infant/toddler professional credentials; they can include continuing education hours and credit programs. This information was collected by Zero to Three from the State Capacity Building Center and was supplemented with information from the National Center on Early Childhood Development, Teaching, and Learning (NCECDTL). These data have not been vetted with states.

Source: Zero to Three (2019). *State policy tracker*. Retrieved October 2019 from <https://www.zerotothree.org/resources/360-state-policy-tracker#downloads>

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### **State allocated new Child Care and Development Block Grant (CCDBG) funds to invest in infant/toddler care**

The Child Care and Development Block Grant (CCDBG) Act was signed in 2014, reauthorizing the Child Care and Development Fund (CCDF) program. The CCDF is the primary federal funding source dedicated to helping low-income families pay for child care, while also setting new requirements to improve child care quality across the country. Improving school readiness and promoting healthy child development is one of the key purposes of the CCDBG Act.<sup>77</sup> With the reauthorization taking place in 2014, new requirements were set in place for states to expand access to child care, expand education to families around child development and other financial assistance programs, enhance health and safety practices to all the

<sup>76</sup> Chen, J. J., Martin, A., & Erdosi-Mehaffey, V. (2017). The process and impact of the infant/toddler credential as professional development: Reflections from multiple perspectives and recommendations for policy. *Early Childhood Education Journal*, 45(3), 359-368.

<sup>77</sup> Office of the Administration for Children & Families: Office of Child Care. (2015). *CCDF reauthorization frequently asked questions – Archived*. <https://www.acf.hhs.gov/occ/resource/ccdf-reauthorization-faq-archived>

providers under the grant and several other requirements.<sup>78</sup> Many states found themselves struggling to meet the new requirements that were set in place with the new reauthorization, prompting Congress to respond to these concerns by providing a national increase by \$2.37 billion dollars to the CCDBG. States could choose how to allocate their increased funding to best align with the needs of their communities.<sup>79</sup>

This indicator has not been updated since it was introduced for the *State of Babies Yearbook: 2020*. States that allocated increased CCDBG funding to improve access to childcare services and specified increasing the number of slots for infants and toddlers are indicated as having allocated new CCDBG funds to invest in infant/toddler care. Data are current as of August 2019.

Source: Banghart, P., King, C., Bedrick, E., Hirilall, A., Daily, S. (2019). *States' use of the Child Care and Development Block Grant Funding Increase*. Child Trends. Retrieved October 2019 from <https://www.childtrends.org/publications/states-use-of-the-child-care-and-development-block-grant-funding-increase>

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### **Group size for infants and toddlers in CCDF licensed center-based child care**

The reauthorized Child Care Development Fund (CCDF) requires states to describe their standards for group sizes in their CCDF plans. Although each state has the ability to set their own standards for group size, the Office of the Administration for Children & Families (ACF) advises states to refer to the recommended standards in the *Caring for Our Children: National Health and Safety Performance Standards*. Group size specifically refers to the number of children assigned to a designated space/classroom under a specific teacher or group of teachers in that classroom. Research has found that smaller infant and toddler group sizes are associated with positive interactions and better developmental outcomes.<sup>80</sup>

The Early Head Start (EHS) standard for group size for children ages 0 to 3 years old is 8 children.<sup>81</sup> This indicator is a count of whether the state's group size requirements meet or exceed EHS standards at the following ages: 11 months, 19 months, and 30 months, as reported in their CCDF plans. States received one point for meeting this benchmark at each age.

This indicator has not been updated since it was introduced for the *State of Babies Yearbook: 2020*. Data reflect fiscal years 2019-2021.

Source: Administration for Children and Families, Office of Child Care. (2018). *Approved CCDF plans (FY 2019-2021)*. <https://www.acf.hhs.gov/occ/resource/state-plans>

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### **Adult/child ratio for infants and toddlers in CCDF licensed center-based child care**

The reauthorized Child Care Development Fund (CCDF) requires states to describe their standards for

78 Banghart, P., King, C., Bedrick, E., Hirilall, A., Daily, S. (2019). *States' use of the Child Care and Development Block Grant funding increase*. Child Trends. <https://www.childtrends.org/publications/states-use-of-the-child-care-and-development-block-grant-funding-increase>

79 Ibid.

80 American Academy of Pediatrics, American Public Health Association. (2011). *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*, Third Edition. [https://nrckids.org/files/CFOC3\\_updated\\_final.pdf](https://nrckids.org/files/CFOC3_updated_final.pdf)

81 Early Childhood Learning & Knowledge Center. (n.d.). Head Start Policy and Regulations: 1302.21 Center-based Option. Retrieved from: <https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/1302-21-center-based-option>

child-to-provider ratios in their CCDF plans. Although each state has the ability to set their own standards for child-to-provider ratios, the Office of the Administration for Children & Families (ACF) advises states to refer to the recommended standards in the *Caring for Our Children: National Health and Safety Performance Standards*. The child-to-provider ratio states the maximum number of children that should be allowed under each adult/provider. Smaller child-to-provider ratios promote improved quality of caregiving and improved verbal interactions between the provider and the child. Additionally, children's safety and sanitation could get compromised if the providers are busy meeting the needs of all the other children.<sup>82</sup>

The Early Head Start (EHS) standard for adult-to-child ratio for children ages 0 to 3 years old is 1 teacher for every 4 children.<sup>83</sup> This indicator is a count of whether the state's ratio requirements meet or exceed EHS standards of 1:4 at the following ages: 11 months, 19 months, 30 months, as reported in their CCDF plans. States received one point for meeting this benchmark at each age.

This indicator has not been updated since it was introduced for the *State of Babies Yearbook: 2020*. Data reflect fiscal year 2019-2021.

Source: Administration for Children and Families, Office of Child Care (2018). *Approved CCDF plans (FY 2019-2021)*. Retrieved from <https://www.acf.hhs.gov/occ/resource/state-plans>

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### **Teacher qualifications for infants and toddlers in CCDF licensed center-based child care**

One of the most important factors contributing to a child development is the care setting they are exposed to. The Child Care and Development Fund (CCDF) require states to develop a system for continuing professional development for teachers. Additionally, each state sets its own requirements around teacher qualifications.

Studies have shown that teachers who have received formal education from an accredited university provide a better quality of care and education to the children they serve. Similarly, teachers holding a four-year degree from a university are more likely to demonstrate optimal teaching and contribute to positive child outcomes to the children in the classroom.<sup>84</sup>

This indicator has not been updated since it was introduced for the *State of Babies Yearbook: 2020*. This indicator documents states' required qualifications for teachers of infants and toddlers, as reported in their CCDF plans. Teacher qualifications were classified into five categories: no credential beyond a high school diploma; Child Development Associate (CDA) or state equivalent credential; specific infant/toddler credential or CDA with an infant/toddler credential; associate's degree; bachelor's degree.

Most states did not further differentiate requirements by child age within the category of infants and toddlers. When requirements did vary by age, the lowest qualifications are reported. If the state made a distinction between types of teachers, qualifications for the lead teacher were used. Data reflect fiscal years 2019-2021.

82 American Academy of Pediatrics, American Public Health Association. (2011). *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs, Third Edition*. [https://nrckids.org/files/CFOC3\\_updated\\_final.pdf](https://nrckids.org/files/CFOC3_updated_final.pdf)

83 Early Childhood Learning & Knowledge Center. (n.d.). Head Start Policy and Regulations: 1302.21 Center-based Option. <https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/1302-21-center-based-option>

84 American Academy of Pediatrics, American Public Health Association. (2011). *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs, Third Edition*. [https://nrckids.org/files/CFOC3\\_updated\\_final.pdf](https://nrckids.org/files/CFOC3_updated_final.pdf)

Source: Administration for Children and Families, Office of Child Care (2018). *Approved CCDF plans (FY 2019–2021)*. <https://www.acf.hhs.gov/occ/resource/state-plans>

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### **State reimburses center-based child care at or above the 75th percentile of current market rates**

Higher-quality child care and early education has been found to benefit low-income children in promoting positive child development outcomes to a greater extent than their more affluent peers.<sup>85</sup> In response to federal efforts to expand high-quality child care to more children, some states have begun to reimburse center-based child care at or above the 75<sup>th</sup> percentile of the current market rates.

Increasing the state reimbursement percentile allows more families to access higher quality child care. Additionally, higher reimbursement rates allow providers to serve more families receiving subsidy, since the cost for serving those families is covered.<sup>86</sup>

The National Women’s Law Center reports whether state payment rates are at or above the 75th percentile of current market rates in Table 4b of the source document. Payment rates are considered to be at this level if rates for all (or nearly all) categories—such as different regions, age groups, types of care, and quality levels (including the base rate)—are at or above the 75th percentile of current market rates. Data are current as of February 2019.

Source: Schulman, K. National Women’s Law Center (2019). *Early progress: State child care assistance policies 2019*. Retrieved July 2020 from <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2019/11/NWLC-State-Child-Care-Assistance-Policies-2019-final.pdf>

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### **Percentage of infants/toddlers, ages 9 through 35 months, who received a developmental screening using a parent-completed tool in the past year**

Developmental screening is an efficient, cost-effective way to identify potential health or behavioral problems. In primary health care settings, the most effective screening tools rely on parent-reported information.<sup>87</sup> Children who get screened are more likely to have delays identified, be referred for early intervention, and be determined eligible for early intervention services.<sup>88</sup> The American Academy of Pediatrics recommends that children receive developmental screening from their physicians at least three times before their third birthday.<sup>89</sup>

85 Greenberg, E., Isaacs, J. B., Derrick-Mills, T., Michie, M., & Stevens, K. (2018). *Are higher subsidy payment rates and provider-friendly payment policies associated with child care quality?* Urban Institute Center on Labor, Human Services, and Population. [https://www.urban.org/sites/default/files/publication/96681/are\\_higher\\_subsidy\\_payment\\_rates\\_and\\_provider\\_friendly\\_payment\\_policies\\_associated\\_with\\_child\\_care\\_quality\\_1.pdf](https://www.urban.org/sites/default/files/publication/96681/are_higher_subsidy_payment_rates_and_provider_friendly_payment_policies_associated_with_child_care_quality_1.pdf)

86 Child Care Aware of America. (2019). *2019 CCDBG state snapshots*. <https://info.childcareaware.org/ccdbg-2019-state-snapshots>

87 Glascoe, F. P. (2000). Early detection of developmental and behavioral problems. *Pediatrics in Review*, 21(8), 272–280.

88 Guevara, J. P., Gerdes, M., Localio, R., Huang, Y. V., Pinto-Martin, J., Minkovitz, C. S., Hsu, D., Kyriakou, L., Baglivo, S., Kavanagh, J., & Pati, S. (2012). Effectiveness of developmental screening in an urban setting. *Pediatrics*, 131(1), 30–37. Doi: [10.1542/peds.2012-0765](https://doi.org/10.1542/peds.2012-0765)

89 American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. *Pediatrics*, 118(1), 405–420.



The denominator for this indicator is all children ages 9 through 35 months. The numerator is those children who received a developmental screening using a parent-completed screening tool in the past year, as reported by parents.

Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016-2018) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 2020 report, which were based on two years of NSCH data (2016-2017), or the 2019 report, which were based on 2016 data. They should be considered improved estimates, not new estimates that can be compared directly to the 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and household income. *Race/ethnicity*: The child's race/ethnicity is reported by their caregiver, and the included subgroups are Hispanic of all races, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American Indian or Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016-2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as "not low-income."

Sources: Child and Adolescent Health Measurement Initiative. (2017). *2016 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). *2017 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). *2018 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

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### **Percentage of infants/toddlers with moderate/severe developmental delay**

Developmental delays among young children can signal the presence of serious physical or social-emotional problems, as well as problems with vision or hearing that, if untreated, can negatively affect learning. Screenings can help identify children who are not meeting expected milestones of development,<sup>90</sup> and should lead to more detailed assessment and appropriate treatment and guidance for parents.

The indicator denominator is all children ages 0-2. The numerator is those whose parents respond "yes" to the question: "Has a doctor, other health care provider, or educator ever told you that this child has developmental delays?" and report that their child currently has a moderate/severe developmental delay.

90 Glascoe, F. P. (2000). Early detection of developmental and behavioral problems. *Pediatrics in Review*, 21(8), 272-280.

Use caution when interpreting this indicator; because this indicator is based on parent reports of doctor's diagnoses, it likely underestimates the prevalence of developmental delays.

Estimates in the *State of Babies Yearbook: 2021* are based on a three year (2016-2018) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 2020 report, which were based on two years of NSCH data (2016-2017), or the 2019 report, which were based on 2016 data. They should be considered improved estimates, not new estimates that can be compared directly to the 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by household income and race/ethnicity. *Race/ethnicity*: The child's race/ethnicity is reported by their caregiver, and the included subgroups are Hispanic of all races, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Asian. The US Census Bureau recommends against using state or national population estimates for the following groups with the NSCH: American Indian or Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. *Household income*: NSCH derives household income-to-poverty ratios based on family income and household size. Missing values were imputed by the Census Bureau, and the single imputation version provided in the 2016-2018 data files is used. Households with incomes less than 200 percent of the federal poverty line are classified as low-income. Households with incomes at or above 200 percent of the federal poverty line are classified as "not low-income."

Sources: Child and Adolescent Health Measurement Initiative. (2017). *2016 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2018). *2017 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

Child and Adolescent Health Measurement Initiative. (2019). *2018 National Survey of Children's Health (NSCH) Stata constructed data set*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from [www.childhealthdata.org](http://www.childhealthdata.org).

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### **Percentage of infants/toddlers receiving services under the Individuals with Disabilities Education Act Part C**

Early intervention services, also known as the Program for Infants and Toddlers with Disabilities, provide services for infants and toddlers with disabilities and their families.<sup>91</sup> In some states, eligibility extends to those who are at risk for developing a disability. States' eligibility criteria for early intervention services vary, as do the services they offer.

The numerator is the cumulative number of infants and toddlers with disabilities ages birth through 2 who received early intervention services under IDEA, Part C during the most recent 12-month period for which data are available. The denominator is the total number of children ages birth through 2 years in the population, as provided by the source. The data reflect 2018.

91 Early Childhood Technical Assistance Center. Part C of IDEA. <http://ectacenter.org/partc/partc.asp#overview>

The way this indicator is calculated for the *State of Babies Yearbook: 2021* and the *State of Babies Yearbook: 2020* is different than how it was calculated for the *State of Babies Yearbook: 2019*. The data reflect a cumulative count, whereas a snapshot count was used for *State of Babies Yearbook: 2019*.

Source: U.S. Department of Education (2020). *IDEA Section 618 data products: Static tables. Part C child count and settings*. Retrieved August 2020 from <https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html>

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### **State's Part C eligibility criteria include infants and toddlers who are at risk of having substantial developmental delays**

The federal Program for Infants and Toddlers with Disabilities, which is Part C of the Individuals with Disabilities Education Act (IDEA), is a grant that aids states' provision of early intervention services for infants and toddlers with disabilities, ages birth through 2 years.<sup>92</sup>

Under IDEA Part C, states provide services to children who are experiencing developmental delays, and children who have been diagnosed with a mental or physical condition putting them at high risk for developmental delay.<sup>93</sup> States vary in their eligibility criteria for Part C services, and in their inclusion of "at-risk infants and toddlers" and/or their way of defining "at-risk infants and toddlers." Among states that have included "at-risk" as part of their eligibility criteria, these conditions may include established risk, biological or medical risk, or environmental risk.

In this indicator, states reported whether their Part C eligibility criteria includes "at-risk" children as eligible for IDEA Part C services or reports that they serve "at-risk" children in their Annual Progress Reports. Data reflect fiscal year 2018-2019. This indicator was new for the *State of Babies Yearbook: 2020*.

Sources: The Office of Special Education Programs (OSEP) (n.d.). *Final SSP/APR: Part C, FFY 2017*. Available at <https://osep.grads360.org/#p=19>. Note that the location of these reports has moved since we originally retrieved them in September 2019.

U.S. Department of Education. (2020). *IDEA Section 618 data products: State level data files: Part C: 2018-19 child count and settings*. Retrieved November 2020 from <https://www2.ed.gov/programs/osepidea/618-data/state-level-data-files/index.html#cccs>

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### **Timeliness of Part C services**

Individual Family Service Plans (IFSPs) are early intervention plans for children, ages birth to three, who qualify under the Individuals with Disabilities Education Act (IDEA). The IFSP is unique in that it uses a family-focused lens. This approach requires a partnership between the family and professionals to create an early intervention that is respectful of the child and family's values and practices.<sup>94</sup>

The federal Program for Infants and Toddlers with Disabilities (Part C of IDEA) requires that the initial evaluation, assessment of the family and child, and an initial IFSP meeting take place within 45 days of receiving a child's referral.<sup>95</sup>

92 Early Childhood Technical Assistance Center. Part C of IDEA. <https://ectacenter.org/partc/partc.asp>

93 Shackelford, J. (2002). *State and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA*. NECTAC Notes. Retrieved from <https://files.eric.ed.gov/fulltext/ED471884.pdf>

94 Minke, K. M., & Scott, M. M. (1993). The development of individualized family service plans: Roles for parents and staff. *The Journal of Special Education*, 27(1), 82-106.

This indicator was new for the *State of Babies Yearbook: 2020* and there is no update for the *State of Babies Yearbook 2021*. The denominator is the total number of eligible infants and toddlers evaluated and assessed for whom an initial IFSP meeting was required. The numerator is the number of those with IFSPs for whom an initial evaluation and assessment and an initial IFSP meeting were conducted within Part C's 45-day requirement, plus the number of documented delays attributable to exceptional family circumstances.

Source: The Office of Special Education Programs (OSEP) (n.d.). *Final SSP/APR: Part C, FFY 2017*. Available at <https://osep.grads360.org/#p=19>. Note that the location of these reports has moved since we originally retrieved them in September 2019.

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## Demographics

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### Number of infants/toddlers

These are vintage 2019 population estimates. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

Source: U.S. Census Bureau, Population Division. (2020). Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and Two or More Races) by Age, Sex, and Hispanic Origin: April 1, 2010 to July 1, 2019. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

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### Percentage of infant/toddler population

The denominator is the total population, based on the Census Bureau's vintage 2019 population estimates. The numerator is the population ages 0-2. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

Source: U.S. Census Bureau, Population Division. (2020). Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and Two or More Races) by Age, Sex, and Hispanic Origin: April 1, 2010 to July 1, 2019. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

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### Percentage of infants/toddlers who are Hispanic

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the total Hispanic population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

95 Individuals with Disabilities Education Act. Sec. 303.310 Post-referral timeline (45 days). Retrieved from: <https://sites.ed.gov/idea/regs/c/d/303.310>

Source: U.S. Census Bureau, Population Division. (2020). *Annual state resident population estimates for 6 race groups (5 race alone groups and two or more races) by age, sex, and Hispanic origin: April 1, 2010 to July 1, 2019*. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

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### **Percentage of infants/toddlers who are non-Hispanic White**

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic White population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

Source: U.S. Census Bureau, Population Division. (2020). *Annual state resident population estimates for 6 race groups (5 race alone groups and two or more races) by age, sex, and Hispanic origin: April 1, 2010 to July 1, 2019*. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

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### **Percentage of infants/toddlers who are non-Hispanic Black**

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic Black population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

Source: U.S. Census Bureau, Population Division. (2020). *Annual state resident population estimates for 6 race groups (5 race alone groups and two or more races) by age, sex, and Hispanic origin: April 1, 2010 to July 1, 2019*. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

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### **Percentage of infants/toddlers who are non-Hispanic Asian**

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic Asian population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

Source: U.S. Census Bureau, Population Division. (2020). *Annual state resident population estimates for 6 race groups (5 race alone groups and two or more races) by age, sex, and Hispanic origin: April 1, 2010 to July 1, 2019*. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

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### **Percentage of infants/toddlers who are non-Hispanic American Indian or Alaska Native**

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic American Indian and Alaska Native population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

Source: U.S. Census Bureau, Population Division. (2020). *Annual state resident population estimates for 6 race groups (5 race alone groups and two or more races) by age, sex, and Hispanic origin: April 1, 2010 to July 1, 2019*. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

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### **Percentage of infants/toddlers who are non-Hispanic Native Hawaiian or Pacific Islander**

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic Native Hawaiian and other Pacific Islander population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

Source: U.S. Census Bureau, Population Division. (2020). *Annual state resident population estimates for 6 race groups (5 race alone groups and two or more races) by age, sex, and Hispanic origin: April 1, 2010 to July 1, 2019*. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

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### **Percentage of infants/toddlers who are non-Hispanic multiple races**

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic population of multiple races ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

Source: U.S. Census Bureau, Population Division. (2020). *Annual state resident population estimates for 6 race groups (5 race alone groups and two or more races) by age, sex, and Hispanic origin: April 1, 2010 to July 1, 2019*. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

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### **Percentage of infants/toddlers living in two-parent families**

The denominator is the total number of children ages 0-2. The numerator is those who have two parents present in their household. The definition of parent includes biological as well as social (step or adoptive) parents, and unmarried partners of a parent. Families with two same-sex parents present in the household are included as two-parent families.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity:* Race/

ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity*: Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

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### **Percentage of infants/toddlers living in one-parent families**

The denominator is the total number of children ages 0-2. The numerator is those who have one parent present in their household. The definition of parent includes biological as well as social (step or adoptive) parents.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity*: Race/ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity*: Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

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### **Percentage of infants/toddlers living with no parents**

The denominator is the total number of children ages 0-2. The numerator is those who have no parents present in their household. The definition of parent includes biological as well as social (step or adoptive) parents.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity:* Race/ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income:* Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity:* Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

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#### **Percentage of infants/toddlers living in grandparent-headed households**

The denominator is the total number of children ages 0-2. The numerator is those who live in a household headed by their grandparent. Note that this classification is not mutually exclusive with other family structure categories.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity:* Race/ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income:* Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity:* Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

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#### **Percentage of infants/toddlers that have mothers in the labor force**

The denominator is the number of children ages 0-2 who live with their mothers. The numerator is those whose mother is in the labor force (either employed or unemployed but looking for work). People in the



armed forces are not in the universe for labor force participation. If there are two mothers in the household, the labor force participation of only the first mother is considered.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity:* Race/ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income:* Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity:* Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

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### **Percentage of infants/toddlers who live with no working parents**

This indicator is new for the *State of Babies Yearbook: 2021*. The denominator is the total number of children ages 0-2 who live with at least one parent. The numerator is the number of children ages 0-2 who live with only disconnected parents, (i.e., parents who were not working in the past 12 months, and were not working for a reason other than going to school). All residential parents must be disconnected, according to the above definition, in order for the child to qualify as living with disconnected parents.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity:* Race/ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income:* Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity:* Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

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### **Percentage of infants/toddlers living in families with incomes below 100 percent of the federal poverty line**

The denominator is the total number of children ages 0–2. The numerator is those who live in families with incomes below 100 percent of the federal poverty line. Note that this poverty rate does not match the rates published by the Census Bureau, because the public-use version of the American Community Survey is not complete.

This indicator was also reported by race/ethnicity. Survey respondents (typically parents) report the infant or toddler’s race and ethnicity. Respondents can select one or more of the following groups: White, Black or African American, American Indian or Alaska Native, Asian Indian, Japanese, Chinese, Korean, Filipino, Vietnamese, other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, other Pacific Islander, and/or some other race. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, and other Hispanic are coded as Hispanic, regardless of response to the race item. We then group the remaining non-Hispanic respondents into the following race categories for analyses: Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian, Non-Hispanic Other, and Non-Hispanic multiple races.

Source: Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2020). *American Community Survey 2019, one-year estimates*. (IPUMS USA: Version 10.0) [Data set]. IPUMS. <https://doi.org/10.18128/D010.V10.0>

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### **Percentage of infants/toddlers living in families with incomes between 100–199 percent of the federal poverty line**

The denominator is the total number of children ages 0–2. The numerator is those who live in families with incomes at or above 100 percent and below 200 percent of the federal poverty line. Note that this poverty rate does not match onto the rates published by the Census Bureau, because the public use version of the American Community Survey is not complete.

This indicator was also reported by race/ethnicity. Survey respondents (typically parents) report the infant or toddler’s race and ethnicity. Respondents can select one or more of the following groups: White, Black or African American, American Indian or Alaska Native, Asian Indian, Japanese, Chinese, Korean, Filipino, Vietnamese, other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, other Pacific Islander, and/or some other race. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, and other Hispanic are coded as Hispanic, regardless of response to the race item. We then group the remaining non-Hispanic respondents into the following race categories for analyses: Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian, Non-Hispanic Other, and Non-Hispanic multiple races.

Source: Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2020). *American Community Survey 2019, one-year estimates*. (IPUMS USA: Version 10.0) [Data set]. IPUMS. <https://doi.org/10.18128/D010.V10.0>

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### **Percentage of infants/toddlers living in families with incomes at or above 200 percent of the federal poverty line**

The denominator is the total number of children ages 0–2. The numerator is those who live in families with incomes at or above 200 percent of the federal poverty line. Note that this poverty rate does not match onto the rates published by the Census Bureau, because the public use version of the American Community Survey is not complete.

This indicator was also reported by race/ethnicity. Survey respondents (typically parents) report the infant or toddler's race and ethnicity. Respondents can select one or more of the following groups: White, Black or African American, American Indian or Alaska Native, Asian Indian, Japanese, Chinese, Korean, Filipino, Vietnamese, other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, other Pacific Islander, and/or some other race. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, and other Hispanic are coded as Hispanic, regardless of response to the race item. We then group the remaining non-Hispanic respondents into the following race categories for analyses: Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian, Non-Hispanic Other, and Non-Hispanic multiple races.

Source: Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2020). *American Community Survey 2019, one-year estimates*. (IPUMS USA: Version 10.0) [Data set]. IPUMS. <https://doi.org/10.18128/D010.V10.0>

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### **Percentage of infants/toddlers living outside of metro areas**

The denominator is the total number of children ages 0-2. The numerator is those who live outside of metro areas. All geographic areas not considered part of a metro area are considered rural.

Source: Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2020). *American Community Survey 2019, one-year estimates*. (IPUMS USA: Version 10.0) [Data set].

# Appendix C. Methodology

## Caveats

Across indicators, we have suppressed estimates that are based on a small number of infants and toddlers. For indicators based on survey data, we suppress estimates based on less than 30 survey respondents. Additionally, estimates using data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) are suppressed if the numerator has less than 10 respondents to protect children’s identity. We have also flagged estimates as unreliable when estimates are unstable—when their 95 percent confidence interval is larger than 20 percentage points—or when all respondents are in one category (e.g., the state has a rate of 100 percent or 0 percent). Readers should also use caution when comparing estimates across states and across time with these flags. See the Appendix B: Indicator Dictionary for details on each indicator.

It is especially important to use caution when interpreting the subgroup analyses. As we present more subgroup data, our estimates are based on fewer survey respondents.

## The state ranking process

We developed a transparent ranking process to facilitate users’ understanding of how states fare on the selected indicators and policy domains. The ranking process follows three steps: rescaling the indicators, calculating domain scores, and calculating the state’s overall ranking. To facilitate the comparison of rankings across years, this process has remained stable over time. Indicators added since the inaugural edition of the yearbook are not included in the calculation of the rankings.



## Rescaling the indicators

Because indicators vary in their units of measurement, as well as in the range of values observed across the states, their values are standardized—that is, mathematically transformed to facilitate comparisons across indicators and across states.

The performance of each state on a given indicator is compared with the highest and lowest values, to create a score ranging from 0 to 100<sup>11</sup>:

- Score (Rescaled Value) =
- $[(\text{Observed Value} - \text{Lowest Value}) / (\text{Highest Value} - \text{Lowest Value})] \times 100$

For indicators (such as low birthweight) where higher scores mark less desirable outcomes, we adjust the directionality before calculating the score, so that higher scores consistently mark more desirable outcomes, while lower scores are less desirable. For example, the percentage of births with low birthweight was changed to percentage of births that are *not* low birthweight before computing the score. With this adjustment, higher values are more desirable for all indicators.

<sup>11</sup> We used a “min-max” scaling procedure, based on the indicators’ maximum and minimum values. We chose this method over Z-scores (another standardization method), as its interpretation is more transparent.

Policy indicators with “yes” or “no” values (e.g., whether the state has expanded Medicaid), are grouped within a domain, and we compute a composite index measuring the percentage of policies a state has enacted. For example, we counted the number of affirmative scores related to the states’ provision of mental health services at home, at pediatric/family practices, and at early care and education programs, and expressed the total as a percentage of the possible maximum (three, in this example). The one exception to this rule is the indicator “Medicaid allows maternal depression screening in well-child visits,” for which we created a scale from 1 to 4, with scores depending on whether such screening was “not covered,” “allowed,” “recommended,” or “required.” These values were then transformed to a 0 to 100 scale, as with the other indicators.

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### **Calculating domain scores**

To create state-level composite scores for each of the three domains (Good Health, Strong Families, and Positive Early Learning Experiences), we simply used an unweighted average of the scores of the component indicators for that domain. Likewise, to compute overall state scores, we used an unweighted average of the domain-level scores.

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### **Assigning states to tiers**

Once the state-level data for each indicator were re-scaled to scores ranging from 0 to 100, we divided the re-scaled data into four tiers to show a state’s performance on each indicator relative to other states, overall, and by domain. These tiers, also referred to as quartiles, represent four roughly equal-size groupings of states, ordered from lowest-performing, to next-to-lowest-, to next-to-highest-, to highest-performing. We use the tiering symbols throughout the *Yearbook* to designate a given state’s placement in one of the four tiers.

In contrast to individualized state rankings (ranging from 1 to 51), this approach emphasizes that differences between any two states can be relatively minor and/or not statistically significant, and all states have room for improvement. Since most of the indicators are based on survey data, minor differences between states may be within the standard error intrinsic to sample designs. We experimented with different numbers of tiers and found that using four groups yielded statistically significant differences on most of the indicators among states’ scores falling in the middle of each group.

# Appendix D. Building Strong Foundations Crosswalk

Building Strong Foundations Core Policy	State of Babies Indicators
<b>Healthy bodies, healthy minds, and healthy parents</b>	<b>Good Health</b>
<ul style="list-style-type: none"> <li>Low-income infants, toddlers, parents, and pregnant women should have quality, affordable, publicly financed health insurance.</li> </ul>	<ul style="list-style-type: none"> <li>Medicaid Expansion</li> <li>Medicaid eligibility for pregnant women</li> <li>Extension of Medicaid coverage beyond 60 days postpartum*</li> <li>Uninsured low-income infants and toddlers*</li> </ul>
<ul style="list-style-type: none"> <li>Infants, toddlers, parents, and pregnant women should receive appropriate health screenings, preventative primary care, and medically necessary treatment services.</li> </ul>	<ul style="list-style-type: none"> <li>Medicaid Expansion</li> <li>Medicaid eligibility for pregnant women</li> <li>Extension of Medicaid coverage beyond 60 days postpartum*</li> <li>State Medicaid policy requires, recommends, or allows maternal depression screenings during well-child visits</li> <li>Infants/toddlers who received coordinated, ongoing, comprehensive care within a medical home*</li> <li>Late or no prenatal care*</li> <li>Infants/toddlers, ages 9-35 months, receiving developmental screening using a parent-completed tool in the past year*</li> <li>Infants/toddlers with preventive medical visits*</li> <li>Infants/toddlers with preventive dental care*</li> </ul>
<ul style="list-style-type: none"> <li>Infants, toddlers, and parents should receive appropriate screening, diagnosis, and treatment services to meet their mental health needs.</li> </ul>	<ul style="list-style-type: none"> <li>State Medicaid plan covers social-emotional screening for young children</li> <li>IECMH services at home</li> <li>IECMH services in medical settings</li> <li>IECMH services in ECE settings</li> </ul>
<ul style="list-style-type: none"> <li>Low-income families with infants and toddlers and pregnant women should have access to nutrition support programs.</li> </ul>	<ul style="list-style-type: none"> <li>Percent of eligible infants who participated in WIC*</li> </ul>
<b>Economically stable families</b>	<b>Strong Families</b>
<ul style="list-style-type: none"> <li>Low-income parents of infants and toddlers should have access to affordable education and training to improve their employment opportunities.</li> </ul>	<ul style="list-style-type: none"> <li>Not addressed in the <i>State of Babies Yearbook: 2021</i></li> </ul>
<ul style="list-style-type: none"> <li>Families in poverty with infants and toddlers should get cash assistance and refundable tax credits to supplement their earnings.</li> </ul>	<ul style="list-style-type: none"> <li>Families with infants/toddlers living below 100 percent of the FPL that receive TANF benefits*</li> <li>State has Child Tax Credit</li> <li>State has Earned Income Tax Credit</li> </ul>

<ul style="list-style-type: none"> <li>Parents with infants and toddlers should have <i>paid sick leave</i> from work when they are ill, when their child or a family member is ill, or to obtain preventative care for themselves or their families. Parents should have <i>paid family and medical leave</i> when a child is born, adopted, or newly fostered, and to be able to provide care should their child become ill.</li> </ul>	<ul style="list-style-type: none"> <li>State requires employers to provide paid sick days that cover care for child*</li> <li>State has a paid family and medical leave program*</li> </ul>
<ul style="list-style-type: none"> <li>Low-income families with infants and toddlers should have affordable, safe, and stable housing.</li> </ul>	<ul style="list-style-type: none"> <li>Infants/toddlers who have moved three or more times since birth*</li> <li>Infants/toddlers who live in crowded housing*</li> </ul>

Strong Parents	Strong Families
<ul style="list-style-type: none"> <li>Families of infants and toddlers should have access to a continuum of parent support services and resources to support their child's development.</li> </ul>	<ul style="list-style-type: none"> <li>Potential home visiting beneficiaries served*</li> <li>State has a paid family and medical leave program</li> </ul>
<ul style="list-style-type: none"> <li>Infants and toddlers in the child welfare system should receive developmentally appropriate support, responsive to the needs of the child and family.</li> </ul>	<ul style="list-style-type: none"> <li>Maltreatment rate per 1,000 infants/toddlers*</li> <li>Infants/toddlers who have been removed from home and placed in foster care*</li> <li>Infants/toddlers who spent less than 1 year in out-of-home placement*</li> </ul>

High-quality child care and early learning opportunities	Positive Early Learning Experiences
<ul style="list-style-type: none"> <li>Low-income families with infants and toddlers should get child care assistance to afford safe, stable, high-quality child care that promotes children's development and parents' education, training, and work.</li> </ul>	<ul style="list-style-type: none"> <li>Families above 200 percent of FPL eligible for child care subsidy</li> <li>Low-/moderate-income infants/toddlers in CCDF-funded care*</li> <li>Regulations for infants and toddlers on group size, adult/child ratios, and teacher qualifications</li> <li>State has infant-toddler professional credential</li> <li>Allocation of CCDBG funds</li> <li>State reimbursement of CCDF funded center-based care</li> </ul>
<ul style="list-style-type: none"> <li>Vulnerable infants, toddlers, pregnant women, and families should have access to comprehensive early childhood services through Early Head Start.</li> </ul>	<ul style="list-style-type: none"> <li>Infants/toddlers below 100 percent of the FPL with access to Early Head Start*</li> </ul>
<ul style="list-style-type: none"> <li>Infants and toddlers with developmental delays or disabilities should be identified and receive early intervention services in a timely manner.</li> </ul>	<ul style="list-style-type: none"> <li>At-risk children included in Part C eligibility definition or are reported as served</li> <li>Infants/toddlers receiving IDEA Part C services*</li> <li>Timeliness of Part C services*</li> </ul>

\* Indicator shows the reach of or the need for a policy in this area.

# Acknowledgments

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The logo features a red location pin with a white baby face inside the top circle.

# STATE OF BABIES YEARBOOK 2021

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