STATE OF BABIES YEARBOOK 2020

How do we ensure that every baby has the chance to grow and thrive? At ZERO TO THREE, we are pleased to continue to pose this question in this second edition of the *State of Babies Yearbook* to those who share our commitment to making the well-being of infants, toddlers, and their families a national priority. For every baby to be a priority, they must first be seen.

The *State of Babies Yearbook: 2020* makes it easier for policy-makers, advocates, and stakeholders to see the babies and families behind the numbers by digging deeper into the data. This year, we explore the very different experiences of babies when viewed through an equity lens and shine light on early disparities among women and babies of color, those born into families with low or modest income, and babies living in rural, non-metropolitan communities.

Babies are born with unlimited potential and all states need to do better by them. 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: 2020* 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.

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

think babies™
Make their potential our priority.

Author Credit: Kim Keating, Patricia Cole, and Mollyrose Schaffner

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Executive Summary

The ***State of Babies Yearbook: 2020*** tells us that the littlest among us face big challenges, and that as a nation and individual states, we must prioritize the policies and programs that can make a difference in babies' ability to reach their full potential. Once again, the data are clear: The state where a baby is born makes a big difference in their chance for a strong start in life. The 2020 *Yearbook* enables us to get closer to the babies behind the numbers and see the substantial disparities and inequities among them and their families. This closer proximity reveals an alarming picture that emphasizes the big barriers babies of color and in families with low income face.

The *Yearbook* is the story of the 12 million infants and toddlers in the U.S. and their families. Each of these young children is born with unlimited potential. But it is also the story of our nation's future. The babies behind the numbers are our society's next generation of parents, workers, and leaders. We can't afford to squander the potential of a single child if our nation is to thrive—nor should it be acceptable that so many have barriers in their way.

Why tell the story of babies? The first 3 years of a child's life shape every year that follows. From birth to age 3, infants and toddlers experience the most rapid physical, cognitive, and emotional development of their lives. During this time, unique in human development, young children's relationships and experiences shape the architecture of their brains in enduring ways that form the foundation for later learning, health, and well-being.

Yet far too many babies face persistent hardships that undermine their ability to grow and thrive. The 2020 *Yearbook* sought to break down the indicators by subgroups because of two realities that reflect the nation's changing demographic landscape:

- More than half of America's infants and toddlers are children of color.
- Two of every five infants and toddlers live in families with low income, meaning they do not have the financial resources to make ends meet.

The data show that the experiences of individual babies within these groups, as well as babies in rural areas, are often different from the averages. By nearly every measure, children living in poverty and children of color face the biggest obstacles—low birthweight, unstable housing, and limited access to quality early learning experiences. The harmful and life-altering effects of these disparities begin even before they are born.

The lessons from the story of America's babies demand our attention: When babies and toddlers do not have the support they need to thrive, their development can suffer and lead to lifelong consequences. The 2019 *Yearbook* found that the national profile of our infants and toddlers contained warning signs that we are not giving our youngest children the fundamental ingredients for a strong foundation. The *State of Babies Yearbook: 2020* tells us that when we look at racial and ethnic groups as well as children who lack economic resources, some of these warning signs become sirens that we must grapple with as a nation if our future is to be secure.

As policymakers set their agendas, 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 our 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. The time to make every baby our national priority is now. To do better for our babies and our nation's future, we need national and state leaders to give "first 100 days" urgency to policies built on the science of brain development and budgets that put babies and families first.

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: 2020* uses this framework that tells us what all babies need to thrive. Major findings in these domains include:

GOOD HEALTH:

The proportion of infants and toddlers receiving well-child visits (92 percent) remains reasonably robust, and there has been incremental expansion of Medicaid coverage in key areas. Yet the evidence of gross disparities—particularly for Black families, in maternal and infant health outcomes such as maternal and infant mortality, low birthweight, and prematurity is strongest in this domain, beginning prenatally and requiring a strong response in national and state policies.

STRONG FAMILIES:

Although family resilience in the face of challenges is at positive levels (85 percent), this and other indicators of family well-being show that low-income families struggle with challenges around basic needs, such as crowded housing and basic income supports, as well as adverse childhood experiences.

POSITIVE EARLY LEARNING EXPERIENCES:

We as a nation are not ensuring that our babies have quality early learning experiences that nourish their early development: From being read to every day, to finding a place in Early Head Start or a subsidy for quality child care, to the basic quality floor states set for child care.

The *State of Babies Yearbook: 2020* bridges the gap between science and policy with national and state-by-state data on the well-being of America's babies. The 2020 edition of the *Yearbook*, along with issue-based briefs, adds to the ability to see the babies behind the numbers through an in-depth look into the substantial disparities and inequities among babies and families when examined by race/ethnicity, income, and geographic setting. Policymakers and advocates can use the profiles as a starting point to look at data related to equity together to reach a common understanding of the story of babies and families in their states. They can also identify the communities that need to be engaged as they identify and advance policies that address the most pressing challenges facing the youngest members of society.

The indicators are grouped into the policy domains of ZERO TO THREE's framework: Good Health, Strong Families, and Positive Early Learning Experiences. To sharpen the picture in the national and state profiles, new indicators were added in both the well-being and policy areas. In rounding out indicators related to policy—whether indicating the presence or absence of a particular policy, the reach of an existing policy, or the need for policy action—we drew from the *Building Strong Foundations* project, developed by ZERO TO THREE and CLASP. This project identified 13 core policy areas that together describe the needs of infants and toddlers and their families based on a large body of developmental research.

The most important new feature of *State of Babies Yearbook: 2020* is the breakout of indicators by subgroups, to the extent possible based on available data. Subgroups include race and ethnicity, income, and residence in an urban or rural area. Although available data help illuminate disparities among America's babies, they also expose a lack of data that leaves frustrating gaps in our understanding of the problems we must address.

To develop policies and direct resources where they are most needed, we are calling for more comprehensive and consistent collection and reporting of disaggregated data by key subgroups at the federal, state, and local levels.

Ensuring all babies have a strong foundation to GROW.

Comparing indicators across states and the District of Columbia yields the conclusion 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.

The *State of Babies Yearbook: 2020* uses 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. We use the following tiering symbols to designate a given state's placement in one of the four tiers.

The 2020 indicators are the next step in a process to reach the set of data points providing the picture of America's babies that will be most useful in spurring action and tracking policies to support young children and their families. 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 roadmap to continue this process of seeking new ways to describe these conditions. Accordingly, the 2020 *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 rerank 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. 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 2020: OVERALL RANKINGS

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

The State of Babies Yearbook: 2020

Why tell the story of America's babies? Over the past 20 years, understanding of a basic scientific fact has spread among policymakers, advocates, and the public: **The first 3 years of a child's life are a critical period of growth and opportunity that shapes every year that follows.** However, as a nation, our current system of policies and programs shows that we have not translated that knowledge into action. Between the ages of 0 and 3, we experience the most rapid physical, cognitive, and emotional development of our lives. The environment in which this development unfolds—family, community, and the state where they live—shapes this foundational development and can affect babies' likelihood of reaching their potential. In that potential lies our country's hope for a strong future**. If we want to know where we are headed as a nation, we must dig deep into the state of babies today and use what we find to change course.** Simply put, we have to get our policies that support babies and their families *right*.

The *State of Babies Yearbook: 2020* reaffirms the central finding of the 2019 edition: **The state in which a baby is born makes a difference in his or her chances for a strong start.** Indicators of babies' well-being and access to supportive programs and policies that can help provide the ingredients to thrive vary widely across states.

But, the story of America's babies is not as simple as looking from one state to another. Indicators that are averages of all babies, as concerning as they might be, are insufficient to convey the experiences of many children. *State of Babies Yearbook: 2020* takes a deeper look at the more than half of the nation's babies who are children of color as well as those in low-income families and in urban or rural areas. **The data are clear: Significant disparities exist in the opportunities available to them to thrive and are often driven by racism**. That means that our policies for babies and families must also dig deep. They must face root causes, including racism, and use a high-power equity lens to ensure they are addressing what matters most to families who are nurturing babies in a world where the challenges they face are sometimes masked, but always present.

The early years matter most.

The science is clear: The first 3 years of a child's life have significant and lasting effects. By age 3, children acquire the abilities to speak, learn, and reason. During this uniquely sensitive time, young children's interactions and experiences combine with genetic influences to shape the architecture of their brains in enduring ways that lay the foundation for lifelong health, well-being, and success.

- **Babies' brains grow at a faster rate during the first 3 years of life than at any later point in their lifetimes—**creating more than one million neural connections per second.[i] These connections form the foundational brain architecture on which all later learning and development will rest. A baby's earliest experiences determine whether that foundation will be strong or fragile, and this brain development is dependent on multiple factors. Relationships and social interactions, as well as nutrition, safety and protection, provision of basic needs, and regular medical care are all important to how a baby's brain grows.[ii]

- **It is critical that all babies have equitable chances to thrive; however, significant disparities exist in opportunities and related outcomes.** Research consistently finds negative effects of poverty and racial discrimination among young children, linked to differences in access to critical resources and services. These effects appear early; at age 2, children in the lowest socioeconomic group already lag behind their peers on measures of language, cognitive abilities, and attachment.[iii]

- **Early experiences and early intervention matter.** When babies and toddlers do not have the supports they need to thrive, their development can suffer, leading to lifelong consequences. Fortunately, the same rapid brain development that makes babies and toddlers so vulnerable to adversities also offers a window of opportunity. Early in life, the brain is most adaptable to a wide range of environments and interactions, and thus can be rewired in response to significant changes in children's circumstances. This points to the importance of early intervention: It is easier and more effective to influence the architecture of a young child's developing brain than to rely on remedial programs later in life.[iv]

Good health, strong families, and positive early learning experiences are the building blocks for a strong start in life. All babies require healthy development in each of these domains to reach their full potential. It is this framework that we apply to fully understand the state of babies.

How do we ensure all babies a strong foundation to GROW?

ZERO TO THREE's policy framework, grounded in the science of early childhood development, incorporates three domains of healthy development to identify and promote comprehensive policies to meet these needs: Good Health, Strong Families, and Positive Early Learning Experiences. *State of Babies Yearbook* indicators in each domain describe 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 2019, the *State of Babies Yearbook: 2020* uses a transparent ranking process to group states into one of four tiers to provide a quick snapshot of how states fare on the selected indicators and domains. Because reaching a

final set of indicators will take several years, the indicators on which tier placement is based have been held constant from the 2019 *Yearbook*. (See page 68 for a discussion of the indicators used and the ranking process). The tiers represent four groupings of states that are approximately equal in size and ordered from highest to lowest performing. We use the tiering symbols throughout the *Yearbook* to designate a given state's placement in one of the four tiers.

The profiles and state 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 12 million infants and toddlers, and those who will follow.

WHAT'S NEW IN 2020?

A major goal of *State of Babies Yearbook: 2020* is to help states see a clearer picture of the babies and families behind the numbers through two enhancements. First, the 2020 *Yearbook* continues to refine and expand the indicators describing well-being and policies, part of a multiyear effort to define a stable set of indicators (see page 66) to give states a more vivid portrait of the three domains. To enable states to go beyond averages of indicators that mask the experiences of individual groups, the *Yearbook* examines data on subgroups in indicators where such breakouts are possible, given available data. Subgroups include race and ethnicity, income levels, and urban or rural residency. Although the *Yearbook* retains the tiers as a useful tool for seeing where babies in various states stand overall, this new data encourages and supports states in focusing inward on the stories of their own babies and families.

The toolkit now includes two sections: Advocacy Tools and Planning Tools.

- **BROADER EQUITY LENS.** A complete story of the nation's babies must go deeper than national and state averages and shed a broad light on the substantial inequities and vastly different experiences of babies and families when examined by race/ethnicity, income, and whether they live in an urban or rural setting. To do so, the *Yearbook* presents findings when available that go beyond national and state averages to explore how babies with different backgrounds are faring when disaggregated by these key subgroups. (Detailed data for states can be found on the stateofbabies.org website.) In keeping with this objective, the 2020 release is accompanied by a new brief—*Maternal and Child Health Inequities Emerge Even Before Birth*—that examines the serious disparities in maternal health and birth outcomes among babies and families of color.

- **NEW AND MODIFIED INDICATORS.** The *Yearbook* includes 16 new indicators that allow more in-depth analyses and understanding of babies' and families' experiences in all three domains of well-being. These enhancements provide additional information on maternal and child health, permanency in child welfare, early intervention for developmental delays, and child care quality. The table below outlines all new and modified indicators. Findings on new and past indicators will also be instrumental in examining equity.

	New	Modified
 **Good Health**	1. Preterm birth 2. Maternal mortality 3. WIC coverage 4. High weight-for-length among WIC recipients	1. Breastfeeding—Ever Breastfed and at 6 months[1] 2. Late or No Prenatal Care[2]
 **Strong Families**	1. Time in out-of-home placement 2. TANF work exemption 3. State child tax credit 4. State earned income tax credit (EITC)	1. Maltreatment rate[3]
 **Positive Early Learning Experiences**	1. Timeliness of Part C services 2. At-risk children included in Part C eligibility definition 3. Group size 4. Adult/child ratio 5. Teacher qualifications 6. Infant/toddler professional credential 7. State reimburses center-based child care 8. Allocation of CCDBG funds	1. Infants/toddlers receiving IDEA Part C services[4]

- **ENHANCED WEBSITE.** The content and functionality of stateofbabies.org are expanded to make it a more informative and interactive resource. We have added materials addressing special topics (e.g., a maternal health and birth outcomes equity brief) and expanding the functionality of the website to provide data by key subgroups (i.e., race/ethnicity, income, and metro/rural). Future enhancements will include more advanced data visualization options and related user functions.

- **ENHANCED RESOURCES.** The *State of Babies* Toolkit has been redesigned to enhance usability and updated to reflect new data from the 2020 *Yearbook,* including disaggregated data that allows users to look beyond averages that can mask significant disparities. The toolkit now includes two sections: Advocacy Tools and Planning Tools. The suite of Advocacy Tools are 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.

1 Breastfeeding estimates presented in the 2020 *Yearbook* may not line up with published estimates from 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.

2 Data for the 2020 *Yearbook* Late/No Prenatal Care indicator Data for the SoBY 2020 come directly from the CDC Wonder database. The 2019 data came from the National Center for Health Statistics report, *Timing and Adequacy of Prenatal Care in the United States, 2016.* This report had not been repeated at the time of the 2020 *Yearbook*.

3 For the 2020 *Yearbook*, maltreatment rate was calculated using the denominator of population estimates published in *Child Maltreatment* for all age 0-2 instead of the Census population estimates used for the 2019 *Yearbook.*

4 For the Part C services calculation in the 2020 *Yearbook*, a cumulative count for the most recent 12-month period was used, whereas a snapshot was used for the 2019 *Yearbook*.

The State of the Nation's Babies

Our Changing Demographics

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

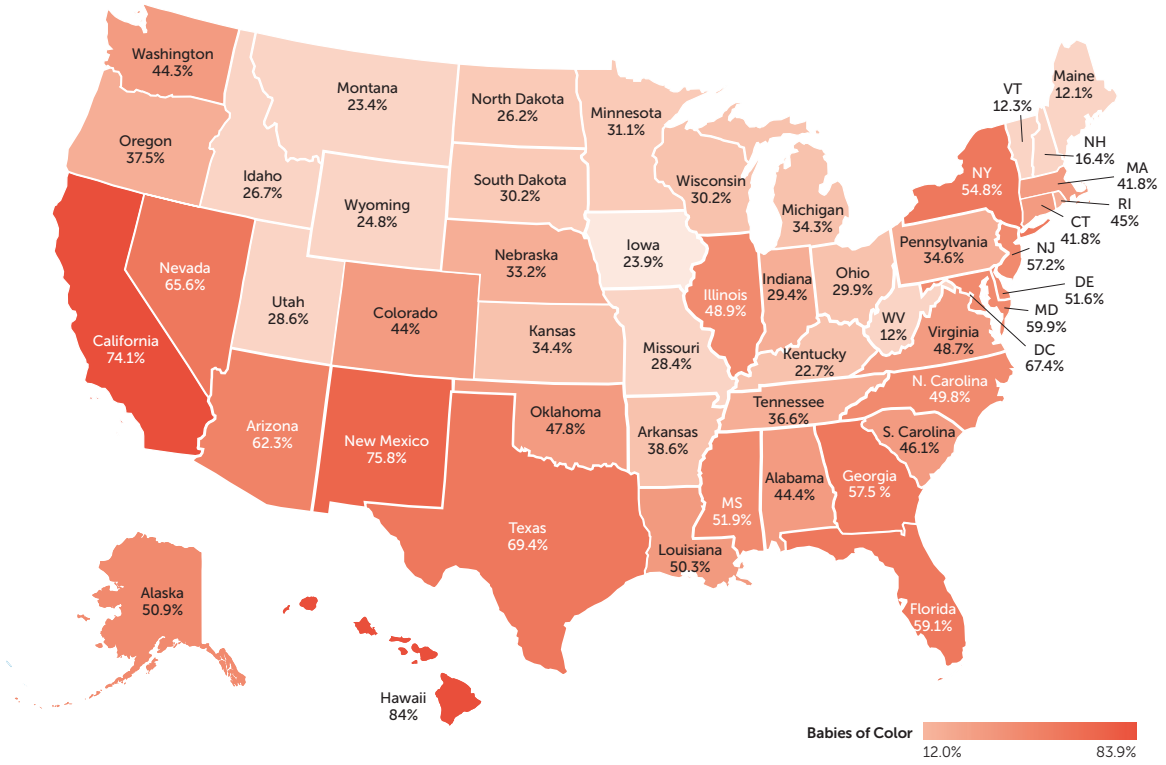
America's babies and parents are more diverse than at any other point in our nation's history.[v] They differ by race and ethnicity, income level, and geographic location, and are raised in a variety of family structures that reflect the changing characteristics of the society overall. For example, one in five babies (20.9 percent) lives with a single parent, nearly one in 10 (8.5 percent) live in grandparent-headed households, and most (61.6 percent) have mothers in the workforce. These demographics have substantial implications for designing and implementing policies and services that best meet the needs of our youngest children.

TAKING A CLOSER LOOK — 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.[vi] 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 only be gained by examining the very different experiences of key subgroups. This begins by taking a closer look by race/ethnicity, income, and urban/rural setting.

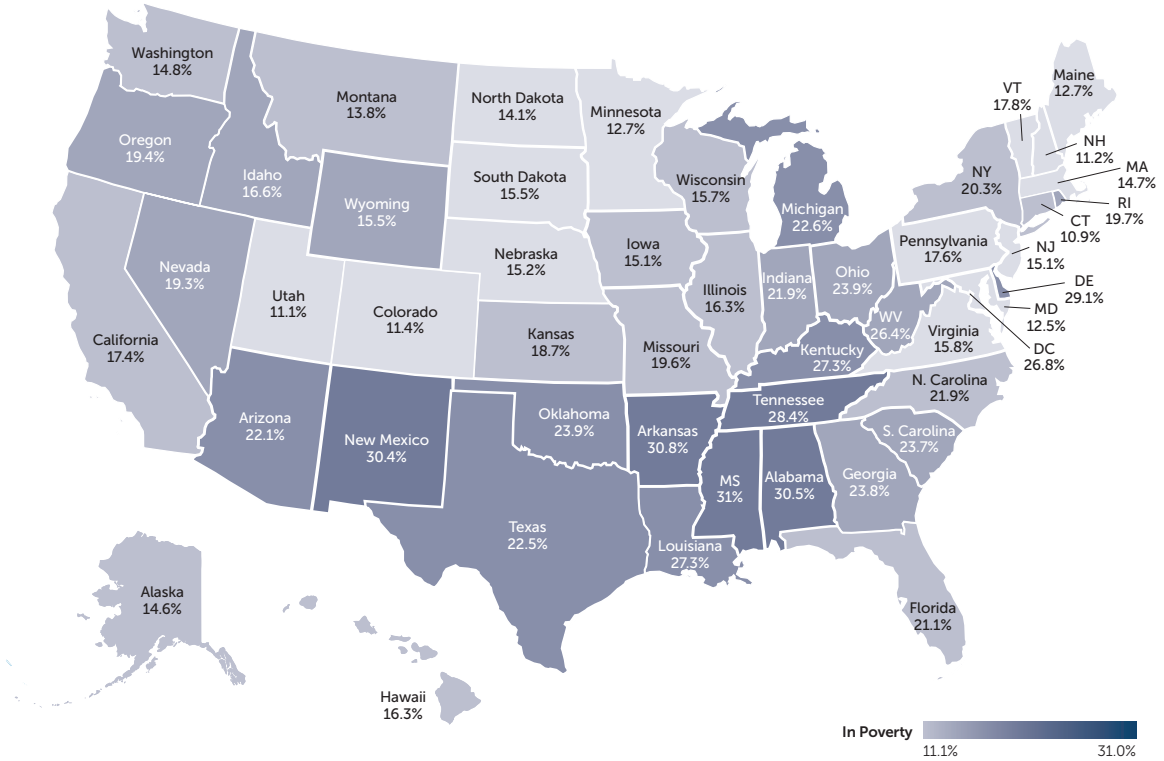
RACE/ETHNICITY. In 2018, more than half (50.7 percent) of America's babies were non-White, continuing a trend that began in 2011 when more than half of all infants born were children of color. Specifically in 2018, 26.2 percent were Hispanic, 13.7 percent Black, 4.9 percent Asian, 0.8 percent American Indian/Alaska Native, 0.2 percent Native Hawaiian/Pacific Islander, and 4.8 percent Multiple Races. Infants and toddlers of color are disproportionately at risk for poorer outcomes in all three domains of well-being. The negative immediate and long-term consequences of early inequities are well documented. The map below illustrates the wide variation in proportions of babies of color by state.

51% OF BABIES ARE CHILDREN OF COLOR



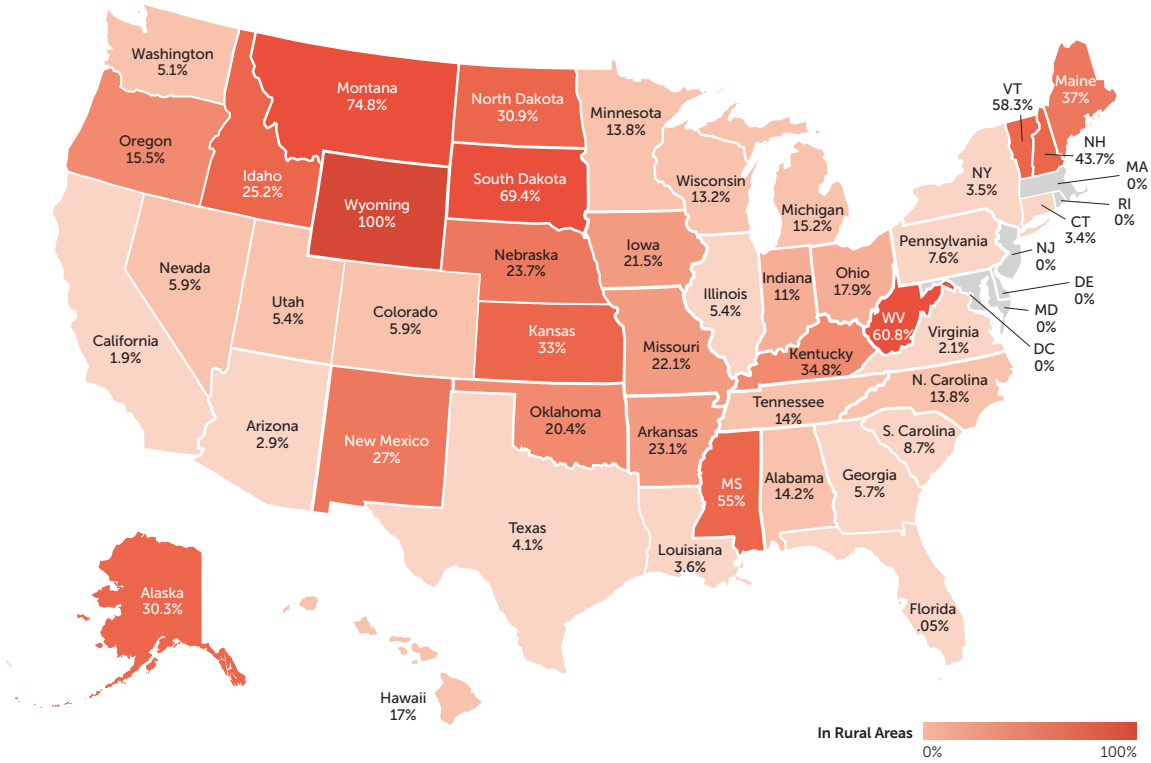
INCOME. Research shows that poverty at an early age can be especially harmful, affecting later achievement and employment.[vii] Yet the youngest Americans are most likely to live in low-income and poor families. As many as 42.1 percent of infants and toddlers live in households with incomes less than twice the federal poverty line (FPL—about $50,000 a year for a family of four in 2018), but still represent a very concerning proportion of young children in families that have difficulty making ends meet. Infants and toddlers represent only 4 percent of the nation's population but 6 percent of those in poverty. One in five (19.8 percent) are in families that live below poverty level that face even greater challenges meeting their basic needs. Almost 16 percent of households with infants and toddlers experience low or very low food security. Another powerful indicator of the status of babies in the United States can be found in our standing among other developed nations. Between 2017 and 2018, the United States dropped from 31st for relative child poverty among 38 economically advanced countries to 32nd.[viii]

1 IN 5 BABIES LIVES IN POVERTY



RURAL/URBAN. In 2018, nearly 1 in 11 of America's babies (8.6 percent) lived in a rural[5] or "non-metropolitan" area of the United States. 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, and also have a higher incidence of disabilities.[ix]

1 IN 11 BABIES LIVES IN A RURAL AREA

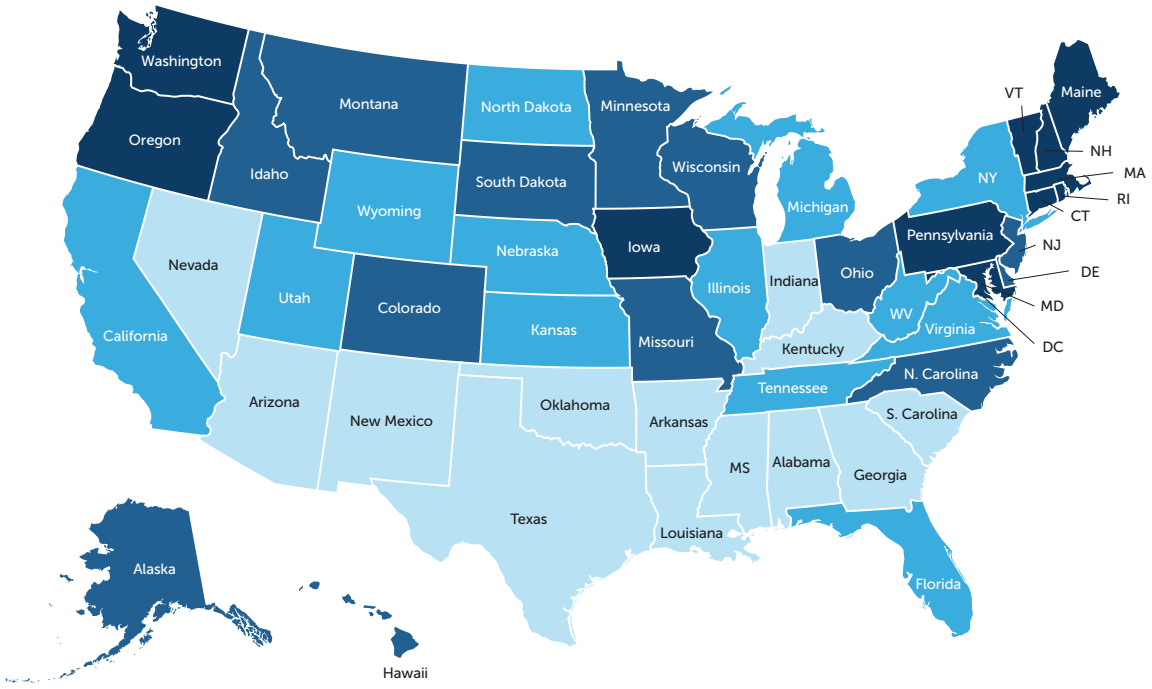


5 Rural is defined by the Office of Management and Budget and Census Bureau as nonmetropolitan areas of "open countryside" and "towns" and places with fewer than 2,500 people as well as "urban clusters with populations ranging from 2,500 to 49,000 people that are not part of a larger metro area."

How States Compare

The map below 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 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. This can reflect initiatives they have undertaken to improve babies' outcomes. Even within states in higher tiers, children and families of color likely have disparate 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. Regional patterns in 2020 were similar to those seen in 2019. States in the Northeast and West were more likely to score in the top two tiers of states across all three domains, as compared to states in the Midwest and South.

STATE OF BABIES YEARBOOK 2020: OVERALL RANKINGS



Good Health

Good physical and mental health provide the foundation for babies to develop physically, cognitively, emotionally, and socially. Access to good nutrition and affordable maternal, pediatric, and family health care are essential to ensure that babies receive the nourishment and care they need for a strong start in life. The 2020 *Yearbook* data indicate that infants and toddlers are doing well or have made gains in areas such as routine medical visits, but the national picture is concerning in areas such as the percentage of babies who experience food insecurity. Health is the area providing the greatest ability to examine the experiences of subgroups. The new data in the *State of Babies Yearbook: 2020* confirms that grave disparities exist in maternal and infant health among mothers and babies of different races and ethnicities. Of particular concern are disparities in maternal and infant mortality, prenatal care, and birth outcomes such as preterm and low birthweight.

What the Research Tells Us

Poor nutrition and recurrent exposure to infectious diseases in early childhood are linked to chronic cardiovascular, respiratory, and mental health problems in adulthood.[x] Research finds that infants and toddlers with access to health coverage are more likely than their uninsured peers to see a doctor regularly and 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. Nearly half of children under age 3 receive medical coverage through Medicaid, and those covered have better long-term health, educational, and employment outcomes than those who were uninsured. Healthy parents are more likely to have healthy children. Research confirms that access to health insurance is a family affair, as children are more likely to be covered if their parents have coverage as well. Medicaid expansion has improved parents' access to care, and it has been associated with lower rates of infant mortality in states that adopted that policy.

Infants and toddlers also need positive relationships to support their healthy social-emotional development, which is critical for positive cognitive development. They and their families may require access to infant and early childhood mental health (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. When social-emotional development suffers significantly, infants and toddlers can experience mental health problems. Even babies can show signs of depression (e.g., inconsolable crying, slow growth, sleep problems).[xi] Maternal depression and anxiety disorders affect approximately 10 percent of mothers with young children.[xii] Mental health disorders in young children often reflect

Infants and toddlers also need positive relationships to support their healthy social-emotional development.

problems in the attachment relationships, which can be impaired if caregivers suffer from depression. Skilled providers can accurately screen for, diagnose, and treat mental health disorders before they affect other areas of development. However, nearly one third of state Medicaid programs do not permit reimbursement for maternal depression screenings that are provided during pediatric visits.

Federal and state policymakers can strengthen these 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.

Subdomain	Indicator	Description	2019 *Yearbook*	2020 *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
	Medicaid expansion state	State adopted Medicaid expansion under the Affordable Care Act	34 states	37 states
	Uninsured low-income infants/toddlers	Percentage of low-income infants/toddlers who are uninsured[a]	5.8%	5.4%
Food Security	Low or very low food security	Percent of households with infants/toddlers experiencing low or very low food security	16.5%	15.9%
Nutrition	Infants ever breastfed	Percentage of infants ever breastfed[a]	83.2%	82.9%
	Infants breastfed at 6 months	Percentage of infants breastfed at 6 months[a]	57.6%	54.6%
	WIC coverage	Percent of eligible infants who participated in WIC	--	85.9%
	High weight-for-length among WIC recipients	Percent of WIC recipients ages 3-23 months who have high weight-for-length	--	Available at state level only
Maternal Health	Maternal mortality rate	Number of pregnancy-related deaths per 100,000 live births	--	17
	Late or no prenatal care received	Percent of women receiving late or no prenatal care	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
	Mothers reporting less than optimal mental health	Percent of mothers of infants/toddlers rating their mental health as worse than "excellent" or "very good"	22.0%	19.8%
Child Health	Infant mortality rate	Deaths per 1,000 live births	5.9	5.8
	Low birthweight	Percent of babies with low birthweight	8.2%	8.3%
	Preterm birth	Percent of babies born preterm	--	10.0%

Subdomain	Indicator	Description	2019 *Yearbook*	2020 *Yearbook*
Child Health	Preventive medical care received	Percent of infants/toddlers who had a preventive medical visit in the past year[a]	90.7%	91.1%
	Preventive dental care received	Percent of infants/toddlers who had a preventive dental visit in the past year[a]	30.0%	31.9%
	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%
Infant and Early Childhood Mental Health[b]	Medicaid plan covers social-emotional screening for young children	State Medicaid plan covers social-emotional screening for young children (ages 0–6) with a tool specifically designed for this purpose	41 states	43 states
	Medicaid plan covers IECMH services—at home	Medicaid plan covers services in home settings	46 states	49 states
	Medicaid plan covers IECMH services—in medical settings	Medicaid plan covers services in pediatric/family medicine practices	45 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

New indicator in 2020

NOTES: [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 Yearbook. 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.

Key Findings

Areas in which babies and their families are doing well or policies have been implemented that contribute to improved outcomes include:

- The number of babies who have received regularly scheduled medical care in the past 12 months remained high at approximately 91 percent in both years.
- More states have implemented Medicaid expansion (37 as compared to 34 at the time of the *2019 Yearbook*).
- Nearly all states have Medicaid plans that cover social-emotional screening of young children (43 at the time of the *2020 Yearbook*, an increase of two states) and the plans of 49 states cover infant and early childhood mental health (IECMH) services provided in the home, 46 states cover IECMH services in pediatric/family

medicine practices, and 34 states cover these services in early care and education settings.

Indicators of serious concern include the proportion of infants and toddlers in low-income families who are not insured, incidence of low birthweight, preterm births, high maternal and infant mortality rates, and the need for greater attention to the social-emotional health of both mothers and babies.

- Despite coverage available through Medicaid and the Children's Health Insurance Program, 5.4 percent of low-income infants and toddlers lack health insurance.

- As many as 1 in 10 babies (10 percent) are born preterm and 1 in 12 (8.3 percent) have low birthweights, which can jeopardize development.

- The national maternal and infant mortality rates are particularly concerning and are higher than rates found in other industrialized countries. Maternal mortality, a new indicator in the 2020 *Yearbook*, occurs at a rate of 17 deaths per 100,000 live births nationally, and disparities in state reporting prevent comparison of the rate across states. Although infant mortality is more consistently reported, the rate remains high and is virtually unchanged, with 5.8 deaths per 1,000 births reported in 2020 compared to 5.9 in the 2019 *Yearbook*. Infant mortality rates continue to vary widely across states (ranging from 3.7 in New Jersey to an alarming 8.6 in Mississippi).

- Nearly one in five mothers of infants and toddlers (19.8 percent) rate their own mental health as worse than "excellent" or "very good," compared to 22 percent reported in the 2019 *Yearbook*. A majority of states, 37, now cover screening for maternal depression during well-child visits, and 43 states cover social-emotional screening of young children.

Cradling Equity: Good Health

Health is the area in which the most data are available on significant differences in certain populations of babies and families. Research, in combination with several of the *Yearbook's* Good Health indicators, offers 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.

Race/Ethnicity

New disaggregated data in the *State of Babies Yearbook: 2020* confirms that grave disparities exist in maternal and infant health among mothers and babies of different races and ethnicities. Researchers have explored connections between health disparities and factors such as poverty caused by parents not earning a living wage, unemployment, or underemployment; living in under-resourced neighborhoods; or low educational attainment. Numerous studies reach the same conclusion: Even after considering the influence of these factors, race accounts for huge differences.[xiii,xiv] As reflected in subgroup analyses of the *Yearbook's* health indicators by race, Black, American Indian, and Hispanic women[6] are more likely than their White counterparts to receive late or no

6 As used by the Office of Management and Budget and the Census Bureau, Hispanic ethnicity can be a characteristic of people of any race. In this brief, we use "Black" and "White" to refer to non-Hispanic members of those racial groups. Except where otherwise indicated, the analysis in this brief is limited to Black, White, and Hispanic women and children, because data on other groups, particularly at a state level, are not reliable.


14.1%
The preterm birth rate for Black women is 55% higher than the rate for White women.

prenatal care.[xv] They are also more likely to die during or after birth or from resulting complications. In comparison to White infants, Black and American Indian infants have a much higher risk of being born preterm and/or with low birthweight,[xvi] are less likely to be breastfed,[xvii] and are more likely to die within their first year.[xviii]

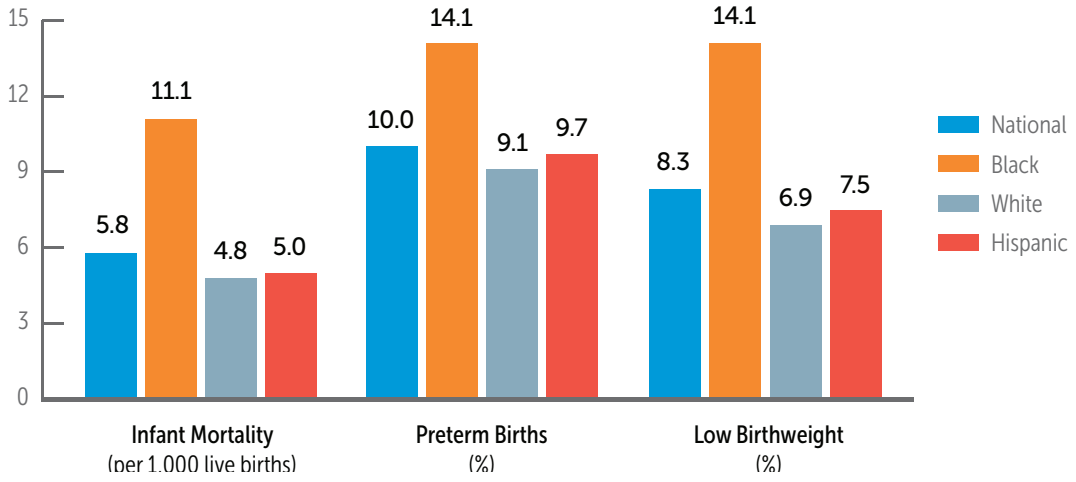
***State of Babies Yearbook: 2020* data confirm that there are clear racial/ethnic disparities within a number of indicators among infants, toddlers, and their mothers.**

- **PRENATAL CARE.** Nationally, the rate of late or no prenatal care is 6.2 percent. **Although 4.5 percent of White women fall in this category, 7.7 percent of Hispanic women and 9.9 percent of Black women get late or no prenatal care**. Compared with Asian/Pacific Islander women (the racial category with the lowest rate), Black women are more than three times as likely to obtain prenatal care late or not at all. American Indian women are more than two times as likely—and White women 41 percent more likely—than Asian/Pacific Islander women to receive late or no prenatal care.[xix]

  Racial/ethnic disparities are even more pronounced in some states. For White women, rates of late/no prenatal range, by state, from 1.2 percent (Rhode Island) to 7.7 percent (New Mexico); for Hispanic women, the range is from 1.9 percent (Rhode Island) to 22.5 percent (Alabama); and for Black women, from 3.2 percent (Rhode Island) to 15.1 percent (Texas). In 24 states[7] and the District of Columbia, the percentage of Black women receiving late or no prenatal care is more than twice the percentage for White women.

- **PRETERM BIRTHS.** Nationally, **the preterm birth rate for Black women (14.1 percent) is 55 percent higher than the rate for White women (9.1 percent), and the rate for Hispanic women (9.7) is 7 percent higher than the rate for White women.** Preterm birth rates for White women range by state, from 6.3 percent (District of Columbia) to 11.8 percent (West Virginia); for Hispanic women, the range is from 5.8 percent (Maine) to 11.1 percent (Iowa and Utah); and for Black women, from 7.7 percent (South Dakota) to 17.3 percent (Mississippi). Preterm birth rates for Black women are substantially

BIRTH OUTCOMES BY RACE



7 Arizona, Colorado, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New Jersey, New York, North Dakota, Oregon, Pennsylvania, South Dakota, Texas, Utah, Washington, and Wisconsin. Data not available for Montana, Vermont, and Wyoming.

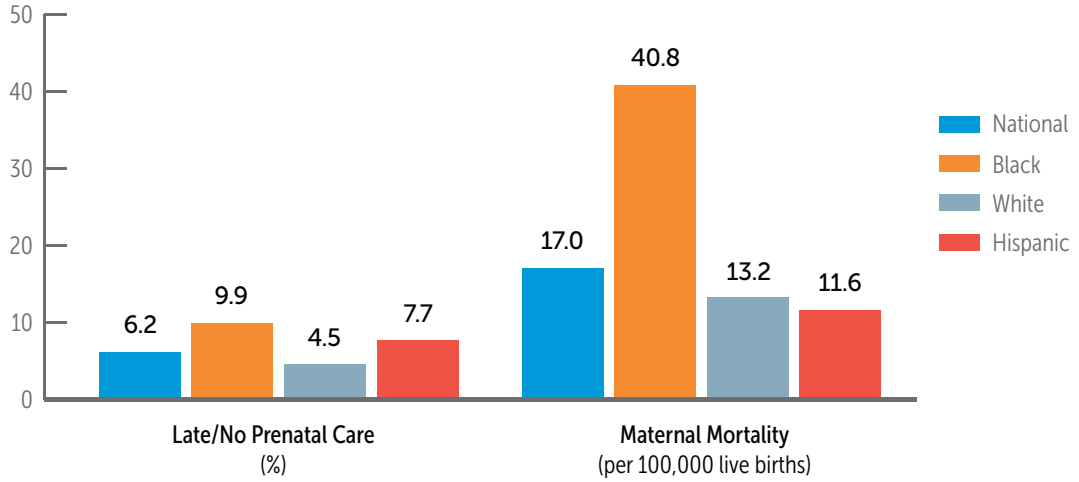
higher than those for White women in Arkansas, Louisiana, Michigan, and Wisconsin. However, in Idaho, Minnesota, and North Dakota, preterm births are slightly less prevalent among Black women than among White women.

- **LOW BIRTHWEIGHT.** Nationally, **the rate of Black women at risk for having low-weight births (14.1 percent) is more than twice that for White women (6.9 percent); the rate for Hispanic women (7.5 percent) is 9 percent higher than the rate for White women.** For White women, rates of low birthweight vary, by state, from 4.8 percent (Alaska) to 9.7 percent (Wyoming); for Hispanic women, rates range from 5.8 percent (Alaska) to 10.4 percent (Montana); and for Black women, from 8.4 percent (South Dakota) to 16.4 percent (Alabama). In 15 states[8] and the District of Columbia, the low birthweight rate for Black women is more than double that for White women.

- **INFANT MORTALITY. Mortality is more than twice as high for Black infants (11.1 per 1,000 births) as it is for White infants (4.8) and is slightly higher for Hispanic infants (5) than for White infants.** For White infants, infant mortality varies by state, ranging from 2.9 per 1,000 births (New Jersey and the District of Columbia) to 7.2 (Arkansas); for Hispanic infants, the range is from 4.1 (Washington) to 10.4 (Montana); and for Black infants, from 7.6 (Massachusetts) to 15 (Wisconsin). In every state (and the District of Columbia) except Kentucky, Massachusetts, Minnesota, and Washington,[9] the mortality rate for Black infants is at least twice that for White infants.

- **MATERNAL MORTALITY.** Nationally, **the maternal mortality rate among Black women (40.8 per 100,000 live births) is more than three times higher than among White women (13.2).**[10] Moreover, this gap has not decreased over multiple decades.[xx] Leading causes of deaths among Black women are heart and circulatory problems; among White women, mental health problems (including suicide and overdose/poisoning) predominate. Complications from cesarean deliveries also play a major role in maternal mortality, along with medical errors, ineffective treatments, and poor care coordination.[xxi,xxii]

MATERNAL HEALTH BY RACE



8 Alabama, Alaska, Arkansas, Georgia, Illinois, Louisiana, Michigan, Mississippi, Missouri, Nebraska, Oklahoma, Pennsylvania, South Carolina, Tennessee, and Wisconsin. Data not available for Montana, Vermont, and Wyoming.

9 Data not available for Idaho, Maine, Montana, New Hampshire, New Mexico, North Dakota, Vermont, and Wyoming.

10 Data are for 2015-2016.

- **BREASTFEEDING.** The national proportion of **mothers who ever breastfed their babies is 85.7 percent among Hispanic mothers, 85.2 percent among White mothers, 68.9 percent among Black mothers, and 82.5 percent among mothers of other races**[11] despite the known health, nutritional, and economic benefits. Nationally, the proportion of mothers who still breastfeed at 6 months postdelivery is 58.4 percent among White mothers, 52.5 percent among Hispanic mothers, 42.4 percent among Black mothers, and 57.5 percent among non-Hispanic mothers of other races. Looking at state-level data, differences by race/ethnicity in rates of breastfeeding *at any point post-delivery* are statistically significant in only a few states.

Beneath the stark differences in these outcomes are disparities in access to health care, the experiences women have in the health care setting, and the cumulative effects of stress (including the stress of experienced racism) on women's health. No single strategy will be sufficient to achieve greater racial equity in maternal health and birth outcomes. To improve outcomes, it is particularly important that the "community voice" be heard throughout all stages of determining appropriate strategies. This includes identifying needs from the perspective of women of color within the state's local communities and working together with them to develop and implement solutions that are responsive to what would be most helpful based on their lived experiences and circumstances.

Income

Six of the *Yearbook's* maternal and child health indicators are examined by income, using two categories: Low Income (i.e., families with incomes below 200 percent of the FPL, approximately $50,000 per year for a family of four) or Above Low Income. These indicators include vaccinations, mothers' mental health, medical visits, dental visits, breastfeeding (ever), and breastfeeding at 6 months. Information for the remaining indicators in this domain is not available because of data not being reported by income, inconsistencies in reporting across states, and/or the data being unreliable to draw conclusions from when disaggregated. In the case of maternal mortality, for example, the incidence of maternal mortality is available at the national level, but states do not report the data in the same way.

- **VACCINATIONS.** Nationally, 70.4 percent of infants and toddlers received the recommended vaccinations. However, when analyzed by income, **significantly fewer babies (64.7 percent) in families with low income received vaccinations than those in families above low income (76.7 percent).** Percentages varied by state, with low income ranging from 55 percent in Oregon to 79.4 percent in Tennessee. Among babies in families above low income, the range was 68.8 percent in Minnesota to 85.4 percent in the District of Columbia. In all states where differences exist, children in families with low income are less likely to be vaccinated than children in families above low income.

- **MOTHER'S MENTAL HEALTH.** Collectively, nearly 1 in 5 (19.8 percent) mothers of infants and toddlers report less than optimal mental health, with numbers ranging widely from 9.6 percent in the District of Columbia to 33.3 percent in Kentucky. When considered by income, **25 percent of low income mothers report less than optimal mental health compared to 16.6 percent of mothers above low income.** The differences between low income and non-low income mothers are significant in 11 states.[12]

11 Counts of mothers identified as belonging to races other than White or Black were too small to produce reliable separate estimates. As a result, we created an "other" category to include all such groups.

12 For the purposes of this report, we use the terms "rural" for areas defined by OMB as "nonmetropolitan" and "urban" for "metropolitan" areas.

- **MEDICAL VISITS.** 91.1 percent of the nation's babies had a preventive medical care visit within the past year. **Babies in families with low income completed visits at a lower rate (87.7 percent) than those in families above low income (93.4 percent).** At the state level, medical visits among babies in families with low income ranged from 75.7 percent in Hawaii to 99.1 percent in New Jersey, compared to 92.7 percent in families above low income; and statistically significant differences were present in three states (New Mexico, New Jersey, and Oklahoma).

- **DENTAL VISITS.** Information on dental visits for infants and toddlers is less easily interpreted because many babies have oral health checked as part of their medical visits. This practice may contribute in part to **fewer babies in families above low income (29.2 percent) having dental visits in the last year reported than babies in families with low income (35.8 percent).** Dental visits also varied widely across states. Among babies in families with low income the proportion ranged from 10.7 percent in Illinois to 62.9 percent in Washington; babies in families above low income ranged from 9 percent in Kentucky to 44.5 percent in Oregon.

- **EVER BREASTFED.** Significant differences exist at both national and state levels in the number of babies who are breastfed. Nationally, 82.9 percent of babies are ever breastfed. However, breastfeeding is more likely for babies in families who are not low income. **In families above low income, 89.1 percent of babies were ever breastfed,**

fewer babies in families with low income (77.1 percent) had been. These differences by income are found in 36 states, and variation is very high. Breastfeeding (ever) of babies in families with low income ranges from 48.4 percent in Mississippi to 91.1 percent in Alaska; and in families above low income ranges from 79.5 percent in Louisiana to 96.4 percent in Washington.

- **BREASTFED AT 6 MONTHS.** Nationally, 54.6 percent of babies are still breastfed at 6 months of age. Similar patterns exist in the number of babies who were ever breastfed and those who are still breastfed at 6 months, but with a larger difference between income levels. **Less than half (44.7 percent) of babies in families with low income were still breastfed compared to 65.2 percent of babies in families above low income.** These differences were found in nearly all states (48), and variation was high. Among babies in families with low income, the range was as few as 21.2 percent in Mississippi to as high as 60.8 percent in Oregon; and for babies in families above low income the range was 49.9 percent in Louisiana to 81.8 percent in Oregon.

Urbanicity

Four indicators of maternal and child health can be examined by urban or rural place of residence.[13] These indicators include low-income uninsured, low birthweight, preterm birth, and late or no prenatal care. Information for the remaining indicators in this domain is not available because of data not being reported by urbanicity, inconsistencies in reporting across states, and/or the data being unreliable to draw conclusions from when disaggregated. Although infant mortality data could not be analyzed across states for urbanicity, national trend data reported by the Centers for Disease Control and Prevention found that in the period from 2013–2015, the infant mortality rate was "highest in rural counties (6.69 infant deaths per 1,000 live births), followed by small and medium urban counties (6.29) and large urban counties (5.49)."[xxiii]

- **LOW INCOME UNINSURED.** Significant differences exist in the number of uninsured babies at national and state levels, when analyzed by urbanicity. Although the national rate of low-income uninsured babies has decreased to 5.4 percent, **rural babies are more likely to be uninsured (7 percent) than those in urban areas (5.1 percent).** Substantial variation is found across states. However, the state-level data for this indicator are unreliable and disaggregated, which limits making comparisons at this level.

Differences in maternal and birth outcomes by urbanicity were small for each of the three indicators. However, potential regional patterns are evident when comparison is made of the range of differences between states on these indicators.

13 For the purposes of this report, we use the terms "rural" for areas defined by OMB as "nonmetropolitan" and "urban" for "metropolitan" areas.

- **LOW BIRTHWEIGHT. No differences were determined in the incidence of low birthweight between rural and urban babies; the rate for both matched the national average of 8.3 percent.** Differences within states were also small (all states had differences of less than 3 percent between these groups). In looking at variation between states, the number of babies born at low birthweight in urban areas ranges from 6.3 percent in Alaska and Vermont to 11.7 percent in Mississippi. Similarly, the incidence of low birthweight in rural areas ranged from as low as 4.8 percent in Massachusetts to 12.5 percent in Mississippi.

- **PRETERM BIRTH.** Nationally, 10 percent of babies are born preterm. **When examined by urbanicity, similar rates were found between preterm births—10 percent in urban areas compared to 10.4 percent in rural areas.** All states had differences of less than 4 percent between urban and rural areas. The largest differences were found in three states; two in which the urban percentage was higher than rural—Massachusetts (2.8 percent) and Michigan (2 percent); and one state in which the rural percentage was higher than urban: South Carolina (2.2 percent).

- **LATE OR NO PRENATAL CARE.** Nationally, 6.2 percent of women receive late or no prenatal care. **Little difference was found between receipt of prenatal care among urban women (6.2 percent) and rural women (6.6 percent).** All states had differences of less than 5 percent between these areas. The largest differences were in three states; in all of them more rural than urban women received late or no prenatal care than women in urban areas—North Dakota (4.7 percent), Arizona (4.6 percent), and South Dakota (3.5 percent).

A number of policies available to states are helping to decrease subgroup differences in maternal health and birth outcomes. Most of these focus on ensuring equitable access to essential health care, including nutrition, and extending support to expectant and new parents. Policies that are influential in addressing the equity gap include those that extend eligibility and length of families' access to Medicaid; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); paid family and medical leave; and home visiting. Innovative approaches, such as group prenatal care[xxiv], doula care[xxv], and breastfeeding support groups[xxvi], also show promise for improving maternal care and birth outcomes for women at risk. Refer to *Inequities in Inequities in Maternal Health and Birth Outcomes* brief for additional information.

Policy Spotlight

MEDICAID EXPANSION: 37 states have adopted Medicaid expansion under the Affordable Care Act. Not only is that good news for the adults receiving coverage under the ACA in those states, but also for young children in those households, as well. The health of a child and their caregiver—most often a parent—are inextricably linked. Recent research shows that children residing in non-expansion states are nearly twice as likely to be uninsured as those in states that have expanded Medicaid.[xxvii] Although this is likely because of multiple factors, one plausible reason for such discrepancies is that the states that expand Medicaid are building a more comprehensive system of coverage while developing the expectation that most people have a pathway to getting insured.[xxviii] Beginning prenatally, comprehensive health care is critical for both baby and mother. Medicaid expansion under the ACA is one way that states can help meet the health needs of their families.

CRADLING EQUITY

Project HOPE in Alabama: Getting at the root of challenges by getting proximate to families

Alabama is a "focal state" in the Project HOPE Consortium (**H**arnessing **O**pportunity for **P**ositive **E**quitable Early Childhood Development). The project seeks to generate real progress toward equitable outcomes for young children (prenatal to age 5) and their families by building the capacity of local communities and coalitions, state leaders, and cross-sector state teams, to prevent social adversities in early childhood and promote child well-being. Examining disaggregated state and local data was a starting point and throughout the project has helped state and community leaders get more proximate to families' challenges. Project HOPE is a Robert Wood Johnson Foundation strategy to advance health equity and child well-being by leveraging the knowledge, tools, and resources of the BUILD Initiative, Nemours National Office of Policy and Prevention, and Boston Medical Center (BMC) Vital Village.

Through a 6-month Leadership Institute, beginning in 2018, selected states developed an application portfolio to be a focal state to work on systems-building and practice changes at the community level. Digging into their own disaggregated data allowed state leaders to see whether racial inequities exist, discuss ways they can be addressed, and explore how addressing them can improve outcomes for children and families. Each state was tasked with connecting with community partners to hear the multiple *family stories* behind the data.

Chosen as a focal state, Alabama targeted two counties already highlighted in an ongoing statewide initiative to reduce infant mortality rates.[14] A cross-sector team of staff from health, mental health, and children and family agencies began the work of combining disaggregated data with community input. Data mapping to the subcounty level on indicators such as infant mortality and health and well-being brought them even closer to the people behind the numbers. Focus groups or "beneficiary voice meetings" with members of the community yielded more thorough insights to the daily challenges communities were facing, getting even more proximate to the problems.

A lesson from Project HOPE is that racial equity and early childhood systems cannot be treated as separate issues. Speaking to families and keeping their voices at the center of this project brought the team closer to challenges and service needs of Alabama families with young children. The team continues the work of addressing inequities families face in receiving support from state services, seeking to modify policy, practice, or programs to bring services to those communities. This is not about new program funding. Continued goals to achieve equity for young children and families are to promote optimal health and well-being, prevent and mitigate early childhood adversities; improve adverse social settings to reduce racial, ethnic, geographic, and economic inequities; shift or realign aspects of systems to increase access to opportunities in communities with significant disparities; and engage community members and create feedback loops for communication between state and local policymakers, practitioners, community leaders, and families.

14 In 2017, Governor Kay Ivey convened the Children's Cabinet to address infant mortality in Alabama. The 2018 the State of Alabama Infant Mortality Reduction Plan created a pilot program with a goal of reducing infant mortality by 20 percent over 5 years. The Alabama Department of Public Health leads a cross-sector group of agencies.


Dear Zoo

Strong Families

Young children develop in the context of their families, where stability and supportive relationships best nurture their growth. Babies need unhurried time 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. Key supports include home visiting services, paid sick, family, and medical leave, and income support through tax credits.

The *State of Babies Yearbook: 2020* shows that crowded housing remains an area of concern, with more than one in six babies and toddlers living in these arrangements that can be detrimental to their development. For babies of color and those in low-income families, these rates are two to three times greater than for White or above-low-income babies. The proportion of infants and toddlers who already have had adverse experiences in their young lives ticked upward slightly, but those in low-income families were two to three times more likely to have had one or more such experience.

More families reported feeling resilient—able to bounce back from unsettling events—but again, fewer low-income families characterize themselves as resilient than families above low income. In terms of supportive policies, two more states have adopted paid family and medical leave policies, bringing the total to nine. As the *Yearbook* expands policy indicators related to economic security in recognition of the importance of income in a child's early development, we found that 30 states supplement the federal Earned Income Tax Credit (EITC) with a state credit. However, the reach of the principle cash assistance program, Temporary Assistance for Needy Families, reaches only slightly more than a fifth of families in poverty who have infants or toddlers.

What the Research Tells Us

Adversities experienced early in life—such as hunger, abuse, neglect, or household instability—can create stress that undermines lifelong development.[xxix] Chronic, unrelenting stress experienced in early childhood, such as that caused by extreme poverty, repeated abuse or prolonged neglect, or severe maternal depression, for example, 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.

Infants and toddlers are the age group most vulnerable to abuse and neglect, and they experience the highest rates of maltreatment.[xxx] 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.[xxxi] Foster care practices not attuned to early development can compound these problems. Child welfare systems should be responsive to the needs of very young children in their policies and practices, but seldom are.[xxxii]

Despite high rates of employment, parents of young children are more likely to live in poverty than adults without children or adults with school-age children. Two key federal tax credits provide income support to low-income working parents: the EITC and the Child Tax Credit (CTC). The EITC is available to income-eligible working parents and is intended to incentivize work and offset federal tax burdens.[xxxiii] The effects of both tax credits are particularly significant for young children and lifting families out of poverty. 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.[xxxiv]

Subdomain	Indicator	Description	2019 *Yearbook*	2020 *Yearbook*
Basic Needs Support	TANF benefits receipt among families in poverty	Percent of families with infants/toddlers living below 100 percent of the FPL that receive TANF benefits[a]	20.6%	21.7%
	Housing instability	Percent of infants/toddlers who have moved three or more times since birth[a]	2.5%	2.7%
	Crowded housing	Percent of infants/toddlers who live in crowded housing	15.6%	15.5%
Child Welfare	Unsafe neighborhoods	Percentage of infants/toddlers living in unsafe neighborhoods, as reported by parents[a]	6.3%	5.8%
	Family resilience	Percentage of families with infants/toddlers who report "family resilience"[a]	82.6%	85.2%
	Adverse childhood experiences—1	Percent of infants/toddlers who have experienced one adverse childhood experience[a]	21.9%	22.4%
	Adverse childhood experiences—2 or more	Percent of infants/toddlers who have experienced two or more adverse childhood experiences[a]	8.3%	8.6%
	Infant/toddler maltreatment rate	Maltreatment rate per 1,000 infants/toddlers[a,b]	16.0	15.9
	Time in out-of-home placement	Percent of infants/toddlers who spent 1 year or more in out-of-home placement.	--	20.2%
	Permanency	Percentage of infants/toddlers exiting foster care who achieve permanency[b]	98.4%	98.6%
Home Visiting	Potential home visiting beneficiaries served	Percent of infants/toddlers who could benefit from evidence-based home visiting and are receiving those services	1.9%	1.9%
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
	Paid family leave	State has a paid family leave program (Y/N)	7 states	9 states

Subdomain	Indicator	Description	2019 *Yearbook*	2020 *Yearbook*
Supportive Policies	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 (11 of which exempt for a single child only)
	State child tax credit	State has a child tax credit	--	6 states
	State earned income tax credit (EITC)	State has an earned income tax credit	--	30 states

New indicator in 2020

NOTES: [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 Yearbook. For a more detailed discussion, see the indicators and methodological appendices.

[b] 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 State of Babies Yearbook: 2019.

Key Findings

Although most indicators in this domain address adversities, most families with an infant or toddler (85.2 percent in the 2020 *Yearbook*) report a favorable level of resilience, an increase from 82.6 percent in the 2019 *Yearbook*. This is a sign that families are feeling more able to bounce back when faced with adversity.

At the same time, families with young children face many challenges that threaten their abilities to meet their children's basic needs and provide the stable 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. 2020 *Yearbook* data show:

- Nationally, 15.5 percent of babies live in crowded housing, an alarming finding that continues from the previous year. In homes where families are crowded, parents are less responsive to infants and toddlers and more likely to use punitive discipline[xxxv]. Crowding has also been associated with children's health problems, including respiratory conditions, injuries, and infectious diseases, and with young children's food insecurity.[xxxvi] Wide variation was found among states, with rates ranging from 5.6 percent in West Virginia to 28.4 percent in California.
- Fewer babies, 2.7 percent, experience housing instability (i.e., have moved three or more times since birth). This is a slight increase from 2.5 percent reported in the 2019 *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. State-level data are not reliable for this indicator and do not allow for comparison.

- Slightly less than 6 percent (5.8 percent) of parents with babies report living in neighborhoods that they feel are unsafe. This represents a drop from the 6.3 percent reported in the 2019 *Yearbook*.

Findings for several indicators in this domain vary across states, with large differences found in rates of maltreatment and exposure to adverse experiences.

- Infants and toddlers have the highest rates of abuse and neglect of any age group, at 16 per 1,000 children ages 0 to 2. This figure is virtually unchanged, with 15.9 reported in the 2020 *Yearbook* and 16 in 2019. However, wide differences are found in states' maltreatment rates, which according to the latest reports range from 1.9 per 1,000 infants and toddlers in Pennsylvania to 38.2 per 1,000 in Michigan.

- Nationally, on average, approximately 8 percent of infants and toddlers (8.6 percent in 2020 compared to 8.3 percent in 2019) have already been exposed to two or more adverse experiences. Although state averages on this indicator range from as low as 1.2 percent in Maryland to 20.9 percent in Oklahoma, most states (34) report less than 10 percent of their babies have had two or more adverse experiences.

At the policy level, many working families with young children can benefit from family income supports available through the Temporary Assistance to Needy Families (TANF) program and tax credits. More cash in families' pockets assists them in meeting their young children's basic needs, such as diapers, and improves their ability to pay for gas and other transportation-related needs that can affect employment.

- Slightly more than one in five (21.7 percent) families with infants and toddlers living in poverty received income-based TANF benefits. Wide variation exists in the proportion of families in poverty with a child under age 3 that receive TANF benefits—from 2.7 percent in Idaho to

88.2 percent in Maryland—reflecting the different emphasis states place on using TANF funds for income support.

- Just under half of all states (24) at the time of this report have implemented policies that exempt single-parent heads of households from work-related requirements if they are caring for a child under 12 months of age—which means that more than half do not have this policy. Given concerns about the quality of infant-toddler care overall, this is an area for further exploration.

- In an effort to boost families' incomes, 30 states provide them with a state Earned Income Tax Credit (EITC) in addition to boost the federal EITC. However, only six states augment the federal Child Tax Credit (CTC) with a state credit.

    - At the time of the 2020 report, 30 states provide families an EITC. State tax credits typically add a refund that is a percentage of the federal credit, but this percentage varies widely, from 3 percent to 85 percent in California (which restricts the range of eligible income).[xxxviii] In the 2018 tax year, families with children received an average federal EITC of $3,191 annually, but credit amounts vary based on filers' income, marital status, and the number of dependent children in the home. The value of the EITC increases with income up to a maximum value, and then phases out gradually as income increases. In 2018, 25 million families received a total of $63 billion in EITC benefits, with state credits adding about another $5 billion.

In addition to lifting children out of poverty, tax credits benefit families at all stages in other ways.

    - Six states offer families a Child Tax Credit. CTC's are important to families with infants and toddlers, because they are specifically meant to benefit families by offsetting the cost of raising a child. State CTCs typically augment the federal CTC by providing a small additional amount per child or a percentage of the federal credit. Colorado restricts its credit to children under age 5. The federal CTC provides a maximum annual credit of $2,000 per child under the age of 17. The federal CTC is partially refundable, meaning that low-income parents who owe little or no federal income tax can receive a refund up to 15 percent of their earnings above $2,500. Families earning less than $2,500 per year are not eligible for the credit. The federal CTC does reach many children, including 94 percent of infants and toddlers. However, because it is not fully refundable, the babies in the lowest income quintile, who could most benefit from an income boost, receive a benefit that is about half of that received by babies in the top income quintile.[xxxix]

These tax credits put more money into family pocketbooks, especially when they are fully refundable. In addition to lifting children out of poverty or making them less poor, tax credits benefit families at all stages in other ways, including improved health and birth outcomes for families with young children.[xxxvii]

30 states provide an Earned Income Tax Credit to boost families' income.

Cradling Equity: Strong Families

Differences in opportunities and challenges for America's babies and the contexts in which they grow are the focus of an extensive body of economic and social science research. The *State of Babies Yearbook: 2020* includes findings on commonalities and differences in families with young children's access to resources that help them meet their babies' daily needs, contributors to family stability, and exposure to adverse events by race/ethnicity, income, and urbanicity on seven indicators where subgroup analyses were possible. Most indicators in this domain could be analyzed only by income.

Infants and toddlers of color, in addition to living disproportionately in poor families, are more likely to live in neighborhoods their parents characterize as unsafe, to experience housing instability (i.e., crowded homes and frequent moves), and to have been exposed to one or more potentially traumatic experiences.[xxxvii] Young children of color, particularly Black and Hispanic babies, are also disproportionately represented in the child welfare system, and their permanency outcomes differ from those of their White peers. They are less likely to receive family preservation services and are more likely to be removed.[xxxviii,xxxix] Once removed from their parents, Black children are more likely to experience negative outcomes, including longer stays in foster care.[xl]

Two *Yearbook* indicators in the Strong Families domain can be analyzed by race/ethnicity—crowded housing and time in out-of-home placement. The findings for both indicators are that infants and toddlers who are Hispanic, Black, or Other race are more likely than their White counterparts to live in crowded housing; a higher percentage of babies of color spent 1 year or more in an out-of-home placement than White babies placed out of home.

Race/Ethnicity

- **CROWDED HOUSING.** Nationally, 15.5 percent of infants and toddlers lived in crowded housing. However, examination by race reveals significant differences in which babies were more likely to live in this condition. **Hispanic babies (29 percent) were more than three times as likely, and Black babies (17.6 percent) and Other race babies (17.5 percent) were twice as likely to live in crowded housing than White babies (7.6 percent).** Racial/ethnic differences were also evident at the state level, with significant differences reported in the vast majority of states when comparisons for babies of color were made to White babies.

- **OUT-OF-HOME PLACEMENT.** The amount of time infants and toddlers who have entered the child welfare system spend in out-of-home placement differs by race. **At the national level, 1 in 5 babies (20.2 percent) has been out-of-home for 1 year or more. This is consistent with that of White (18.7 percent), Hispanic (19.8 percent), and Other race (20.2 percent) babies; however, the proportion of Black babies (23.4 percent) is nearer to 1 in 4.** There also is wide variation across states for babies in all categories of race/ethnicity and data are not available by race from many states.

Income

- **CROWDED HOUSING. Significantly more babies living in families with low income (24.6 percent) live in crowded housing than babies living in families above low income (7.9 percent)**; and the difference is

significant in all states. Babies in low-income families experiencing crowded housing also varied a great deal across states. As few as 8.7 percent of babies in low-income families in West Virginia were reported to be in crowded housing compared to as many as 44.9 percent in California.

- **NEIGHBORHOOD SAFETY.** Nationally, 5.8 percent of parents of infants and toddlers report living in neighborhoods that are not safe. **More than twice as many low-income parents (8.4 percent) report their neighborhood is unsafe than parents above low-income (4 percent)**. There is wide variation across states, ranging from as few as less than 1 percent of low-income parents in Rhode Island reporting unsafe neighborhoods to 25.4 percent in Nevada. Less variation is found among parents above low income; those that consider their neighborhood unsafe range from less than 1 percent in Alabama to 11.8 percent in California. Significant differences between income groups are found within three states—Colorado, Nevada, and New York.

- **RESILIENCE.** As many as 85.2 percent of families with young children report being resilient in their ability to face challenges. **Fewer low-income families (79 percent) characterize themselves as resilient than families above low-income (89 percent)**. Variation across states also is highest for low-income families, ranging from 60.7 percent of families in Arizona reporting resilience to 97.2 percent of low-income families in Alabama. Differences between the rates of resilience reported by low income and above low-income families were significant within eight states—Alabama, Alaska, Arizona, Colorado, Montana, Ohio, South Carolina, and Texas.

- **HOUSING INSTABILITY.** The incidence of high instability due to mobility (i.e., families moving three or more times within their babies' first 3 years) is low at 2.7 percent nationally. However, **babies in families with low income are twice as likely to have such frequent moves (3.8 percent) than those in families above low income (1.9 percent)**. More variation is found across states in the mobility of low-income families, which ranges from less than 1 percent of low-income families in Texas to 16.4 percent of families in Alaska. In contrast, high mobility ranged from as few as less than 1 percent of families above low income in Delaware to 5.6 percent of families above low income in Nevada. Differences between income groups were significant in only two states— Maine and West Virginia.

Significantly more babies living in families with low income (24.6%) live in crowded housing than babies living in families above low income (7.9%).

- **ADVERSE EXPERIENCES.** More than one in five babies (22.4 percent) nationally has already had at least one adverse childhood experience (e.g., witnessing or experiencing violence or abuse, or living in a home where there is substance abuse) and nearly one in nine (8.6 percent) has experienced two or more. When examined by income level, **babies in families with low income are more than twice as likely than babies in families above low income to have one adverse experience**, at 33.2 percent and 15 percent, respectively. The incidence of one adverse experience also varies widely by state, particularly among babies in families

with low income, with rates ranging from 14.7 percent in Illinois to as high as 52.8 percent in Nevada. A similar pattern is found among babies that have had two or more adverse experiences. **Babies in families with low income are more than three times as likely to have two or more adverse experiences than those in families above low income**, 15.1 percent low income compared to 4.1 percent above low income. This also varies substantially by state among families with low income, ranging from less than 1 percent in Maryland to as high as 32.1 percent in Oklahoma.

Urbanicity

- **CROWDED HOUSING. When examined by rural vs. urban settings, more** babies in urban areas live in crowded housing (16.6 percent) than babies in rural areas (12.1 percent). Significant differences were present in 14 states, with the largest differences between urban and rural crowding found in Alaska. Depending on the state, crowded housing could be higher in rural areas. For example, 14.2 percent of Alaska's babies in urban areas live in crowded housing compared to 39.7 percent in the state's rural areas.

Policy Spotlight

PAID FAMILY AND MEDICAL LEAVE: Nine states have enacted state Paid Family and Medical Leave (PFML) policies. This is welcome news for families in these states as the majority of Americans still lack access to PFML policies even though research has indicated that comprehensive PFML policies are strongly associated with reduced infant and post-neonatal mortality rates,[xlv] and improved health outcomes for children and caregivers.[xlvi] Researchers conservatively estimate that providing 12 weeks of job-protected paid leave in the U.S. would result in nearly 600 fewer infant and post-neonatal deaths per year.[xlvii] Time at home with newborns, infants, and toddlers gives parents the time they need to breastfeed, attend well-child medical visits, and ensure that their children receive all necessary immunizations,[xlviii] and may have long-term benefits for children's health. California's statewide paid family leave program, in effect since 2004, is associated with improved health outcomes for children in early elementary school, including reduced issues with maintaining a healthy weight, Attention Deficit Hyperactivity Disorder and hearing-related problems, particularly for less-advantaged children, likely because of reduced prenatal stress, increased breastfeeding, and increased parental care during infancy.[xlix]

In California, about 12.3 million claims have been paid since 2004.[l] In recent years, nearly one third of claims were for family caregiving or child bonding, whereas the other two thirds were for personal medical reasons. About 5 percent of covered workers use the program each year.[15] In 2017, approximately 1.4 percent of the covered workforce made a PFL claim and 3.6 percent a TDI claim.[li] Men have filed a growing share of bonding and caregiving claims over time. Since implementation, the program has been expanded multiple times—to broaden the range of family members for whom caregiving leave can be taken, to increase benefit levels for lower- and middle-wage workers, and to make more workers eligible for job protection when they take parental leave.[lii]

15 Estimate based on the total number of Temporary Disability Insurance (TDI) and Paid Family Leave (PFL) claims approved annually as a share of the annual average size of the workforce covered by the state plan each year.

CRADLING EQUITY

Early Childhood Court in Broward County, Florida: Using the Infant-Toddler Court Program's Race Equity Assessment Tool to advance equity.

A family court in Broward County, Florida, is undertaking a focused effort to advance equity and address disparities in the community's child welfare system. Florida's Early Childhood Court emerged in 2014 and is part of the national Infant-Toddler Court Program (ITCP) using ZERO TO THREE's Safe Babies Court Team™ (SBCT) approach. The Early Childhood Court addresses child welfare cases involving children under age 3 and is a problem-solving court where legal, societal, and individual problems intersect. Driven by an examination of data on young children and families, the Early Childhood Court is using the ITCP's Race Equity Assessment Tool to create shared awareness and concrete strategies to improve services and outcomes for babies and toddlers of color.

Almost half of the children served by the ITCP across the country are children of color.[xli] That means the odds of achieving reunification and ensuring well-being are immediately stacked against them. Research shows that children of color—especially Native American and African American

(non-Hispanic)—are disproportionately represented at all levels of the child welfare system and, once involved, experience disparate treatment and outcomes.[xlii] At the center of the ITCP is a commitment to social justice and equity, with an intentional focus on equity strengthened by the core components of the SBCT approach. The program's approach supports system-level change that promotes positive outcomes for children of color. Recent evaluations show no difference in program outcomes based on race and ethnicity. ITCP sites are in a unique position to advance equity, bringing together many key community stakeholders. Each court team is made up of judges, community coordinators, child welfare representatives, early intervention representatives, and other staff who work directly with the families and children, guided by a set of guiding principles and core components.[xliii]

The ECC in Broward County is zeroing in on addressing disparities within the child welfare system using the ITCP's Race Equity Assessment Tool. The tool's first step is to "Get the Big Picture" by developing a shared awareness of the disproportionate representation and outcome disparities for children of color.[xliv] One aspect of that process is participation of ECC members and other court staff in shared training. This includes locally provided training on the history of inequity and the effect of structural and institutional racism on children, families, and systems as well as training to increase worker understanding and history of implicit biases and how they affect practices in child welfare today. The ECC is working with the Center for the Study on Social Policy, an ITCP partner, to gather and analyze their own data, child welfare data, and community data—beginning the second step in the Race Equity Assessment Tool.

The next steps in the tool require iterative work to "Lay the Foundation" and "Build the Structure" with further work to engage key partners, identify priority areas, and develop concrete strategies to address disparities within the County's child welfare system. "Laying the Foundation" requires sites to acquire and review local data about the community and the population served to better examine child welfare practice in the community. The court teams also collect data for the infants and toddlers they serve, disaggregated by race. Closely examining these data helps the court team begin to see whether, and in what ways the SBCT approach is advancing equity in their community. Sharing data across systems is critical as well, including child welfare agency data allowing insight to the experiences of young children being served outside of the SBCT approach. By developing and implementing strategies to address disparities, the ITCP is taking steps to improve outcomes of healthy development and well-being for infants and toddlers of color. In order to "Build the Structure," Court Teams must identify champions to lead and support the work and ensure regular and ongoing review of data and strategies to advance equity. Additionally, court team members should ask questions and think critically about the effect of proposed actions on children and families of color in particular.

Broward County's work to address inequities in the child welfare system in the ECC is ongoing.

Positive Early Learning Experiences

Infants and toddlers learn through play, active exploration of their environment, and, most importantly, through interactions with the significant adults in their lives. The quality of babies' early learning experiences has a lasting effect on their preparedness for lifelong learning and success. Overall, as a nation we are not emphasizing the ways early development is supported—through strong relationships and interactions with trusted adults—or the importance of monitoring and providing services to ensure their foundational development is on track. For example, fewer than half of babies are read to every day, suggesting that parents do not realize that very young children benefit from reading as well as talking and singing. Less than a third receive developmental screening. Only a handful of babies and toddlers benefit from Early Head Start's comprehensive support for parenting and early development. Finally, the vast majority of states set minimum quality requirements for infant-toddler child care too low to ensure babies have the opportunities for one-on-one interactions with skilled caregivers they need to grow socially, emotionally, and cognitively.

What Research Tells Us

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.[liii] 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.[liv] 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.[lv]

Second only to the early learning experience within the immediate family, child care is the context in which early childhood development most frequently unfolds, starting in infancy.[lvi]

Parents of children under age 3 are more likely to use informal child care (provided by friends, family, or neighbors) than formal child care.[16] The federal Early Head Start (EHS) program was created to help minimize the disparities caused by poverty by supporting the healthy development of expectant mothers and low-income infants and toddlers. However, only 7 percent of babies and toddlers who are eligible for Early Head Start are currently being served.

Early identification of developmental delays and intervention are critical during the rapid growth of babies in the first 3 years. 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.[lvii] For this reason, the American Academy of Pediatrics recommends that before their third birthday children receive developmental screening from their physicians at least three times.

16 American Academy of Pediatrics. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. *PEDIATRICS* 2006;118:405–420.

Subdomain	Indicator	Description	2019 *Yearbook*	2020 *Yearbook*
Early Care and Education Opportunities	Parent reads to baby every day	Percent of parents who report reading to their infants/toddlers every day[a]	38.2%	37.8%
	Parent sings to baby every day	Percent of parents who report singing songs or telling stories to their infants/toddlers every day[a]	56.4%	57.6%
	% income-eligible infants/toddlers with Early Head Start access	Percent of infants/toddlers below 100 percent of the FPL with access to Early Head Start	7.0%	7.0%
	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
	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
	Families above 200 percent of FPL eligible for child care subsidy	Income eligibility level for child care subsidy above 200 percent of the FPL	12 states	13 states
	Low/moderate income infants/toddlers in CCDF-funded care	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	4.2%	4.2%
	Allocated CCDBG funds	State allocated new Child Care and Development Block Grant (CCDBG) funds to invest in infant-toddler care	--	34 states
Child Care Quality	Group size	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, six states for two age groups, one for three age groups)
	Adult/child ratio	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, two states for three age groups)

Subdomain	Indicator	Description	2019 *Yearbook*	2020 *Yearbook*
Child Care Quality	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; Child Development Associate (CDA) or state equivalent; Specific infant/toddler credential or CDA with infant/toddler credential; associate's degree; bachelor's degree (value 3-15)	--	Six states—CDA/state equivalent (45 states—No credential beyond high school)
	Infant/toddler professional credential	State has adopted an infant/toddler credential	--	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
Early Intervention and Prevention Services	Developmental Screening	Percent of infants/toddlers, ages 9 through 35 months, who received a developmental screening using a parent-completed tool in the past year	30.4%	31.1%
	Delay	Percent of infants/toddlers with moderate/severe developmental delay[a,b]	1.1%	1.0%
	At-risk children included in Part C eligibility definition	State includes "at-risk" children as eligible for Individuals with Disabilities Education Act (IDEA) Part C services	--	2 states
	Percent of infants/toddlers receiving IDEA Part C services	Percent of infants/toddlers receiving IDEA Part C services	3.1%	9.7%[17]
	Timeliness of Part C services	Percent of eligible infants and toddlers required to have an initial Individualized Family Service Plan (IFSP) meeting who had the meeting within 45 days	--	Not available at national level

New indicator in 2020

NOTES: [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 Yearbook. For a more detailed discussion, see the indicators and methodological appendices.

[b] 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 State of Babies Yearbook: 2019.

17 For 2020 calculation, cumulative count for most recent 12-month period used, whereas snapshot used for 2019.

37.8%

of infants and toddlers are read to every day.

Despite the importance of the early learning that takes place at home, surprisingly few parents report engaging in daily reading or singing with their babies, interactions that are closely related to children's language development. These low rates of language interaction, particularly for reading, suggest that many parents and other caregivers may not understand that children begin acquiring language skills from birth and are not too young to enjoy books with those who nurture them.

- **Nationally, only 37.8 percent of infants and toddlers are read to every day,** with state averages ranging from a low of 28.2 percent in California to a high of 59.4 percent in Vermont.

- **Parents talked and sang to their young children at a higher rate (57.6 percent)** than seen for reading. State averages ranged from 47.2 percent in Mississippi to 70.8 percent in Vermont.

The extent to which states support families in accessing and affording early care and learning opportunities varies significantly by state. Low-income children particularly can benefit from high-quality early care and learning opportunities, but they are less likely to have access to these programs and care settings.[lviii] Child care costs can take more than one third of a single parent's paycheck in most states. Despite the high cost of infant care, few families receive financial assistance for it.

- **Only 13 states allow child care subsidies for families with incomes above 200 percent of the FPL—**approximately $50,000 for a family of four—and only 4.2 percent of infants and toddlers in low- or moderate-income families (i.e., incomes equal to or below 150 percent of the State Median Income) that feel the pinch of the high cost of care receive subsidies.

- Infants and toddlers in families with incomes below the FPL are eligible for Early Head Start, which provides comprehensive services that promote positive child development. However, as was the case in 2019, **only 7 percent of eligible infants and toddlers have access to Early Head Start services.** Access varies widely across states, ranging from a low of 3 percent in Nevada to 23 percent in the District of Columbia.

Parents who require child care to work or attend school need access to affordable, high-quality options that promote positive development. Recognizing that some components of quality can affect the cost of care, with the result that lower costs for care in a state do not necessarily signal a good value for children, the 2020 *Yearbook* seeks to provide some context by looking at the floor states set for quality through their licensing requirements. The Head Start Program Performance Standards are a benchmark for Early Head Start. The Early Head Start evaluation found that programs implementing these standards early and thoroughly had the broadest pattern of effects for children.[lix] States do not share the same definitions of what constitutes quality care for infants and toddlers, and 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 an adult. New indicators in the 2020 *Yearbook* offer an initial picture of the states' requirements and standards for center-based child care.

- **More states have adult/child ratios that meet or exceed the standards set by Early Head Start (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 [infants] one of the ages, 12 states achieve it for [infants and one-year-olds] two ages, 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 Early Head Start (eight infants or toddlers in a group) for infants than for older babies.** 23 states meet or exceed the requirement for 1 of the ages (infants), 7 states achieve it for 2 ages (infants and toddlers), and only 1 state achieves it for all 3 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 requirementsfall short of with EHS' 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.

Early intervention efforts also differ across states, despite the rapid pace of development babies experience in the first 3 years. New and modified indicators in the 2020 *Yearbook* shed additional light on screening as well as timeliness and receipt of IDEA Part C services.

- Nationally, **only 31.1 percent of infants and toddlers ages 9 through 35 months received a developmental screening in the past year.** The percentage who received a developmental screening ranged widely among states from a low of 16 percent in Florida to as many as 60 percent in Oregon.

- At the time of this *Yearbook*, only **two states include "at-risk" children as eligible for IDEA Part C services**.

Cradling Equity: Positive Early Learning Experiences

Because they are two to three times more likely to be affected by poverty than their White counterparts, parents of color are, on average, less able to afford the high cost of infant and toddler child care, and they are more likely to live in economically disadvantaged communities that lack high-quality early care providers. Options for care are further limited by the fact that women of color with very young children make up more than half of mothers in low-wage jobs (i.e., jobs paying $10.50 or less per hour) that have irregular, unpredictable work schedules and non-traditional hours.[lx] Of mothers with infants and toddlers in low-wage jobs, 21 percent are Black and 30 percent are Hispanic. Combined with the limited availability of child care subsidy funding, the likelihood of lower income levels means parents of color may have fewer options when choosing their preferred setting for care.

Families of color are more likely to use informal child care arrangements provided by relatives or friends and are less likely either by choice or necessity to access formal child care arrangements. Parents' child care decisions, especially concerning infants and toddlers, are very personal and any type of setting—center, family child care home, or informal care—can be high quality. Parents' decisions can also be affected by the care that is available in their neighborhoods. For example, research shows that Hispanic families are overrepresented in "child care deserts," areas with an insufficient supply of licensed child care.[lxi] Research suggests that the receipt of a subsidy may influence parents' decisions to access regulated or licensed care.[lxii] Ironically, eligible Black families nationally have greater than average access to subsidies under CCDF, whereas Hispanic and Asian families have less than average access.[lxiii] The problem is that the subsidy system is woefully underfunded so very few families over all receive any direct assistance in paying for care.

The combined stressors of economic instability and unpredictable work schedules also undermine parents' availability to engage in important early learning experiences at home,[lxiv] such as daily reading and singing, that promote early literacy skills and language development. Although some support systems, such as Early Head Start and Child Care Development Block Grant (CCDBG) funding, are designed to decrease the gap in access to early learning opportunities, the reach of this assistance is limited and varies by race.

Three *Yearbook* indicators in the Positive Early Learning Experiences domain could be analyzed by subgroup—whether a parent Reads Every Day, Sings Every Day to their baby, and whether babies receive Developmental Screening. Reliable subgroup analyses of these indicators could only be completed by income.

Income

- **READS EVERY DAY.** Although the overall rate at which parents read daily to their infants and toddlers is 37.8 percent, **parents above low-income (43.9 percent) are 52 percent more likely than low-income parents (28.9 percent) to report reading to their babies**. Daily reading among low-income parents varied from as low as 14.5 percent in California to 59.1 percent in Vermont. Among parents above low income, reading rates ranged from 29.7 percent in Idaho to 66.6 percent in Maine. The difference between income groups is statistically significant in 12 states, with the largest difference in Connecticut where 59.8 percent of parents above low income read to their babies daily compared to 27.2 percent of low-income parents.

- **SINGS EVERY DAY.** Nationally, 57.6 percent of parents report singing or telling stories to their babies every day, however differences are found by income. **More parents above low-income (62.9 percent) sing/tell stories daily than low-income parents (49.9 percent).** Rates vary widely by state, ranging from 43.6 percent in Mississippi to 75.3 percent among parents above low income; and from 30.2 percent in North Dakota to 74.1 percent in Alaska among low-income parents. In seven states, the differences between income groups were statistically significant (District of Columbia, Georgia, New Mexico, New York, North Dakota, Rhode Island, and Texas). The rates of singing and telling stories in these states are more than 20 percent higher for parents above low income.

- **DEVELOPMENTAL SCREENING.** As few as 31.1 percent of babies have received a developmental screening for potential

developmental delays. **Babies in families above low income (33.9 percent) are 26 percent more likely to have a developmental screening than babies in low-income families (26.9 percent).** The rate of screening among babies in families above low income ranges from 14.8 percent in Mississippi to as high as 66.6 percent in Oregon. Similar variation is found across states for babies in low-income families, ranging from as few as 8.9 percent screened in Missouri to 52.5 percent in Oregon. Differences between income groups were substantive within six states (Alabama, Colorado, Delaware, Idaho, Iowa, and Missouri). The rates of screening in these states are more than 20 percent higher for babies in families above low income.

Policy Spotlight

SPOTLIGHT ON QUALITY EARLY CARE AND LEARNING: At the time of the 2020 *Yearbook*, 13 states set their income eligibility levels for child care subsidies—child care assistance for low-income families—above 200 percent of the Federal Poverty Level. Families with low and moderate income who have infants and toddlers rely on child care assistance in order to afford safe, stable, high-quality child care that promotes children's development and caregivers' education, training, and work. Investments in comprehensive early education, 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.[lxv] 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.[lxvi] However, the cost burden of child care remains high for many families across our nation, with only 4.2 percent of infants and toddlers in families with low or moderate income receiving child care subsidies. Moreover, because of chronically low levels of investment in child care, receiving care for infants and toddlers is often at the lower rungs of the quality ladder, despite being unaffordable for many families. According to national studies, the majority of infants and toddlers are in poor to mediocre care,[lxvii] and more recent state studies show that this trend continues.[lxviii] However, intentional investments can make a difference, moving infant-toddler care up to higher levels of quality.[lxix]

For infants and toddlers living in families with the lowest income levels, lessons about the benefits of comprehensive early childhood services have not gone unheeded. In 1994, **Early Head Start,** based on some of the same strong research cited previously, became the only federal program dedicated to comprehensively promoting healthy child and family development for pregnant women, infants, and toddlers living in families with incomes below the FPL. This focus acknowledges both the importance of the first 3 years in establishing the foundation for future development and the greater likelihood that young children in overburdened and under-resourced families will fall behind, starting in infancy and even before.[lxx] A rigorous evaluation demonstrated real, positive changes for children and families who participated in Early Head Start, reaffirming the value of focusing on the parent-child relationship. Since the creation of EHS, research on early brain development has found that poverty can affect brain development and growth in key areas, an effect mitigated by strong parental relationships.[lxxi] Yet, despite this research and the fact that babies and toddlers are the age group most likely to live in poverty, EHS is able to serve only 7 percent of eligible families with current funding.

CRADLING EQUITY

Connecticut's Early Childhood Consultation Partnership: Using early childhood mental health consultation to improve equitable outcomes for the youngest learners.

Connecticut's Early Childhood Consultation Partnership (ECCP) was spurred by the need to address suspensions and expulsions of the state's youngest learners, which historically affect young children of color more often than their White peers.[lxxii] ECCP uses early childhood mental health (IECMH) consultation to create more equitable outcomes for infants, toddlers, and preschoolers in public and private child care settings. This nationally recognized program builds the capacity of families, caregivers, and systems to meet the social-emotional and behavioral health needs of infants, toddlers, and preschoolers to promote enduring and optimal outcomes for young children. ECCP is funded by the state's Department of Children and Families (DCF), and administered by Advanced Behavioral Health, Inc.

An evidence-based, best practice program backed by three randomized control trials, ECCP provides IECMH prevention and intervention services to children who are at risk for suspension or expulsion from early care and education settings because of behavioral and mental health concerns. ECCP links mental health services to child care programs, foster care, kinship care homes, substance abuse residential facilities, and community resource centers.[lxxiii] Research shows child outcomes associated with the state's ECCP program include: a decrease in child externalizing

(continued)

behaviors (such as inattention, hyperactivity, impulsivity, and aggression),[lxxiv] an increase in child prosocial behavior (such as social skills, cooperation, and self-control)[lxxv], mixed results in child internalizing behaviors (such as withdrawn, anxious, or sad), and a significant reduction in expulsions.[lxxvi]

Research in the early 2000s brought to light that preschool children were being expelled at three times the rate of children in kindergarten through 12th grade.[lxxvii] Importantly, the majority of young children being expelled were Black boys.[lxxviii] Further, researchers found that Black and Hispanic boys, beginning at a very young age, are more frequently suspended and expelled from early childhood programs than other children.[lxxix] Although Connecticut, like other states, passed a law in 2015 severely limiting expulsion and/or removal of the state's youngest learners, the practice continues. Access to positive early learning experiences already is particularly challenging for young children of color. Because they are more likely to be affected by poverty, parents of color are, on average, less likely to afford the high cost of high-quality child care and more likely to live in economically disadvantaged communities that lack high-quality child care options.[lxxx] These stressors undermine parents' availability to engage in early learning experiences at home[lxxxi] that can bolster young children's development. Further excluding children of color from overburdened and under-resourced families from positive early learning experiences loses the opportunity to change the very trajectory of their lives.

To best provide quality services to Connecticut's youngest learners and their caregivers, ECCP works effectively and purposefully across state systems. ECCP partners with the state's Departments of Children and Families as the core funder; Education through the alignment with the Social and Emotional Domains of Connecticut's Early Learning Standards; Social Services as a member of the Emergency Preparedness Early Childhood subcommittee; Public Health by working within and supporting child care centers; and the Office of Early Childhood which houses many key partners. A centralized information system guides the ECCP work and supports quality assurance and continuous quality improvement efforts. Each staff member participates in a 3-month intensive training that includes training on implicit bias. ECCP also uses staff meetings as a time to embed bias and racism into conversation and training to keep the topic top of mind.

Policies and Progress in the State of Babies

Drawing Core Policies From Building Strong Foundations

In refining the policy-related indicators for the *State of Babies Yearbook: 2020*, we looked to the framework of core policies ZERO TO THREE and the Center for Law and Social Policy (CLASP) created in the *Building Strong Foundations: Advancing Comprehensive Policies for Infants, Toddlers, and Families* project. That framework includes four principles encompassing 13 core policy areas that describe the needs of infants and toddlers and their families based on a large body of developmental research. The principles correspond with the ZERO TO THREE policy domains—Good Health, Strong Families, Positive Early Learning Experiences—used in the *State of*

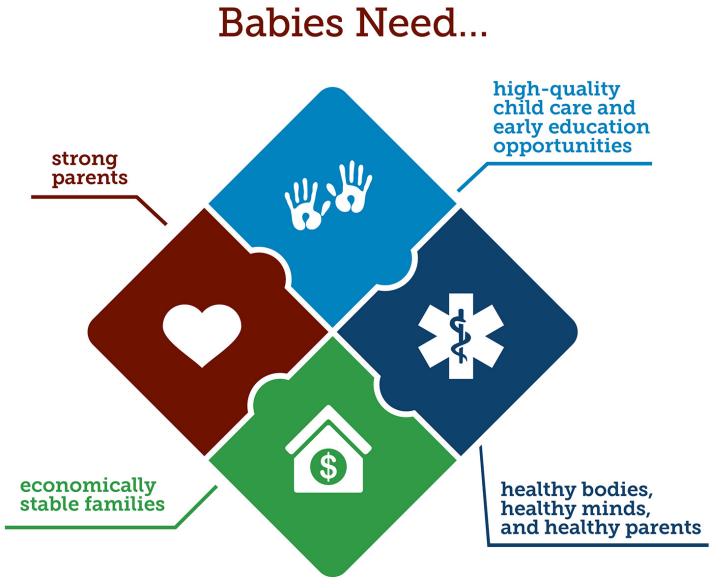
Babies Yearbook: 2020, with Strong Families representing two of the principles in *Building Strong Foundations*. Papers on each of the core policies with supporting research may be found on the *Building Strong Foundations* webpage, along with other materials including the rationale for investing in programs that support children's development in the earliest years and a brief exploring racial inequities in policies that affect babies and families.

The matrix [on the follow page] crosswalks the 13 core policy areas with the *State of Babies Yearbook: 2020* indicators, showing the presence or absence of policies in that area, the reach of current policies, or the need for policies to address a concerning condition. Only one area, access for parents to affordable education and training, was out of the scope of the 2020 *Yearbook*, although we will continue to explore ways to capture key policies. In other areas, *Yearbook* indicators reveal areas of concern that need addressing through policies, but determining the extent to which they are on states' radar screens would likely necessitate collecting data directly from states. Three such areas include:

- Housing support for families with children: Funding for rental and other assistance comes largely from the federal government, but local housing authorities interact with families and state policy initiatives have been very small.

- Parent support services and resources: Although the *State of Babies Yearbook: 2020* reports data on the reach of evidence-based home visiting services, this program approach is only part of a systems approach to supporting parents in nurturing their children's development. Primary-care based parenting supports, Family Resource Centers, and WIC sites are all mechanisms that deliver these services. In addition, some communities are working to build in widespread approaches, such as universal access to newborn home visits and developmental specialists embedded in pediatric practices across the community. The presence and reach of such efforts as well as their adoption in state policies would require outreach to state agencies.

- Child welfare policies that use a developmentally appropriate approach to services for infants and toddlers: ZERO TO THREE surveys of state policies show few states use a developmental lens to address the needs of infants, toddlers, and families entering the child welfare system, with little change between 2013 and 2019.[lxxxii] Future *State of Babies Yearbook* work could survey states on a small number of key policies, supplemented by state prevention plans in response to the Families First Prevention Services Act.



BUILDING STRONG FOUNDATIONS CORE POLICY	*STATE OF BABIES* INDICATORS
Healthy bodies, healthy minds, and healthy parents.	**Good Health**
• Low-income infants, toddlers, parents, and pregnant women should have quality, affordable, publicly financed health insurance.	• Medicaid Expansion • Medicaid eligibility for pregnant women • Uninsured low-income infants and toddlers*
• Infants, toddlers, parents, and pregnant women should receive appropriate health screenings, preventative primary care, and medically necessary treatment services.	• Late or no prenatal care* • Medicaid Expansion • State Medicaid policy requires, recommends, or allows maternal depression screenings during well-child visits • Medicaid eligibility for pregnant women • Infants/toddlers, ages 9-35 months, receiving developmental screening using a parent-completed tool in the past year* • Infants/toddlers with preventive medical visits* • Infants/toddlers with preventive dental care*
• Infants, toddlers, and parents should receive appropriate screening, diagnosis, and treatment services to meet their mental health needs.	• State Medicaid plan covers social-emotional screening for young children • IECMH services at home • IECMH services in medical settings • IECMH services in ECE settings
• Low-income families with infants and toddlers and pregnant women should have access to nutrition support programs.	• Percent of eligible infants who participated in WIC*
Economically stable families	**Strong Families**
• Low-income parents of infants and toddlers should have access to affordable education and training to improve their employment opportunities.	• Not addressed in the *State of Babies Yearbook: 2020*
• Families in poverty with infants and toddlers should get cash assistance and refundable tax credits to supplement their earnings.	• Families with infants/toddlers living below 100 percent of the FPL that receive TANF benefits* • State has Child Tax Credit • State has Earned Income Tax Credit

* Indicator shows the reach of or the need for a policy in this area.

Economically stable families	Strong Families
• Parents with infants and toddlers should have *paid sick leave* 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 *paid family and medical leave* when a child is born, adopted, or newly fostered, and to be able to provide care should their child become ill.	• State requires employers to provide paid sick days that cover care for child • State has a paid family and medical leave program
• Low-income families with infants and toddlers should have affordable, safe, and stable housing.	• Infants/toddlers who have moved three or more times since birth* • Infants/toddlers who live in crowded housing*
Strong Parents	**Strong Families**
• Families of infants and toddlers should have access to a continuum of parent support services and resources to support their child's development.	• Potential home visiting beneficiaries served* • State has a paid family and medical leave program
• Infants and toddlers in the child welfare system should receive developmentally appropriate support, responsive to the needs of the child and family.	• Maltreatment rate per 1,000 infants/toddlers* • Infants/toddlers who spent 1 year or more in out-of-home placement*
High-quality child care and early learning opportunities	**Positive Early Learning Experiences**
• 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.	• Families above 200 percent of FPL eligible for child care subsidy • Low-/moderate-income infants/toddlers in CCDF-funded care* • Regulations for infants and toddlers on group size, adult/child ratios, and teacher qualifications • State has infant-toddler professional credential • Allocation of CCDBG funds • State reimbursement of CCDF funded center-based care
• Vulnerable infants, toddlers, pregnant women, and families should have access to comprehensive early childhood services through Early Head Start.	• Infants/toddlers below 100 percent of the FPL with access to Early Head Start*
• Infants and toddlers with developmental delays or disabilities should be identified and receive early intervention services in a timely manner.	• At-risk children included in Part C eligibility definition • Infants/toddlers receiving IDEA Part C services* • Timeliness of Part C services*

* Indicator shows the reach of or the need for a policy in this area.

Progress for Young Children and Families Over the Past Year

State and federal policies that affect young children and their families interact, so policy levers may lie in different places. Many state policies are implementing federal policies that provide funding and guidelines, but sometimes states lead the way in enacting policies that support families. States usually have latitude in how large federal programs such as Medicaid or the Child Care and Development Block Grant (CCDBG) are administered, even if state choices are affected by federal funding levels. In some cases, the reach of a program such as Early Head Start is dependent on federal funding; yet states can make decisions about adding their own

investments as they see the small proportion of eligible babies and toddlers that are served. In some areas, smaller federal grants help seed promising approaches, fill gaps not met through large funding streams, or promote systems building that creates a better continuum of services for families while using resources more efficiently. In other areas, such as paid family and medical leave, states lead the way, helping to tip the scale so federal policy catches up.

Examples of areas where these various levers have been at work in the year since *State of Babies Yearbook: 2020* include:

PAID FAMILY AND MEDICAL LEAVE

Although the federal government has a national unpaid leave policy, the Family and Medical Leave Act, the United States lags far behind other industrialized nations in a paid leave policy that would give families job-protected paid leave for the birth or adoption of a child, and for caring for themselves or another family member with a serious illness.

STATE PROGRESS: Family leave policy is an area where states are leading. Since the 2019 *Yearbook*, two more states have enacted paid leave policies, bringing the total to nine.

FEDERAL DEVELOPMENTS: Congressional attention to paid family and medical leave continued to build throughout 2019 on both sides of the aisle, culminating with a December win as Congress passed paid parental leave for most federal employees. The Senate Finance Committee established a bipartisan working group to consider federal paid family leave policy. Several paid leave or loan proposals for families are currently on the table. The most comprehensive proposal, the Family and Medical Insurance Leave (FAMILY) Act, topped 200 cosponsors in the House of Representatives with bipartisan support.

MEDICAID

Medicaid, together with the Children's Health Insurance Program, covers about 45 percent of children under 6 and almost three quarters of young children living in or near poverty.[lxxxiii] States determine who they will cover and the types of services that may be reimbursed, although all states must provide the comprehensive approach of the Early and Periodic Screening, Diagnostic, and Treatment benefit. These health programs are a gateway for a range of critical health and developmental services that can help mitigate the effect of adverse experiences and chronic, unrelenting stress. Medicaid Expansion, where 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.[lxxxiv]

States determine who they will cover and the types of services that may be reimbursed.

STATE PROGRESS: States choosing the Medicaid Expansion option to cover more low-income adults increased from 34 to 37. The picture of mental health coverage for mothers and babies also is encouraging. States with provisions relating to maternal depression screening during well-child visits now stands at 37. Almost all states cover services related to infant and early childhood mental health: 43 now cover social-emotional screening for children age 6 and under using a special screening tool, 49 cover infant-early childhood mental health services in the child's home, and 46 cover such services in primary care or early care and learning settings.

FEDERAL DEVELOPMENTS: The Administration has issued guidance allowing states to apply to use funds for the Medicaid Expansion population in a block grant that would cap the amount of federal funds available, likely resulting in reduced numbers of people receiving coverage.

CHILD CARE AND DEVELOPMENT BLOCK GRANT

The Child Care and Development Block Grant (CCDBG) is the major source of child care subsidies for low-income families, setting overall 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). Three percent of CCDF funds must be used to improve the quality of services for infants and toddlers.

STATE PROGRESS: CCDBG had struggled with stagnant funding for more than 15 years when, in Fiscal Year 2018, Congress passed an historic $2.4 billion increase. 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.[lxxxv]

FEDERAL DEVELOPMENTS: Congress continued to build on the historic FY 2018 increase with a modest increase of $50 million in FY2019 and a more robust increase of $550 million in FY2020.

Early Head Start can be a model for states seeking to address the needs of babies and families facing the most challenges.

EARLY HEAD START

Early Head Start (EHS) is the only federal program dedicated to comprehensively promoting healthy child and family development for pregnant women, infants, and toddlers living in families with incomes below the poverty line. Although its grants generally flow directly to local communities, EHS can be a model for states seeking to address the needs of babies and families facing the most challenges. In recent years, federal funds have been set aside expressly for expanding EHS, including through Early Head Start-Child Care Partnerships that in some instances have been awarded directly to states to help infuse quality into child care programs and influence state policies. 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.[lxxxvi]

FEDERAL DEVELOPMENTS: The FY2020 appropriations bill included an increase of $100 million for Early Head Start expansion, continuing the effort over the last 6 years to pump $850 million directly into expanding this important program for babies and families in poverty. A Head Start and Early Head Start funding increase of $550 million (of which $100 million is set aside to expand Early Head Start, including through EHS-Child Care Partnerships) will allow for more children to be reached by EHS—an essential support for pregnant women, infants, and toddlers.

34 states

planned to allocate more CCDBG funding for quality improvement activities related to infants and toddlers.

Creating a Roadmap for the *State of Babies Yearbook*

The indicators in *State of Babies Yearbook: 2020* are the next step in a process to reach the set of data points providing the picture of America's babies 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* enhances the state profiles with new indicators of both child well-being and policy as well as an added dimension of select indicators disaggregated by subgroups related to race/ethnicity, income, and urban/rural location. To provide continuity for states in cross-country comparisons while we go through this multiyear refinement process, *State of Babies* will hold constant the indicators that are the basis for states' tier determinations.

We hope states will 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 additional indicators and disaggregation by subgroup 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.

As became clear when ZERO TO THREE and Child Trends embarked on this initiative 2 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. As noted in the *State of Babies Yearbook: 2019*, we intended in year two to refine the indicators and expand the policies tracked.

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 roadmap to reach a more stable set of indicators.

THE STATE OF BABIES ROADMAP

We continue to explore 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. Our current plan for each year is outlined in this roadmap.

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.

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.

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. Although there are many measures we might have included in each of these domains, in the 2020 *Yearbook*, as we did for 2019, 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 and the District of Columbia.
- 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 56 indicators address the following topics, by domain and subdomain:

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
 **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

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. Panelists also provided feedback on our approach to ranking states.

As new data become available, we will continue to refine indicators and consider incorporating additional indicators. For the second edition of the report, we have added more than a dozen additional policy indicators. See Appendix C for a list of changes to indicators between the two reports, and the full list of indicators.

Note that many of the indicators here are interrelated 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.

Based on our experience in 2019, we went back to some data sources and identified new possibilities to add more descriptive data elements or fill gaps in the data picture. For example, because childhood obesity is a major public health problem, we added data on infants and toddlers in families receiving Supplemental Nutrition for Women, Infants, and Children (WIC). Even though those families are a subset of the population as a whole, recent research shows that WIC has a positive role in reducing childhood obesity. We determined that tracking the indicators for weight compared with length, as well as the reach of the WIC program, would promote this beneficial policy. In another example, we were concerned about the extreme difficulty of obtaining data on child care quality. We added indicators of the quality floor set by state child care licensing for centers through licensing compared with the Early Head Start standards to start a deeper look at how states compare to benchmarks of quality.

To round out 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.

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 above, the *State of Babies Yearbook: 2019* is a starting place and we intend to continue to refine indicators in future editions and consider creative ways to measure state policies.

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.

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:[18]

Score (Rescaled Value) =

[(Observed Value – Lowest Value) / (Highest Value – Lowest Value)] X 100

For indicators (such as low birthweight or poverty) where higher scores mark less desirable outcomes, we adjust the directionality before calculating the score, so higher scores consistently mark more desirable outcomes, whereas lower scores are less desirable. For example, the percentage of births with low birthweight was changed to the 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 (such as, 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.

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.

18 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.

ASSIGNING STATES TO TIERS

Once the state-level data for each indicator were rescaled to scores ranging from 0 to 100, we divided the rescaled 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. Because 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.

Giving advocates the tools to connect data to policy

For advocates, program administrators, and legislators to act effectively, they require basic information about the infants and toddlers in their state, starting with the size of this population, where infants and toddlers are being cared for, and the economic circumstances of their families. Assessing current policies and practices is also important to inform new policy decisions. National and state profiles in the *Yearbook* present a snapshot of how the nation's babies—particularly those who begin life exposed to selected risk factors—are faring in the domains essential for a good start in life: Good Health, Strong Families, and Positive Early Learning Experiences.

The *State of Babies Yearbook: 2020* is a tool to help advocates and policymakers:

1. "Tell the story" of infants and toddlers in their states and nationally.
2. Compare their state's progress for infants and toddlers with that of other states, using a common set of indicators.
3. Identify indicators on which babies and toddlers are lagging, so states can work on responsive policy.
4. Use annual updates to monitor trends in the experiences of infants, toddlers, and their families, and track progress in the states' policies.

State policymakers and advocates can use the data to understand where their youngest children are doing well, and where they face challenges. New disaggregated data in the *State of Babies Yearbook: 2020* allows stakeholders *to* recognize disparities, take concrete steps to reform policies, and invest in communities where resources are unequal. Improving outcomes for young children can be achieved by building on the strengths of existing practices and taking innovative steps where the data indicate challenges still exist, as shown below.

IN THE SHORT TERM

Communicate: Use indicator data and state rankings to communicate how a state compares to the nation and other states.

Identify challenges: Use indicator data to identify opportunities where potentially easy interventions could produce measurable and compelling results.

Strengthen support for current initiatives: Use state profile information to bolster the rationale for programmatic, policy, and legislative changes.

IN THE LONG TERM

Track progress: Monitor changes to key indicators, and track policy wins with annual updates of the *State of Babies Yearbook.*

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 do 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.

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** (Link) allows groups to take the first steps in analyzing the data in the State Profiles.

- **Infants and Toddlers in the Policy Picture: A Self-Assessment Toolkit for States** (www.zerotothree.org/selfassessmenttoolkit) is a comprehensive guide for examining the current status of services for infants, toddlers, and their families, and for setting systemwide priorities for improvement.

- The ***State of Babies Yearbook: 2020*** **Toolkit** (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.

Additionally, 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
- Innovation in Cross-System Collaboration to Better Support Babies
- Planting Seeds in Fertile Ground: Steps Every Policymaker Should Take to Advance Infant and Early Childhood Mental Health
- Advancing State Policies for Infants and Toddlers: Lessons Learned From Three States

In addition, the ZERO TO THREE State Initiatives Database (https://www.zerotothree.org/resources/states) is a collection of articles highlighting 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 age 0 to age 3. 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.

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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	(ID, LA, OK, SD) – 380 (IA)	24 states > 200 percent
	State adopted Medicaid expansion under the Affordable Care Act	37 states	--	--
	Percentage of low-income infants/toddlers who are uninsured	5.4 percent	0.6 percent (VT) – 15.5 percent (ND)	4 states > 10 percent
Food Security	Percent of households with infants/toddlers experiencing low or very low food security	15.9 percent	5.0 percent (KS) – 32.9 percent (AR)	14 states > 20 percent
Nutrition	Percentage of infants ever breastfed	82.9 percent	60.5 percent (MS) – 92.4 percent (AK)	14 states < 80 percent
	Percentage of infants breastfed at 6 months	54.6 percent	31.8 percent (MS) – 72.2 percent (OR)	13 states < 50 percent
	Percent of eligible infants who participated in WIC	85.9 percent	53.9 percent (UT) – 100 percent (DC, MD, OH, RI)	18 states < 80 percent
	Percent of WIC recipients ages 3–23 months who have high weight-for-length	Not available at national level	6.1 percent (CO) – 18.2 percent (SD)	8 states < 10 percent
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 percent	1.7 percent (RI) – 11.3 percent (NM)	2 states > 10 percent
	State Medicaid policy requires, recommends, or allows maternal depression screenings during well-child visits	37 states	--	--
Maternal Health	Percent of mothers of infants/ toddlers rating their mental health as worse than "excellent" or "very good"	19.8 percent	9.6 percent (DC) – 33.3 percent (KY)	17 states < 20 percent

GOOD HEALTH

Subdomain	Indicator	National Average/ Policy Count	Range	Summary
Child Health	Deaths per 1,000 live births	5.8	3.7 (MA) – 8.5 (MS)	12 states > 7
	Percent of babies with low birthweight	8.3 percent	5.9 percent (AK) – 12.1 percent (MS)	4 states > 10 percent
	Percent of babies born preterm	10.0 percent	7.8 percent (OR) – 14.2 percent (MS)	22 states > 10 percent
	Percent of infants/toddlers who had a preventive medical visit in the past year	91.1 percent	85.4 percent (NM) – 96.8 percent (ME, OR)	17 states < 90 percent
	Percent of infants/toddlers who had a preventive dental visit in the past year	31.9 percent	18.4 percent (IL) – 48.6 percent (WA)	10 states < 25 percent
	Percentage of infants/toddlers receiving the recommended doses of DTaP, polio, MMR, Hib, HepB, varicella, and PCV vaccines by ages 19 through 35 months	70.4 percent	65.6 percent (GA) – 82.1 percent (MA)	22 states < 70 percent
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	Percent of families with infants/ toddlers living below 100% of the federal poverty line (FPL) that receive TANF benefits	21.7%	2.7% (ID) – 88.2% (DC)	42 states < 33%
	Percent of infants/toddlers who have moved three or more times since birth	2.7%	Less than 1% (DE, CT) – 9.2% (NM)	12 states > 5%
	Percent of infants/toddlers who live in crowded housing	15.5%	5.6% (WV) – 28.4% (CA)	36 states > 10%
Child Welfare	Percentage of infants/toddlers living in unsafe neighborhoods, as reported by parents	5.8%	0.5% (GA) – 12.8% (OK)	5 states > 10%
	Percentage of families with infants/toddlers who report "family resilience"	85.2%	77.1% (VA) – 91.8% (IN)	46 states > 80%
	Percent of infants/toddlers who have experienced one adverse childhood experience	22.4%	13.5% (ME) – 31.1% (OK)	31 states > 20%
	Percent of infants/toddlers who have experienced two or more adverse childhood experiences	8.6%	1.2% (MD) – 20.9% (OK)	1 state > 20%
	Maltreatment rate per 1,000 infants/toddlers	15.9	1.96 (PA) – 38.29 (MI)	19 states > 20
	Percent of infants/toddlers who spent 1 year or more in out-of-home placement.	20.2%	4.9% (IL) – 71.1% (NY)	16 states > 25%
	Percentage of infants/toddlers exiting foster care who achieve permanency	98.6%	89.1% (AK) – 100% (DC, DE, IA, NH)	3 states < 95%
Home Visiting	Percent of infants/toddlers who could benefit from evi-dence-based home visiting and are receiving those services	1.9%	0.2% (NV) – 9.9% (MO)	5 states > 5%

STRONG FAMILIES

Subdomain	Indicator	National Average/ Policy Count	Range	Summary
Supportive Policies	State requires employers to provide paid sick days that cover care for child (Y/N)	11 states	--	--
	State has a paid family leave program (Y/N)	9 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	37.8%	28.2% (CA) – 59.4% (VT)	7 states > 50%
	Percent of parents who report singing songs or telling stories to their infants/toddlers every day	57.6%	30.5% (MS) – 70.8% (VT)	48 states > 50%
	Percent of infants/toddlers below 100% of the FPL with access to Early Head Start	7.0%	3% (NV) – 23% (DC)	11 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) – 17.6% (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	24.61% (SD) – 89.1% (DC)	11 states > 50%

POSITIVE EARLY LEARNING EXPERIENCES

Subdomain	Indicator	National Average/ Policy Count	Range	Summary
Early Care and Education Opportunities	Income eligibility level for child care subsidy above 200% of the FPL	13 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) – 9.7% (VT)	16 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, six states for two age groups, one 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, two 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)	Six 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	1 state	--	--

POSITIVE EARLY LEARNING EXPERIENCES

Subdomain	Indicator	National Average/ Policy Count	Range	Summary
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	31.1%	16.0% (FL) – 60.0% (OR)	44 states < 40%
	Percent of infants/toddlers with moderate/severe developmental delay	1.0%	Less than 0.1% (8 states) – 5.6% (IL)	7 states > 2%
	State includes "at-risk" children as eligible for IDEA Part C services	2 states	--	--
	Percent of infants/toddlers receiving IDEA Part C services	9.7%	2.9% (AR) – 28.0% (MA)	32 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)	11 states < 95%

Appendix B. *State of Babies Yearbook: 2020* Indicator Dictionary

GOOD HEALTH

Income cutoff (percentage of the federal poverty line [FPL]) for Medicaid eligibility for pregnant women (as of January 2019)

Caring well for infants and toddlers begins with prenatal care. Medicaid/Children's Health Insurance Program (CHIP) helps lower-income women 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.

The data here reflect Medicaid rules in effect as of January 2019, as reported by the Kaiser Family Foundation.

Source: Kaiser Family Foundation. (2019). *Where are states today? Medicaid and CHIP eligibility levels for children, pregnant women, and adults.* Retrieved from https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/#table2

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. Because children generally require less costly care than adults, expanding the pool of insured residents can bring down medical expenses for everyone. For example, states with expanded Medicaid coverage can offer mental health services (including depression screening treatment) to many more low-income parents. Expanded Medicaid coverage has been shown to improve children's use of preventive care,[1] reduce infant mortality,[2] lower families' out-of-pocket medical expenditures,[3] reduce the amount of their unpaid medical bills,[4] and bring down the poverty rate.[5]

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 as of September 2019. 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. (2019). *Status of state Medicaid expansion decisions: Interactive map*. Retrieved from https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

1 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.

2 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://www.ncbi.nlm.nih.gov/pmc/articles/PMC5844390/.

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

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

5 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

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. Although 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 FPL. 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 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 other and 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 nonmetropolitan 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.

All statistical tests using ACS were conducted using person weights, without replicate weights. Though replicate weights usually increase standard errors, the difference is generally not large enough to alter the significance of coefficients (IPUMS USA, n.d.[6]).

Source: American Community Survey 2016, five-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E., Jose Pacas, J., & Sobek, M. (2019). I*PUMS USA: Version 9.0* [dataset]. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

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.[7] Infants who experience food insecurity are more likely to have insecure attachment relationships, and to perform poorly on tests of cognitive development.[8] For infants and toddlers, even mild levels of food insecurity may result in developmental deficits during this period of rapid brain growth.[9] Screening for food insecurity is easily accomplished within many community settings.

6 IPUMS USA. (n.d.). *Replicate weights in the American Community Survey / Puerto Rican Community Survey*. Retrieved from https://usa.ipums.org/usa/repwt.shtml

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. Retrieved from 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., ... Frank, D. A. (2008). Household food insecurity: Associations with at-risk infant and toddler development. *Pediatrics*, *121*(1), 65–72.

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: Current Population Survey, Food Security Supplement 2017. Flood, S., King, M., Rodgers, R., Ruggles, S., & Warren, J. R. (2017). *Integrated Public Use Microdata Series, Current Population Survey*: Version 6.0 [dataset]. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D030.V6.0

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 mothers. Maternal health benefits include earlier return to pre-pregnancy weight, reduced rates of breast and ovarian cancers, and decreased risk of hip fractures and osteoporosis later in life. Breastfeeding mothers also report higher rates of mother-infant attachment and bonding, feelings of maternal empowerment, and confidence.[10] Experts recommend that babies breastfeed 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 2017. The numerator is the number of that group who were ever breastfed, according to mother's report.

For the percentage of infants breastfed at 6 months, the denominator is the number of toddlers ages 19–35 months in 2017. The numerator is the number of that group who were breastfed for any amount of time at 6 months of age, according to mother's report.

For the *State of Babies Yearbook: 2020,* we calculated data based on the National Immunization Survey, whereas for the *State of Babies Yearbook: 2019,* information was obtained from the CDC Breastfeeding Report Card. For both indicators, the 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 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. *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 2015 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. (2018). *The 2017 National Immunization Survey-Child, Centers for Disease Control and Prevention*. Retrieved from https://www.cdc.gov/vaccines/imz-managers/nis/datasets.html

10 Child Trends DataBank. (2018). *Breastfeeding*. Retrieved from https://www.childtrends.org/indicators/breastfeeding

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 5 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.[11]

This indicator is new for *State of Babies Yearbook: 2020*. The estimates reported are from 2016. Results for U.S. territories are included in the total for the United States. The estimated coverage rates exceed 100 percent for infants in the District of Columbia, Maryland, Ohio, and Rhode Island. This is likely a result of sampling variability in the CPS-ASEC survey data used to estimate the number of eligible 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 (2019). *WIC 2016 eligibility and coverage rates*. Retrieved from https://www.fns.usda.gov/wic/wic-2016-eligibility-and-coverage-rates

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

Although 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.[12] The American Academy of Pediatrics recommends using the weight-for-length growth standards to assess the nutritional status of children younger than 2.[13] These standards have been recognized internationally in efforts to prevent child malnutrition and obesity.[14]

This indicator is new for *State of Babies Yearbook: 2020*. The estimates are from 2016. High weight-for-length is defined as ≥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 (45–110 cm) in the WHO growth standards were excluded. In addition, children with biological 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 non-Hispanic White, non-Hispanic Black, Hispanic, Asian/Pacific Islander, and American Indian/Alaska native.

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* [on-line]. Retrieved from https://www.cdc.gov/nccdphp/dnpao/data-trends-maps/index.html

11 Black, M. M., Cutts, D. B., Frank, D. A., Geppert, J., Skalicky, A., Levenson, S., ... & Meyers, A. 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.

12 Center for Disease Control and Prevention: Division of Nutrition, Physical Activity, and Obesity. Growth Chart Training: Using WHO Growth Charts. Retrieved from: https://www.cdc.gov/nccdphp/dnpao/growthcharts/who/using/assessing_growth.htm

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

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

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.[15] A mother's death is detrimental to the development of the newborn child and poses a great hardship to the affected household.

This indicator is new for *State of Babies Yearbook: 2020.* Data reflect 2015–16. Maternal mortality is reported at the national level only, as the CDC does not recommend comparing state-level estimates.

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.

Source: Petersen, E. E., Davis, N. L., Goodman, D., Cox, S., Syverson, C., Seed, K., ... Barfield, W. (2019). Racial/ethnic disparities in pregnancy-related deaths—United States, 2007–2016. *Morbidity and Mortality Weekly Report*, *68*, 762–765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3

Percentage of women receiving late or no prenatal care

Women 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. Mothers 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.[16] However, it is important that prenatal care starts early, and that the care follows guidelines for frequency and timing, so that medical professionals can respond effectively to specific maternal risk factors.[17]

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 come 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.

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 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 (U.S. DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2018, on CDC WONDER Online Database, September 2019. Retrieved from http://wonder.cdc.gov/natality-expanded-current.html

15 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.

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

17 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), 306–316.

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[18] 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 Healthy Policy's website states that this information is based on state Medicaid websites and direct communication with state Medicaid officials, as of September 2018. These data were not updated for *State of Babies Yearbook: 2020*, as new data were not available.

Source: National Academy for State Health Policy. (2018). *Medicaid fee for service policies for maternal depression screening in a well-child visit* [Interactive Map]. Retrieved from https://healthychild.nashp.org/screening/maternal-depression-screening/#toggle-id-1

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

The links between parental mental health—depression, particularly—and child well-being are well established in research.[19] The negative effects of maternal depression can begin prenatally.[20] 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.[21] Untreated depression in mothers or fathers is also associated with greater risk for delays in cognitive and motor development,[22] child maltreatment,[23] and neglectful parenting practices.[24] Several intervention models are effective in treating parents' depression.[25]

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

18 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

19 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. Retrieved from https://ccf.georgetown.edu/wp-content/uploads/2016/07/Maternal-Depression-4.pdf

20 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.

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

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

23 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. Retrieved from www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/depression_caregivers/depression_caregivers.pdf

24 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.

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

mental/emotional health status as "good," "fair," or "poor." Estimates in the *State of Babies Yearbook: 2020* are based on the 2016–17 combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 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.

This indicator can be disaggregated by household income. NSCH derives household income-to-poverty ratios based on family income. Missing values were imputed by Census, and we use the single imputation version provided in the combined 2016–2017 data file. Households with incomes less than 200 percent of the FPL are classified as low-income. Households with incomes at or above 200 percent of the FPL 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 from www.childhealthdata.org

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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 poor access to prenatal care, violent neighborhoods, or inadequate child supervision. 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).[26]

The Centers for Disease Control and Prevention (CDC) website reports the infant mortality rate as the number of infant deaths per 1,000 live births. The estimates here are for 2017.

This indicator can be disaggregated by mother's race/ethnicity. Subgroup data reflect 2015-17. The included subgroups are non-Hispanic White, non-Hispanic Black, American Indian or Alaska Native, Asian or Pacific Islander, and Hispanics of all races.

Source: Centers for Disease Control and Prevention. (2019). *Infant mortality rates by state* [Interactive Map]. Retrieved September 2019 from 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 from https://www.cdc.gov/nchs/pressroom/states/dc/dc.htm

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 from https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_10_tables-508.pdf

26 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

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.[27] 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; mother's low weight gain during pregnancy, or low pre-pregnancy weight; and mother's stress during pregnancy.[28]

The National Center for Health Statistics defines low birthweight as a weight of less than 2,500 grams, or 5 pounds and 8 ounces. 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 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 (U.S. DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2018, on CDC WONDER On-Line Database, *About natality, 2016–2018 expanded*. Retrieved from http://wonder.cdc.gov/natality-expanded-current.html

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

Preterm births are the second leading cause of death among children younger than 5.[29] The percentage of babies born preterm can be reduced through early intervention with mothers before and after pregnancy. However, the interventions most effective in improving infant survival rates are those that support the mother 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.[30]

This indicator is new for *State of Babies Yearbook: 2020.* 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 mother's race/ethnicity and urbanicity. *Race/ethnicity:* The included subgroups are Non-Hispanic Black, Non-Hispanic White, and Hispanic of all races.

27 Reichman, N. (2005). Low birthweight and school readiness. In school readiness: Closing racial and ethnic gaps. *The Future of Children*, *15*(1), 91–116. Retrieved from https://www.princeton.edu/futureofchildren/publications/docs/15_01_FullJournal.pdf

28 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.

29 World Health Organization. (2015). *WHO recommendations on interventions to improve preterm birth outcomes.*

30 Ibid.

Urbanicity: CDC Wonder classifies each mother 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 (U.S. DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2018, on CDC WONDER On-Line Database, *About natality, 2016–2018 expanded*. Retrieved October 2019 from http://wonder.cdc.gov/natality-expanded-current.html

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Percentage of infants/toddlers who had a preventive medical care visit in the past year (medical/dental)

Preventive medical care (also known as "well-child care") is a critical opportunity to detect a developmental delay or disability, so early treatment can reduce its effect on both the child and family.[31] Well-child visits also allow medical providers to promote behaviors conducive to healthy development, and 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.[32]

For the medical care indicator, 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. For the dental care indicator, the denominator is children ages 1–2, and the numerator is those children who ever had one or more preventive dental visits.

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This indicator can be disaggregated by household income. NSCH derives household income-to-poverty ratios based on family income. Missing values were imputed by Census, and we use the single imputation version provided in the combined 2016-2017 data file. Households with incomes less than 200 percent of the FPL are classified as low-income. Households with incomes at or above 200 percent of the FPL 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 from www.childhealthdata.org

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

32 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.

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 2017. 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.

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. *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 2015 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: Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases. (2018). *Combined 7-vaccine series coverage among children 19-35 months by state, HHS region, and the United States, National Immunization Survey-Child (NIS-Child), 2017*. Retrieved from https://www.cdc.gov/vaccines/imz-managers/coverage/child-vaxview/data-reports/7-series/trend/index.html.

Subgroup source: U.S. Department of Health and Human Services (DHHS), National Center for Immunization and Respiratory Diseases. (2018). *The 2017 National Immunization Survey-Child.* Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/vaccines/imz-managers/nis/datasets.html

State Medicaid plan covers social-emotional screening for young children (from birth 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. 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 designed for the purpose of identifying young children who may need further evaluation for social-emotional and behavioral difficulties. The estimates used here are from 2018.

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)*. Retrieved from http://www.nccp.org/publications/pdf/text_1211.pdf

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. Low-income families 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 (IECMH) services in any of the following settings: home, pediatric/family medicine practices, and early care and education programs.

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)*. Retrieved from http://www.nccp.org/publications/pdf/text_1211.pdf

STRONG FAMILIES

Percentage of families with infants/toddlers living below 100 percent of the FPL that receive TANF benefits

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) besides 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.[33] Families living in poverty with an infant or toddler often are the least likely to have economic security.

The numerator for this indicator is the number of TANF-receiving families whose youngest child was younger than 3 in Fiscal Year 2018. The denominator is the number of families whose youngest child is younger than 3, and have incomes below the FPL, 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

Current Population Survey 2019. Flood, S., King, M., Rodgers, R., Ruggles, S., & Warren, J. R. (2019). *Integrated public use microdata series, current population survey: Version 6.0* [dataset]. Minneapolis, MN: IPUMS. Retrieved from https://doi.org/10.18128/D030.V6.0

33 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

Housing insecurity (percentage of infants/toddlers who have moved three or more times since birth, and percentage of infants/toddlers who live in crowded housing)

The physical environment, and, in particular, housing quality has marked effects on development—perhaps especially so for the youngest children, since they lack independent mobility. In addition, 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. Overcrowded living conditions can also be associated with negative outcomes. In homes where families are crowded, parents may be less responsive to infants and toddlers, and more likely to use punitive discipline.[34] Crowding has also been associated with children's health problems, including respiratory conditions, injuries, and infectious diseases, and with young children's food insecurity.[35]

For the percentage of infants/toddlers who have moved three or more times since birth, the indicator 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.

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This indicator can be disaggregated by household income. NSCH derives household income-to-poverty ratios based on family income. Missing values were imputed by Census, and we use the single imputation version provided in the combined 2016–2017 data file. Households with incomes less than 200 percent of the FPL are classified as low-income. Households with incomes at or above 200 percent of the FPL 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 from www.childhealthdata.org

For the percentage of infants/toddlers who live in crowded housing, the indicator 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 2013–2017.

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

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

35 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.

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 other, and 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.

All statistical tests using ACS were conducted using person weights, without replicate weights. Though replicate weights usually increase standard errors, the difference is generally not large enough to alter the significance of coefficients (IPUMS USA, n.d.[36]).

Source: American Community Survey 2017, five-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Meyer, E., Pacas, J., & Sobek, M. (2019). *IPUMS USA: Version 9.0* [dataset]. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

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.[37] Parents in these neighborhoods may restrict children's opportunities for outdoor play.[38]

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.

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This indicator can be disaggregated by income. NSCH derives household poverty levels based on family income. Missing values were imputed by Census, and we use the single imputation version provided in the combined 2016–17 data file. Households with incomes less than 200 percent of the FPL are classified as low-income. Households with incomes at or above 200 percent of the FPL are classified as not low-income.

36 IPUMS USA. (n.d.). *Replicate weights in the American Community Survey / Puerto Rican Community Survey*. Retrieved from https://usa.ipums.org/usa/repwt.shtml

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

38 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.

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 from 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.[39]

The indicator denominator is the number of children ages 0–2. The numerator is those children whose parent responded "most of the time" or "all of the time" to all four family resilience items: "When your family faces problems, how often are you likely to do each of the following?" 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.

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This indicator can be disaggregated by income. NSCH derives household poverty levels based on family income. Missing values were imputed by Census, and we use the single imputation version provided in the combined 2016–2017 data file. Households with incomes less than 200 percent of the FPL are classified as low-income. Households with incomes at or above 200 percent of the FPL 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 from 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.[40] Survey items asked parents to indicate whether their child had ever expe-

39 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*. Retrieved from https://www.childtrends.org/wp-content/uploads/2017/03/2017-16FlourishingFromTheStart-1.pdf

40 Shonkoff, J. P., Garner, A. S., 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

rienced 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 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.

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 ACEs items: (a) hard to get by on family's income; (b) parent or guardian divorced or separated; (c) parent or guardian died; (d) parent or guardian served time in jail; (e) saw or heard parents or adults slap, hit, kick, punch one another in the home; (f) was a victim of violence or witnessed violence in neighborhood; (g) lived with anyone who was mentally ill, suicidal, or severely depressed; (h) lived with anyone who had a problem with alcohol or drugs; and (i) treated or judged unfairly because of 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.

Estimates in the *State of Babies Yearbook: 2020* are based on the 2016–17 combined National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 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.

This indicator can be disaggregated by income. NSCH derives household poverty levels based on family income. Missing values were imputed by Census, and we use the single imputation version provided in the combined 2016–2017 data file. Households with incomes less than 200 percent of the FPL are classified as low-income. Households with incomes at or above 200 percent of the FPL 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 from www.childhealthdata.org

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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.[41] 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."[42] 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 especially neglect—are more common in economically disadvantaged families

41 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

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

than in families with higher incomes.[43] Note that the data source for this indicator is agency-confirmed reports, which are likely to underestimate the actual prevalence of maltreatment.

The indicator numerator is the number of unique maltreatment victims ages 0–2 (substantiated or indicated), as reported in the *Child Maltreatment 2017* report. The denominator is the total number of children ages 0–2 in 2017, according to the *Child Maltreatment 2017* report. 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 and definitions of maltreatment vary significantly.

Sources: U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). *Child maltreatment 2017*. U.S. Government Printing Office. Retrieved from https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment

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

Unstable conditions at home can cause infants and toddlers to be placed in out-of-home care. 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).[44] 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 is new for *State of Babies Yearbook: 2020.* The denominator is all infants and toddlers ages 0–2 who entered care in 2016, and who either left care by 2017 or were also in the dataset for 2017. The numerator is the number of infants and toddlers in this cohort who exited care after 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 White, non-Hispanic Black, and Hispanic (of any race), and non-Hispanic other and multiple races. The non-Hispanic other and multiple races category includes non-Hispanic American Indian/Alaska native, non-Hispanic Hawaiian/other Pacific Islander, and non-Hispanic more than one race.

Source: Adoption & Foster Care Analysis Reporting System (2016–17). https://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/afcars

43 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.

44 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.

Percentage of infants/toddlers exiting foster care who achieve permanency

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.[45]

For this indicator, 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.

Use caution when interpreting this indicator, as states' child welfare systems can vary significantly.

Source: Adoption & Foster Care Analysis Reporting System (2017). https://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/afcars

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 they 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.[46] Yet, in most communities, the need for home visiting services far outpaces current capacity.[47]

The denominator is the number of children ages 0–2 who could benefit from home visiting according to the source document, which the National Home Visiting Resource Center defines as all children ages 0–2. Estimates are based on the American Community Survey. The numerator is calculated by multiplying the total number of children who received home visiting by the percentage these who are ages 0–2. Data reflect 2017.

Source: National Home Visiting Resource Center. (2018). *Data supplement to the 2017 home visiting yearbook*. James Bell Associates and the Urban Institute. Retrieved from https://www.nhvrc.org/wp-content/uploads/NHVRC_Yearbook_2018_FINAL.pdf

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.

45 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

46 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. Retrieved from https://www.acf.hhs.gov/sites/default/files/opre/homvee_executive_summary_2018_508.pdf

47 National Home Visiting Resource Center. (2017). *2017 Home visiting yearbook*. Retrieved from https://www.nhvrc.org/wp-content/uploads/NHVRC_Yearbook_2017_Final.pdf

When parents cannot stay home with a child who is ill, the child may attend a group care setting where others can become sick, affecting multiple families. Employee productivity also suffers when parents must make stopgap arrangements for their child's care.

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.

Source: National Partnership for Women and Families. *Paid sick day—state and district statues.* (2019). Retrieved from http://www.nationalpartnership.org/research-library/work-family/psd/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, can lessen the likelihood of maternal depression, promote fathers' involvement in childrearing, increase mothers' attachment to the labor force, and reduce reliance on public assistance.[48]

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. States that have enacted a policy, but whose policy has not yet taken effect are counted as having a policy. Oregon signed a paid family leave policy into law in August 2019, after data were collected for this indicator. The indicator has been updated, but rankings do not reflect this update.

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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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) besides 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.[49] States can determine exemptions that can be made for single-parent unit households with different household circumstances.

48 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/

49 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 from https://www.acf.hhs.gov/sites/default/files/opre/2018_welfare_rules_databook_final_08_07_2019_508.pdf

This indicator is new for *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. 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 from 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.[50] 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), to the CTC helps to pay for the cost of raising children.[51] Research suggests that families receiving more refundable tax credit do better in school, have a higher chance of going to a university, and will likely earn more as adults.[52] Some states have also implemented a child tax credit to complement the federal CTC.

This indicator is new for *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. (2018). *State tax credits*. Retrieved from http://www.taxcreditsforworkersandfamilies.org/state-tax-credits

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State offers an earned income tax credit

The Earned Income Tax Credit (EITC) is a federal tax credit for working people with low and moderate earnings. The Earned Income Tax Credit 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.[53] The EITC is currently targeted toward workers who are raising children, with eligibility depending on the worker's income, marital status, and number of children.

State EITCs provide an additional benefit to families by reducing their state income tax liability.[54]

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

51 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.

52 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. Retrieved from https://www.cbpp.org/sites/default/files/atoms/files/6-26-12tax.pdf

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

54 National Conference of State Legislatures. (2019). *Tax credits for working families: Earned income tax credit (EITC).* National Conference of State

Several states, such as California, Louisiana, Maryland, New Jersey, and others, have recently increased the amount of their credits and/or extended eligibility to a greater pool of people to provide support and access to more families.[55]

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.[56]

This indicator is new for *State of Babies Yearbook: 2020* and documents whether a state offers an EITC. States that have enacted a law regarding EITC that has not yet gone into effect are counted as having the policy.

Source: Tax Credits for Workers and Their Families. (2018). *State tax credits*. Retrieved from http://www.taxcreditsforworkerandfamilies.org/state-tax-credits/

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 language.[57] 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.[58] 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.[59]

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: 2020* are based on the 2016-17 combined National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 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.

Legislatures. Retrieved from https://www.ncsl.org/research/labor-and-employment/earned-income-tax-credits-for-working-families.aspx

55 Williams, E., & Waxman, S. (2019). *States can adopt or expand earned income tax credits to build a stronger future economy.* Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/state-budget-and-tax/states-can-adopt-or-expand-earned-income-tax-credits-to-build-a?fa=view&id=4084

56 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. Retrieved from https://www.cbpp.org/sites/default/files/atoms/files/6-26-12tax.pdf

57 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.

58 Raikes, H., Pan, B. A., Luze, G. J., Tamis-LeMonda, C. S., Brooks-Gunn, J., Constantine, J., ... 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.

59 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.

This indicator can be disaggregated by income. NSCH derives household poverty levels based on family income. Missing values were imputed by Census, and we use the single imputation version provided in the combined 2016–2017 data file. Households with incomes less than 200 percent of the FPL are classified as low-income. Households with incomes at or above 200 percent of the FPL 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 from www.childhealthdata.org

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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: 2020* are based on the 2016–17 combined National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 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.

This indicator can be disaggregated by income. NSCH derives household poverty levels based on family income. Missing values were imputed by Census, and we use the single imputation version provided in the combined 2016–2017 data file. Households with incomes less than 200percent of the FPL are classified as low-income. Households with incomes at or above 200percent of the FPL 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 from www.childhealthdata.org

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Percentage of infants/toddlers below 100 percent of the FPL 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.[60] 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 they were more likely to be responsive, warm, and supportive. EHS families had lower rates of subsequent child maltreatment than those in a control group.[61]

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

Source: National Head Start Association. (2019). *Access to Head Start in the United States state-by-state fact sheets.* Retrieved from https://nhsa.app.box.com/s/rbuxmgf0fun72gr1r5akm8q65qj40ufo

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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. The amount parents pay for care is generally less than the total cost of providing care; still, parents can pay more than $23,000 per year for center-based infant care, depending on where they live. The new federal standard is that families should spend no more than 7 percent of their income for child care.[62]

The average cost of care for single parents has not been updated since *State of Babies Yearbook: 2019*, as updated data are not available. The indicator denominator is the median income for single-parent families based on the 2015 U.S. Census Bureau's American Community Survey, 5-year estimates. The numerator is the 2016 annual cost of center-based infant care, based on the Child Care Aware of America's February 2017 survey of Child Care Resource and Referral State Networks. Because of data availability, the numerator for South Dakota is based on Child Care Aware of America's 2016 State Fact Sheets report.

The calculation of cost of care for married parents is consistent with *State of Babies Yearbook: 2019* 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, 5-year estimates. 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. Because of availability gaps, data for Florida, Illinois, Louisiana, Montana, North Carolina, South Carolina, and South Dakota, are based on Child Care Aware of America's 2016 State Fact Sheets report. Additionally, in the

60 Early Childhood Learning & Knowledge Center. (2018) Early Head Start Program Options. U.S. Department of Health & Human Services, Administration for Children & Families. Retrieved from https://eclkc.ohs.acf.hhs.gov/programs/article/early-head-start-program-options

61 Green, B. L., Ayoub, C., Bartlett, J. D., Furrer, C., Cohen, R. C., Buttita, K., ... 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

62 Child Care Aware of America. (2018). *The U.S. and the high cost of child care*. Retrieved from http://usa.childcareaware.org/advocacy-public-policy/resources/research/costofcare/

2019 state fact sheets, the data for Alabama, New Jersey, and Wyoming are from 2017, and the data for Pennsylvania are from 2016.

Sources: Child Care Aware of America. (2016). *2017 Appendices: Parents and the high cost of child care.* Retrieved from http://usa.childcareaware.org/wp-content/uploads/2018/01/2017_CCA_High_Cost_Appendices_FINAL_180112_small.pdf

Child Care Aware of America. (2019). *Child Care in America: 2019 state fact sheets*. Retrieved from https://usa.childcareaware.org/advocacy-public-policy/resources/research/statefactsheets

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Income eligibility level for child care subsidy is at or above 200 percent of the FPL

According to reputable estimates, families in every state need an income at least twice the FPL 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.[63]

The National Women's Law Center reports the income eligibility limits for a child care subsidy as a percentage of the 2018 FPL for a family of three, or $20,780 a year. Eligibility limits that are equal to or above 200 percent of the FPL are coded as "yes," and eligibility limits that are less than 200 percent of the FPL are coded as "no." Data reflect policies as of 2018.

Colorado, Texas, and Virginia set different income limits, by region, so it is not possible to compute this indicator for these states.

Source: Schulman, K. (2018). *Overdue for investment: State child care assistance policies 2018*. National Women's Law Center. Retrieved from https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2018/11/NWLC-State-Child-Care-Assistance-Policies-2018.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.[64]

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 used the following steps: (a) obtained the state median incomes for four-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 2017 1-year American Community Survey

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

64 Ibid.

(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 to this threshold; (f) exported the 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 2017 (based on estimates from the Administration for Children and Families Office of Child Care).

Sources: Administration for Children and Families, Office of Child Care, FY 2017 CCDF Data Tables (Preliminary). Retrieved from https://www.acf.hhs.gov/occ/resource/preliminary-fy2017

Administration for Children and Families, Office of Community Services. The Low-Income Home Energy Assistance Program IM 2017-3. *State Median Income Estimates for Optional Use in FY 2017 LIHEAP Programs and Mandatory Use in FY 2018*. Retrieved from https://www.acf.hhs.gov/ocs/resource/liheap-im2017-03

American Community Survey 2017, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Meyer, E., Pacas, J., & Sobek, M. (2019). *IPUMS USA: Version 9.0* [dataset]. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

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 are two of the key purposes of the CCDBG Act.[65] With the reauthorization taking place in 2014, new requirements were set in place for states to expand access to child care to at-risk families, expand education to families around child development and other financial assistance programs, enhance health and safety practices to all the providers under the grant, and several other requirements.[66] 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[67]

This indicator is new for *State of Babies Yearbook: 2020.* States that that allocated increased CCDBG funding to improve access to child care 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 from https://www.childtrends.org/publications/states-use-of-the-child-care-and-development-block-grant-funding-increase

65 An Office of the Administration for Children & Families: Office of Child Care. (2015). *CCDF reauthorization frequently asked questions—ARCHIVED.* Retrieved from https://www.acf.hhs.gov/occ/resource/ccdf-reauthorization-faq-archived

66 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 from https://www.childtrends.org/publications/states-use-of-the-child-care-and-development-block-grant-funding-increase

67 Ibid.

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.[68]

The Early Head Start (EHS) standard for group size for children ages 0 to 3 years old is eight children.[69] This indicator, which is new for *State of Babies Yearbook: 2020,* 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.

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

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 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 promotes 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.[70]

The Early Head Start (EHS) standard for adult-to-child ratio for children ages 0 to 3 years old is one teacher for every four children.[71] 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, and 30 months, as reported in their CCDF plans. States received one point for meeting this benchmark at each age.

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

68 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, 3rd Edition*. Retrieved from https://nrckids.org/files/CFOC3_updated_final.pdf

69 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

70 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, 3rd edition*. Retrieved from https://nrckids.org/files/CFOC3_updated_final.pdf

71 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

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. Well-trained and qualified teachers are more likely to succeed in promoting classroom skills.[72] The federal grant does not set specific requirements around teacher qualifications but does 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 4-year degree from a university are more likely to demonstrate optimal teaching and contribute to positive child outcomes to the children in the classroom.[73]

This indicator, new for *State of Babies Yearbook: 2020*, documents states' required qualifications for teachers of infants and toddlers, as reported in their CCDF plans. Teacher qualifications were classified into five categories: (a) no credential beyond a high school diploma; (b) Child Development Associate (CDA) or state equivalent credential; (c) specific infant/toddler credential or CDA with an infant/toddler credential; (d) associate's degree; and (e) 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.

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

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.[74]

This indicator is new for *State of Babies Yearbook: 2020* and 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.

72 An Office of the Administration for Children & Families: Office of Child Care. (2015). *CCDF reauthorization frequently asked questions—ARCHIVED.* Retrieved from: https://www.acf.hhs.gov/occ/resource/ccdf-reauthorization-faq-archived

73 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, 3rd edition*. Retrieved from https://nrckids.org/files/CFOC3_updated_final.pdf

74 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.

Source: ZERO TO THREE. (2019). *State policy tracker*. Retrieved from https://www.zerotothree.org/resources/360-state-policy-tracker#downloads

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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 more in promoting positive child development outcomes than their more affluent peers.[75] 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 75th 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.[76]

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 2018.

Source: Schulman, K. (2018). *Overdue for investment: State child care assistance policies 2018*. National Women's Law Center. Retrieved from https://nwlc.org/resources/overdue-for-investment-state-child-care-assistance-policies-2018

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.[77] Children who get screened are more likely to have delays identified, be referred for early intervention, and be determined eligible for early intervention services.[78] The American Academy of Pediatrics recommends that children receive developmental screening from their physicians at least three times before their third birthday.[79]

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: 2020* are based on the 2016–17 combined National Survey of Children's Health (NSCH). These results are more reliable than the results presented in

75 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. Retrieved from 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

76 Child Care Aware of America. (2019). *2019 CCDBG state snapshots*. Retrieved from https://info.childcareaware.org/ccdbg-2019-state-snapshots

77 Glascoe, F. P. (2000). Early detection of developmental and behavioral problems. *Pediatrics in Review*, *21* (8), 272–280.

78 Guevara, J. P., Gerdes, M., Localio, R., Huang, Y. V., Pinto-Martin, J., Minkovitz, C. S., ... Pati, S. (2012). Effectiveness of developmental screening in an urban setting. *Pediatrics*, *13*(1), 30–37. DOI: 10.1542/peds.2012-0765

79 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 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.

This indicator can be disaggregated by income. NSCH derives household poverty levels based on family income. Missing values were imputed by Census, and we use the single imputation version provided in the combined 2016–17 data file. Households with incomes less than 200 percent of the FPL are classified as low-income. Households with incomes at or above 200 percent of the FPL 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.

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,[80] 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.

Estimates in the *State of Babies Yearbook: 2020* are based on the 2016-17 combined NSCH. These results are more reliable than the results presented in the 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.

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.

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 from www.childhealthdata.org

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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.[81]

80 Glascoe, F. P. (2000). Early detection of developmental and behavioral problems. *Pediatrics in Review, 21*(8), 272–280.

81 Early Childhood Technical Assistance Center. *Part C of IDEA.* Retrieved from: https://ectacenter.org/partc/partc.asp

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.[82] 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.

This indicator is new for *State of Babies Yearbook: 2020*. States reported whether their Part C eligibility criteria include infants and toddlers who are at risk of having substantial developmental delays (or "at-risk infants and toddlers") under IDEA section 632(5)(B)(i) in their Annual Progress Reports for fiscal year 2017.

Source: The Office of Special Education Programs (OSEP). (n.d.). *Final SSP/APR: Part C, FFY 2017.* Retrieved from https://osep.grads360.org/#report/apr/publicView

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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.[83] 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 way this indicator was calculated changed for *State of Babies Yearbook: 2020.* 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. This is a cumulative count, whereas we used a snapshot in *State of Babies Yearbook: 2019.* The denominator is the total number of children ages birth through 2 years, as provided by the source. Data reflect 2017.

Source: U.S. Department of Education (2017). *IDEA Section 618 data products: Static tables. Part C child count and settings*. Retrieved from https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html#partc-cc

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Timeliness of Part C services

Individualized Family Service Plans (IFSPs) are early intervention plans for children, ages birth to 3, who qualify under 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.[84]

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.[85]

82 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

83 Early Childhood Technical Assistance Center. Part C of IDEA. http://ectacenter.org/partc/partc.asp#overview

84 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.

85 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

The denominator for this indicator 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*. Retrieved from https://osep.grads360.org/#report/apr/publicView

DEMOGRAPHICS

Number of infants/toddlers

These are vintage 2018 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.html

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Percentage of infant/toddler population

The denominator is the total population, based on the Census Bureau's vintage 2018 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.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 2018 population estimates. The numerator is those of Hispanic origin. Hispanic origin is considered an ethnicity, not a race, and Hispanics 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.html

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 2018 population estimates. The numerator is those who are non-Hispanic White. Hispanic origin is considered an ethnicity, not a race, and Hispanics 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.html

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 2018 population estimates. The numerator is those who are non-Hispanic Black. Hispanic origin is considered an ethnicity, not a race, and Hispanics 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.html

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 2018 population estimates. The numerator is those who are non-Hispanic Asian. Hispanic origin is considered an ethnicity, not a race, and Hispanics 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.html

Percentage of infants/toddlers who are non-Hispanic American Indian or Alaskan Native

The denominator is the total population ages 0–2, based on the Census Bureau's vintage 2018 population estimates. The numerator is those who are non-Hispanic American Indian and Alaska Native. Hispanic origin is considered an ethnicity, not a race, and Hispanics 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.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 2018 population estimates. The numerator is those who are non-Hispanic Native Hawaiian and other Pacific Islander. Hispanic origin is considered an ethnicity, not a race, and Hispanics 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.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 2018 population estimates. The numerator is those who are non-Hispanic of multiple races. Hispanic origin is considered an ethnicity, not a race, and Hispanics 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.html

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Percentage of infants/toddlers who are non-Hispanic Native Hawaiian, other Pacific Islander or multiple race categories

This is an alternative, nonmutually exclusive race/ethnicity category. The denominator is the total population ages 0–2, based on the Census Bureau's vintage 2018 population estimates. The numerator is the non-Hispanic population ages 0–2 who are Native Hawaiian and other Pacific Islander, or multiple race categories. Hispanic origin is considered an ethnicity, not a race, and Hispanics 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.html

Percentage of infants/toddlers who are non-Hispanic American Indian, Alaskan Native, Native Hawaiian, other Pacific Islander or multiple race categories

This is an alternative, nonmutually exclusive race/ethnicity category. The denominator is the total population ages 0–2 based on the Census Bureau's vintage 2018 population estimates. The numerator is the non-Hispanic population ages 0–2 who are American Indian Alaska Native, Native Hawaiian and other Pacific Islander, or multiple race categories. Hispanic origin is considered an ethnicity, not a race, and Hispanics 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/2010-2018/2018-natstcopr-meth.pdf

Source: U.S. Census Bureau, Population Division. (2019). *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, 2018*. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.html

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 income and urbanicity. *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 FPL. 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 FPL. *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: Current Population Survey 2018. Flood, S., King, M., Rodgers, R., Ruggles, S., & Warren, J. R. (2018). *Integrated public use microdata series, current population survey: Version 6.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D030.V6.0

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 income and urbanicity. *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 FPL. 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 FPL. *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: Current Population Survey 2018. Flood, S., King, M., Rodgers, R., Ruggles, S., & Warren, J. R. (2018). *Integrated public use microdata series, current population survey: Version 6.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D030.V6.0

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 income and urbanicity. *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 FPL. 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 FPL. *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: Current Population Survey 2018. Flood, S., King, M., Rodgers, R., Ruggles, S., & Warren, J. R. (2018). *Integrated public use microdata series, current population survey: Version 6.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D030.V6.0

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 income and urbanicity. *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 FPL. 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 FPL. *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: Current Population Survey 2018. Flood, S., King, M., Rodgers, R., Ruggles, S., & Warren, J. R. (2018). *Integrated public use microdata series, current population survey: Version 6.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D030.V6.0

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 income and urbanicity. *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 FPL. 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 FPL. *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: Current Population Survey 2018. Flood, S., King, M., Rodgers, R., Ruggles, S., & Warren, J. R. (2018). *Integrated public use microdata series, current population survey: Version 6.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D030.V6.0

Percentage of infants/toddlers living in families with incomes below 100 percent of the FPL

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 FPL. 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.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Meyer, E., Pacas, J., & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset].* Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of infants/toddlers living in families with incomes between 100-199 percent of the FPL

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 FPL. 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.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of infants/toddlers living in families with incomes at or above 200 percent of the FPL

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 FPL. 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.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

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: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of non-Hispanic White infants/toddlers living in families with incomes below 100 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is those in the racial/ethnic group who live in families with incomes below 100 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of non-Hispanic Black infants/toddlers living in families with incomes below 100 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is those in the racial/ethnic group who live in families with incomes below 100 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of non-Hispanic infants/toddlers of races other than White or Black, or of multiple races, living in families with incomes below 100 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is those who live in families with incomes below 100 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of Hispanic infants/toddlers living in families with incomes below 100 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is the number of those who live in families with incomes below 100 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. % Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset].* Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of non-Hispanic White infants/toddlers living in families with incomes between 100–199 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is the number of those in families with incomes at or above 100 percent and below 200 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. % Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of non-Hispanic Black infants/toddlers living in families with incomes between 100–199 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is the number of those who live in families with incomes at or above 100 percent and below 200 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset]*. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of non-Hispanic infants/toddlers of races other than White or Black, or of multiple races, living in families with incomes between 100–199 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is the number of those who live in families with incomes at or above 100 percent and below 200 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset].* Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of Hispanic infants/toddlers living in families with incomes between 100–199 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is the number of children those who live in families with incomes at or above 100 percent and below 200 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset].* Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of non-Hispanic White infants/toddlers living in families with incomes at or above 200 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is the number of those who live in families with incomes at or above 200 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset].* Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of non-Hispanic Black infants/toddlers living in families with incomes at or above 200 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is the number of those who live in families with incomes at or above 200 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2019). *IPUMS USA: Version 9.0 [dataset].* Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of non-Hispanic infants/toddlers of races other than White or Black, or of multiple races, living in families with incomes at or above 200 percent of the FPL

The denominator is the total number of children ages 0-2 in the racial/ethnic group. The numerator is the number of those who live in families with incomes at or above 200 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. and Sobek, M. (2019). IPUMS USA: Version 9.0 [dataset]. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Percentage of Hispanic infants/toddlers living in families with incomes at or above 200 percent of the FPL

The denominator is the total number of children ages 0–2 in the racial/ethnic group. The numerator is the number of those who live in families with incomes at or above 200 percent of the FPL. Some states have very small cell sizes and estimates may be unreliable.

Source: American Community Survey 2018, one-year estimates. Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. and Sobek, M. (2019). IPUMS USA: Version 9.0 [dataset]. Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V9.0

Appendix C. Methodology

INDICATORS

Indicator Selection

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. Although there are many measures that we might have included in each of these domains, 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 and the District of Columbia.
- 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.

In making our selection for the inaugural *State of Babies Yearbook: 2019*, ZERO TO THREE and Child Trends reviewed potential indicators and obtained input from a panel of early childhood experts. Panelists also provided feedback on our approach to ranking states.

For the second edition of the report, *State of Babies Yearbook: 2020,* we have added and refined indicators across the domains. Notably, we have added more than a dozen policy indicators. Table C.1 below highlights the new indicators. See Appendix B for descriptions of each indicator, how they are constructed, and changes between editions of the report in how some indicators were constructed.

Table C.1. New indicators for *State of Babies Yearbook: 2020*

Domains	Indicators	
Good Health	• Babies born preterm • Maternal mortality • WIC coverage	• High weight-for-length among WIC recipients
Strong Families	• TANF exemption • State child tax credit	• Time in out-of-home placement • Earned income tax credit (EITC)
Positive Early Learning Experiences	• Part C eligibility definition • Timeliness of Part C services • Infant/toddler professional credential • Allocated CCDBG funds	• Group size • Adult/child ratio • Teacher qualifications • State reimburses center-based child care

Subgroup indicators

Beginning with *State of Babies Yearbook: 2020,* we have disaggregated indicator data by selected subgroups, subject to data availability. Specific indicators are now presented on-line by race/ethnicity, income, and urbanicity, where possible. Table C.2 presents the indicators that are disaggregated for each characteristic.

Table C.2. Indicators available for selected disaggregation

Domains	Race/Ethnicity	Income	Urbanicity
Good Health	• Maternal mortality (national only) • Babies born with low birthweight • Babies born preterm • Late or no prenatal care received • Infant mortality • Received recommended vaccines • Infants ever breastfed • Infants breastfed at 6 months • Uninsured low-income infants/toddlers • High weight-for-length among WIC recipients	• Mothers reporting less than optimal mental health • Preventive medical care received • Preventive dental care received • Received recommended vaccines • Infants ever breastfed • Infants breastfed at 6 months	• Babies born with low birthweight • Babies born preterm • Late or no prenatal care received • Uninsured low-income infants/toddlers
Strong Families	• Crowded housing • Time in out-of-home placement	• Crowded housing • Unsafe neighborhoods • Family resilience • 1 ACE • 2 or more ACEs	• Crowded housing
Positive Early Learning Experiences		• Parent reads to baby every day • Parent sings to baby every day • Developmental screening received	

The definition of subgroups varies by dataset. See Appendix B for details on how each subgroup was defined for each indicator. For the indicators based on survey data (as opposed to population data, such as birth certificates), we conducted significance testing between groups. All *t*-tests were conducted using R statistical computing.

Suppression

Infants and toddlers make up a relatively small proportion of the population. When examined at the state level, and especially at the subgroup level within states, data include relatively few infants and toddlers. We have suppressed some estimates that are based on small cell sizes, and marked additional estimates as unreliable. Suppression took place before ranking, so the data presented in the report are those that were used in the rankings.

In deciding which estimates to suppress and flag as unreliable, we followed two universal rules. We suppressed estimates based on fewer than 30 cases. We also marked estimates based on samples as unreliable if they were exactly 0 percent or 100 percent. In addition to these universal rules, we suppressed or flagged additional estimates according to dataset-specific guidelines, explained in Table C.3.

Table C.3. Data suppression guidelines

Dataset	Suppressed if:	Marked as unreliable if:
National Survey of Children's Health (NSCH)	Denominator less than 30	The absolute confidence interval width is greater than 20%; or the relative confidence interval width is greater than 120% of the estimate; or the estimate is exactly 0% or 100%
American Community Survey (ACS) 5-year estimates	Denominator less than 30	Estimate is 0% or 100%
American Community Survey (ACS) 1-year estimates	Denominator less than 30; or coefficient of variation is greater than 0.61, or the weighted total for the denominator is less than 3,000[1]	Estimate is 0% or 100%
Current Population Survey (CPS)	Denominator less than 30	Estimate is 0% or 100%
National Immunization Survey (NIS)	Denominator is less than 30; or relative confidence interval width is greater than 58.8% of the estimate	Estimate is 0% or 100%; or Confidence interval is greater than 20
The Adoption and Foster Care Analysis and Reporting System (AFCARS)	Denominator is less than 30; or numerator is less than 10.	

[1] We additionally suppressed the estimate for the proportion of infants and toddlers of "other" racial/ethnic groups living in poverty for the District of Columbia.

STATE RANKING PROCESS

We developed a transparent ranking process to facilitate users' understanding of how states fare on the indicators and policy domains. The ranking process follows three steps: rescaling the indicators, calculating domain scores, and calculating the state's overall ranking.

This process is the same as used in *State of Babies Yearbook: 2019.* For consistency's sake, the same indicators are included in rankings for both years—new indicators are not included in the rankings.

Table C.4. Indicators included in the state ranking process

Domains	Indicators included in ranking	Indicators not included in ranking
Good Health	• Uninsured low-income infants/toddlers • Mothers reporting less than optimal mental health • Preventive medical care received • Preventive dental care received • Eligibility limit for pregnant women in Medicaid • Medicaid expansion state • State Medicaid policy for maternal depression screening in well-child visits • Late or no prenatal care received • Babies with low birthweight • Infant mortality • Medicaid plan covers social-emotional screening for young children • Medicaid plan covers IECMH services at home • Medicaid plan covers IECMH services at pediatric/family medicine practices • Medicaid plan covers IECMH services at ECE programs • Received recommended vaccines • Low or very low food security • Infants ever breastfed • Infants breastfed at 6 months	• Babies born preterm • Maternal mortality • WIC coverage • High weight-for-length among WIC recipients

Domains	Indicators included in ranking	Indicators not included in ranking
Strong Families	• Crowded housing • Housing instability • Unsafe neighborhoods • Family resilience • 1 ACE • 2 or more ACEs • Potential home visiting beneficiaries served • Infant/toddler maltreatment rate • Paid sick time that covers care for child • Paid family leave • TANF benefits receipt among families in poverty • Infants/toddlers exiting foster care to permanency[1]	• TANF exemption • State child tax credit • Time in out-of-home placement • Earned income tax credit
Positive Early Learning Experiences	• Parent reads to baby every day • Parent sings to baby every day • Developmental screening received • % income-eligible infants/toddlers with Early Head Start access • Cost of care, as % of income, married families • Cost of care, as % of income, single parents • Percentage of infants/toddlers receiving IDEA Part C services • Low/moderate income infants/toddlers in CCDF funded care • Infants/toddlers with developmental delay[1]	• Part C eligibility definition • Timeliness of Part C services • Infant/toddler professional credential • Allocated CCDBG funds • Group size • Adult/child ratio • Teacher qualifications • State reimburses center-based child care • Families above 200% of FPL eligible for child care subsidy[2]

[1] These indicators appear in the *State of Babies Yearbook* domain tables only, because of concerns about their data quality (see Appendix B for more information). They are included in the rankings, to be consistent with *State of Babies Yearbook: 2019*.

[2] This indicator was excluded from the rankings because there are three states where the policy varied within the state. Including this indicator in the state ranking process penalizes these states when they are coded as missing, so we have decided to omit this indicator from 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, we standardized their values—that is, they are 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:[1]

Score (Rescaled Value) =

[(Observed Value – Lowest Value) / (Highest Value – Lowest Value)] X 100

For indicators (such as low birthweight or poverty) where higher scores mark less-desirable outcomes, we adjust the directionality before calculating the score, so higher scores consistently mark more desirable outcomes, whereas 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 across 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 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 summary 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.

1 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.

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. Because 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.

ERRATA: *STATE OF BABIES YEARBOOK: 2019*

1. There was an error with Vermont's infant mortality rate. Data were recorded as 0.0, where the value should have been "missing." This error was corrected before publication, so the correct data are presented with the state report; however, the incorrect data were used in the ranking process.

2. There was a mistake in the coding of poverty rates, which affected those data, as well as data for the low-income uninsured indicator. Infants and toddlers for whom data on income were missing were erroneously coded as "in poverty" instead of "missing," leading to a slight over-estimation of the number of infants and toddlers living in poverty. This coding error has been corrected for *State of Babies Yearbook: 2020*.

3. There was a mistake in the coding for number of families in poverty, which affected the denominator for the TANF indicator. This error has been corrected for *State of Babies Yearbook: 2020*.

4. The estimate for food insecurity for one state should have been suppressed because of small cell size. It was not and was used for ranking purposes.

Resources

***STATE OF BABIES YEARBOOK: 2020* WEBSITE** 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 Toolkit*.

***STATE OF BABIES YEARBOOK: 2020* TOOLKIT** 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.

STATE SELF-ASSESSMENT TOOL
https://www.zerotothree.org/selfassessmenttoolkit
This online tool helps state policy leaders and advocates assess the current status of services for infants, toddlers, and their families, and to set priorities for improving policies, funding, and systems (available in English and Spanish).

Acknowledgments

First and foremost, we want to extend our gratitude to the experts who served on the advisory panel to guide the modification and expansion of the indicators used in the *State of Babies Yearbook: 2020.* These individuals include *(listed alphabetically by last name)* W. Steven Barnett, NIEER; Leanne Barrett, Rhode Island Kids Count; Alice Carter, University of Massachusetts Boston; Rachel Chazen Cohen, University of Massachusetts Boston; Donna Cohen Ross, Consultant, formerly Center for the Study of Social Policy; Deborah Daro, Chapin Hall; Diane Horm, University of Oklahoma; Florencia Gutierrez, Annie E. Casey Foundation; Stephen Matherly, Utah Department of Health; Colleen Murphy, Ounce of Prevention Fund; Rafael Perez-Escamilla, Yale School of Public Health; Nancy Shier, formerly Ounce of Prevention Fund; and Cecilia Zalkind, Advocates for Children of New Jersey.

We also wish to express our appreciation for the guidance on the indicator selection provided by ZERO TO THREE Board members, Brenda Jones Harden and Tammy Mann.

This report would not have been possible without the guidance, thoughtful feedback, and insight of key leaders at ZERO TO THREE, including Matthew Melmed, Myra Jones-Taylor, Elizabeth DiLauro, and Jamie Colvard. We also wish to thank the research team at Child Trends, including Sarah Daily, Renee Ryberg, Jessie Laurore, Gayane Baziyants, David Murphey, Gabriel Piña, and Alexander Gabriel, for their extensive work providing the data and analysis for the report.

Special thanks to our ZERO TO THREE communications team – Ernestine Benedict, Lauren Donovan, Arielle Beer, Madeline Daniels Benderev, Mauricio Dominguez, and Max Samis, whose savvy expertise helped to ensure that this was a polished product and was disseminated widely. Our appreciation is also extended to Studio Civico for the artful *Yearbook* design and the team at Social Driver for expanding and enhancing the functionality and design of the website and state profiles.

This report was made possible through the generous support of the Perigee Fund and the Tikun Olam Foundation.

Suggested Citation: Keating, K., Cole, P., & Schaffner, M. (2020). *State of babies yearbook: 2020.* Washington, DC: ZERO TO THREE.

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