

State of Babies Yearbook: 2021 Indicator Dictionary

Good Health

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

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

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

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

Pregnant workers protection

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

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

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

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

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

State adopted Medicaid expansion under the Affordable Care Act

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

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

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

Percentage of low-income infants/toddlers who are uninsured

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

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

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

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

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

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

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

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

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

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

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 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 guidance¹² 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 February 2020. States were listed as 1 if they require maternal depression screening during well-child visits, listed as 2 if they recommend screening, listed as 3 if they allow screening, and listed as 4 if no policy is in place about this maternal depression screening requirement.

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

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

Late or no prenatal care

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

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

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

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

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

The links between parental mental health—particularly depression—and child well-being are well established in research.¹⁵ The negative effects of maternal depression can begin prenatally.¹⁶ 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.¹⁷ Untreated depression in mothers or fathers is also associated with greater risk for delays in cognitive and motor development,¹⁸ child maltreatment,¹⁹ and neglect-

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

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

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

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

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

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

19 Administration for Children and Families. (2007). Depression among caregivers of young children reported for child maltreatment. National Survey of Child and Adolescent Well-Being: Research Brief No. 13. www.acf.hhs.gov/programs/opre/abuse_nscaw/reports/depression_caregivers/depression_caregivers.pdf

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 US Department of Health and Human Services. (2020). *Oral health in America: A report of the surgeon general*. US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health. Retrieved December 2020 from <https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf>

25 Filstrup, S. L., Briskie, D., Da Fonseca, M., Lawrence, L., Wandera, A., & Inglehart, M. R. (2003). Early childhood caries and quality of life: child and parent perspectives. *Pediatric dentistry*, 25(5), 431-440. https://www.researchgate.net/profile/Marita_Inglehart/publication/8980934_Early_childhood_caries_and_quality_of_life_Child_and_parent_perspectives/links/56792e2c08aeaf87ed8af72.pdf

26 Jackson, S. L., Vann Jr, W. F., Kotch, J. B., Pahel, B. T., & Lee, J. Y. (2011). Impact of poor oral health on children's school attendance and performance. *American Journal of Public Health*, 101(10), 1900-1906. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222359/>

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

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

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

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

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

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

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

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

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

28 Long, W. E., Bauchner, H., Sege, R. D., Cabral, H. J., & Garg, A. (2012). The value of the medical home for children without special health care needs. *Pediatrics*, 129(1), 87-98. https://pediatrics.aappublications.org/content/129/1/87?ijkey=9ab7a63be22b823793d6c92ad721129ebf98c0fe&keytype2=tf_ipsecsha

29 Homer, C. J., Klatka, K., Romm, D., Kuhlthau, K., Bloom, S., Newacheck, P., Van Cleave, J., & Perrin, J. M. (2008). A review of the evidence for the medical home for children with special health care needs. *Pediatrics*, 122(4), e922-e937. https://pediatrics.aappublications.org/content/122/4/e922?ijkey=809ac017f019f-89122cb130b06716342cf7c08ab&keytype2=tf_ipsecsha

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

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

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

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

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.³⁰ Low weight is often associated with pre-term delivery, but can occur also with full-term births. Research points to a number of factors that can contribute to the likelihood of low weight at birth, including smoking during pregnancy; low weight gain during pregnancy, or low pre-pregnancy weight; and the pregnant parent's stress during pregnancy.³¹ The National Center for Health Statistics defines low birth weight as a weight of less than 2,500 grams, or 5 pounds and 8 ounces.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 *Ibid.*

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

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

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

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

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

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

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

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.³⁵ A mother's death is detrimental to the development of the newborn child, and poses a great hardship to the affected household.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.³⁷ Families with low incomes may not be able to afford these services unless they are covered by Medicaid. Ideally, a state's Medicaid plan covers infant and early childhood mental health (I-ECMH) services in any of the following settings: home, pediatric/family medicine practices, and early care and education programs.

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

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

Percentage of eligible infants who participated in WIC

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

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

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

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

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

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

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

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

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

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

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

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

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

State efforts to extend Medicaid coverage beyond 60 days postpartum

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

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

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

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

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

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

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

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

Strong Families

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.⁴⁹ Parents in these neighborhoods may restrict children’s opportunities for outdoor play out of concern for safety.⁵⁰

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

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

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

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

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

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

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

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

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

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

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

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

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.⁵¹

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

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

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

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

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

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

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

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.⁵² Survey items asked parents to indicate whether their child had ever experienced one or more of the following: economic hardship, divorce/separation of parent, death of a parent, a parent who served time in jail, being a witness to domestic violence, being a victim of or witness to neighborhood violence, living with someone who was mentally ill or suicidal, living with someone with an alcohol/drug problem, or being treated or judged unfairly due to race/ethnicity.

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

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

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

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

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

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

⁵³ Child and Adolescent Health Measurement Initiative (CAHMI) (2019). *2017-208 National Survey of Children's Health (2 years combined data set): Child and family health measures, national performance and outcome measures, and subgroups, STATA codebook, Version 1.0*. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved November 2020 from www.childhealthdata.org

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

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

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

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

Sources: Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services (2020). Adoption and Foster Care Analysis and Reporting System (AFCARS), Foster Care File 2019 [Data set]. National Data Archive on Child Abuse and Neglect. <https://doi.org/10.34681/7424-OJ56>

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

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

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

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

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

Sources: Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services (2019). Adoption and Foster Care Analysis and Reporting System (AFCARS), Foster Care File 2018 [Data set]. National Data Archive on Child Abuse and Neglect. <https://doi.org/10.34681/7424-OJ56>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

57 National Home Visiting Resource Center. (2017). *2017 Home visiting yearbook*. [Https://www.nhvrc.org/wp-content/uploads/NHVR_C_Yearbook_2017_Final.pdf](https://www.nhvrc.org/wp-content/uploads/NHVR_C_Yearbook_2017_Final.pdf)

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

State has a paid family leave program

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

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

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

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

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

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

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

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

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

TANF work exemption for single parents of infants

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

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

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

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

State offers a child tax credit

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

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

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

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

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

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

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

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

State offers an earned income tax credit

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

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

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.⁶⁶

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

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

Positive Early Learning Experiences

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

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

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

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

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

language.⁶⁷ Since language development is fundamental to many areas of learning, skills developed early in life help set the stage for later school success. By reading aloud to their young children, parents help them acquire the skills they will need to be ready for school.⁶⁸ 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.⁶⁹

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

72 Child Care Aware of America. (2019). *The U.S. and the high cost of child care: 2019*. Retrieved from https://cdn2.hubspot.net/hubfs/3957809/2019%20Price%20of%20Care%20State%20Sheets/Final-TheUSandtheHighPriceofChildCare-Appendices.pdf?_hssc=122076244.2.1605543695491&_hstc=122076244.abdbe2aa1098f4ba8bfffad2689acb437.1602611682546.1605025891932.1605543695491.68_hfp=3629513924&hsCtaTracking=b84e60b8-da54-4971-9364-7d5667e1a1b7%7C0be5fe22-5bef-4e54-908a-f95a653d2b14

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

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

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

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

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

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

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

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

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.⁷⁵

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

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

⁷⁵ Ibid.

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

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

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

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

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.⁷⁶

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

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

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

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

76 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.

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

providers under the grant and several other requirements.⁷⁸ 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.⁷⁹

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

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

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.⁸⁰

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

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

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

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

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

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

⁷⁹ Ibid.

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

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

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

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

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

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

Teacher qualifications for infants and toddlers in CCDF licensed center-based child care

One of the most important factors contributing to a child development is the care setting they are exposed to. The Child Care and Development Fund (CCDF) require states to develop a system for continuing professional development for teachers. Additionally, each state sets its own requirements around teacher qualifications.

Studies have shown that teachers who have received formal education from an accredited university provide a better quality of care and education to the children they serve. Similarly, teachers holding a four-year degree from a university are more likely to demonstrate optimal teaching and contribute to positive child outcomes to the children in the classroom.⁸⁴

This indicator has not been updated since it was introduced for the *State of Babies Yearbook: 2020*. This indicator documents states' required qualifications for teachers of infants and toddlers, as reported in their CCDF plans. Teacher qualifications were classified into five categories: no credential beyond a high school diploma; Child Development Associate (CDA) or state equivalent credential; specific infant/toddler credential or CDA with an infant/toddler credential; associate's degree; bachelor's degree.

Most states did not further differentiate requirements by child age within the category of infants and toddlers. When requirements did vary by age, the lowest qualifications are reported. If the state made a distinction between types of teachers, qualifications for the lead teacher were used. Data reflect fiscal years 2019-2021.

⁸² American Academy of Pediatrics, American Public Health Association. (2011). *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs, Third Edition*. https://nrckids.org/files/CFOC3_updated_final.pdf

⁸³ Early Childhood Learning & Knowledge Center. (n.d.). Head Start Policy and Regulations: 1302.21 Center-based Option. <https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/1302-21-center-based-option>

⁸⁴ American Academy of Pediatrics, American Public Health Association. (2011). *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs, Third Edition*. https://nrckids.org/files/CFOC3_updated_final.pdf

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

State reimburses center-based child care at or above the 75th percentile of current market rates

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Higher-quality child care and early education has been found to benefit low-income children in promoting positive child development outcomes to a greater extent than their more affluent peers.⁸⁵ 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.⁸⁶

The National Women's Law Center reports whether state payment rates are at or above the 75th percentile of current market rates in Table 4b of the source document. Payment rates are considered to be at this level if rates for all (or nearly all) categories—such as different regions, age groups, types of care, and quality levels (including the base rate)—are at or above the 75th percentile of current market rates. Data are current as of February 2019.

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

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.⁸⁷ Children who get screened are more likely to have delays identified, be referred for early intervention, and be determined eligible for early intervention services.⁸⁸ The American Academy of Pediatrics recommends that children receive developmental screening from their physicians at least three times before their third birthday.⁸⁹

⁸⁵ Greenberg, E., Isaacs, J. B., Derrick-Mills, T., Michie, M., & Stevens, K. (2018). *Are higher subsidy payment rates and provider-friendly payment policies associated with child care quality?* Urban Institute Center on Labor, Human Services, and Population. https://www.urban.org/sites/default/files/publication/96681/are_higher_subsidy_payment_rates_and_provider-friendly_payment_policies_associated_with_child_care_quality_1.pdf

⁸⁶ Child Care Aware of America. (2019). *2019 CCDBG state snapshots*. <https://info.childcareaware.org/ccdbg-2019-state-snapshots>

⁸⁷ Glascoe, F. P. (2000). Early detection of developmental and behavioral problems. *Pediatrics in Review*, 21(8), 272-280.

⁸⁸ Guevara, J. P., Gerdes, M., Localio, R., Huang, Y. V., Pinto-Martin, J., Minkovitz, C. S., Hsu, D., Kyriakou, L., Baglivo, S., Kavanagh, J., & Pati, S. (2012). Effectiveness of developmental screening in an urban setting. *Pediatrics*, 13(1), 30-37. Doi: [10.1542/peds.2012-0765](https://doi.org/10.1542/peds.2012-0765)

⁸⁹ American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. *Pediatrics*, 118(1), 405-420.

The denominator for this indicator is all children ages 9 through 35 months. The numerator is those children who received a developmental screening using a parent-completed screening tool in the past year, as reported by parents.

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

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

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

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

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,⁹⁰ and should lead to more detailed assessment and appropriate treatment and guidance for parents.

The indicator denominator is all children ages 0–2. The numerator is those whose parents respond “yes” to the question: “Has a doctor, other health care provider, or educator ever told you that this child has developmental delays?” and report that their child currently has a moderate/severe developmental delay.

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

Use caution when interpreting this indicator; because this indicator is based on parent reports of doctor's diagnoses, it likely underestimates the prevalence of developmental delays.

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

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

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

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

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

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.⁹¹ In some states, eligibility extends to those who are at risk for developing a disability. States' eligibility criteria for early intervention services vary, as do the services they offer.

The numerator is the cumulative number of infants and toddlers with disabilities ages birth through 2 who received early intervention services under IDEA, Part C during the most recent 12-month period for which data are available. The denominator is the total number of children ages birth through 2 years in the population, as provided by the source. The data reflect 2018.

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

The way this indicator is calculated for the *State of Babies Yearbook: 2021* and the *State of Babies Yearbook: 2020* is different than how it was calculated for the *State of Babies Yearbook: 2019*. The data reflect a cumulative count, whereas a snapshot count was used for *State of Babies Yearbook: 2019*.

Source: U.S. Department of Education (2020). *IDEA Section 618 data products: Static tables. Part C child count and settings*. Retrieved August 2020 from <https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html>

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.⁹²

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.⁹³ States vary in their eligibility criteria for Part C services, and in their inclusion of "at-risk infants and toddlers" and/or their way of defining "at-risk infants and toddlers." Among states that have included "at-risk" as part of their eligibility criteria, these conditions may include established risk, biological or medical risk, or environmental risk.

In this indicator, states reported whether their Part C eligibility criteria includes "at-risk" children as eligible for IDEA Part C services or reports that they serve "at-risk" children in their Annual Progress Reports. Data reflect fiscal year 2018-2019. This indicator was new for the *State of Babies Yearbook: 2020*.

Sources: The Office of Special Education Programs (OSEP) (n.d.). *Final SSP/APR: Part C, FFY 2017*. Available at <https://osep.grads360.org/#p=19>. Note that the location of these reports has moved since we originally retrieved them in September 2019.

U.S. Department of Education. (2020). *IDEA Section 618 data products: State level data files: Part C: 2018-19 child count and settings*. Retrieved November 2020 from <https://www2.ed.gov/programs/osepidea/618-data/state-level-data-files/index.html#cccs>

Timeliness of Part C services

Individual Family Service Plans (IFSPs) are early intervention plans for children, ages birth to three, who qualify under the Individuals with Disabilities Education Act (IDEA). The IFSP is unique in that it uses a family-focused lens. This approach requires a partnership between the family and professionals to create an early intervention that is respectful of the child and family's values and practices.⁹⁴

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.⁹⁵

92 Early Childhood Technical Assistance Center. Part C of IDEA. <https://ectacenter.org/partc/partc.asp>

93 Shackelford, J. (2002). *State and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA*. NECTAC Notes. Retrieved from <https://files.eric.ed.gov/fulltext/ED471884.pdf>

94 Minke, K. M., & Scott, M. M. (1993). The development of individualized family service plans: Roles for parents and staff. *The Journal of Special Education*, 27(1), 82-106.

This indicator was new for the *State of Babies Yearbook: 2020* and there is no update for the *State of Babies Yearbook 2021*. The denominator is the total number of eligible infants and toddlers evaluated and assessed for whom an initial IFSP meeting was required. The numerator is the number of those with IFSPs for whom an initial evaluation and assessment and an initial IFSP meeting were conducted within Part C's 45-day requirement, plus the number of documented delays attributable to exceptional family circumstances.

Source: The Office of Special Education Programs (OSEP) (n.d.). *Final SSP/APR: Part C, FFY 2017*. Available at <https://osep.grads360.org/#p=19>. Note that the location of these reports has moved since we originally retrieved them in September 2019.

Demographics

Number of infants/toddlers

These are vintage 2019 population estimates. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

Source: U.S. Census Bureau, Population Division. (2020). Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and Two or More Races) by Age, Sex, and Hispanic Origin: April 1, 2010 to July 1, 2019. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

Percentage of infant/toddler population

The denominator is the total population, based on the Census Bureau's vintage 2019 population estimates. The numerator is the population ages 0-2. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

Source: U.S. Census Bureau, Population Division. (2020). Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and Two or More Races) by Age, Sex, and Hispanic Origin: April 1, 2010 to July 1, 2019. Retrieved September 2020 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>

Percentage of infants/toddlers who are Hispanic

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the total Hispanic population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

95 Individuals with Disabilities Education Act. Sec. 303.310 Post-referral timeline (45 days). Retrieved from: <https://sites.ed.gov/idea/regs/c/d/303.310>

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

Percentage of infants/toddlers who are non-Hispanic White

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic White population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natscopr-methv2.pdf>

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

Percentage of infants/toddlers who are non-Hispanic Black

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic Black population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natscopr-methv2.pdf>

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

Percentage of infants/toddlers who are non-Hispanic Asian

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic Asian population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natscopr-methv2.pdf>

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

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

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic American Indian and Alaska Native population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

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

Percentage of infants/toddlers who are non-Hispanic Native Hawaiian or Pacific Islander

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic Native Hawaiian and other Pacific Islander population ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

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

Percentage of infants/toddlers who are non-Hispanic multiple races

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2019 population estimates. The numerator is the non-Hispanic population of multiple races ages 0-2. Hispanic origin is considered an ethnicity, not a race, and Hispanic individuals may be of any race. Estimates are produced using a cohort component method, based on the 2010 Census, and births, deaths, and migration occurring since. For more information, see the Census Bureau's documentation: <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2010-2019/natstcopr-methv2.pdf>

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

Percentage of infants/toddlers living in two-parent families

The denominator is the total number of children ages 0-2. The numerator is those who have two parents present in their household. The definition of parent includes biological as well as social (step or adoptive) parents, and unmarried partners of a parent. Families with two same-sex parents present in the household are included as two-parent families.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity: Race/*

ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income:* Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity:* Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

Percentage of infants/toddlers living in one-parent families

The denominator is the total number of children ages 0-2. The numerator is those who have one parent present in their household. The definition of parent includes biological as well as social (step or adoptive) parents.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity:* Race/ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income:* Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity:* Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

Percentage of infants/toddlers living with no parents

The denominator is the total number of children ages 0-2. The numerator is those who have no parents present in their household. The definition of parent includes biological as well as social (step or adoptive) parents.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity*: Race/ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity*: Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

Percentage of infants/toddlers living in grandparent-headed households

The denominator is the total number of children ages 0-2. The numerator is those who live in a household headed by their grandparent. Note that this classification is not mutually exclusive with other family structure categories.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity*: Race/ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity*: Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

Percentage of infants/toddlers that have mothers in the labor force

The denominator is the number of children ages 0-2 who live with their mothers. The numerator is those whose mother is in the labor force (either employed or unemployed but looking for work). People in the

armed forces are not in the universe for labor force participation. If there are two mothers in the household, the labor force participation of only the first mother is considered.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity*: Race/ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity*: Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

Percentage of infants/toddlers who live with no working parents

This indicator is new for the *State of Babies Yearbook: 2021*. The denominator is the total number of children ages 0-2 who live with at least one parent. The numerator is the number of children ages 0-2 who live with only disconnected parents, (i.e., parents who were not working in the past 12 months, and were not working for a reason other than going to school). All residential parents must be disconnected, according to the above definition, in order for the child to qualify as living with disconnected parents.

This indicator can be disaggregated by race/ethnicity, income, and urbanicity. *Race/ethnicity*: Race/ethnicity is reported by the survey respondent who is likely the child's caregiver. The Current Population Survey includes race and ethnicity data for the following single categories as well as specific combinations or two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian or Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. The *State of Babies Yearbook: 2021* categorizes CPS race and ethnicity data into the following categories: Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian/Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March ASEC supplement of the CPS. Total family income is divided by the official poverty rate cutoff provided by CPS to calculate the ratio of family income to the federal poverty line. Infants and toddlers are considered to live in low-income families if this ratio is less than 2. Infants and toddlers are considered to live in non-low-income families if their family's total income is at least twice the federal poverty line. *Urbanicity*: Metropolitan (urban) areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan (rural) areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., and Warren, J. R. (2020). *Current Population Survey 2019*. (IPUMS, Current Population Survey: Version 7.0) [Data set]. IPUMS. <https://doi.org/10.18128/D030.V7.0>

Percentage of infants/toddlers living in families with incomes below 100 percent of the federal poverty line

The denominator is the total number of children ages 0-2. The numerator is those who live in families with incomes below 100 percent of the federal poverty line. Note that this poverty rate does not match the rates published by the Census Bureau, because the public-use version of the American Community Survey is not complete.

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

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

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

The denominator is the total number of children ages 0-2. The numerator is those who live in families with incomes at or above 100 percent and below 200 percent of the federal poverty line. Note that this poverty rate does not match onto the rates published by the Census Bureau, because the public use version of the American Community Survey is not complete.

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

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

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

The denominator is the total number of children ages 0-2. The numerator is those who live in families with incomes at or above 200 percent of the federal poverty line. Note that this poverty rate does not match onto the rates published by the Census Bureau, because the public use version of the American Community Survey is not complete.

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

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

Percentage of infants/toddlers living outside of metro areas

The denominator is the total number of children ages 0-2. The numerator is those who live outside of metro areas. All geographic areas not considered part of a metro area are considered rural.

Source: Ruggles, S., Flood, S., Goeken, R., Grover, J., Erin Meyer, E. Jose Pacas, J. & Sobek, M. (2020). *American Community Survey 2019, one-year estimates*. (IPUMS USA: Version 10.0) [Data set].