All impact the goal of promoting the optimal development that enables babies to reach their potential. Some indicators, such as low birthweight or early adverse experiences, show the extent to which babies have experiences that can undermine their development. Others, such as having health insurance, receiving TANF benefits, or receiving child care subsidies, show how access to services can promote healthy development. Policies, such as coverage of IECMH services or providing paid family and medical leave, show how states seek to provide the policy environment that enables all babies to thrive. Those indicators that can be disaggregated by race and ethnicity, income, and urbanicity give a more granular picture of the disparities among babies and the need for policies and practices that promote equity in accessing the ingredients for strong development.

The *Yearbook's* national findings on all indicators for 2022 and previous editions are summarized in tables in the sections for each domain and can be viewed in full online in the interactive National Profile, where the data can be examined by subgroup for all indicators where race/ethnicity, income, and urbanicity data if available. In addition, Appendix A: Summary of Indicator Values provides information on the variation and range of state findings for each indicator.

In the sections that follow, we highlight the notable key findings within each domain, focusing on the results obtained on new indicators, indicators where the data are most concerning, and where disparities exist. We also detail where there are opportunities for improvement through policy. In addition to the *Yearbook's* key findings, which reflect the conditions for babies and families prior to COVID-19, we present the more recent related findings on the pandemic's effects from the RAPID Survey data collected throughout 2021.

Good Health

Healthy development starts in the prenatal period and even before with the health of future parents. It follows that disparities begin during that period as well. The 2022 findings reveal significant disparities in the health outcomes of mothers[6] and babies of color, with the starkest differences found among Black and American Indian/Alaska Native families. This finding echoes previous *Yearbook* editions and the 2021 brief *Racism Creates Inequities in Maternal and Child Health, Even Before Birth.* The indicators exhibiting these disparities can undermine the development of babies, potentially affecting them throughout their lives. The persistence of these inequities continues to make clear the need for policies that directly address and eliminate the effects of generations of structural racism and the remaining barriers that limit access to responsive, quality health care.

Disparities in health are also evident for babies in families with low income, particularly in their access to preventive care.

Ensuring babies and mothers have every opportunity to maintain optimal physical and mental health is critical during this period of rapid growth to provide the foundation for babies' lifelong physical, cognitive, emotional, and social well-being. The Good Health domain examines indicators of mothers' and babies' physical and social-emotional well-being, and it presents policy indicators that assess the extent to which states have adopted policies that ensure families with infants and toddlers have access to and coverage for health care; support nutrition; and promote social-emotional health through coverage of maternal depression screening in well-child visits,

[6] The terms "mother," "pregnant women," and "breastfeeding" are used throughout the *Yearbook* for consistency with the language used in the data sources. However, the authors acknowledge that "pregnant people" and "chest feeding" are more inclusive of individuals who may not identify with these terms.

social-emotional screening of babies, and delivery of IECMH services in various settings.

Access to preventive care, such as well-child medical visits, dental visits, and vaccinations, is essential for the health of all babies and provides an important gateway to developmental support for families. The COVID-19 pandemic has given rise to new challenges that threaten babies' and toddlers' chances at a healthy start in life. Most notably, RAPID findings show disruptions in preventive care and increases in child and caregiver emotional distress, both of which have the potential to negatively impact babies' physical and social-emotional health in the long term. The pre-COVID-19 findings of the *Yearbook* and RAPID data amid the pandemic point out the urgent need for policies that ensure access for all families with young children. Specifically, as illustrated in the findings for Good Health, the nation's babies and families require permanent, comprehensive policies that (a) extend insurance coverage to more people; (b) ensure children have access to a medical home where developmental and family needs receive consistent attention; and (c) support maternal, infant, and early childhood mental health.

Key findings

Key findings for Good Health in 2022 show few areas in which change has occurred for babies and families, and the data reflect persistent disparities, particularly when analyzed by race/ethnicity and income. It is also important to note that no update was available from the data sources for some indicators. These indicators include preventive medical visits and states' Medicaid coverage for IECMH services. For these indicators, we continue to report the data from the latest data set release and note this for the reader because an unchanged value from the previous year, or years, may not yet reflect what is happening within the states.

HEALTH CARE ACCESS AND AFFORDABILITY

Ensuring equitable access to integrated, affordable maternal, pediatric, and family health care is essential to meeting babies' and families' health and developmental needs. Policy improvements from the last decade, which propelled significant gains in access to health coverage, seem to have stalled, and concerning disparities remain.

MEDICAID EXPANSION As of July 2021, **39 states had adopted or implemented Medicaid expansion,** reflecting no additional states from the previous year. Medicaid expansion improves parents' access to care. In addition to increasing the likelihood of babies and families receiving care, Medicaid expansion has been associated with lower rates of infant mortality in states that adopted this policy.

UNINSURED BABIES IN FAMILIES WITH LOW INCOME Despite coverage available through Medicaid and CHIP, **5.1 percent of low-income infants and toddlers still lacked health insurance,** virtually unchanged from the previous report, and substantial variation continued to be found when examined by race/ethnicity and urbanicity.

Race and Ethnicity. Most notably, the percentage of American Indian/Alaska Native babies (12.7 percent) in families with low income without health insurance was more than double the national average of 5.1 percent and was also above the average among Other Race (7.2 percent), White (5.7 percent), and Hispanic (5.5 percent) babies. The incidence of uninsured babies was lower than the national average for Black (3.4 percent), Asian (4.5 percent), and Multiple Race (3.3 percent) babies.

Urbanicity. The percentage of babies in families with low income without health insurance was higher than the national average in rural areas (6.7 percent), compared to urban areas (4.7 percent).

"At 12 weeks after the birth of my child, I was still suffering from anxiety and depression. Having to return to work in order to support my family was emotionally and mentally tough. As an educator, I felt that I did a disservice to my students by returning to the classroom and not having enough time to address my symptoms."

Zurii D., Las Vegas, NV

CHIP MATERNAL COVERAGE FOR UNBORN CHILD OPTION According to this new indicator for the *2022 Yearbook,* **17 states have implemented the Maternal Coverage for Unborn Child option.** This option extends coverage to undocumented pregnant women by covering their unborn child as a targeted low-income child, who will be covered by Medicaid or CHIP at birth. Health coverage for pregnancies under this option includes prenatal care and labor and delivery services, and it ends with the birth of the child.[viii] The need for health coverage is shared by all children, including those born into immigrant families. States can elect to implement several options to address this need, including the option to extend coverage to an unborn child once a pregnancy is confirmed through the "unborn child option."

MEDICAL HOME Only half (51.5 percent) of infants and toddlers had a medical home. Babies benefit most from care and screening provided by a consistent medical provider or practice—a medical home—from which they receive coordinated, ongoing, comprehensive care. Significantly fewer babies in families with low income (41.6 percent) had medical homes than their peers in families above low income (58.4 percent). When examined by race, fewer Asian (41.8 percent), Hispanic (41.4 percent), and Black (41.0 percent) babies had medical homes than the national average. White infants (59.1 percent) were more likely than the national average to have a medical home.

EXTENSION OF MEDICAID COVERAGE FOR PREGNANT WOMEN While states provide pregnant women with Medicaid benefits, **only three states extend Medicaid eligibility beyond the federal requirement of 60 days postpartum.**[ix] This number reflects a decrease from five states in the *2021 Yearbook*, due to the expiration of the policy in two states. However, at the time of this report, a number of states are adopting the five-year state option of extending coverage provided in the American Rescue Plan.

The postpartum period after birth is a particularly important and sensitive time for both the parent who carried the child and their newborn baby. Parents can face a variety of health challenges

postpartum including depression, anxiety, pain, and complications that may have arisen during pregnancy or childbirth. Medicaid coverage provides an avenue for parents with moderate to low income to receive financial support as it relates to their pregnancy and the postpartum period. However, coverage gaps can leave many people in need of support during a very vulnerable time of their lives.

POLICY RECOMMENDATIONS AND RELATED ACTIONS Our recommendations for improvement in Health Care Access and Affordability include:

- **Extend Medicaid coverage for mothers and babies.** While expanded access to health coverage for parents remains a primary goal, several smaller changes to Medicaid could enhance maternal and infant health as well as the role of primary care in prevention and promoting strong development:
  - Mandating Medicaid coverage for women through 12 months postpartum and promoting coverage of approaches such as doulas
  - Ensuring coverage of IECMH services that include multigenerational therapies for babies and caregivers
  - Mandating Medicaid coverage for all children until they are 3 years old
  - Requiring a certain percentage of Medicaid funding to be used for health promotion and prevention, including addressing the social determinants of health, and promoting use of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) to monitor and address developmental needs

Related federal policy actions and state opportunities

Proposed legislation in the House-passed reconciliation bill that would strengthen access to early and ongoing access to health care for pregnant women with low income and their babies includes provisions that would permanently authorize CHIP. Also, key provisions for Medicaid would extend coverage for postpartum women, increasing from the current requirement of 3 months to 12 months, and would provide 12 months of continuous eligibility to their babies.

The American Families Plan substantially increases funding for Medicaid and proposes mandatory spending for Medicaid, including eliminating funding caps for Puerto Rico and U.S. territories. The plan would also make it easier for eligible people to get and stay covered, and it reduces deductibles for marketplace plans under the Affordable Care Act.

State Opportunity. States should adopt the option provided in the American Rescue Plan (ARP) to extend Medicaid and CHIP postpartum coverage to 12 months. States that have not adopted Medicaid expansion can now receive incentives to do so.

NUTRITION

Consistent access to healthy, nutritious food during the prenatal period and first years of life is vital for families to ensure their babies receive the nourishment and care they need for a strong start in life.

BABIES EVER BREASTFED/BREASTFED AT 6 MONTHS Despite the known benefits of breastfeeding, only a little more than one-half of babies in the U.S. are still breastfed at 6 months. **The percentage of babies ever breastfed was 84.2 percent,** approximately the same percentage reported in previous years; **56.8 percent of babies are still breastfed at 6 months.** Breastfeeding is beneficial 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.[x] Skin-to-skin contact in breastfeeding also increases oxytocin levels, resulting in breastfeeding parents reporting higher rates of attachment.[xi]

Substantial differences are found in breastfeeding at 6 months by race and ethnicity and by income that reflect the influence of numerous cultural, historical, and economic factors, such as lasting negative connotations of forced wet nursing by Black women during slavery and lack of workplace accommodations and time for breastfeeding parents in low-wage jobs, who are disproportionately women of color.

Race and Ethnicity. The percentage of babies breastfed at 6 months was lower than the national average among Hispanic (52.8 percent) and Black babies (47.8 percent). The percentage of White babies (60.9 percent) breastfed at 6 months was higher than the average.

Income. At the national level, babies in families with low income (47.4 percent) are less likely to be breastfed at 6 months than those in families above low income (65.9 percent).

WIC COVERAGE Nationally, the percentage of eligible infants who participated in WIC was 97.8 percent. While this would appear to be a substantial increase from the nearly 80 percent reported in the last *Yearbook*, this latest rate is not comparable to previous years due to a change in how the U.S. Department of Agriculture calculated eligibility. However, as levels of food insecurity rise amid COVID-19, the importance of connecting families with young children to nutrition assistance has only increased. WIC is a federal grant program that provides access to food, nutrition information, and health care referrals to women and children, from pregnancy through the time the child reaches age 5.[xii] Participating in WIC is associated with lower levels of infant mortality, better cognitive development for the child, and more nutritious diets.[xiii] However, differences in the reach of WIC coverage are revealed when examined by race and ethnicity.

Race and Ethnicity. WIC coverage rates among Hispanic (96.1 percent) and White (89.8 percent) eligible infants were lower than the national average, though only slightly so for Hispanic infants. Black and Other Race eligible infants (both reported to be covered at 100 percent[7]) were higher than the national average.

POLICY RECOMMENDATIONS AND RELATED ACTIONS Our recommendations for improvement in Nutrition include:

- Removing administrative and other barriers to modernize and streamline access to WIC and SNAP;
- Resolving gaps in coverage for WIC;
- Providing additional funding for targeted outreach to reach all eligible families; and
- Extending the WIC certification periods to 2 years and enrollment for children until their sixth birthday.

Related federal policy actions and state opportunities

The Wise Investment in our Children Act of 2021 offers an essential step in closing nutrition gaps and enhancing access to WIC. This bipartisan legislation would extend child eligibility to age 6, extend postpartum eligibility to 2 years, and extend the infant certification period to 2 years.

The Providing Urgent Maternal Protections (PUMP) for Nursing Mothers Act provides the opportunity to close the coverage gap; ensures nursing workers have access to remedies that are available for other violations of the Fair Labor Standards Act; extends protections to 2 years after the child's birth and protects lactating workers in the event of stillbirth, adoption, or surrogacy; directs the Department of Labor to issue guidance to assist employers in complying with the law; and provides employers clarity on implementation and pay requirements. The PUMP Act works toward combatting lactation discrimination in the workplace while closing gaps in labor laws that have previously excluded millions of workers.

In the House-passed Build Back Better Act, the number of schools able to offer free meals to all students through the Community Eligibility Provision would be expanded. States would have the option to implement the Community Eligibility Provision statewide, allowing all students in the state to receive school breakfast and lunch at no charge. The reconciliation bill would also extend Summer Electronic Benefits Transfer (EBT) for students who receive free or reduced-price school meals while allowing states and Indian Tribal Organizations that participate in WIC to also provide Summer EBT.

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

[7] The reliability of rates for Black and Other Race eligible infants could not be established.

MATERNAL HEALTH

The physical and emotional health and well-being of mothers and infants are intrinsically intertwined, beginning in the critical prenatal period and throughout babies' first 3 years. Whether babies are born healthy and with the potential to thrive as they grow greatly depends on their mother's/birthing person's well-being—not just before birth, but even prior to conception. To have a healthy pregnancy and positive birth outcomes, mothers require access to appropriate health care services before, during, and after pregnancy. However, maternal health is one of the most pronounced areas in which there are striking disparities, particularly when examined by race and ethnicity.

As detailed in our 2021 brief, *Racism Creates Inequities in Maternal and Child Health, Even Before Birth,* the connection between maternal and child well-being is particularly important among women of color and their babies due to the intergenerational effects and stressors of lived experiences with institutional and interpersonal racism. These inequities are evident in pregnant women's receipt of prenatal care and maternal mortality rates, as shown in Figures 4 and 5.

LATE OR NO PRENATAL CARE RECEIVED

Nationally, **the percentage of women receiving late or no prenatal care was 6.4 percent,** a slight increase from 6.2 percent last reported. There are wide disparities across racial and ethnic groups, with much higher rates than average for Native Hawaiian/Pacific Islander and American Indian/Alaska Native women.

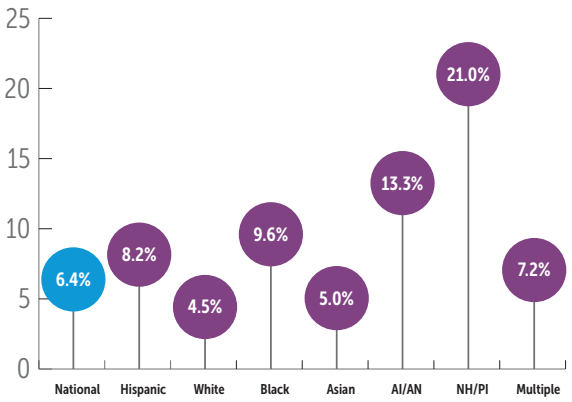
Race and Ethnicity. The percentages of Asian (5.0 percent) and White (4.5 percent) pregnant women who received late or no prenatal care was lower than the national average. The percentages of Native Hawaiian/Pacific Islander (21.0 percent) and American Indian/Alaska Native (13.3 percent) pregnant women who received late or no prenatal care were strikingly high and more than twice the national average. Late or no receipt of prenatal care was also higher than the national average among Black (9.6 percent), Hispanic (8.2 percent), and Multiple Race (7.2 percent) pregnant women.

Urbanicity. Minimal difference was found in receipt of late or no prenatal care among urban and rural pregnant women. The percentage of urban pregnant women (6.3 percent) was slightly below the national average and rural pregnant women (6.5 percent) were slightly above the average.

MATERNAL MORTALITY (DEATHS PER 100,000 LIVE BIRTHS) Alarmingly, maternal mortality has increased to 20.1 pregnancy-related deaths per 100,000 live births from 17.4 reported in the *2021 Yearbook*, a 16 percent increase. The increase for Black mothers, was even larger (18 percent), resulting in a rate of 44 per 100,000 live births. The nation's maternal (and infant) mortality

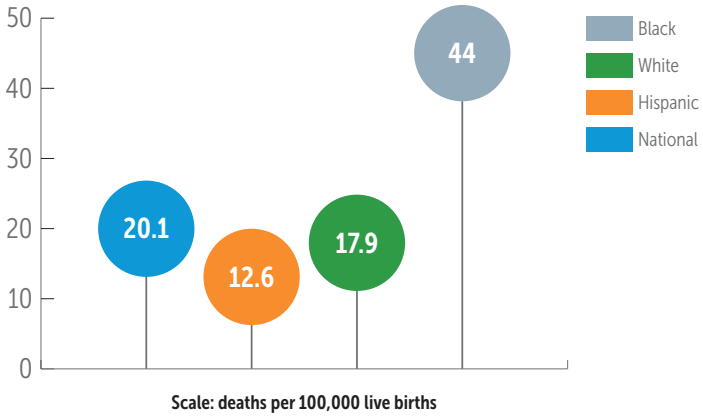
LATE OR NO PRENATAL CARE

Figure 4.



MATERNAL MORTALITY RATE

Figure 5.



rates are concerning and, as previously noted, are higher than rates found in other industrialized countries. Maternal mortality encompasses pregnancy-related deaths, defined as deaths during pregnancy or within one year of the end of pregnancy from a pregnancy complication.[xiv] Differences in states' definitions and reporting practices continue to prevent reporting maternal mortality rates at the state level. Examination of this indicator is possible by race/ethnicity for only three groups (White, Hispanic, and Black mothers), where analysis of the data continues to show deep disparities.

Race and Ethnicity. The maternal mortality rates for Hispanic (12.6) and White (17.9) mothers were lower than the national average. The maternal mortality rate for Black mothers (44.0) continued to be alarmingly high and more than twice the national average.

MOTHERS REPORTING LESS THAN OPTIMAL MENTAL HEALTH Mothers reporting less than optimal mental health remained high. **More than one in five mothers of infants and toddlers (21.9 percent) rated their own mental health as worse than "excellent" or "very good."** This was an increase from the finding of 20.3 percent reported in the *2021 Yearbook*. When examined by race and income the following differences were found:

Race and Ethnicity. The percentage of White mothers (22.8 percent) reporting less than optimal mental health was above the national average. Fewer Black (21.3 percent), Hispanic (20.3 percent), and Asian (16.0 percent) mothers reported this than the national average.

Income. Mothers of infants and toddlers in families with low income (26.9 percent) were more likely to rate their mental health as worse than "excellent" or "very good" than mothers in families above low income (18.8 percent).

POLICY RECOMMENDATIONS AND RELATED ACTIONS Our recommendations for improvement in Maternal Health include:

- Increasing support and access to culturally responsive promising models (e.g., midwifery, doula care, group prenatal care, and breastfeeding support);
- Expanding Medicaid coverage through the first year postpartum;
- Removing administrative and other barriers to support participation in the WIC nutrition program;

- Expanding access to paid family leave; and
- Requiring employment protections and reasonable accommodations for pregnant workers.

RELATED FEDERAL POLICY ACTIONS AND STATE OPPORTUNITIES The bipartisan Black Maternal Health Momnibus Act (H.R. 959), which passed in the House in November 2021, includes 12 bills aimed at addressing the nation's maternal health crisis. If passed into law, its provisions would improve maternal health and birth outcomes and eliminate the profound racial and ethnic disparities found among Black and American Indian/Alaska Native families. The comprehensive package of bills includes historic levels of funding that would "grow and diversify the perinatal workforce, including midwives and doulas; invest in community-based organizations working to promote maternal health equity; address social determinants of health like housing, nutrition, and environmental conditions; and expand access to maternal mental health care."[xv]

The ARP includes a provision that makes major changes to Medicaid coverage for pregnant and postpartum women living with low income. The ARP adds new incentives for states to take up Affordable Care Act Medicaid expansion and also gives all states the new option to extend the postpartum coverage period under Medicaid from 60 days following pregnancy to a full year. Taking effect April 1, 2022, and available for 5 years, the new option requires participating states to provide full Medicaid benefits during pregnancy and the extended postpartum period.

The House-passed Pregnant Worker's Fairness Act will benefit pregnant workers and their families by providing economic security and reasonable accommodations that are not a hardship to one's employer (e.g., provide a stool for the worker's use, assign lighter duty), as well as preventing loss of employment during this period when women's workforce participation is declining.

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

CHILD HEALTH

The *2022 Yearbook's* findings make clear that more intensified efforts are needed to make improvements on a number of indicators that contribute to babies' immediate and future health.

Birth outcomes. Most strikingly, the incidence of negative birth outcomes (i.e., preterm births and low birthweight) and rates of infant mortality remain high and are unchanged from previous *Yearbook* findings. As detailed in this section and depicted in Figures 6 and 7, deep racial and ethnic disparities persist on these critical indicators of infant health. However, the pattern of disparities is also apparent in most states. The root causes of these inequities lie in differences in access to quality care, implicit biases encountered in medical treatment, and the cumulative effects of racism-related stress (also known as "weathering") that, as the data show, are most prominent among Black and American Indian/Alaska Native women. These experiences result in high rates of preterm births and babies born at low birthweight, and they contextualize their babies' mortality outcomes.[xvi]

BABIES BORN PRETERM Nationally, **1 in 10 babies (10.2 percent) are born preterm,** placing them at early risk for health complications. Preterm births (births before 37 weeks of completed gestation) are the second leading cause of death among children younger than 5 years old.[xvii] The percentage of babies born preterm can be reduced through early intervention. The most effective interventions for improving infant survival rates are those that support the pregnant woman before, during, and after pregnancy. These can ensure that complications often associated with preterm delivery, such as infection, neurological challenges, and lung immaturity, are treated early.[xviii] The largest differences on this indicator are found when viewed by race and ethnicity. Analysis is also possible by urbanicity; however, minimal differences are found between babies in urban and rural settings.

Race and Ethnicity. The percentages of Hispanic (10.0 percent), White (9.3 percent), and Asian (8.7 percent) babies born preterm were lower than

the national average of 10.2 percent, though only slightly for Hispanic and White infants. Preterm births were significantly higher than the national average for Black (14.4 percent), American Indian/Alaska Native (11.7 percent), Native Hawaiian/Pacific Islander (11.2 percent), and Multiple Race (10.9 percent) babies.

Urbanicity. The incidence of preterm births was similar for infants born in urban and rural areas. Preterm birth among urban babies (10.2 percent) is the same as the national average, and preterm birth among rural babies (10.6 percent) is only slightly higher than the average.

BABIES WITH LOW BIRTHWEIGHT Similar to the last edition of the *Yearbook*, as many as **1 in 12 infants (8.3 percent) were born at low birthweight,** nationally. Low birthweight (weight of less than 5.5 pounds at birth) is strongly associated with poor developmental outcomes that, beginning in infancy, can affect school readiness and extend into adult life.[xix] Low birthweight is often associated with pre-term delivery, but it can occur also with full-term births.

Race and Ethnicity. The percentages of American Indian/Alaska Native (8.0 percent), Hispanic (7.6 percent), White (6.9 percent), and Native

Hawaiian/Pacific Islander (7.5 percent) infants born at low birthweight were below the national average of 8.3 percent. The incidence of low birthweight was strikingly higher than the national average for Black infants (14.2 percent), approaching nearly twice the national rate and affecting 1 in 7 Black babies. Low birthweight was also above the national average for Multiple Race (9.1 percent) and Asian babies (8.7 percent).

Urbanicity. The percentage of infants born at low birthweight was very similar for babies in rural and urban areas, with the percentage of urban babies (8.3 percent) equaling the national average and rural babies (8.4 percent) slightly higher than the average.

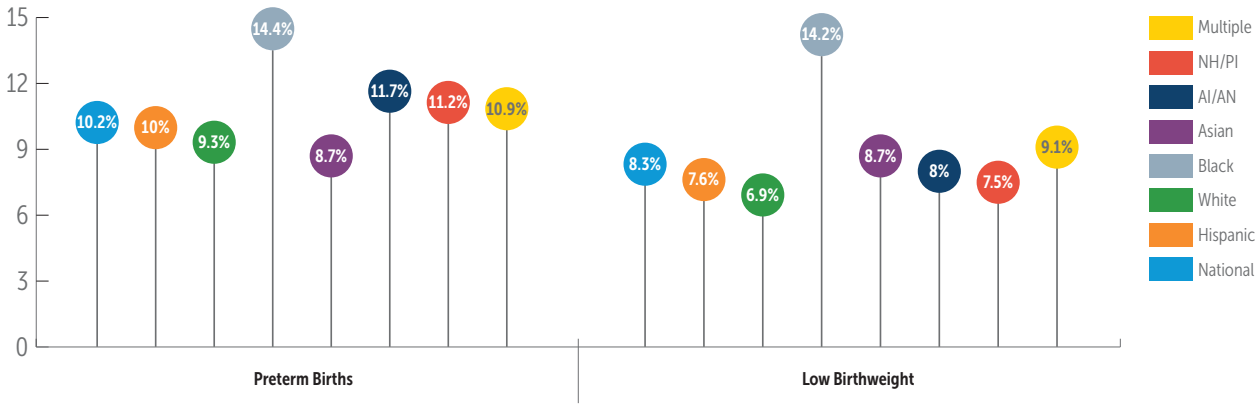
INFANT MORTALITY RATE (DEATHS PER 1,000 LIVE BIRTHS) The national infant mortality rate was 5.6 deaths per 1,000 live births, higher than the rates of many other high-income countries,[xx] and the disparities by race and ethnicity continue to be profound. Infant mortality is defined as a death within the first year of life and is typically measured as the number of deaths per 1,000 live births.[xxi] After birth defects, preterm birth and low birthweight are two of the most common causes of infant mortality[xxii].

Race and Ethnicity. The infant mortality rates for Hispanic (4.9 per 1,000 live births) and White (4.6) babies were lower than the national average and slightly decreased from the previous report. The mortality rate for Asian (3.6) babies was also lower than the national average. The infant mortality rates for Black (10.8), Native Hawaiian/Other Pacific Islander (9.4), and American Indian/Alaska Native (8.2) babies were markedly higher than the national average, with Black infant mortality nearly twice the national rate.

Preventive Care. The *Yearbook's* pre-pandemic findings on the health of babies and their families continued to be positive in two areas of preventive health care—medical visits and vaccinations. However, differences remain in receipt of care among babies in families with low income. In contrast, a substantial number of babies have the benefit of receiving care in a medical home. And, as will be reported at the end of this section, the pandemic continued to disrupt families' abilities to maintain their previous levels of preventive care.

PREVENTIVE MEDICAL VISITS[8] Although nationally, a high percentage of babies (91 percent) had received regularly scheduled preventive medical care in the past 12 months, only 87.8 percent of babies in families with low income received a preventative medical visit in the previous year as compared to 93.4 percent of those in families above low income.

NEGATIVE BIRTH OUTCOMES BY RACE AND ETHNICITY Figure 6.



[8] Note: Due to a change in National Survey of Children's Health question language, this indicator was not updated for the 2021 or 2022 *Yearbook*. Sample sizes do not support looking at subgroups beyond income.

VACCINATIONS Receipt of vaccinations was relatively high, with 72.8 percent of babies overall having completed vaccinations according to schedule. However, fewer babies in families with low income (66.1 percent) received all recommended vaccines, compared with those in families above low income (79.2 percent).

MEDICAL HOME Only one-half (51.5 percent) of infants and toddlers had a medical home. Babies benefit most from care and screening provided by a consistent medical provider or practice—a medical home—from which they receive coordinated, ongoing, comprehensive care. Yet, significantly fewer babies in families with low income (41.6 percent) had medical homes than their peers in families above low income (58.4 percent). When examined by race and ethnicity, fewer Asian (41.8 percent), Hispanic (41.4 percent) and Black (41.0 percent) babies had medical homes than the national average. White infants (59.1 percent) were more likely than the national average to have a medical home.

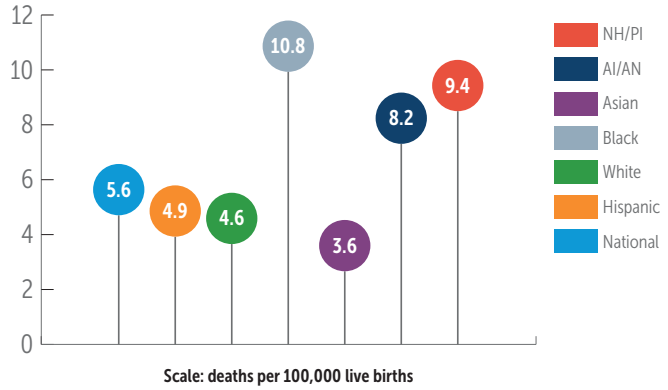
EFFECTS OF COVID-19 ON PREVENTIVE CARE

According to the 2021 RAPID data, 24.3 percent of families surveyed[9] reported that they had missed a well-baby or well-child visit, a decrease from 37.8 percent in 2020. Despite the decrease, the rate of missed visits continues to be worrisome, and nearly 3 times higher than the pre-pandemic level of 9 percent. As many as 68.7 percent of families reported concern about exposure to COVID-19 as the reason for missed visits, with inability to find child care (reported by 15.5 percent of families) being the second most frequent reason.

COVID-19's impact on health care continues to be significant. Many preventive health measures for young children have been compromised during the pandemic, especially for lower-income households and Black and Latinx households. Well-child visits are an essential part of good health, giving physicians the chance to screen for early issues with development, child and caregiver mental health, physical safety, and child–caregiver relationships. Young children also receive vital vaccinations against deadly childhood illnesses during these visits. Among the families surveyed in 2021, 13.1 percent (a decrease from 18.1 percent in 2020) reported that their children had missed a recommended vaccine, which creates an increased risk for outbreaks in childhood illnesses such as hepatitis, measles, and whooping cough.[xxiii]

Subgroup analysis of the RAPID data further reveals that Black and Latinx babies, children with disabilities, and those in families with low income are disproportionately missing well-child visits and accompanying vaccines. The percentage of Black (34.8 percent) and Latinx (31.2 percent) babies missing well-child visits continued to be significantly higher than the national average of 24.3 percent; the percentage of White babies (23.0 percent) was slightly below the average. A similar pattern was found in missed vaccinations (see Figure 8). As reported in 2020, young children with disabilities were more likely than children without disabilities to miss preventive visits at key milestone ages of 12 and 24 months.[xxiv] Families with low income were also more likely than middle- and high-income households to miss check-ups and vaccinations, reporting concerns about cost and significantly more challenges finding care for other family members necessary to attend doctor visits (see Figure 9).

INFANT MORTALITY BY RACE AND ETHNICITY Figure 7.



[9] Analyses for health and health care are based on responses collected from 1,353 caregivers who responded to at least one follow-up survey between the dates of January 5 and December 14, 2021. Proportions/percentages are calculated on the basis of item-level response rates, not out of the total sample size. The data for these analyses are not weighted.

POLICY RECOMMENDATIONS AND RELATED ACTIONS Our recommendations for improvement in Child Health include:

- **Transforming pediatric care to support early development.** Pediatric primary care is a universal touchpoint that reaches almost every baby, toddler, and young child in the nation. We can transform the pediatric setting into a family-centered support by adding a child development specialist to the primary care team, an approach pioneered by ZERO TO THREE's HealthySteps program, driving better developmental trajectories and outcomes for young children and parents.

RELATED FEDERAL POLICY ACTIONS AND STATE OPPORTUNITIES Early Childhood Support in Pediatric Offices would provide new funding for Early Childhood Development Expert Grants to help cities place early childhood development experts in primary care practices with a high percentage of patients with Medicaid and CHIP.

Additional investments include the Maternal and Child Health Block Grant, designed to promote and improve the health and well-being of mothers, children, and their families, as well as the funding of Community Health Centers to continue providing culturally competent care, help patients overcome geographic barriers, and reach the most vulnerable populations.

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

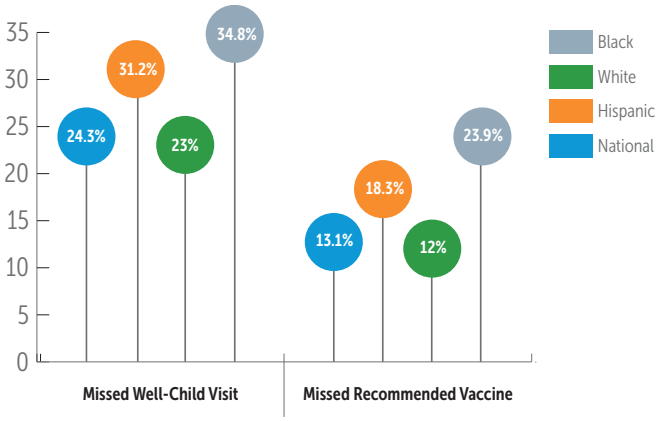
INFANT AND EARLY CHILDHOOD MENTAL HEALTH

IECMH is the developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture.[xxv] Experts from a range of disciplines consider IECMH to be the foundation of healthy, lifelong development. During the infant and toddler years, there are many opportunities to promote emotional health, to prevent emotional disturbances from taking root, and to treat mental health problems before they can manifest into more severe problems later in life.[xxvi] Availability of mental health services for babies and families has only increased in importance with the additional stressors caused by the pandemic. RAPID survey findings in 2021 reveal the ongoing effects of these stressors in the form of caregiver distress and child emotional distress.

SOCIAL-EMOTIONAL SCREENING OF YOUNG CHILDREN The Medicaid plans of **43 states cover**

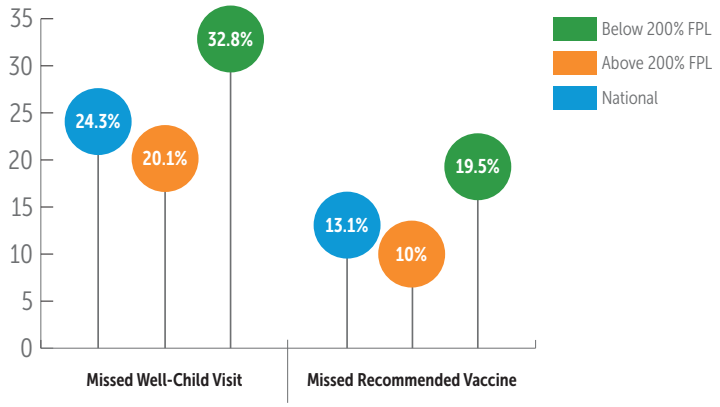
DISRUPTIONS IN PREVENTIVE HEALTH DURING THE COVID-19 PANDEMIC BY RACE/ETHNICITY

Figure 8.



DISRUPTIONS IN PREVENTIVE HEALTH DURING THE COVID-19 PANDEMIC BY INCOME LEVEL

Figure 9.



social-emotional screening of young children, which was high when last reported.

MEDICAID COVERAGE OF IECMH SERVICES Nearly all states' Medicaid plans cover IECMH services provided in settings most accessible to families with young children. **49 states covered IECMH services in the home, 46 states covered these services in pediatric/family medicine practices,** and **34 states covered these services in early care and education settings.** Despite broadening public recognition of the significance of babies' social-emotional health and access to IECMH services, at the time of development of this *Yearbook*, no update was available to the survey of state IECMH services. The available data on which we can report are unchanged from the 2020 and *2021 Yearbook* editions.

EFFECTS OF COVID-19: RAPID FINDINGS ON SOCIAL-EMOTIONAL HEALTH In 2021, caregivers with infants and toddlers continued to report increased emotional distress amid the pandemic, which coincided with an increase in their children's emotional distress (see Figures 10 and 11). Overall, child and caregiver mental health has improved since the pandemic began, with modest variation across racial and ethnic subgroups. Emotional support can serve as an important buffer against emotional distress in young children,[xxvii] but families are reporting lower levels of emotional support and higher levels of loneliness than before the pandemic.

The pandemic's effects on the social-emotional health of families with young children are particularly concerning given that the early years are crucial to the developing brain. Prolonged stressful early life experiences can permanently impact children's brain and biological systems, increasing the risk of learning difficulties and lifelong health problems such as obesity and heart disease.[xxviii] It is important to note that, as the RAPID findings continue to demonstrate, caregiver and child mental health are linked. Higher rates of caregiver anxiety, depression, and stress in 2021 were directly related to increases in young children's emotional distress, although the relationship was weaker than seen in the previous year.[xxix]

POLICY RECOMMENDATIONS AND RELATED ACTIONS Our recommendations for improvement in children's mental health include:

- Increasing the capacity to support strong IECMH. How young children feel about themselves and relate to others is at the core of all learning and development. Our nation must build the infrastructure and means to promote and address the foundational mental health needs of young children.

- Infusing all early childhood settings, such as pediatric care, child care, and home visiting, with an understanding of IECMH to promote positive social-emotional development and seek support from IECMH professionals to address behavioral health concerns.

- Developing a well-trained IECMH workforce by establishing IECMH Centers of Excellence and clinical leadership programs to address mental health needs of infants and toddlers, especially the effects of trauma and other ACEs. Such IECMH expertise should be infused in state child welfare systems to support babies and families who have experienced trauma.

- Consistently applying the science of IECMH with the widespread use of developmentally appropriate practices and tools. Promoting the use of developmentally appropriate assessment instruments and the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5)[xxx] to assess and diagnose mental health disorders in young children will help fill a critical gap.

RELATED FEDERAL POLICY ACTIONS AND STATE OPPORTUNITIES The ARP includes much-needed mental health funding for families with infants and toddlers and designates record amounts for the Community Mental Health Block Grant (MHBG) and the National Child Traumatic Stress Network. Provisions in the MHBG urge states to dedicate a portion of their block grant funding through the new Prevention and Early

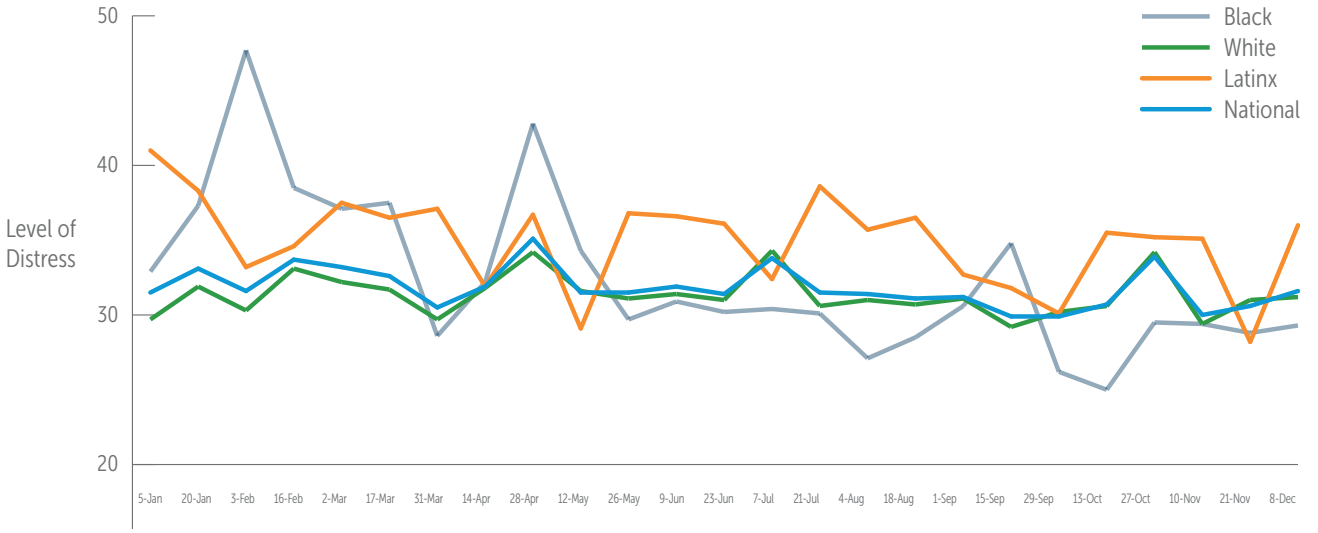
Intervention Set-Aside for services and activities related to infants and toddlers, such as expanding the IECMH workforce; improving the quality of services available to children and families; increasing knowledge of IECMH among professionals who see children most; and strengthening systems and networks for identification and referral to reach more young children in need.

Additional investments include the reintroduction in 2021 of the *Resilience Investment, Support, and Expansion ("RISE") from Trauma Act* to expand the trauma-informed workforce and increase resources for communities. The bill gives specific attention to the needs of trauma-affected young children, the specialized training required for clinicians who work with them, and provider shortages.

State Opportunity. States can specify in their Medicaid plans that multigenerational mental health therapies for babies and caregivers are covered based on the children's eligibility.

CAREGIVER EMOTIONAL DISTRESS TREND (BIWEEKLY JAN 5 – DEC 14, 2021) Figure 10.

CHILD EMOTIONAL DISTRESS TREND (BIWEEKLY JAN 5 – DEC 14, 2021) Figure 11.



NOTE: Parent emotional distress was obtained by an average composite score of depression, anxiety, stress, and loneliness symptoms, ranging from 0 to 100.

State Spotlight

Maine Conducts Study on Disparities in Access to Prenatal Care

Systemic racism in the United States has created an environment in which maternal health outcomes—already among the worst in the world—are significantly worse for communities that are Black, Indigenous, and People of Color. While the causes for such negative maternal health outcomes and disparities by race and ethnicity are complex and interrelated, one factor that helps to improve maternal health outcomes for every population is access to uninterrupted, high-quality prenatal care.[xxxi] In Maine, it was found that Black, Indigenous, and People of Color communities not only have worse maternal health outcomes than their White counterparts, they also have reduced access to prenatal care.

In 2021, the Maine Permanent Commission on the Status of Racial, Indigenous, and Tribal Populations was directed to study the extent of disparities in access to prenatal care through data and other information; study the causes of the disparities in access to prenatal care, including through interviews with those women who had no prenatal visit until the last trimester or who had no prenatal care at all; and recommend solutions to disparities in access to prenatal care in the state.

Authorized through state legislation, the Commission was charged with studying the extent and causes of disparities as well as with conducting interviews with individuals who had no prenatal care or did not have prenatal care until their third trimester. The study found that while severe maternal morbidity has been increasing nationally over recent years, Maine data showed relatively similar annual numbers. However, during that same time period, the severe maternal morbidity rate was 176 percent higher among Black delivery hospitalizations than among White delivery hospitalizations in Maine. It was also found that White pregnant people in Maine are more likely to receive adequate prenatal care and have access to prenatal care as early as they want than their Black, Indigenous, and People of Color counterparts.

Many factors drive the disparities observed in maternal health outcomes among Black, Indigenous, and People of Color communities. The report groups the main driving factors into four broad categories: racism, structural barriers, the social determinants of health, and community norms. On the basis of the data collected through the survey, five recommendations are made to improve maternal and child health outcomes for Black, Indigenous, and People of Color communities: expand community-led data gathering and align with statewide systems; invest in relationship-centered care; address structural inequities; support community-led education; and enhance statewide data collection to better serve communities.

For more information on Maine's report on racial disparities in access to prenatal care, visit here.

Good Health—Summary of All Indicators Table 4.

Subdomain	Indicator	Description	2019 *Yearbook*	2020 *Yearbook*	2021 *Yearbook*	2022 *Yearbook*
Health Care Access/ Affordability	Eligibility limit (% FPL) for pregnant women in Medicaid	Income cutoff (percent of the FPL) for Medicaid eligibility for pregnant women (median)	200	200	200	200
	Medicaid expansion state	State-adopted Medicaid expansion under the Affordable Care Act	34 states	37 states	39 states	39 states
	Uninsured low-income infants/toddlers[a]	Percentage of low-income infants/toddlers who are uninsured	5.8%	5.4%	5.1%	5.1%
	• CHIP Maternal Coverage for Unborn Child option	State extends CHIP coverage to undocumented pregnant women by covering their unborn child as a targeted low-income child	--	--	--	17 states
	Medical home	Percentage of infants/toddlers who received coordinated, ongoing, comprehensive care within a medical home	--	--	50.9%	51.5%
	Extension of Medicaid coverage for pregnant women postpartum	State efforts to extend Medicaid coverage beyond 60 days postpartum	--	--	45 states—no law beyond mandatory 60 days; 5 states—law covering either (a) some women but not all, or (b) all women but for less than 1 year; 1 state—law covering all women for 1 year postpartum	48 states—no law beyond mandatory 60 days; 3 states—law covering either (a) some women but not all, or (b) all women but for less than 1 year; 0 states—law covering all women for 1 year postpartum
Nutrition	Infants ever breastfed[a]	Percentage of infants ever breastfed	83.2%	82.9%	83.6%	84.2%
	Infants breastfed at 6 months[a]	Percentage of infants breastfed at 6 months	57.6%	54.6%	55.1%	56.8%
	WIC coverage[a]	Percentage of eligible infants who participated in WIC	--	85.9%	79.3%	97.8%
	High weight-for-length among WIC recipients	Percentage of WIC recipients 3–23 months old who have high weight-for-length	--	Available at state level only	Available at state level only	Available at state level only

Subdomain	Indicator	Description	2019 *Yearbook*	2020 *Yearbook*	2021 *Yearbook*	2022 *Yearbook*
Maternal Health	Maternal mortality rate	Number of pregnancy-related deaths per 100,000 live births	--	17.4	17.4	20.1
	Late or no prenatal care received	Percentage of women receiving late or no prenatal care	6.2%	6.2%	6.2%	6.4%
	State Medicaid policy for maternal depression screening in well-child visits[a]	State Medicaid policy requires, recommends, or allows maternal depression screenings during well-child visits	36 states	37 states	43 states	44 states
	Mothers reporting less than optimal mental health	Percentage of mothers of infants/toddlers rating their mental health as worse than "excellent" or "very good"	22.0%	19.8%	20.3%	21.9%
	Pregnant worker protections	Protections or accommodations are set in place for pregnant working people	--	--	31 states (3–state employees only; 23–state and private with limitations; 5–all employees)	31 states (3–state employees only; 23–state and private with limitations; 5–all employees)
Child Health	Infant mortality rate	Deaths per 1,000 live births	5.9	5.8	5.7	5.6
	Low birth weight	Percentage of babies with low birth weight	8.2%	8.3%	8.3%	8.3%
	Preterm birth	Percentage of babies born preterm	--	10.0%	10.0%	10.2%
	Preventive medical care received[a]	Percentage of infants/toddlers who had a preventive medical visit in the past year	90.7%	91.1%	91.1%	91.1%
	Preventive dental care received[a]	Percentage of infants/toddlers who had a preventive dental visit in the past year	30.0%	31.9%	32.9%	34.5%
	Received recommended vaccines	Percentage of infants/toddlers receiving the recommended doses of DTaP, polio, MMR, Hib, HepB, varicella, and PCV vaccines by ages 19–35 months	70.7%	70.4%	72.8%	72.7%