



STATE OF BABIES YEARBOOK 2023



Yearbook Basics

The *State of Babies Yearbook: 2023* is part of ZERO TO THREE's Think Babies initiative. ZERO TO THREE created Think Babies to make the potential of every baby a national priority. When we "Think Babies" and invest in infants, toddlers and their families, we ensure a strong future for all. Learn more at thinkbabies.org.

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

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

The indicators in the *Yearbook* are augmented with findings from the RAPID Survey of families with young children. RAPID is a survey project based at the Stanford Center on Early Childhood, which provides ongoing, actionable data on the experiences and well-being of the important adults in young children's lives to inform immediate and long-term program and policy decisions.



ZERO TO THREE
Early connections last a lifetime



Make their potential our priority.

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* This report uses the terms "Hispanic" and "Latino/a/e" interchangeably to refer to persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, Spanish, and other Hispanic descent; they may be of any race. Usage generally follow the data source.

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The *State of Babies Yearbook: 2023* tells us the story of the 11 million babies in the United States.

The data presented in our latest Yearbook paint a clear picture: bold action is needed to address the urgent needs of infants, toddlers and their families. The nation's COVID response showed us that government action can be effective in providing families the supports they need to create opportunities for all babies to thrive. Yet, we are now backtracking. We cannot pretend that challenges faced by families with young children related to income inequality, housing, child care, physical health and mental health were brought about solely by the public health emergency and, therefore, required only a temporary policy solution and commitment of resources. It is long past time to advance a sustained, bold agenda to support babies and their families.

It is with a deep sense of urgency and shared mission that I introduce you to the fifth edition of ZERO TO THREE's *State of Babies Yearbook*, providing a comprehensive look into the health and well-being of the 11 million babies who grace our nation. The *Yearbook* is far more than a collection of data and insights; it's a fervent call to action to stand as champions for change to ensure that every baby has a strong start in life.



Reflecting on the babies who were born five years ago, when the first edition of the *Yearbook* was released, their entry into the K-12 educational system marks a significant milestone. Most of their lives have been shaped by the COVID pandemic. Not surprisingly, the data confirm that the pandemic and associated economic downturn left many babies, especially babies of color, experiencing low income and living in conditions that science tells us can have a detrimental impact on healthy development.

Amid these challenges, the *Yearbook* cast a spotlight on the bold action that policymakers at both the state and federal levels took to mitigate the pandemic's consequences. During this time, we saw the largest investment in child care in our nation's history and the provision of continuous access to health care through Medicaid. Most notably, changes to the Child Tax Credit (CTC) lifted 2.9 million children out of poverty, with 6.4 million children added to public health insurance and child care funding aiding nearly 10 million children.

The evidence is unequivocal: investments in responsive policies bear fruit. The numbers tell an inspiring story, showing that policy choices can break the chains of poverty, safeguard health coverage and provide essential child care support for families with young children.

Yet, even as we celebrate these victories, we stand at a crossroads of policy and possibility. Congress and the Biden Administration had a chance to step up with a lasting commitment to support young children and families—long called for by ZERO TO THREE and its partners. Proposals on the table included a national paid family medical leave policy, expansion of access

to high-quality early care and education and other critical reforms originally introduced as part of the Administration's American Families Plan and then included in the Build Back Better Act, which successfully passed through the U.S. House. But when the final law—the Inflation Reduction Act—was negotiated, policies impacting babies were left out.

In the reality of divided government following the 2022 mid-term elections, it's hard to conclude anything other than our nation is now backtracking on bold investment in our youngest children—and our future.

The pandemic is over, but for millions of babies and their families, the state of emergency continues. Job losses and wage cuts still affect Americans every day, as they did before the pandemic. So do illness and injury, hunger, eviction and homelessness—and even unexpected deaths. When these issues occur, there are real consequences for babies' healthy development and learning. And as before COVID, these threats more often affect babies of color and those living in poverty, perpetuating inequities that put them at greater risk.

Now, more than ever, we must unite. We know what must be done. The *State of Babies Yearbook: 2023* is a blueprint for enacting comprehensive policy solutions that babies and their families need to thrive. It identifies five imperatives where urgent action is needed at the federal level: maternal health, infant and early childhood mental health (IECMH), child care, housing and economic security.

Together, let us elevate our voices to drive real, lasting change. every baby deserve equal opportunity to thrive and to step onto a life path paved with promise.

Stand with us as advocates, as changemakers, as baby champions. Together, we can shape a reality where every baby is embraced by possibility, where every family is empowered and where our nation's tomorrows are infinitely brighter.

With resolute determination,



Miriam Calderón
Chief Policy Officer
ZERO TO THREE





STATE OF BABIES YEARBOOK 2023

Five Urgent Policy Areas to Ensure a Strong Foundation

The *State of Babies Yearbook: 2023* presents a stark reality that the story of babies in the United States has not changed materially over the past five years. As we look at the data provided in the *State of Babies Yearbook: 2023*, we see that **the number of infants and toddlers continues to decline**. Today, there are about 11 million babies in our country, 900,000 fewer than five years ago. The data tell us that **diversity remains the hallmark of America's babies, a source of strength and renewal**. More than one-half, 52 percent, of infants and toddlers born today are of color. And, unfortunately, **poverty and disparities in access to resources along racial and ethnic lines continue to be defining features of a baby's experience**. Two million infants and toddlers in America live in poverty, and poverty and low income remain the most striking demographic of babies in the United States. **The state where babies are born and spend their first years also is a significant indicator as to whether a child will have a strong start in life.**

Disparities among babies in geography and by race and income emphasize the need for federal action to complement state efforts. For the *State of Babies Yearbook: 2023*, an analysis of the indicators pinpointed five priorities where urgent federal and state policy is needed to advance equitable opportunities for babies and their families. The five urgent priorities for national action are:

- **Maternal health.** The *Yearbook* shows deep and growing disparities in maternal mortality and birth outcomes, particularly for Black women and birthing people and infants, creating inequities even before birth.
- **Infant and early childhood mental health.** The *Yearbook*, including data from the RAPID Survey, raises concerns about the key factors that shape babies' early mental health: their parents' emotional well-being and the level of adverse experiences they encounter, particularly for Black, Native American and Hispanic infants and toddlers in families with low income driven by material hardship.
- **Child care.** The *Yearbook* data show that child care remains a significant struggle for families—in areas related to cost, availability and quality—as well as for early childhood educators who are undercompensated and overstressed. This undermines the access of infants and toddlers to high-quality early education and care experiences and contributes to stress and economic insecurity for families, particularly families of color, those in rural communities and those with low-income.
- **Housing.** *Yearbook* findings on young children in crowded housing and other unsafe situations reveal the threat the nation's housing crisis poses to early development, with alarming disparities for Asian, Native American, Black and Hispanic infants and toddlers.
- **Economic security.** The *Yearbook* shows a large proportion of babies living with low income (particularly Black, Latine and Native American babies), and startling levels of babies in deep poverty, carrying significantly troubling implications for their development and long-term success in school and as adults.



The United States is at an inflection point. Our nation and our states demonstrated the ability to implement policies during the COVID crisis to better meet the needs of babies and families. And there is strong demand from the public for further investments and reforms; 87 percent of parents with infants and toddlers say that addressing the needs of children and families should be either a top or important priority for Congress. The *State of Babies Yearbook: 2023* can be used as a guide to help every baby get a strong start in life. By using the data and insights provided, policymakers can set priorities and take action to create a more equitable and promising future for all babies and families across the nation.

The *State of Babies Yearbook* includes a complete demographic profile of the nation's infants and toddlers, including their race and ethnicity,* poverty level and family income, family structure, parental work status and urbanicity. These characteristics aid in analyzing the implications of the *Yearbook* indicators. As in previous editions, the *Yearbook* uses key indicators to rank states in four GROW tiers—**G**etting Started, **R**eaching Forward, **I**mproving **O**utcomes and **W**orking Effectively—based on how babies are faring and the presence of responsive policies. GROW rankings, together with the state profiles, help compare the progress across states in creating more equitable opportunities for babies and families.

What Makes Challenges for Babies So Urgent?

Put simply, babies can't wait. During their first three years, brain development occurs at a pace more rapid than at any other time of life, forming 1 million new neural connections per second. These connections are laying the foundation for all later learning and development, as infants and toddlers acquire the ability to see, hear, think, process language and reason.

Babies' earliest relationships and experiences with their parents and other caregivers dramatically influence brain development, social-emotional and cognitive skills, and future health and success in school and life. The social and physical environment in which these relationships and experiences occur, as well as many inputs to family needs (both material and social), are critical to healthy development. When children do not have what they need to thrive, early adverse experiences become integrated into their bodies, impacting lifelong development, emotional success and mental and physical health. If we do not get it right from the start for babies, we are wasting potential or, at best, helping children play catch up as they grow.

As a society, we have a stake in the young children who will be our future workers, innovators and leaders. With every year of inaction, our nation allows children to grow up without necessary supports, increasing the need for costly remedial actions down the road or resigning ourselves to a future reduction in productivity.



U.S Babies: National Profile and Key Findings

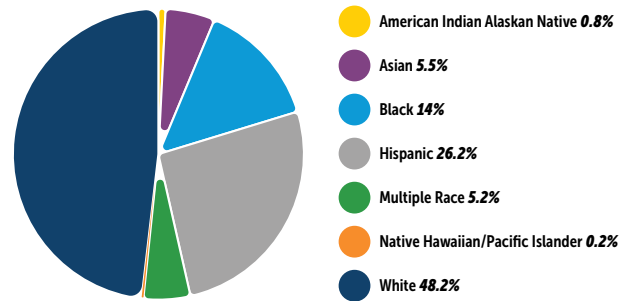
Three demographic factors highlighted in the *State of Babies Yearbook*—the decline in numbers, diversity and income disparities—are particularly salient in considering outcomes and policies that affect the state of the nation’s infants and toddlers.



In using the *Yearbook* indicators to discuss the five urgent issues identified in this report, examining these indicators by race and ethnicity, as well as by income, is crucial to the story and the urgency of need. (A complete overview can be found in Appendix A).

- **The number of infants and toddlers is declining.** The birthrate decline in America began almost 20 years ago, with a striking impact on the infant-toddler cohort. Since the first *Yearbook* in 2019, the number of infants and toddlers has declined by approximately 900,000, from 11.9 million to 11 million. The causes of this decline are complex, and even if the contribution of the lack of family-friendly policies cannot be calculated precisely, such policies almost certainly contribute to this trend and may affect any potential rebound.
- **Diversity remains the hallmark of America's babies today, a source of strength and renewal.** More than one-half (52 percent) of infants and toddlers are of color. (See Figure I-1). Unfortunately, this diversity of infants and toddlers raises concern that an increasing number of children will be exposed to past and present systemic racism and implicit bias at an early age. RAPID Survey data show that, in particular, Black and Latine parents of infants and toddlers already have concerns about the impact of racism on their young children. Black parents report being most concerned about their children being treated unfairly by other children (49.6 percent), having fewer choices in life (48.7 percent) and being excluded from events or groups (44.1 percent). Latine families report being most

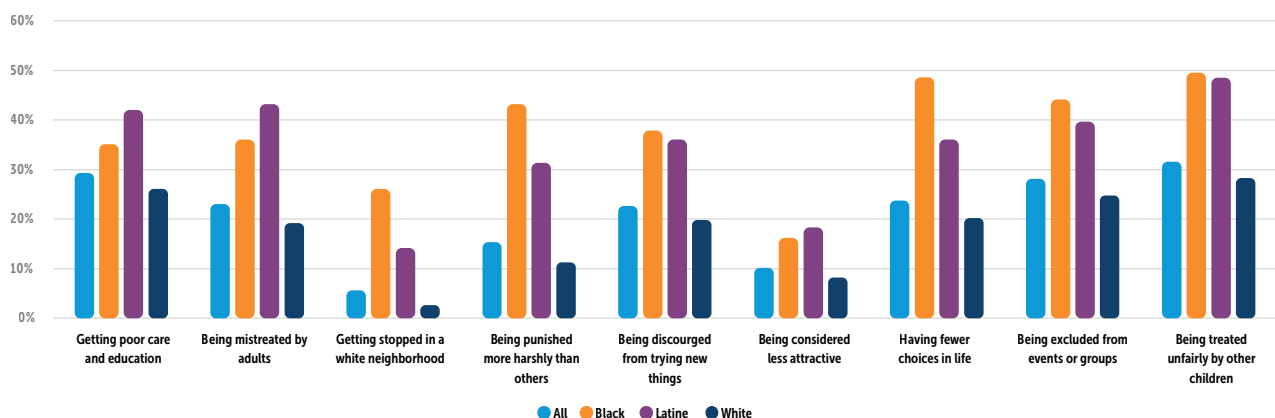
INFANT AND TODDLER BY RACE AND ETHNICITY Figure I-1



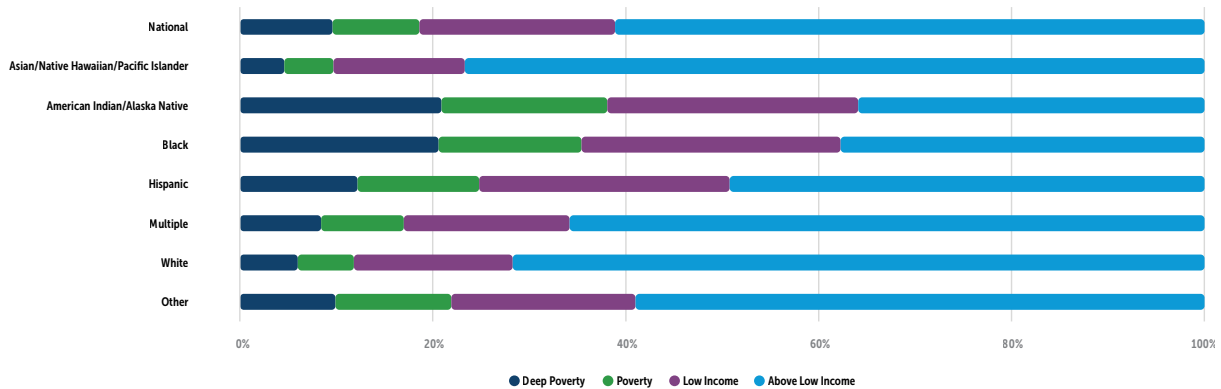
concerned about their children being treated unfairly by other children (48.5 percent), being mistreated by adults (43.2 percent) and receiving poor care and education (42 percent). (See Figure I-2).

- **Poverty and disparities in access to resources along racial and ethnic lines are defining features of a baby's experience.** Two million infants and toddlers in America live in poverty, and poverty and low income remain the most striking demographic factor of babies in the United States, illustrating the intersectionality of income with race and ethnicity, as shown in Figure I-3. In 2021, nearly two in five (38.9 percent) of the nation's infants and toddlers lived in families earning less than 200 percent of the federal poverty level (\$55,000 a year for a family of four), meaning they lacked the financial resources to make ends meet.

CONCERN ABOUT CHILDREN BY RACE/ETHNICITY Figure I-2



BABIES BY FAMILY INCOME AND RACE AND ETHNICITY Figure I-3

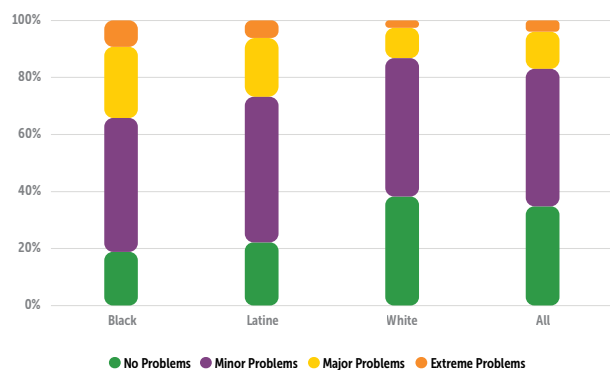


During the same period, approximately three in five Black (62.3 percent) and Native American (61.4 percent) infants and toddlers lived in families with low income. Most alarming, one-fifth of all Black and Native American infants and toddlers lived in deep poverty (defined as 50 percent of the federal poverty level), higher than the national rate of 18.6 percent of all babies living in poverty. Babies in rural areas (24.7 percent) also are more likely to experience poverty, with one in eight (13 percent) living in deep poverty. These poverty and income levels are concerning, as babies' rapid brain development during their early years makes them particularly vulnerable to the material hardship and family stress that accompany poverty, with long-term consequences for later success in school and employment.

The intersection of race and income highlights the persistent effects of past and present systemic racism and discriminatory practices that have limited access to financial resources, educational opportunities and fair job and wage structures for families of color.

Recent economic conditions find families of color continuing to experience the greatest hardships. RAPID Survey findings for 2022 and early 2023 show that Black and Latine families with infants and toddlers are more likely to have some level of financial problems, with more than one-third of Black families and one-quarter of Latine families experiencing major or extreme issues, compared with 16 percent of all children nationally (see Figure I-4). This urgent issue of economic security for infants and toddlers is discussed in Urgent Priority #5: The Economic Insecurity That Engulfs Many Babies.

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR FAMILY FINANCIALLY AT THIS TIME? Figure I-4



A photograph of a man with dark hair and a mustache, wearing a yellow and white striped shirt, looking off to the side. A young girl with dark hair and bangs, wearing a grey shirt, is sitting on his shoulders, resting her hands on his face. The background is a bright blue sky with some green foliage visible on the left. On the left side of the page, there are decorative white circles of varying sizes, some containing small colored dots (blue, orange, purple).

State Progress for Babies: GROW Rankings

Geography matters. The state where babies are born and spend their first years makes a difference in whether they have access to the resources needed for a strong start in life.

While the *State of Babies Yearbook* facilitates considering the urgent needs of babies and families nationally, it also tells the story of babies in each of the 50 states, the District of Columbia and Puerto Rico—and where they stand in relation to each other. As in previous editions, the *Yearbook* uses key indicators to rank states in four GROW tiers—**G**etting Started, **R**eaching Forward, **I**mproving **O**utcomes and **W**orking Effectively—based on how babies are faring and the presence of responsive policies. These rankings, together with the state profiles, help compare progress across states.

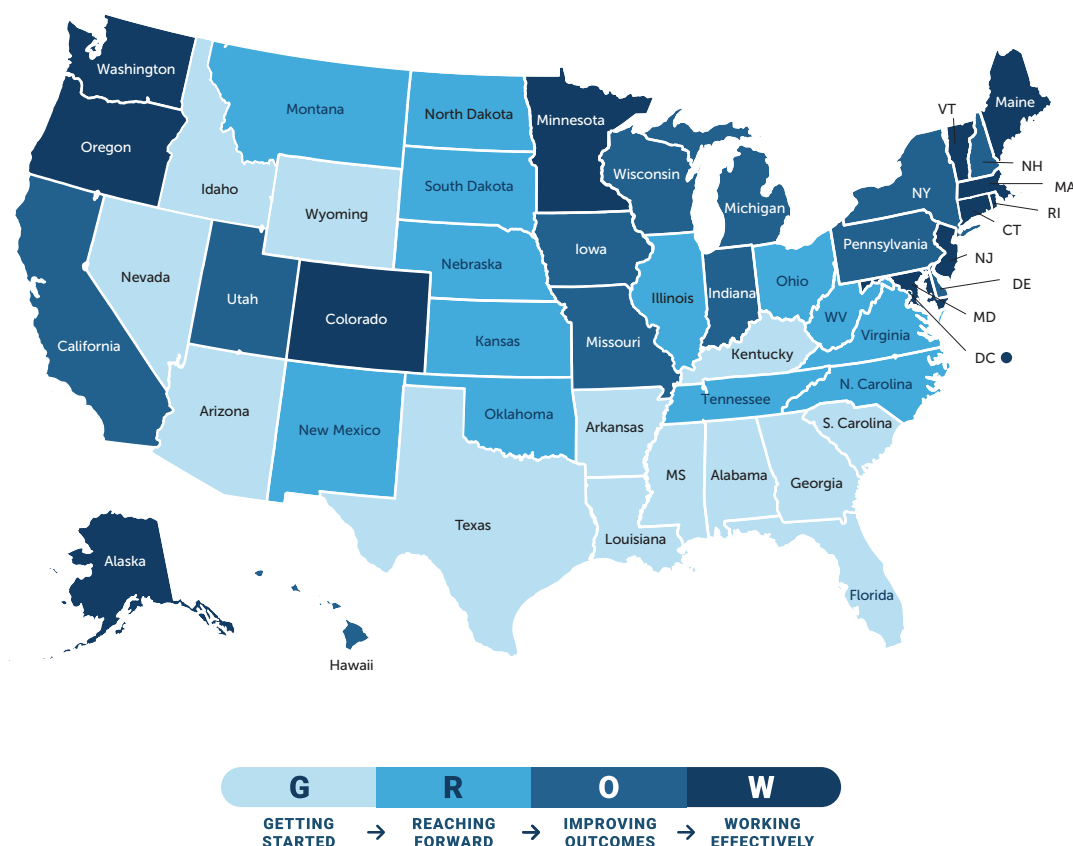
Figure I-5 shows at a glance where babies stand in each state according to overall GROW rankings. Regional patterns in 2023 were similar to those seen in previous years, with few exceptions. Specifically, states in the Northeast and Northwest were more likely to score in the top two tiers of states across all three domains, as compared with states in the Southwest, Midwest and South.

In interpreting a state's tier placement, it is important to bear in mind that the ranking is determined relative to all other states' performance, and not based on an identified benchmark. Therefore, some states may shift even if their indicators have remained stable because other states have improved. Moreover, a lower overall rank should not obscure the fact that a state may have promising indicators within one or more domains that can reflect initiatives the state has undertaken to improve babies' outcomes. In fact, all states, including those in higher tiers, have indicators on which they can improve—and all have room to grow.

A Powerful Tool for Policymakers

The GROW rankings enable a much deeper look at well-being and policies than just overall comparison by state, making data as it exists on the *State of Babies Yearbook* website a powerful tool for state policymakers and advocates to

2023 OVERALL RANKING OF STATES Figure I-5



discern where they need to place their efforts and to set goals for improvement at the state, domain and indicator levels.

Yearbook data were selected to illustrate and analyze how babies and families are faring in the three domains of what babies need to thrive articulated in ZERO TO THREE’s policy framework—Good Health, Strong Families and Positive Early Learning Experiences. A profile of each state and the District of Columbia incorporates the indicators, organized by these domains and further into subdomains, such as Children’s Health or Basic Needs. Finally, the profiles depict each indicator in the GROW tiers, so that users can see where individual states fall and the range of outcomes across states, as well as analyze performance on an indicator across states through the website’s “Compare Indicators” function.

Using the web-based profiles, state policymakers and advocates can look at a complete set of the same data elements used in our national analysis, tailored for their state. They can see where their state stands for each domain and indicator compared with other states. And where disaggregated data are available and sample sizes are large enough, they can look at how subpopulations—babies of different races and ethnicities, of different incomes, and of either

metropolitan or rural residence—are faring compared to the state and national averages on individual indicators, such as premature births or babies living in crowded housing.

For example, state users of the *Yearbook* who examined subpopulation data and discovered that babies of color were faring poorly even in a highly ranked state have moved to address those problems. Others have employed their state’s standing on a key indicator to set goals for improvement. The important point is that the data help pinpoint challenges and potential policies for addressing them— and by doing so, help propel action. In addition to indicators of well-being, state policymakers and advocates can see what policies a particular state has instituted or is lacking in comparison with other states. This year, the *State of Babies Yearbook* website will link to ZERO TO THREE’s database of state policy initiatives so that policymakers can get ideas and network with colleagues from other states.

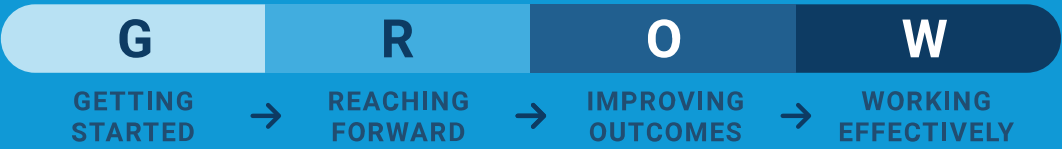
Applying an Equity Lens

The interactive profiles and rankings available on the *State of Babies Yearbook: 2023* website include all available subpopulation data for individual indicators, enabling state policymakers and advocates to apply an equity lens to their analysis. Where possible, indicators are disaggregated by race and ethnicity, income and urbanicity. Examining the data by subgroups beneath the averages helps users deepen their understanding of who is benefiting from programs, services and policies, and adjust accordingly. As in the example above, policymakers in higher ranked states in particular should examine indicators for subpopulations, where they may find a different story for their states’ babies than highly ranked averages suggest.

Table I-1 *State of Babies Yearbook 2023: Overall Rankings* presents more information about the GROW tiers and a list of how all 50 states and the District of Columbia compared with each other in 2023. The tiers represent four groupings of states that are approximately equal in size, ordered from highest- to lowest-performing. Appendix D includes a detailed methodology used in the ranking process. Appendix E includes additional information on the indicators included in the ranking, as well as additions in demographic data



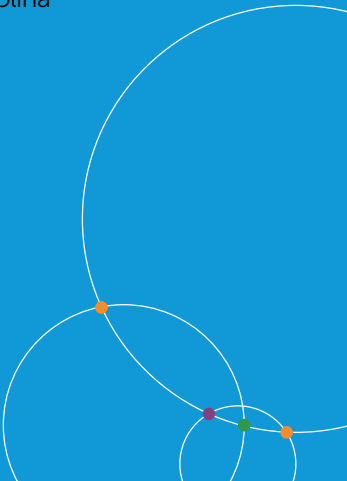
The GROW symbols designate the tiers, from lowest to highest, referring to the different stages of growth in terms of well-being and policies. These symbols are used in the state profiles and throughout the *Yearbook* to designate a given state's placement on this GROW scale. Each indicator for a state also falls along the scale, visible in the state's profile.



Data provided in individual state profiles, in conjunction with the rankings, provide policymakers and advocates a resource to inform decision making and serve as a catalyst to make investments and implement strategic changes in areas of identified need. A comprehensive view of each state's profile data is available at stateofbabies.org.

STATE OF BABIES YEARBOOK 2023: OVERALL RANKINGS Table I-1

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



About the Data in the *State of Babies Yearbook: 2023*

State of Babies Yearbook Data: The 90 indicators and demographic data points included in the profiles and used for the state rankings are drawn from key national data sets (e.g., U.S. Census Bureau population statistics, the American Community Survey and the National Survey of Children's Health), as well as the policies in place to promote their success. The data dictionary in Appendix E details the sources for individual indicators, while Appendix A describes these indicators in additional detail. Because the data reported in these sources are retrospective by one or more years, indicators do not yet fully reflect the consequences families have experienced since the onset of the COVID-19 pandemic in 2020.

RAPID Survey Data: Additional data on families with infants and toddlers is drawn from the national Rapid Assessment of Pandemic Impact on Development (RAPID) Survey of families with children aged 5 and under. The RAPID Survey data in this *Yearbook* were collected between January 2022 and April 2023, providing a current look at how families with babies are faring that supplements the *Yearbook's* indicators, which are drawn from more retrospective national data sets.

As in previous *Yearbook* editions, the *State of Babies Yearbook: 2023* indicators and RAPID

Survey data are disaggregated by race and ethnicity, income and urbanicity, where possible. The 2023 *Yearbook* continues to refine the information presented to tell the story of babies. Table I-2 summarizes this year's changes. The *State of Babies Yearbook* website, www.stateofbabies.org, includes these indicators in profiles for the nation and each state, organized by the three domains of ZERO TO THREE's policy framework (Good Health, Strong Families and Positive Early Learning Experiences), as well as state rankings.

2023 INDICATOR MODIFICATIONS Table I-2

| | |
|--|--|
| Demographics | 1. NEW: infants and toddlers living in deep poverty (50 percent or below the federal poverty level) 2. NEW: one parent working full-time 3. NEW: one parent working full-time among families in poverty |
| Good Health | 4. NEW: WIC usage reported by three age groups (infants, 1-year-olds and 2-year-olds) |
| Strong Families | No changes |
| Positive Early Learning Experiences | 5. DELETED: state-allocated Child Care Development Block Grant funds to infants and toddlers |







Urgent Priority #1:

The Crisis in Maternal and Infant Health

A healthy pregnancy and birth are the foundation for children's future health and development, making the well-being of women and pregnant/birthing people critical. Whether babies are born healthy and with the potential to thrive as they grow depends greatly on their mother's/ birthing person's health and wellness—not just before birth, but prior to conception. Thus, birth outcomes and infant health are highly interconnected with women and birthing people's access to quality healthcare before, during and after pregnancy; their experiences while receiving care; and other social and economic factors, all of which can reflect the influences of past and present systemic racism.

Maternal and infant health in the United States remains a crisis, with our country having the highest maternal mortality rate among Organization for Economic Co-operation and Development (OECD) nations. And, tragically, the Centers for Disease Control and Prevention (CDC) estimates that 80 percent of pregnancy-related deaths are preventable.¹ Moreover, stark racial disparities in maternal and infant health outcomes have persisted for decades and worsened during the pandemic. The *Yearbook* data reveal significant racial disparities in prenatal care and other indicators of maternal health such as preterm births and low birthweight. The situation is worsening in the wake of the Supreme Court decision overturning *Roe v. Wade*. States' actions to severely limit access to reproductive healthcare further complicate access to providers and hospitals and pose multiple challenges for maternal health.

Policies must address access to coverage and care, with particular attention paid to culturally responsive services. In addition, if the nation is to make real progress in tackling these challenges, it is critical to address the root causes of health inequities, such as housing, economic security, safety, nutrition and mental health. One example of bold action that has dramatically improved outcomes for babies and their mothers/ birthing persons is the pandemic-era policy encouraging states to take up the option of extending comprehensive, continuous health insurance coverage during pregnancy and for no less than 12 months following the end of pregnancy. To date, 46 states have adopted or plan to adopt the permanent Medicaid option for extending coverage 12 months postpartum,² and there is growing support to make this a requirement in Medicaid and the Children's Health Insurance Program.



FAMILY STORY

My son Mason is 2½ years old. One thing that I am passionate about in my family is ensuring that we are always filling our space with love and that we are confident to speak up for things we believe in. I want us to know that we deserve to be free from stress and systematic barriers. I have been a Head Start Family Advocate and a community advocate for a long time, and so when I had my baby, I was educated. I knew how to keep myself healthy during pregnancy. I knew I wanted a more natural, organic birth for my baby. I knew I wanted to breastfeed. And I also knew that the maternity mortality rates for Black mothers and the infant mortality rates for Black babies reflect our nation's history of racial inequity.

So I prepared. I looked for a practice that included midwifery that accepted Medicaid. I hired a doula. I thought through a birth plan that reflected what I wanted for the birth. I gave birth during COVID but hoped I could set up a system that could provide me with the attentive, individual care I deserved.

But I was disappointed throughout my pregnancy. I asked to see the same midwife each visit, but I saw a different provider for many visits and had to explain over and over and ask and re-ask the questions that troubled me. I developed a rash early in my pregnancy that got worse and worse and that was continually treated as athlete's foot (though it was much later diagnosed as eczema). I was not referred to a dermatologist until after birth. When I tested as prediabetic, I was told to lose weight. My blood pressure started climbing, and I couldn't afford a blood pressure cuff. No one told me that I could access one for free through Medicaid. When I was diagnosed with pre-eclampsia, late in my pregnancy, an unfamiliar midwife got annoyed when I asked for guidance: "We can just induce, if that's what you want," she kept telling me. And because it was my first baby, and I did not know what to do, I relented.

In violation of my birth plan, I was induced, though my doula was able to be with me during birth. She was an important advocate, pushing back on practices that were not comfortable for me, or helpful. Even so, my birth plan stated that I wanted a midwife to attend my birth. Instead, I was induced by a student, who busted my water without consent! It caused my labor to stall, and the student was performing cervix checks early in dilation, also in violation of my birth plan.

I am grateful every day that Mason was born healthy. But over and over again, my maternal health providers ignored my worries about my health and my wishes for my birth. They insisted I lose weight and limit my stress, but gave me no meaningful strategies. I spent my pregnancy Googling and guessing. I felt disrespected and judged and, ultimately, inadequate. Pregnant people should have more options for care. We should have familiar health providers. And most of all, we should have providers who understand the system, who take time to fully diagnose and treat an issue, and who listen to their patients.

*Mahogany L.
Louisville, Kentucky*



Indicators Underscore Concerns About Racial Disparities in Maternal and Infant Health

The *Yearbook* indicators for both the prenatal period and birth outcomes show that women and birthing people are not receiving the care they need to protect their own health and have healthy outcomes at birth and afterward.

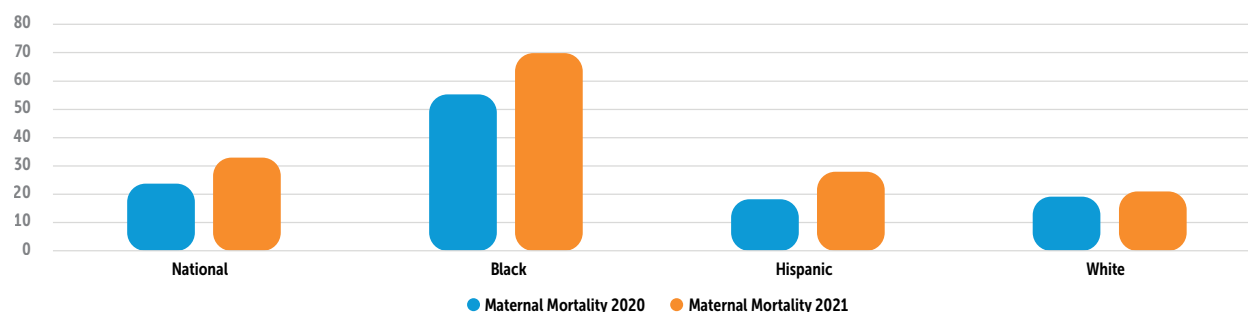


Systemic barriers, along with discrimination in the healthcare system and the cumulative experiences of systemic racism that women and birthing people of color experience throughout their lives, drive the significant racial disparities seen in the data for Black, Latine, American Indian/Alaska Native (AI/AN), and Native Hawaiian women and birthing people and their newborn infants. Difficulties accessing prenatal care, and by extension quality care in giving birth, will only grow as more communities lose obstetrical services.

Maternal Mortality: Maternal mortality refers to a pregnancy-related death that occurs while a woman or birthing person is pregnant or within one year of the end of pregnancy.³ *State of Babies Yearbook* and CDC data⁴ show the maternal mortality rate continued its alarming rise to 23.8

deaths per 100,000 live births in 2020 and 32.9 in 2021. (See Figure 1-1). (The 2021 data shown here was reported after the *Yearbook* data collection ended). The continued steep increase in maternal mortality is largely driven by a rise in the rate for Black women and birthing people, increasing to 55.3 deaths per 100,000 live births in 2020 and 69.9 in 2021. Latine women and birthing people also saw a large increase, from 18.2 per 100,000 live births in 2020 to 28.0 in 2021, putting them well over the national average. While the *Yearbook's* annual data source does not include data for Indigenous women and birthing people, CDC trend data from 2017 to 2019 reveal high levels among Native Hawaiian (62.8 per 100,000 live births) and American Indian/Alaska Native (32 per 100,000 live births) pregnant women and birthing people.⁵

MATERNAL MORTALITY (BY RACE AND ETHNICITY) 2020 AND 2021 (PER 100,000 LIVE BIRTHS) Figure I-1



The Pandemic's Impact on Maternal Mortality

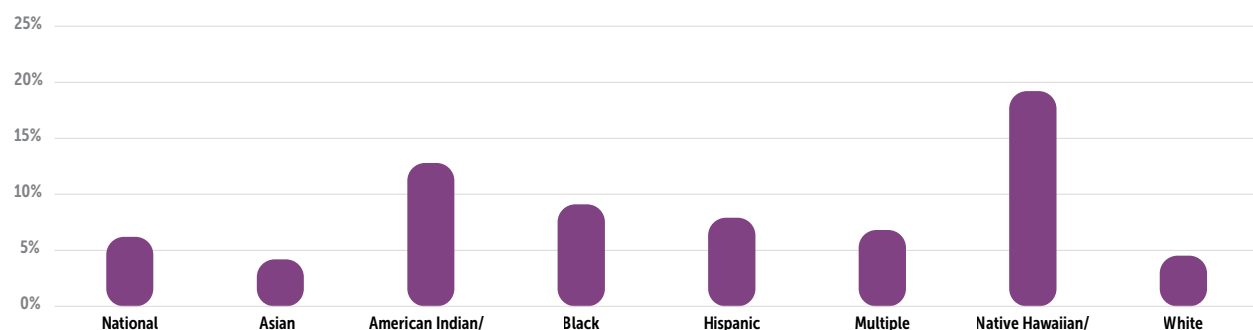
The pandemic worsened pregnancy outcomes, including maternal deaths, and deepened racial disparities with greater impacts of COVID-19 on Black and Latine women and birthing people.⁶ The Government Accountability Office (GAO) found COVID-19 contributed to the large increases in maternal deaths reported in 2020 and 2021, serving as a contributing factor in one-fourth of maternal deaths during the period. Pregnant women and birthing people, especially Latine women/birthing people, were more likely to be hospitalized with COVID-19 and need intensive care.⁷ As obstetrical care required creative approaches such as telehealth visits and self-monitoring, women and birthing people with low income were less likely to be able to afford equipment for these strategies⁸ and more likely to experience such problems as lack of transportation or child care to enable them to attend in-person healthcare visits.⁹ They were also more likely to have underlying conditions that made their pregnancies high-risk, increasing the potential consequences of being unable to access care.¹⁰

GAO noted that pandemic conditions underscored the impacts of racism on maternal health, discussed further below, as systemic racism contributes to the presence or exacerbation of underlying health conditions. The disproportionate impact of the pandemic and resulting economic fallout on the health and economic security of people of color also exacerbated chronic stress. Further, the pandemic increased distrust in the healthcare system via frequent changes to information about pregnancy and COVID-19, as well as policies limiting partners in delivery rooms.¹¹

Access to Prenatal Care: Access to regular, reliable, culturally responsive prenatal care is critically important to reducing maternal mortality and morbidity, as well as producing positive maternal health outcomes. *Yearbook* indicators show that a greater percentage of pregnant people of color are more likely to start prenatal care late in pregnancy, particularly Native Hawaiian (19.2 percent), Native American (12.8 percent) and Black (9.1 percent) pregnant people, when compared the average of all pregnant people (6.2 percent). (See Figure 1-2).

Lack of Health Insurance: The inability to afford health insurance is a key reason for difficulties accessing early prenatal care and extended postpartum care. In general, women and birthing people of color and non-citizens are more likely to be uninsured. Among nonelderly women and birthing people with low income, nearly one in five (19 percent) were uninsured in 2021,¹² with 22 percent of all nonelderly Latine and Native American women/birthing people uninsured during the same period.¹³ Despite the importance of good preconception health for a healthy pregnancy, many women and birthing people

LATE OR NO PRENATAL CARE BY RACE AND ETHNICITY Figure I-2



with low income are ineligible for Medicaid, especially in states that have not adopted Medicaid expansion, and are thus less likely to receive preconception and early prenatal care.

Studies show that Medicaid expansion is associated with improved maternal and child health, including reduced disparities in birth outcomes such as infant mortality, preterm birth and low birth weight.¹⁴ However, a study of Medicaid expansion in 2019 found that non-Medicaid expansion states (17 at the time) accounted for more than one-half of uninsured women and birthing people of childbearing age. Currently, only 10 states have yet to adopt Medicaid expansion, but two of these states (Texas and Florida) accounted for approximately one in four uninsured women/birthing people of childbearing age in 2019.¹⁵ In all states, many women and birthing people become eligible for Medicaid when they become pregnant, but the delay experienced if they have not previously been on Medicaid contributes to late access to prenatal care. Even so, the *Yearbook* shows 19 states set their eligibility levels below 200 percent of poverty, which still excludes some women/

birthing people who may not be able to afford coverage elsewhere.

An effort to extend Medicaid and Children's Health Insurance (CHIP) coverage during the period after birth has been extremely successful, with 46 states having either adopted a federal option to extend coverage for 12 months postpartum or planning to do so in the future.

Maternity Care Deserts: Geography is another significant predictor of receipt of prenatal care. More than one-third (36 percent) of the nation's counties are considered prenatal care deserts, meaning they are without hospitals providing obstetric care, freestanding birth centers or even individual obstetric providers, including obstetricians or licensed midwives.¹⁶ Many more counties have limited maternity care access. This lack of care is increasing in rural areas and tribal lands, with low-income women and birthing people overrepresented in counties considered maternity care deserts.¹⁷ The need to drive long distances for basic prenatal care, or to obtain care for high-risk pregnancies that require immediate attention if something goes wrong, present further threats to the health of pregnant people.



Disparities in Other Maternal Health Outcomes

The *Yearbook* does not capture measures of maternal morbidity—health problems that could have long-term consequences for a birthing person’s health and, often, for the developing fetus. However, the disparities in birth outcomes readily apparent in *Yearbook* data are evidence of the importance of quality maternal care and the consequences of neglecting the needs of many women and pregnant/birthing people.

Infant Mortality Rate: The prenatal period has a significant impact on infant mortality (i.e., the number of babies who die before their first birthday). The national infant mortality rate is 5.4 deaths per 1,000 live births. The mortality rate is markedly higher for Black (10.6), Native Hawaiian/Other Pacific Islander (8.2), and American Indian/Alaska Native (7.9) infants. The Black infant mortality rate is nearly twice that of the national rate. (See Figure 1-3).

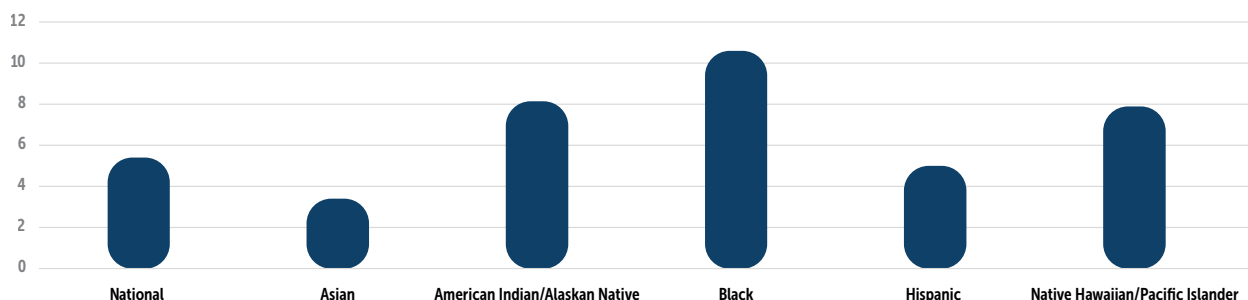
The United States ranks 37th among OECD nations in infant mortality. Even the best performing state (Vermont) would only rank 25th.¹⁸ Several of the leading causes of infant mortality, such as birth defects, preterm birth, low birthweight and pregnancy complications,¹⁹ stem from conditions

experienced during the prenatal period, as well as genetic factors. Quality maternal care could prevent or reduce the effects of these issues.

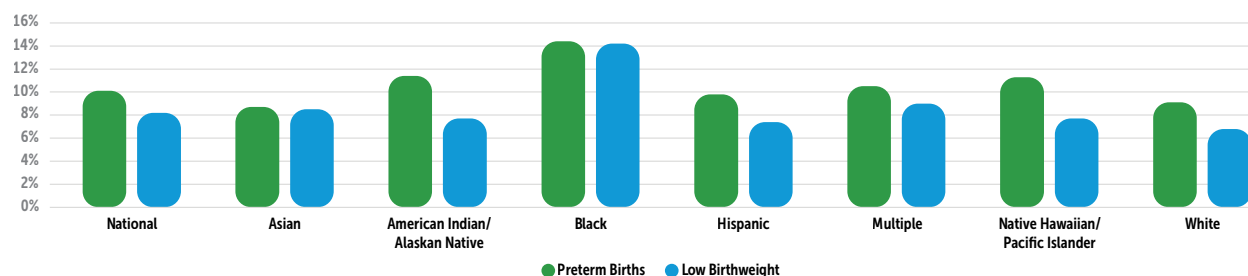
Preterm Births: One in 10 births are preterm (i.e., the baby is born before 37 weeks of completed gestation). Preterm birth rates are significantly higher than the national average (10.1 percent) for Black (14.4 percent), American Indian/Alaska Native (11.4), Native Hawaiian (11.3) and multiple race (10.5) infants. (See Figure 1-4). Factors that can contribute to prematurity range from multiple gestations or physical characteristics of the uterus, little or no prenatal care, chronic medical conditions, poor nutrition and substance use. Improved prenatal care would provide the close monitoring needed to ensure a healthy birth. Premature babies are at higher risk of such developmental issues as cerebral palsy, language and cognitive deficits, and learning disabilities.²⁰

Low Birthweight: Of all infants, 8.2 percent are born with a weight of less than 5.5 pounds. The national average for Black infants born at low birthweight is strikingly high at 14.2 percent. (See Figure 1-4). Low birthweight is often associated with premature birth, but other factors can also

INFANT MORTALITY BY RACE AND ETHNICITY (PER 1,000 LIVE BIRTHS) Figure I-3



BIRTH OUTCOMES Figure I-4



lead to slow growth during pregnancy. Risk factors for low birthweight include chronic health conditions, infections during pregnancy, use of such substances as alcohol or tobacco, multiple gestations and exposure to unhealthy environmental conditions such as air pollution.²¹

All of these factors point to the need for quality prenatal care to prevent, address or monitor low birthweight, which is strongly associated with poor developmental outcomes that affect school readiness and extend into adult life.

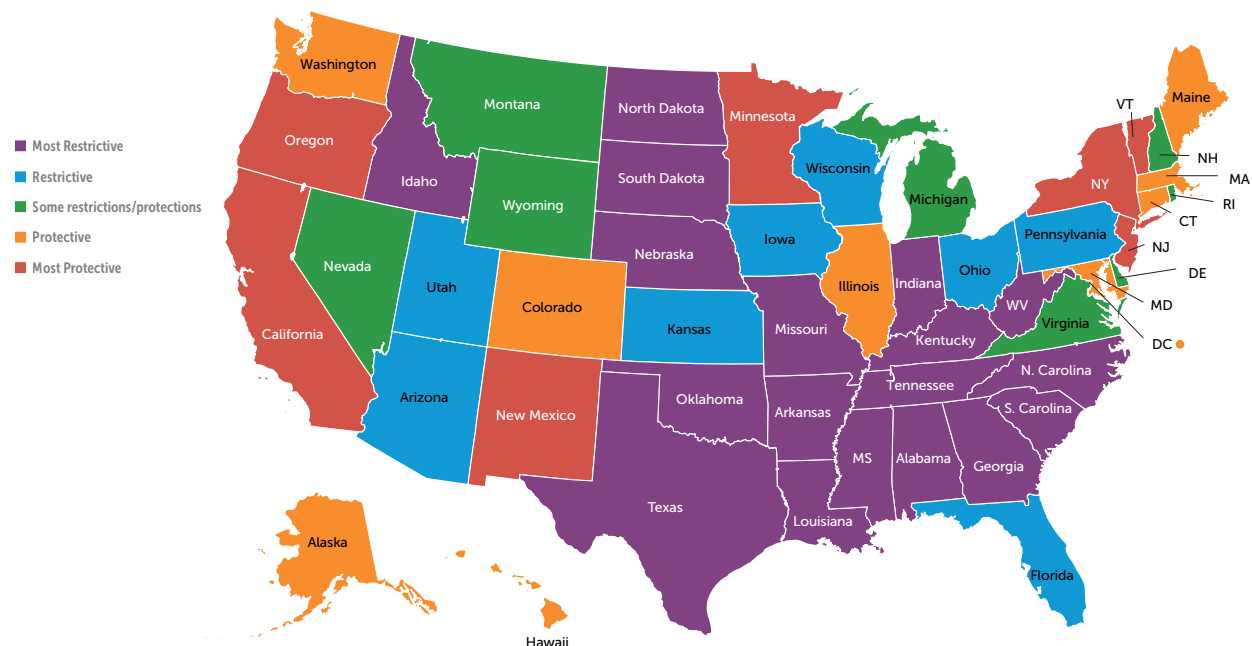
Reproductive Health

A growing challenge to maternal and infant health is access to reproductive healthcare. States that have instituted restrictions on women and birthing people's access to comprehensive reproductive healthcare, most commonly by legislating the provision of reproductive healthcare services that result in women/birthing people no longer being empowered to make their own decisions in consultation with their doctors, are likely to see maternal and infant health disparities exacerbated. Studies find associations between unintended pregnancies and lower initiation of breastfeeding,^{22,23,24} as well as a greater likelihood of preterm births and low birthweight babies.^{25,26} There is also evidence of negative maternal mental health outcomes associated with unintended births, such as depressive symptoms.^{27,28,29} Moreover, restrictive reproductive

health care policies are likely to deepen disparities along racial, economic and geographic lines. Prior to the Supreme Court decision overturning *Roe v. Wade*, women/birthing people who were young, Black, Latine, experiencing poverty, and/or living in rural settings already had the least access to reproductive healthcare.

States that have adopted restrictive policies on reproductive healthcare access also have fewer supportive policies in place. A comparison of the placement of 18 states with the most restrictive policies on reproductive healthcare access (as of September 2023) with the *Yearbook's* quartile-based GROW ranking system revealed many of these states falling into the lower tiers (see figure 1-5). In general, these states share a number of areas in need of improvement:

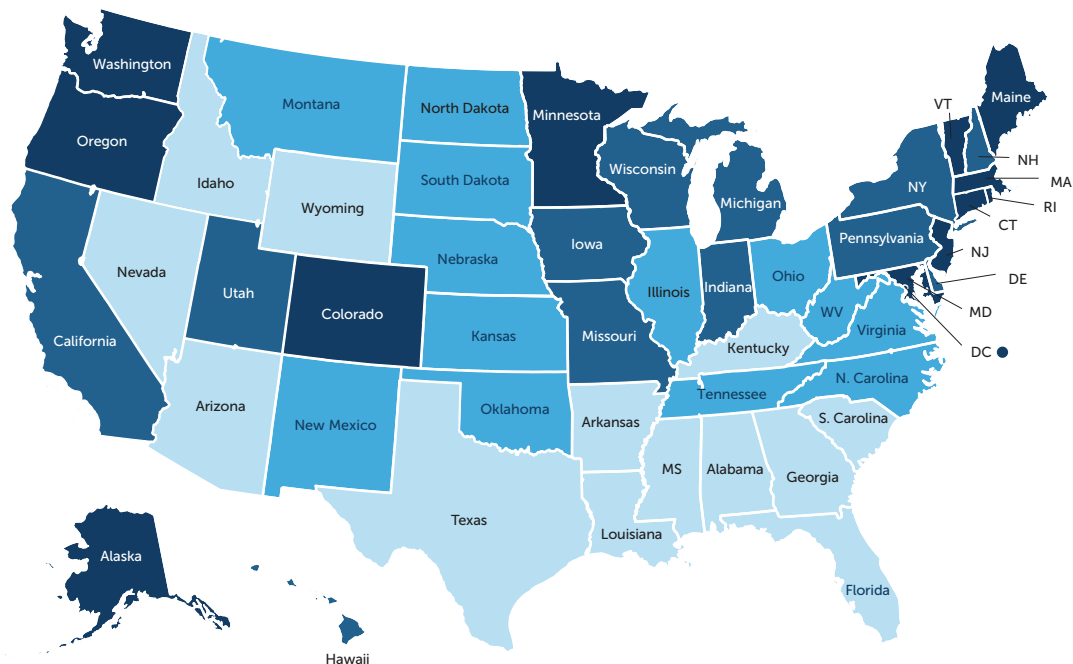
RESTRICTIVE AND PROTECTIVE ABORTION MAP (SEPTEMBER 2023) Figure I-5



Source: Adapted from Guttmacher Institute <https://states.guttmacher.org/policies>

- higher levels of babies in families with low income (15 of 18) or in poverty (16 out of 18)
- poorer maternal and child health outcomes such as infant mortality (15 of 18) and low birth weight (12 of 18) than seen nationally
- a higher percentage of babies in families with low or very low food security (13 out of 18)
- a higher incidence of babies with one adverse childhood experience (14 of 18) or two or more adverse experiences (11 of 18)
- the lowest levels of families with babies in poverty receiving TANF cash assistance (17 out of 18 in the lowest two quartiles for the percentage of families with infants/toddlers living below 100 percent of the federal poverty line that receive TANF benefits)
- the absence of policies that assist families with the high costs of parenting infants and toddlers:
 - Earned Income Tax Credit (12 of 18 states, no policy)
 - State Child Tax Credit (14 of 18 states, no policy)
 - Paid Family and Medical Leave (0 out of 18 states)
 - Paid Sick Leave that includes caring for a child (0 out of 18 states)
- comprehensive maternal and infant toddler health coverage (Most of the 18 states have adopted the 12-month postpartum Medicaid extension; however, they make up 5 of the 10 states that have yet to expand Medicaid, and 10 of 18 have higher percentages of uninsured infants and toddlers with low income.)

2023 OVERALL RANKING OF STATES Figure I-5



Racism and Discrimination Impact Disparities

Research also makes clear that barriers to realizing good maternal health, such as discrimination in healthcare settings and high levels of stress are in large part rooted in racism and in turn are key drivers of racial disparities in maternal and infant care.

Discrimination in the Healthcare System:

Research has found evidence of racism among healthcare providers in the United States, such as racist beliefs, emotions and practices³⁰ that can particularly affect pregnant people of color at a time when their health is at increased risk and their need for a trusted provider is at its highest. Quality of prenatal care encompasses not only the skills, professional advice and personalized treatment of the provider and facility, but also the ability to build a relationship that fosters trust and ensures patients' participation in decision making.^{31,32} People of color are more likely to experience interactions with healthcare providers that are unsupportive and disempowering. Black and Hispanic individuals have highlighted concerns related to racism—such as disparities

in health outcomes, discomfort associated with receiving care from physicians of dissimilar races/ethnicities and fear of being victims of medical experimentation—as negatively impacting their access to medical care.³³ Moreover, people of color often receive care in or only have access to lower-quality hospitals.^{34,35}

Stress and “Weathering”: The accumulation of chronic stress and individuals' efforts to cope with it can have a serious impact on health, leading to an increased physiological burden across multiple biological systems.³⁶ Such an accumulation of stress can build in people of color based on repeated experiences with institutionalized and interpersonal racism, detrimentally affecting health outcomes and resulting in the maternal health disparities apparent in our *Yearbook* data. Black individuals of all socioeconomic statuses^{37,38,39} can experience *weathering*, defined as the build-up of daily emotional stress related to exposure to racism that leads to differences in health outcomes experienced over one's lifespan, which can affect the incidence of preterm births, low birth weight and infant mortality.^{40,41,42}

Risks Associated with Low Income: Women and birthing people of color are overrepresented among those living in poverty or with low income, and they disproportionately experience risks associated with economic insecurity, including unstable or poor-quality housing, environmental toxins, unsafe neighborhoods and a lack of material resources. *Yearbook* data show these experiences are disproportionately affecting babies of color and those in families with low income. Approximately 40 percent of Black and Hispanic/Latine mothers and birthing people, many of whom were economically insecure before giving birth, experienced poverty around the time of birth, even taking into account government support such as nutrition, housing and energy assistance.⁴³ The circumstances associated with economic insecurity are themselves influenced by systemic racism that affects wage and employment patterns and access to resources. In turn, these circumstances contribute to increased stress levels, threatening maternal and child well-being beginning prenatally.





Policies to Improve Maternal and Infant Health

Improving maternal and infant health requires building a system of policies and services that both expand access to healthcare and seek to improve the cultural responsiveness and quality of care for the women and birthing people of color whose lives and babies are most at risk.

Broad, supportive policies create healthcare and coverage infrastructure, but many solutions must be tailored to local needs and come from within the community itself. Improving access to care without addressing underlying factors associated with past and present systemic racism will not alleviate disparities. For example, compared with White women/birthing people receiving late or

no prenatal care, Black women/birthing people accessing prenatal care during the first trimester still experience higher rates of infant mortality.⁴⁴ Federal and state policy should create conditions and funding streams that facilitate community and culturally driven responses to the needs of pregnant and birthing people.

Use a Comprehensive Approach to Policies

Enact the Momnibus Act: This collection of measures introduced in both the House and Senate,⁴⁵ which recognizes that solutions must be multifaceted, addresses every aspect of maternal health concerns, including investments in the social determinants of health, diversification of the perinatal workforce, improvements to services for veterans and incarcerated mothers/birthing people and the promotion of innovative payment models.

Create Multifaceted, Regional Approaches to Providing Perinatal Healthcare, Especially in Rural Communities: The closure of obstetrical units, especially in rural areas, cannot easily be reversed, but policies must support states and communities in implementing models to both ensure pregnant women and birthing people have

better access to services and to prevent further closures. Such solutions often involve regional, cooperative approaches, with locations around the country innovating in this area. Potential solutions include creating networks of providers and using telemedicine to connect rural patients with providers and providers with specialists in large hospital centers. Strategies may also include cultivating a rural health workforce, including nurses, obstetricians, nonclinical partners and emergency medicine partners.⁴⁶ For lower-risk pregnancies, freestanding birthing centers, often focused on midwifery, can provide an alternative to hospital delivery in a home-like setting. There also may be a need for higher payments to ensure that units stay open.



Expand Access to Health Insurance

Adopt Medicaid Expansion: Only 10 states have yet to adopt Medicaid expansion, with South Dakota and North Carolina adopting this policy subsequent to the *Yearbook* data cutoff date. Medicaid expansion reduces maternal and infant mortality and improves access to healthcare both prior to conception and at the beginning of pregnancy, increasing the likelihood of better health overall.⁴⁷ The *Yearbook*'s GROW ranking shows that most of the states that have not yet adopted expansion rank in the lower tiers for child and family health and wellbeing.

Require States to Adopt 12-months Postpartum Medicaid Eligibility: States' rapid action to take advantage of the option to extend Medicaid coverage to 12-months postpartum (see text box) shows how the policy is valued as a tool in helping redress the maternal health and mortality crisis. Congress should make this option mandatory and ensure that it is accompanied by policies to screen pregnant people, refer them for ongoing services, and coordinate between OB/GYN and behavioral health providers.

Expand Eligibility for Pregnancy Coverage Through Medicaid and the Children's Health Insurance Program: Medicaid eligibility for pregnant people is determined at the state level, with 13 states having set eligibility at or below 190 percent of the federal poverty limit. Increasing eligibility levels would afford more pregnant people the ability to access prenatal care, especially early in their pregnancy.

National Policy Win: Most States Embrace Extension of Postpartum Coverage

The American Rescue Plan Act of 2021 and subsequent legislation have accelerated state efforts to extend postpartum Medicaid coverage from 60 days to 12 months. A key strategy in reducing maternal morbidity and mortality, postpartum Medicaid extension is expected to reduce the number of new parents who lose their health insurance shortly after birth and lead to improved health and economic outcomes for parents and their babies. The *Yearbook* lists 29 states that acted to extend postpartum coverage beyond Medicaid's required 60 days. By July 2023, 36 states including the District of Columbia were implementing postpartum Medicaid extensions to 12 months, with another 10 states in the planning stages to adopt this policy.⁴⁸



Improve Quality and Cultural Responsiveness of Healthcare

Increase Financial Reimbursement Support for and Access to Culturally Sensitive, Promising Practice Models, Such as Midwifery Care, Group Prenatal Care, Doula Care and Breastfeeding Support:

Culturally responsive practice approaches have demonstrated effectiveness in improving maternal care and infant health. For example, integrating midwives into care is associated with improved birth outcomes and lower Caesarian rates. Preliminary evidence suggests that doulas are also impacting these

outcomes. Group prenatal care can reduce preterm births and increase breastfeeding. Cultural grounding often shapes the adaptation of such practices for individual populations. These approaches emphasize and build a relationship between pregnant/birthing people and their providers.⁴⁹

Promote Diversity and Reduced Bias in the Healthcare Workforce: States should work to expand efforts to recruit people of color into perinatal health and mental health workforces, including investing in the types of perinatal healthcare workers, such as midwives and doulas, that can provide culturally responsive care. Additionally, employers should work to address interpersonal racism among healthcare providers through medical training and research (e.g., by addressing disparities in how race/ethnicity and racism are integrated into teaching and practice, such as in assessing disease risk, and determining diagnoses and treatments).

Minnesota: Promoting Equity in Prenatal Care

Advocates in Minnesota believe that prioritizing policy opportunities focused on those facing racial, geographic, and economic inequities ensures a state where all infants, toddlers and their families thrive. A growing body of research suggests that doulas providing pregnancy and childbirth support improve birth outcomes, especially when the doulas share racial and ethnic backgrounds with expecting parents. To recruit more doulas of color, Everyday Miracles provides a community-based training program paid for by Blue Cross and Blue Shield of Minnesota, the state's largest nonprofit health insurer. Further bolstering the provision of doula care, Minnesota lawmakers in 2023 raised Medicaid reimbursement rates for doulas from one of the lowest in the country to the highest. These efforts to address maternal health disparities build on the implementation of the Dignity in Pregnancy and Childbirth Act⁵⁰ in January 2023, which required hospitals with obstetric care and birth centers to develop or access a continuing education course on anti-racism training and implicit bias, and launched birthing modules to empower perinatal care providers to ensure Black and Indigenous women and birthing people receive quality care.



Adopt and Implement National Family Policies

Establish a National Paid Family and Medical Leave (PFML) Policy: PFML's benefits are far-reaching in terms of maternal health and early childhood development. PFML can reduce infant mortality, reduce low birth weight and preterm births (particularly for Black mothers/birthing people), increase breastfeeding and improve emotional well-being. (See text box.)

Enact Legislation to Guarantee Paid Sick Leave: Paid sick days increase the ability to attend perinatal care visits as well as infant healthcare visits.

Provide Economic Supports Before and After Birth: Pregnancy and birth benefits, as well as the enhanced, expanded Child Tax Credit, relieve financial stress before and immediately after a baby is born.

Expand Participation of Pregnant Women and Birthing People in WIC: The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) has a positive impact on maternal and infant health and is likely to be associated with a lower risk of preterm birth, low birth weight and infant mortality.⁵¹ However, only 46 percent of pregnant people currently participate in the program, compared with 60 percent of postpartum breastfeeding women/birthing people and 82 percent of non-breastfeeding women/birthing people.⁵² Multiple strategies are needed to

increase participation rates, including promoting greater cultural competence and diversity in WIC staff and outreach efforts, increasing efforts to encourage use of fresh fruits and vegetables and ensuring that more WIC providers make these foods available, and offering implicit bias training to WIC providers. WIC can also support participation in Circles of Support for women and pregnant/birthing people. However, current funding disputes—with severe cuts to WIC in the House of Representatives and funding falling short of increasing need—jeopardize even current participation levels.

Can Cash Be Medicine?

The lead crisis in the Flint, Michigan, water supply illuminated the overlay of this serious hazard for child development with another pernicious threat: high levels of deep and concentrated poverty in many neighborhoods. Children's health leaders from the effort to eliminate lead pipes now have teamed up with researchers and an array of public and private funders to write a prescription to lift pregnant people, infants and children out of poverty and into health. Rx Kids is a cash allowance program aimed at the perinatal period, with a one-time prenatal allowance of \$1,500 and a monthly allowance of \$500 a month for all infants until the age of one.⁵³ The Michigan government has committed funds from the Temporary Assistance for Needy Families program as well as the American Rescue Plan Act. Broad community engagement will be part of this unique city-wide approach that aims to change the trajectory of the entire community. A robust evaluation will document the benefits of this approach to inform state and national policy around maternal-infant health, early childhood investments, economic and racial justice, and health equity.



Benefits of Paid Family and Medical Leave for Maternal and Infant Health

Strong association with reduced infant and post-neonatal mortality rates: Researchers conservatively estimate that 12 weeks of job-protected paid leave would result in nearly 600 fewer infant and post-neonatal deaths per year.⁵⁴

Increased breastfeeding: Studies show that paid leave yields higher rates and longer periods of breastfeeding, which reduces the rates of childhood infections.⁵⁵ For young children, breastfeeding is associated with numerous benefits, including reduced rates of disease, overweight and obesity.⁵⁶ Breastfeeding is also associated with positive outcomes for the breastfeeding parent, including reduced rates of breast and ovarian cancers.⁵⁷

Improved child health:

- Time at home with newborns, infants and toddlers gives parents the flexibility they need to breastfeed, attend well-child medical visits and ensure that their children receive all necessary immunizations. This time may also have long-term benefits for children's health.⁵⁸
- California's statewide paid family leave program is associated with improved health outcomes for children in early elementary school, including reduced issues with maintaining a healthy weight, attention deficit hyperactivity disorder (ADHD) and hearing-related problems, particularly for less-advantaged children, likely due to reduced prenatal stress, increased breastfeeding and increased parental care during infancy.⁵⁹

Health and mental health benefits for new mothers/birthing people: Each week of paid leave up to 12 weeks reduces the odds of a new mother/birthing person experiencing symptoms of postpartum depression.⁶⁰ New Jersey's paid leave program was strongly associated with improvements in new mothers'/birthing persons' physical health.⁶¹ Research indicates maternity leave policies during the birth of a first child are linked to reduced depression in older age.⁶²

Better care for children: Parents who use California's paid leave program report that leave has a positive effect on their ability to care for their new children and arrange child care.⁶³ Parents using Rhode Island's program are much more likely to report higher satisfaction with their ability to care for their new children and arrange child care, better health and lower general stress.⁶⁴

Maltreatment prevention: Preliminary research in California suggests that paid leave may also help prevent child maltreatment, perhaps by reducing risk factors such as parental stress and depression.⁶⁵



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Urgent Priority #2:

Seizing the Opportunity to Promote Positive Infant and Early Childhood Mental Health

Infant and early childhood mental health (IECMH) is fundamental to all early development and learning and encompasses concepts such as social and emotional development and early relational health. IECMH is the developing capacity of the child from birth to 5 years of age 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. These are the ingredients children need not just for their earliest learning, but also for later success in school and throughout life.

Babies' relationships with parents and other close caregivers play important roles in shaping their mental health, molding the architecture of their brains and setting the stage for other aspects of development, such as language and cognitive development. Positive, supportive relationships can also buffer young children from the impact of adverse experiences and can mean the difference between positive and negative outcomes in school and life. Parents' mental health concerns, particularly maternal depression, can affect not only their own well-being but that of their infants and young children. Taken together, the research is clear that the mental health of young children is inextricably tied to the well-being of their parents and primary caregivers, including early educators.

Yearbook indicators illustrate this policy area's urgency, showing that many infants and toddlers experience circumstances that could undermine IECMH's central influence on early development. The pandemic's isolation and hardships increased parents' overall emotional distress, with a corresponding increase in young children's emotional distress. In addition, *Yearbook* data point to continued exposure to conditions such as poverty, crowded housing, maltreatment and/or structural racism for babies and caregivers. These experiences can create chronic, unrelenting stress that undermines caregiver well-being, essential early relationships and babies' healthy development and learning.

The earliest years present a unique opportunity for ensuring strong mental health from the start for infants, toddlers and their caregivers by building the continuum of services for promotion, prevention, developmentally and culturally appropriate assessment and diagnosis, and treatment. Yet, the country lacks a strong system of supports for parents, caregivers and child-serving professionals, all of whom play a role in shaping and particularly promoting strong early childhood mental health. An expanded, diverse IECMH workforce is critical to building this continuum.

Bold pandemic policies recognized the importance of mental health funding and seamless health coverage to access services. The American Rescue Plan Act invested \$4 billion to address the mental health issues the pandemic thrust to the surface. Yet, these funds' uses did not spotlight young children's needs. Moreover, unwinding the pandemic's continuous Medicaid coverage is severing many adults as well as children from coverage that allows them to access mental health supports. The country still needs to bring young children's mental health squarely into overall mental health policy. Such policies must strengthen the continuum by leveraging the health system to provide multigenerational support, expanding community supports and family-oriented policies, and strengthening the capacity of the IECMH system, including building a diverse workforce.



FAMILY STORY

I have two children, a high schooler and a toddler. I know the importance of social and emotional development to our children's future. I know it as a professional—I work as a Family Coordinator at a high school. I love the work, which helps me advocate for and support the community that I love. Many of the kids I work with had a strong social and emotional foundation, and I see what that has meant to their development. I see their confidence, their ability to interact with others and to find success. But too often, I know that some of the kids who I work with could have benefited from infant and early childhood mental health services early on.

I also know it as a parent—my high schooler had a rough beginning. I experienced domestic violence, and while I tried to protect my young son, I could not protect him from all things. He expressed his anger in ways that got him in trouble, and I did not know how to help him deal with his trauma, or what services were available to support his social and emotional development. The “helpers” in my community made damaging assumptions about how I contributed to his trauma, and who I was as a young parent. In so doing, they made his trauma worse. Today, he is on the path to graduate from high school, and I am so proud of him. But we are still working to help him heal wounds from almost two decades ago. Now, I want to make things better for his younger sister. She is very sensitive, and I worry about her sadness. When I have asked for services for her, my worries are often minimized. But I know that just down the street, there are communities where these kinds of services are available and well used. I am frustrated and deeply concerned for my children and my community.

Mental health is a taboo topic in minority communities, and 10 times that when involving infants and toddlers! The social-emotional needs of so many children from birth to three years old go unmet because many families, especially families in low-income areas, aren't given information so they can be better informed and prevent, to the best of their abilities, long-term impacts of not rendering proper healthcare—physical and mental. We need to make sure that all children have access to the services they need, when they are most helpful.

*Emily C.
Bronx, New York*

A woman with long brown hair, wearing a red and white patterned shirt, is sitting on a colorful, patterned rug. She is holding a baby who is wearing a green dress with a white floral pattern. The woman is pointing at a book she is holding, and the baby is looking at the book. The background is a blurred indoor setting.

State of Babies Data Raise Concerns About Early Mental Health

The *Yearbook*, including data from the RAPID Survey, raises concerns about the key factors that shape babies' early mental health: their parents' emotional well-being and the level of adverse experiences they encounter.

Yearbook indicators show persistent disparities by race/ethnicity and income for babies with adverse experiences. RAPID data show that emotional distress has stabilized, but is still elevated in key areas such as stress, loneliness and child

behaviors. Disparities in material hardship that are sources of family stress continue, as do other adverse experiences including higher rates of maltreatment for babies which carries significant implications for early mental health.

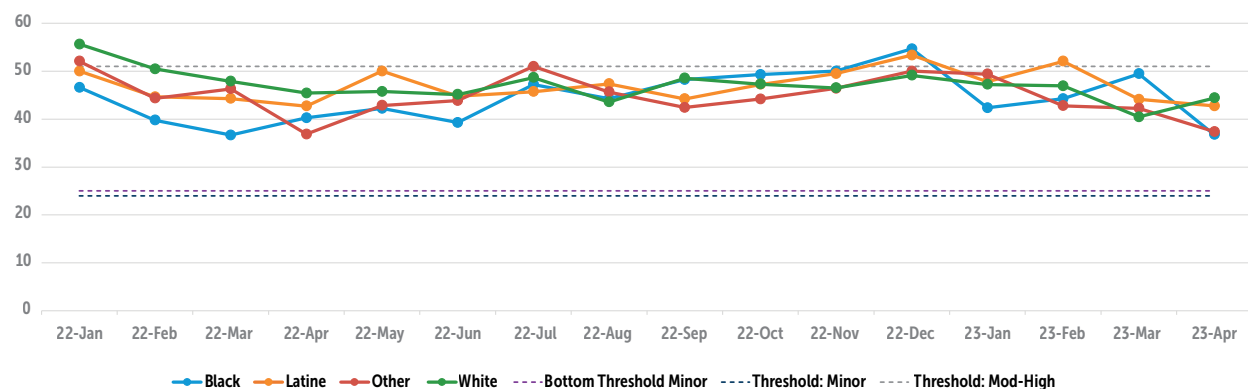
Parent and Child Mental Health

Parents' mental health concerns, particularly maternal depression, can affect not only their own well-being but also that of their infants and young children. Untreated depression, substance use disorder, experiences of interpersonal and community violence, and trauma disrupt parenting and the responsive care young children need to thrive.¹ RAPID Survey data collected during the pandemic clearly showed that

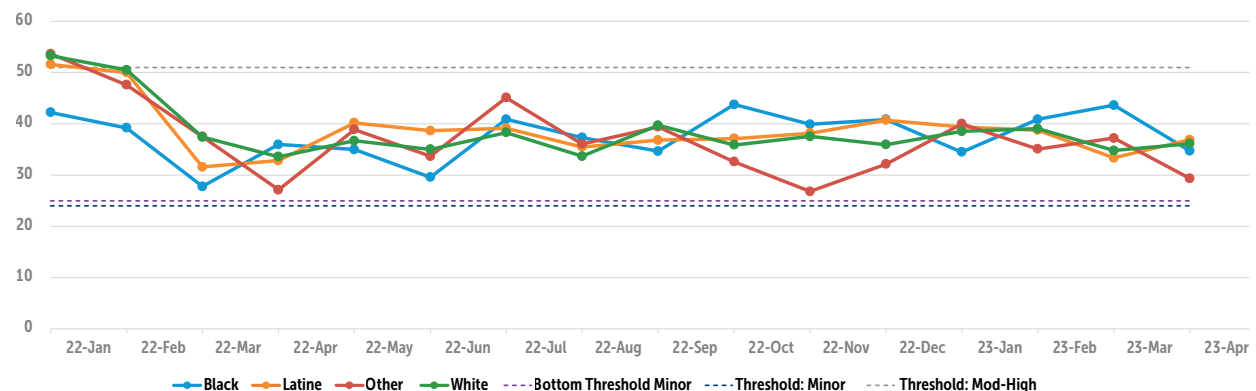
increased levels of financial hardship led to higher ratings of emotional distress among parents and were accompanied by increases in infant-toddler emotional distress, although at lower rates.²

Parents' Emotional Distress: From January 2022 through April 2023, parents' overall emotional distress ratings moderated but were consistently at a somewhat elevated level. Stress and loneliness measurements remained high,

PARENT MENTAL HEALTH STRESS SCORE BY RACE AND ETHNICITY Figure 2-1



PARENT MENTAL HEALTH LONELINESS SCORE Figure 2-2

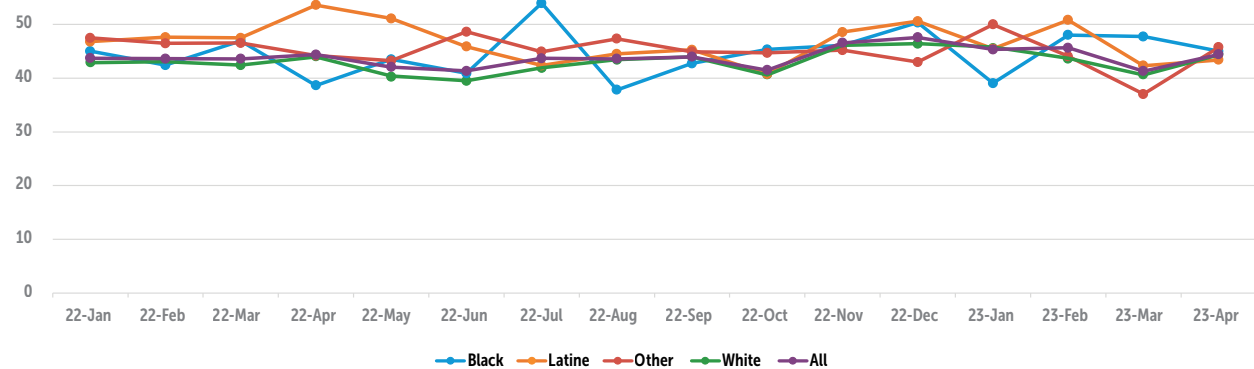


squarely within a range that raises concerns at a minor level, occasionally moving up to a level of moderate concern. (See Figures 2-1 and 2-2). Experiences across race and ethnicity were more closely aligned than earlier in the pandemic, although the concerns of Black parents and those of other races were more volatile.

Children’s Emotional Distress: RAPID data also show that as the pandemic waned, children’s emotional distress, similar to that of their parents, leveled off, yet remained at an elevated level.

However, externalizing behaviors were higher, at a level where symptoms would be at least of minor concern. (See Figure 2-3). This pattern seems consistent with reports of increased challenging behaviors as young children interact more with the outside world after the relative isolation of the pandemic. Black and Latine children, as well as those of other races, appear to have had more volatility in measures of externalizing symptoms, possibly reflecting the greater hardships they experienced during the pandemic.

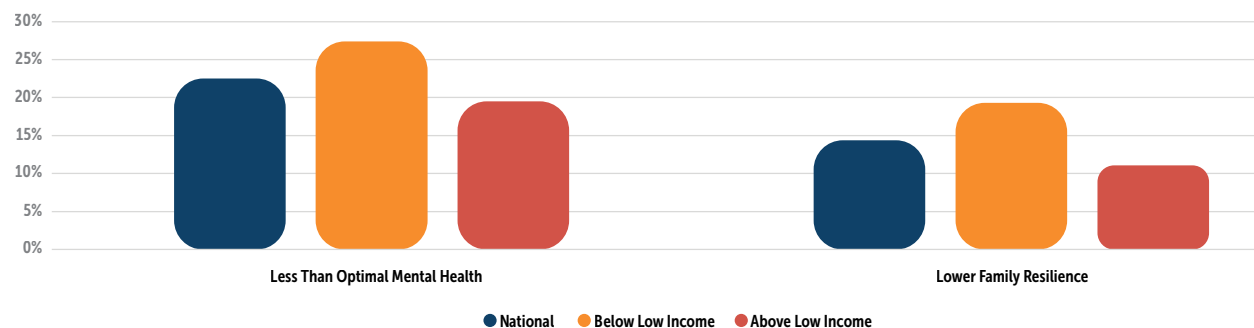
CHILD MENTAL HEALTH EXTERNALIZING SYMPTOMS SCORE (FUSSY AND DEFIANT) BY RACE AND ETHNICITY Figure 2-3



Parental Mental Health and Income: Concerns about parental mental health are often tied to economic challenges. *Yearbook* indicators show that mothers’ mental health was more likely to be

less than optimal among those with low income, and fewer families with low income were likely to say they are resilient. (See Figure 2-4).

FAMILIES’ EMOTIONAL SECURITY BY INCOME Figure 2-4

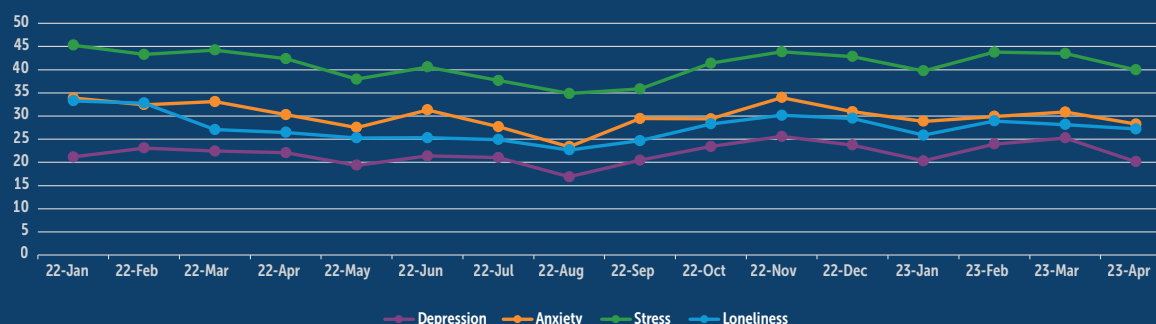


Early Childhood Educators Also Face Mental Health Challenges

The chaos of the pandemic for child care programs, coupled with low wages and continuing staff shortages, has had a significant impact on the well-being of early childhood educators.³ Just as these adults help shape young children's early development, so too does their emotional well-being affect their ability to connect with the young children who spend many hours in their care. The RAPID Survey data on early educators who work with infants and toddlers included in the *Yearbook* show they are under considerable strain as staffing challenges and financial worries mount. Half of these early educators reported experiencing burnout. Similar to the elevated emotional distress of parents, measures of early childhood educators' well-being since early 2022 show continued elevated levels, especially for stress. (See Figure 2-5.)

RAPID Survey data reported for early educators of all ages of children show that providers have experienced material hardships such as hunger and housing worries throughout the pandemic and economically challenging times.⁴ These hardships have also contributed to stress and mental health concerns. Urgent Priority #3: Commitment to Early Care and Education as a Public Good discusses the challenges for early educators in greater detail. The levels of stress, burnout and mental health concerns are highlighted here to underscore the necessity for policies promoting early childhood mental health to address the needs of all the significant adults in children's lives, including early childhood educators.

CHILD CARE PROVIDER WELLBEING SYMPTOMS OVER TIME 2022-23 Figure 2-5



Many Young Children Experience Adversity That Impacts IECMH

While positive early childhood experiences promote strong mental health, negative experiences can adversely impact brain development, with serious lifelong consequences. These experiences can cause stress that, if chronic and unrelenting, can alter how the brain wires and undermine the strength of early brain architecture. Adverse experiences such as living in poverty, parental depression, maltreatment and violence in the home or neighborhood can contribute to social and emotional issues such as behavioral problems, as well as delays in cognitive and language skills. These issues stem from the disruption of parents' abilities to provide responsive, stimulating caregiving in an environment of adversity.⁵

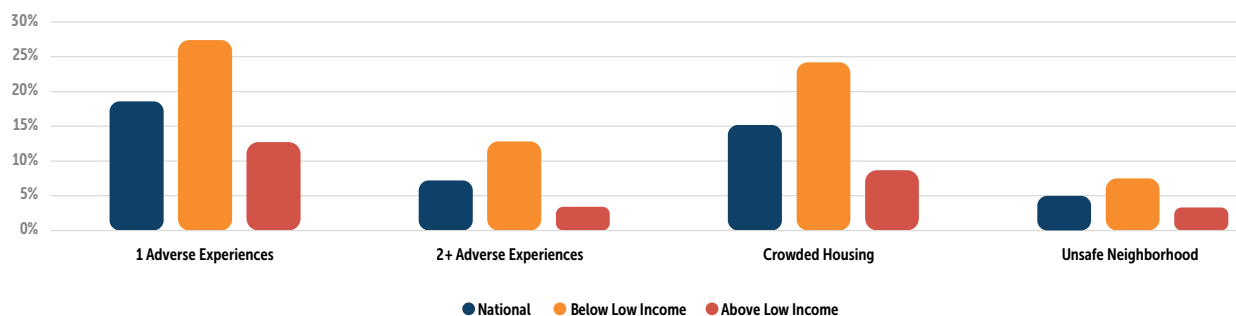
When an infant or young child's emotional health deteriorates significantly, they can, and do, experience mental health disorders. Approximately 9.5% to 14.2% of children from birth to 5 years old experience emotional, relational or behavioral disturbances.⁶ Young children who live in families dealing with adverse experiences and exposure to trauma are at heightened risk of developing IECMH disorders.⁷ And the stressors of poverty can multiply these risks. It is important to note, however, that even in a nurturing environment, mental health problems can still manifest. If untreated, IECMH disorders can have detrimental effects on every aspect of a child's development, as noted above, and young children do not "grow out" of them. Over time, these issues often become more frequent, intense

and more expensive to address with interventions or treatment. When mental health concerns are identified early on, there are services that can redirect a child's course and place those who are at risk on a pathway for healthy development.

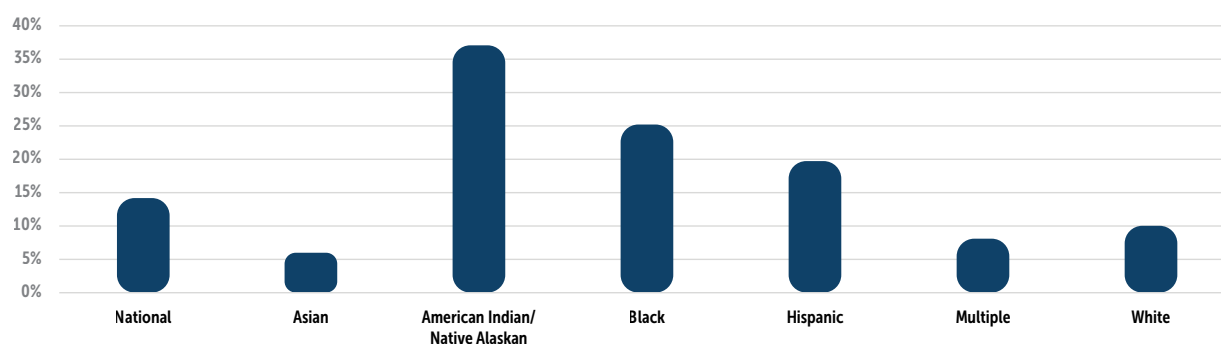
Adversity Intensified by Low Income: Adverse childhood experiences (ACEs) are stressful events in a child's life that can affect development and future health, with risk increasing as the number of ACEs accumulates. Studies of ACEs have focused on a set of indicators of household instability, abuse and neglect, but the range of experiences that can have an adverse impact extends beyond these factors.⁸ (See Figure 2-6).

The *Yearbook* includes indicators that raise concerns about the exposure of infants and toddlers, especially those in families with low income, to adverse conditions that can elevate family stress, placing them at risk for mental health and developmental problems. The *Yearbook* presents indicators that ask families about whether their babies have had any of a group of adverse early experiences, including income insecurity, death or separation of parents or guardians, incarceration of a family member, family violence and/or exposure to racism. Babies in families with low income were more likely than babies in families with higher incomes to have one early adverse experience or two or more early adverse experiences. They were also more likely to have experiences shown in two other indicators of specific adverse experiences—

STRESS-INDUCING EXPERIENCES BY INCOME BY RACE AND ETHNICITY Figure 2-6



HOUSEHOLDS WITH BABIES WITH HIGH OR VERY HIGH FOOD INSECURITY BY RACE AND ETHNICITY Figure 2-7



crowded housing and/or unsafe neighborhoods. (See Figure 2-6). Finally, living in poverty is itself an adverse experience, as will be discussed in Urgent Priority #5: The Economic Insecurity That Engulfs Many Babies. A large proportion (38%) of infants and toddlers live in families with low income, including more than 18% in poverty.

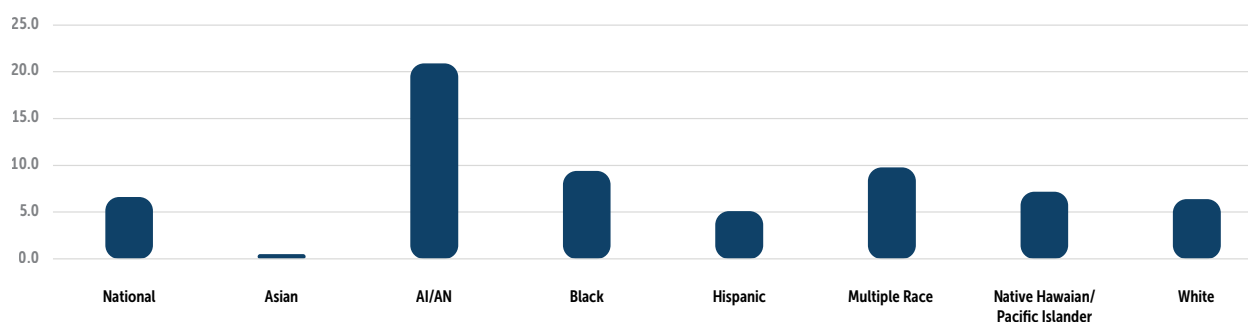
Food Insecurity: Household food insecurity, another source of family stress and adversity, has remained at a high level of 15.3%. Examining this indicator by race and ethnicity reveals disturbing findings: more than one-third (37.1%) of American Indian and Alaska Native (AI/AN) infants and toddlers live in households with low or very low food insecurity, as do one-quarter (25.2%) of Black and one-fifth (19.7%) of Hispanic infants and toddlers. (See Figure 2-7). The *Yearbook* section on economic security provides a more in-depth discussion of food insecurity.

Child Maltreatment: Mental health concerns are particularly heightened for infants and toddlers who have experienced maltreatment, especially

when they have been removed from their homes and placed in foster care. The maltreatment rate for infants and toddlers is 15.5 per 1,000, with the rate for infants alone being 25.3 per 1,000—the highest rate by far of any age group, including toddlers (10.7 per 1,000 for 1-year-olds and 9.8 per 1,000 for 2-year-olds).⁹

The *Yearbook* finds that 6.6 per 1,000 babies are placed in foster care, with Native American babies having an alarmingly high rate of 20.9 per 1,000. Black, Native Hawaiian, and multiple race infants and toddlers also have disparately high rates of removal (9.4, 7.2 and 9.8 per 1,000, respectively). (See Figure 2-8.) Babies in the child welfare system, who cannot process what is happening to them, are found to have high levels of social and emotional disturbance, particularly attachment disruption.^{10,11} A study of infant-toddler court programs using the Safe Babies™ approach found one-half of the children in need of IECMH services, specifically Child Parent Psychotherapy, which the program ensured they received.¹²

INFANTS AND TODDLERS PLACED IN FOSTER CARE BY RACE AND ETHNICITY Figure 2-8



Barriers to IECMH Services

While efforts to increase the capacity to support IECMH along the entire continuum of promotion, prevention, developmentally and culturally appropriate assessment and diagnosis, and treatment have grown over the past few years, families and professionals in other systems still face barriers to finding services and support. A lack of specially trained IECMH providers, especially those representing the diversity of babies and families, is a critical need.

Financing for basic screening services is improving, but states are only slowly grappling with the conundrum of how to reimburse for the diagnosis of very young children, many preverbal, as well as services that must be provided in the context of the adults who care for these very young children. The lack of supports for parents and caregivers across systems that could fill an essential role in promoting positive IECMH is also a barrier. Finally, even with the indicators that a large proportion of infants and toddlers live in circumstances that increase the stress that can undermine their mental health, monitoring of early development and mental health remains inconsistent, particularly within child health and early learning and care settings.

Workforce Challenges: Efforts to promote positive IECMH often encounter difficulty finding qualified, culturally responsive and diverse IECMH professionals, making the IECMH workforce a critical focus for policy efforts. Specially trained IECMH professionals are essential to providing consultation that infuses IECMH knowledge into child-serving settings and to diagnosing and treating young children when problems do emerge. A short supply of IECMH professionals hampers successful implementation of all parts of the IECMH continuum.

For example, Washington state has noted shortages in qualified IECMH professionals, with infant-toddler services less likely to be provided even among mental health professionals who serve children ages 5 and under.¹³ In a survey of state efforts to integrate IECMH into Early Intervention programs under Part C of the Individuals with Disabilities Education Act (IDEA), multiple states reported workforce issues such as a lack of qualified IECMH providers or geographic



mismatches as barriers to accessing services.¹⁴ Parents in ZERO TO THREE's Family Advocacy Network have cited difficulty finding mental health services that are culturally responsive, as well as the need for more diversity among mental health professionals.

Financing: The potential for IECMH coverage through Medicaid is not fully maximized. Even in states that are beginning to cover behavioral health as part of managed care and accountable care organizations, there is still work to do to ensure efforts are targeted enough to support IECMH services. General policies common for adult mental health cannot be extended downward to infants and toddlers, who require specific IECMH services to be reimbursable.

For example, diagnosis of an infant or toddler can take several sessions. And treatment involves the dyad of parent or close caregiver and baby. Neither of these factors is contemplated in the mental health reimbursement system oriented around adults. Further, both diagnosis and treatment require a provider specially trained in the mental health of very young children, using age-appropriate screening and diagnostic tools. Only 15 states require or recommend use of the

DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (or its predecessor, the DC: 0–3R), developmentally based systems for diagnosing mental health and developmental disorders in infants and young children through 5 years old.¹⁵ Coverage of screenings for mothers and children is improving, however, with now up to 46 states offering such benefits.¹⁶

Gaps in Supportive Services: Access to high-quality, culturally responsive supportive services for parents and caregivers, including services to address their own mental health needs, is a key part of promoting all children's mental health, as well as preventing IECMH problems when families are under stress. Supports that can help parents cope with their own stresses and nurture their babies' positive development are not widely available or not infused with an understanding of how they can better support IECMH.

For example, the *Yearbook* finds that only about one-half of infants and toddlers have a medical home, where family issues potentially can be identified and addressed through a dyadic or multigenerational approach. Those least likely to have a medical home include Black (39.6%) and Latine/Hispanic (40.7%) infants and toddlers, as well as young children living in families at or below low-income levels (40%). (See Figure 2-9.) The *Yearbook* also shows that only 2.1% of infants and toddlers receive home visiting services, with a range of 1.25% to 6.2% in the state with the greatest number of such services (Kansas). (This indicator is based on total infants and toddlers because home visiting programs do not have specific eligibility criteria that families must meet to receive services).

Monitoring Development and Mental Health Needs Improvement

Despite multiple indicators that signal young children could be at risk developmentally, and particularly for social and emotional concerns, the nation has not developed a strong system of monitoring and screening young children. As noted above, only about one-half (51%) of babies have medical homes, where children can receive consistent developmental monitoring and

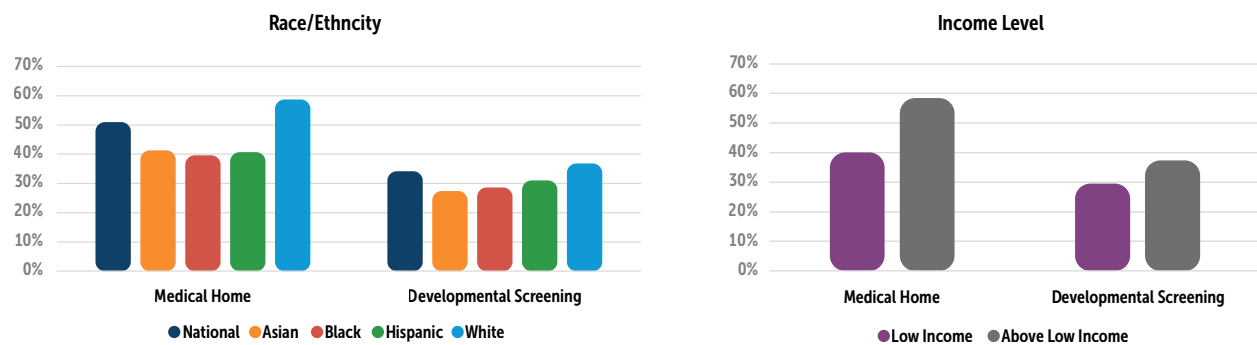


multigenerational services. Parents reported low rates of basic developmental screening for infants and toddlers (34.2% overall), with particularly low rates for those with low income (29.5% compared, with 37.3% for babies in families above low income). (See Figure 2-9).

Early Intervention (EI) services under Part C of the Individuals with Disabilities Education Act cover social and emotional development, and states are working to incorporate stronger supports

for babies with social-emotional delays and mental health concerns. Few states require use of a tool specifically for social and emotional screening, although the majority recommend one.¹⁷ Moreover, the *Yearbook* finds only six states extend EI eligibility to children with characteristics that place them at risk for developmental concerns. While expanding eligibility more broadly can help states reach more infants and toddlers, cost and workforce constraints may prevent other states from adopting this course.

INFANTS AND TODDLERS WITH A MEDICAL HOME AND RECEIVING DEVELOPMENTAL SCREENING BY RACE AND ETHNICITY Figure 2-9



Policies to Build Strong Early Mental Health

Infancy and early childhood offer the opportunity to promote a strong foundation from the start, setting children on a positive course for later mental health and learning. Policymakers must ensure that broad discussions of mental health policy reform include young children and specifically address infants and toddlers.



Policymakers should take an active role in promoting and endorsing a full continuum of services—promotion, prevention, developmentally and culturally appropriate assessment and diagnosis, and treatment—to best support babies and young children, and the significant adults in their lives. Federal policy should facilitate, and states should adopt, comprehensive approaches to monitoring development, supporting families in nurturing their children’s development and connecting to needed services. Moreover, given

the significant time young children spend in non-parental care, these efforts should be inclusive of early care and education settings.

Given the role that economic and material hardship plays in elevating family stress, policies to address other urgent needs as outlined in the sections of this report on economic security, child care and housing are also part of an overall approach to ensuring the early emotional health of babies.

Leveraging the Health System to Support Development

Establish early childhood specialists in primary care. Embedding early childhood development experts in primary care leverages the most common touch point for babies’ primary care and can transform this setting to drive better developmental trajectories and outcomes for young children and caregivers. ZERO TO THREE’s

HealthySteps program pioneered this approach to whole-family, team-based care in support of healthy development and caregiver well-being. Existing federal funding streams such as those in the Bureau of Primary Health Care’s Health Center Program and the Maternal and Child Health Bureau should be expanded to build early



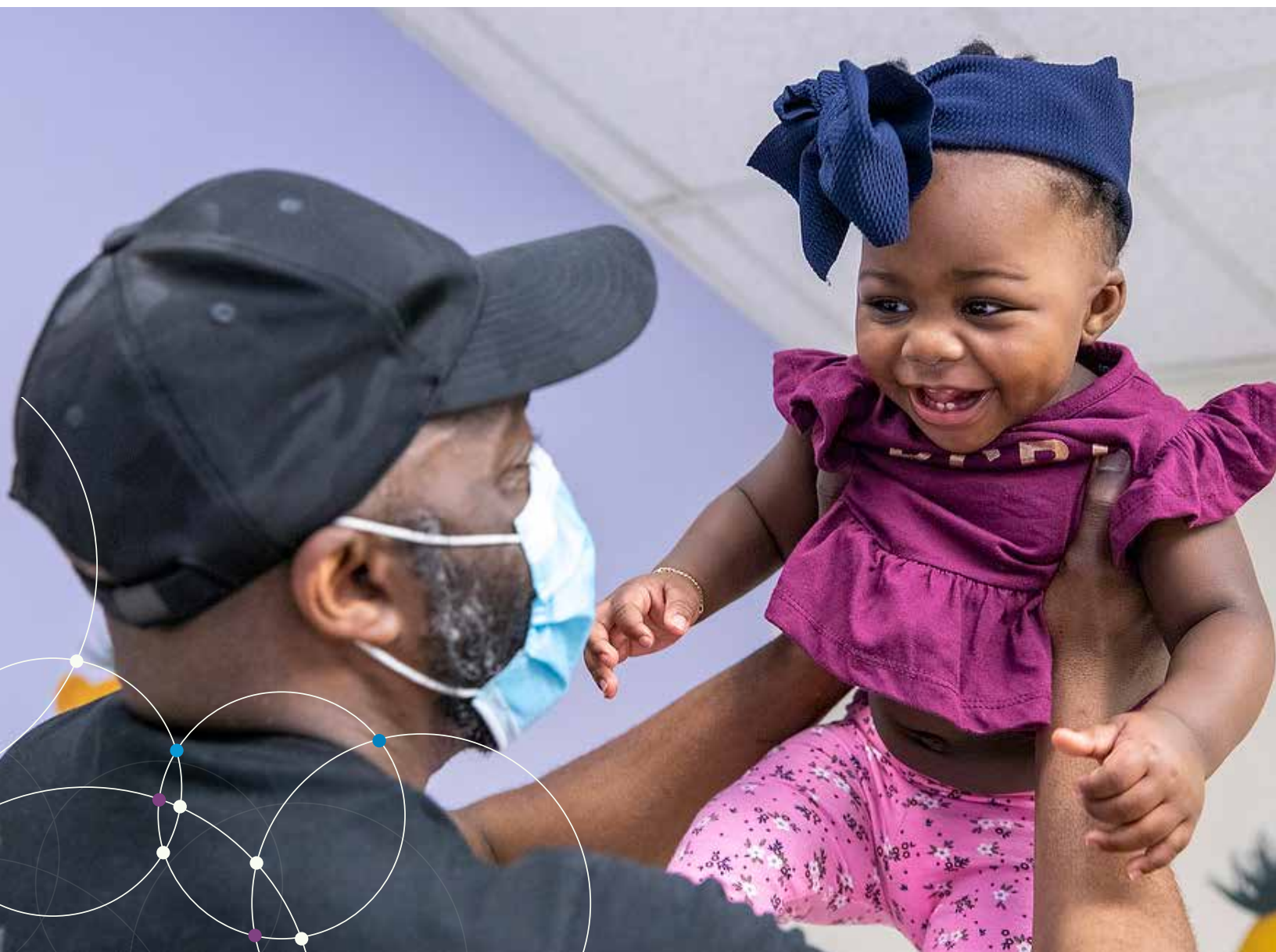
California Creates a Dyadic Services Benefit

In a groundbreaking move for funding early development and family services, California’s Medi-Cal program now incorporates coverage for dyadic services, which includes preventive services provided to the child and caregiver at the same location. Medi-Cal also expanded its family therapy benefit, which now covers family therapy without requiring the child to have a diagnosis, allowing for greater access to this existing dyadic service.¹⁸ This policy change recognizes the fundamental importance of the parent’s well-being to young children’s development, opening the door to identifying and addressing concerns for both parent or caregiver and child in one site. HealthySteps, a program of ZERO TO THREE that incorporates an early childhood development specialist into primary care practices, was a model for this innovative approach.

childhood systems that include the healthcare setting and facilitate this transformation of primary care. States can also support early childhood experts in primary care by including such dyadic approaches in their Medicaid plans, as California has done to allow reimbursement for preventive services, as well as other funding mechanisms.

Increase Medicaid's focus on IECMH and development to reach the infants and toddlers most at risk for developmental concerns. Requiring continuous coverage for all children until the age of 6 would enable the monitoring and treatment of children throughout early childhood. Currently, states have the option to

provide continuous coverage for 12 months, which will be required as of January 1, 2024. Oregon and Washington have received, and New Mexico has applied for waivers to extend continuous coverage until age 6. Other steps include promoting more rigorous application of Medicaid's Early, Periodic Screening, Diagnosis and Treatment to adhere to screening schedules and ensure early mental health and family need screens are included; requiring state Medicaid plans to cover and collect data on maternal depression screening during well-child visits and social-emotional screening for young children; and ensuring access to age-appropriate diagnosis and treatment, including through the *DC:0-5™*.



Develop Community Approaches to Supporting Families and Early Social and Emotional Development

Promote family strengthening through funding to encourage community-wide approaches to ensure that every family can access comprehensive support for parenting, positive child development and family services. Such readily accessible support through early childhood specialists in primary care, home visiting, family resource centers, parenting-support programs and other approaches can help address the social determinants of health and form protective factors that buffer young children from intolerable stresses that can derail their development.

Expand early childhood mental health consultation to infuse understanding of supporting early social and emotional

development into child-serving settings. Such support is particularly important for early childhood educators, who face increasing burnout and mental health challenges while also caring for young children emerging from the pandemic with increased emotional distress often communicated through challenging behaviors or withdrawal. Early childhood mental health consultation is also a key support for home visitors and others who work with young children and families. These adults, but especially early childhood educators, play an important role in helping children develop regulatory skills. Mental health consultants can help them interpret and address child behaviors that adults see as challenging and support the relationship between parents or close caregivers and children, as well as attend to their own self-care.

Collective Movement Toward a Diverse IECMH Workforce

Since 2021, a national IECMH Clinical Workforce Diversity Collective initiated by ZERO TO THREE has brought together more than 25 representatives from across the United States from diverse backgrounds, cultures and disciplines to explore the need for radical, systematic change in the IECMH field and workforce. The Diversity Collective is not only pursuing increases in diversity, equity and inclusion in the IECMH field, but is seeking to radically change the field to de-center the focus of Eurocentric, colonial theory, practice and power, and to actualize the centering of the knowledge, practices and ways of being of non-dominant people, including Black, Indigenous, People of Color and other marginalized peoples. Through participation in an intense collective process of joining together diverse perspectives, experiences and knowledge, the Diversity Collective has developed a long-range vision and several policy and systems benchmarks for the evolution of the IECMH field and workforce.

Enact the bipartisan Strengthening America's Families Act to establish community teams to use a comprehensive, two-generational approach to holistically address the needs of infants, toddlers and families at risk for involvement or already in the child welfare system, including concerns about mental health and the impacts of trauma. The bill is based on the Safe Babies approach, which ensures babies and families receive a comprehensive array of needed services and has demonstrated that careful coordination ensures infants and toddlers have medical homes, receive appropriate social and emotional as well as developmental screens, and are successfully referred to IECMH services.



Increase the Capacity to Address Infant and Early Childhood Mental Health and Perinatal Mental Health

- Develop a well-trained and diverse **IECMH workforce**, with a particular focus on addressing trauma and adverse experiences and providing healing-centered care. Federal funding should establish IECMH Centers of Excellence and clinical leadership programs. States should assess workforce needs and devise strategies to train providers to meet them.
- Promote applying the science of **IECMH classification systems** such as the DC:0-5™ to assess and diagnose mental health disorders in infants and young children.
- Leverage current funding streams to **better integrate IECMH** into states' overall mental health policy, including dedicating at least 10% of Community Mental Health Services Block Grant funds for services for children from birth to age 5 experiencing or at risk for mental health disorders.
- **Increase funding for the National Maternal Mental Health Hotline.** The Maternal Mental Health Hotline is staffed by qualified counselors and provides specialized culturally and linguistically appropriate voice and text support for mothers and families. Additional

Regional Approach to IECMH Workforce Needs

Having too few mental health clinicians with the specialized training needed to serve babies and their families creates a barrier for states looking to build out a robust IECMH prevention, promotion and treatment continuum. To boost the pool of mental health professionals prepared to serve children from birth to age 4, Alabama hosted a cross-state Child-Parent Psychotherapy training collaboration, including practitioners from Georgia and South Carolina.¹⁹ This pilot collaboration expanded with funding from Georgia's Departments of Early Care and Learning and Public Health to provide training to an additional 60 clinicians in 2022.

funding will enable states to increase public awareness about maternal mental health conditions and the hotline.

- **Increase funding for the Screening and Treatment for Maternal Depression and Related Behavioral Disorders (MDRBD) Program.** Maternal mental health conditions are the most common pregnancy and postpartum complications and can have a detrimental impact on new parents' abilities to provide the supportive relationships their infants need; however, 75% of affected women remain untreated. MDRBD programs train health providers to screen, assess and treat for maternal mental health conditions and provide specialized psychiatric consultation to assist the providers in meeting the needs of their patients. Additional funding will support the establishment of new state programs and improvements in existing programs.

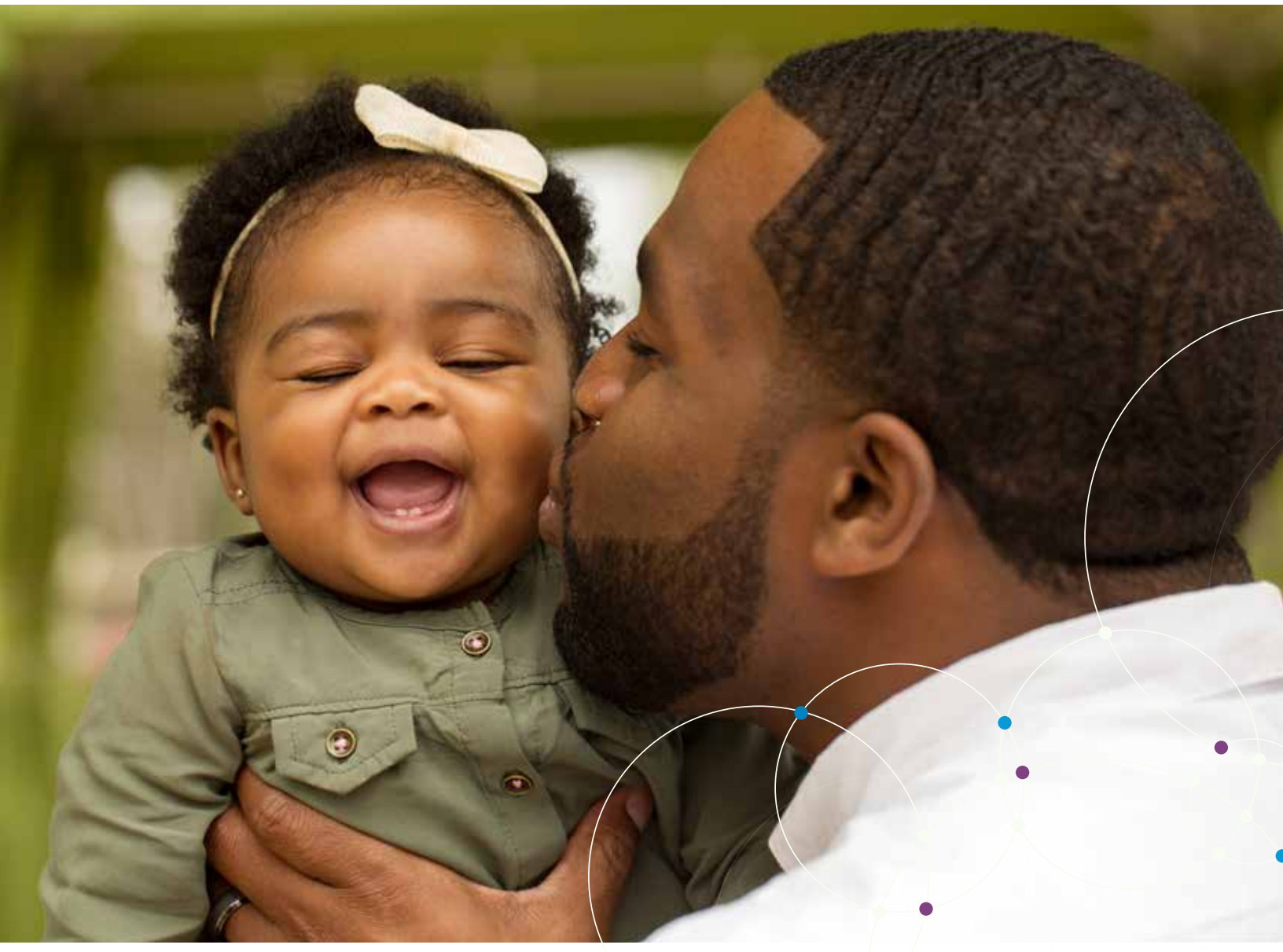


Adopt Broad-Based Family Policies

Paid family and medical leave Gives parents or other caregivers time to begin developing all-important, close relationships with their newborn or newly adopted children and supports improved maternal mental health. For children with ongoing health and developmental needs, paid leave allows parents and caregivers to attend regular therapeutic sessions.

Paid sick days gives parents and caregivers time to care for themselves and children with short-term illnesses and to attend visits to address health and mental health needs.

Expanded Child Tax Credits help relieve stress created by economic hardship and allow parents to give up second jobs or gig work to make ends meet and spend more time with their children, which is especially important for families with infants and toddlers.



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Urgent Priority #3:

A Commitment to Early Care and Education as a Public Good

While parents and families are the primary influence on young children's healthy development, early care and education settings also play a significant role. Beginning at infancy, participation in child care has become the norm for the vast majority of young children in the United States. The *Yearbook* shows that 62 percent of mothers of infants and toddlers are in the labor force, while RAPID Survey data show that nonparental child care use continues to rise in the wake of the pandemic. In early care and education settings, children learn to interact with their peers, establish relationships with other adults and have experiences that foster language, cognitive, physical and social-emotional development.

Research shows that high-quality early care and education programs can positively impact young children’s development and learning, and influence good health and educational outcomes well into adulthood.¹ Early care and education is also an essential family support. An affordable, high-quality, accessible early care and education arrangement promotes well-being for the family by ensuring that parents and caregivers (particularly mothers) can work, as well as by expanding adults’ knowledge of child development and helping advance their career and educational goals. A strong child care system is also a key support for employers and good for the economy overall.

Yet, despite a steady increase in families’ reliance on nonparental care over several decades, and mounting evidence that young children’s well-being depends on caregiving that is healthy and safe and meets their developmental needs, the U.S. has failed to act boldly to ensure equitable access to early care and education. Families navigate a broken system characterized by high cost that often puts quality child care out of reach, with few options that meet their scheduling needs and preferences.

Data from the *State of Babies Yearbook* as well as other sources show that families with low income and families of color are impacted the most by the state of child care. These families often reside in communities with low supply of quality child care options and spend a higher share of their income on child care, given the limited availability of publicly funded programs. Moreover, early educators, a majority of whom are women of color, immigrants and/or low-income women, also bear the brunt of failed child care policies. They, like parents, engage children in close relationships that nurture development, yet the nation’s approach to financing early care and education continues to devalue this profession’s important work with low levels of compensation and respect and inadequate working conditions.

The pandemic exposed the fragility of an underfunded early care and education system. Child care arrived at the brink of collapse during the crisis before an historic federal investment of nearly \$40 billion in federal emergency relief funds provided through the American Rescue Plan Act (ARPA) helped stabilize the situation.²

These resources saved the jobs of more than 1 million early educators and enabled continued care for as many as 9.6 million children.³ Now the system is again facing a crisis as those funds end. If Congress fails to act to provide additional emergency funding for child care, estimates project that approximately 70,000 child care programs will close, potentially disrupting the care of 3.2 million children and their families.⁴ It is long past time that our nation invests in an early care and education system that ensures all babies have access to quality early care and education at a cost their parents can afford, regardless of race, income or where they live—and that respects and rewards early educators for the critically important work they do.



FAMILY STORY

My husband Clarence and I have two daughters, Mackenzie (6) and Makayla (2). Makayla was born during the pandemic with a heart condition. Clarence was an essential worker, and we worried about keeping Makayla safe and healthy. She had two open-heart surgeries before turning 10 months old. As her family, we encourage her to explore and encourage her curiosity.

For the last nine years, I have worked at a nonprofit early learning center in downtown St. Louis that provides child care, as well as Early Head Start and Head Start. I am proud that we provide high-quality care, as I know how important that is for young children and their development. But, when our program is at capacity, I have trouble helping the families I work with find care because slots are limited. I try to help families explore other options, but children sit on wait lists—ours and others’—for months because there aren’t enough open spots or educators. Sometimes, they have access to some kind of care arrangement, but the truth is, access without quality isn’t access at all. Children need quality.

Working families like mine don't have equal access to quality, affordable child care. Even with a discount from my job, we couldn't afford the child care at my program, and we did not qualify for subsidies. At the end of my maternity leave with Makayla, my husband and I were faced with no good options. My husband had to quit his job to care for Makayla for about five months so that I could return to work. Only then were we able to qualify for an Early Head Start program. Without his income, we struggled with paying bills and had to make difficult choices about how we spent our money. It was a relief when he was able to return to work, but it is still hard to make ends meet. We don't qualify for other services, because we make “too much money.” When Makayla turns 3, she will age out of Early Head Start, and there is a gap before she will be able to join the program that her sister attends on scholarship. We are worried about how we will manage the transition.

All babies and toddlers need high-quality care while their families work. Congress should be investing in child care, Early Head Start and Head Start, and in building a system that works for families, providers and young children.

*Latrice D.
Berkeley, Missouri*

A woman with dark braids is smiling and reading a book to a young child with curly hair. The child is looking down at the book. The book has the word 'STORIES' visible on the page. The background is a soft, out-of-focus light blue.

Challenges for Babies, Families and Early Educators

Nonparental Care Patterns: As the pandemic has waned, parents have returned to the workforce and child care use has rebounded. RAPID Survey data show that except for a dip in usage in the summer of 2022, the percentage of families with infants and toddlers using nonparental care grew across all income groups in the period from January 2022 through April 2023 (See Figure 3-1).

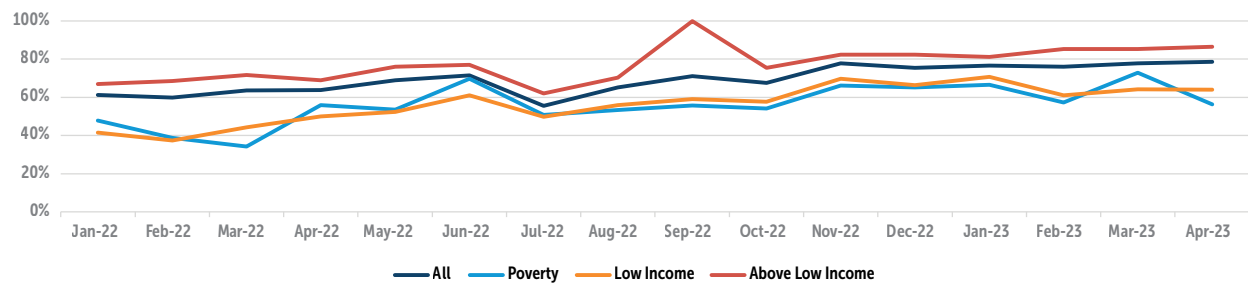
In general, families with lower incomes are less likely to use nonparental care than those with higher incomes, which can be accounted for partly by the limited supply of public funding directed at infants and toddlers. Families participating in the RAPID Survey echoed that pattern, with 46 percent of those with low income saying they used parental care only (compared with 24 percent of families with above low income) and reporting greater fluctuation in their use of nonparental care.

Studies of nonparental care use among families with children under age 3 reveal that more babies are cared for in home-based settings (30 percent) than at centers (12 percent) as their primary care arrangement, with nearly one-half receiving care from an *unpaid* family, friend or neighbor caregiver with whom they have a previous relationship.⁵ The RAPID Survey revealed different patterns of use by income level. Overall, non-center-based care (42 percent) was the most prevalent type of care, but families with low

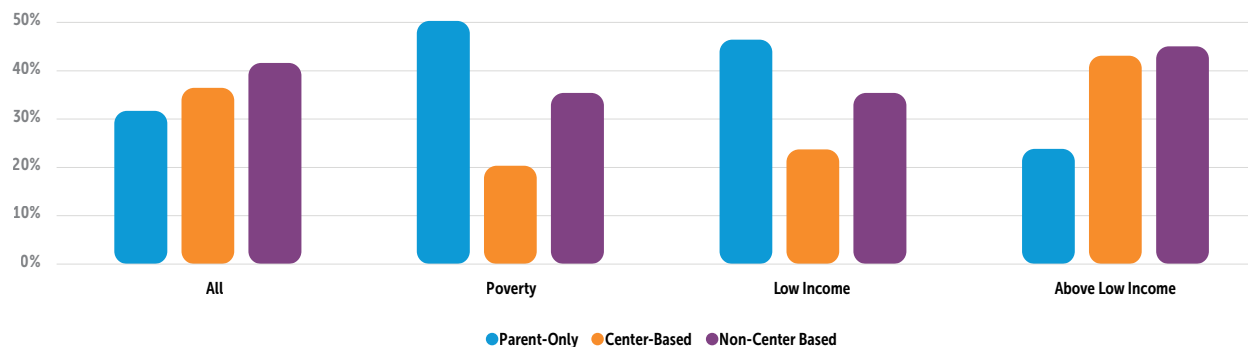
income were less likely to use this type of care than those with above low income (35 percent compared with 45 percent), instead relying more on parental care.

Families with low income were more likely to report using parent-only or home-based care options, while families with above low income were much more likely to use nonparental care, center-based and/or home-based care. The RAPID Survey data showed that more than one-third (36 percent) of parents used center-based care for their babies, including 43 percent of families above low income and 24 percent of families with low income. (Note that some families could have indicated they used more than one arrangement.) (See Figure 3-2.) Family friend and neighbor caregivers are often overlooked in quality initiatives, including those offering increased workforce supports and compensation. This is concerning given the high usage of this type of care for infants and toddlers.

NON-PARENTAL CHILD CARE USE BY INCOME LEVEL Figure 3-1



TYPE OF CHILD CARE ARRANGEMENT BY INCOME Figure 3-2



Lack of Affordability and Access: The *Yearbook* data indicate that child care remains unaffordable in every state across the country, with the cost of infant care ranging from 7.3 percent of a married family’s income in Mississippi to 16.7 percent in California—all higher than the federal affordability standard of 7 percent of family income. At the same time, even for families who can afford care, it is often difficult to access.

RAPID survey data reveal that during every month from January 2022 to April 2023, more than three-quarters (77 percent) of parents looking for infant-toddler child care had difficulty finding care. In addition, 58 percent of families reported having to make alternative child care arrangements so that they could work. Difficulties in finding care and increased juggling of arrangements can be expected to rise again as COVID relief dollars that stabilized the child care sector during the pandemic expire. Even prior to the pandemic, child care access was a particularly difficult challenge for parents with young children, as more than one-half of Americans lived in an area with more than three children under age 5 for every one licensed child care slot.⁶



Vermont’s Child Care Assistance Program.

Vermont’s *2023 Child Care Bill*⁷ provides sustainable public funding for child care, investing \$125 million annually into the system, improving accessibility and quality, increasing compensation for early educators and expanding income eligibility for the state’s child care subsidy program up to 575 percent of the federal poverty level. The bill will also create a new child care subsidy eligibility category for resident families who otherwise qualify for the program except for their citizenship status (solely state-funded).

These investments will impact the accessibility of child care by providing resources to expand programs, offer care at nontraditional hours and ensure culturally competent and multilingual services. The bill’s affordability feature means that approximately 7,450 more children and their families can benefit from financial assistance for child care. Increased rates, readiness grants and capacity initiatives will help bolster child care program staffing and capacity—including to maintain and/or expand infant and toddler capacity. The bill also mandates collaboration between Vermont’s Office of Racial Equity and the agency administering the subsidy program to enhance accessibility and eliminate disparities by providing application materials in multiple languages and collaborating on outreach efforts.



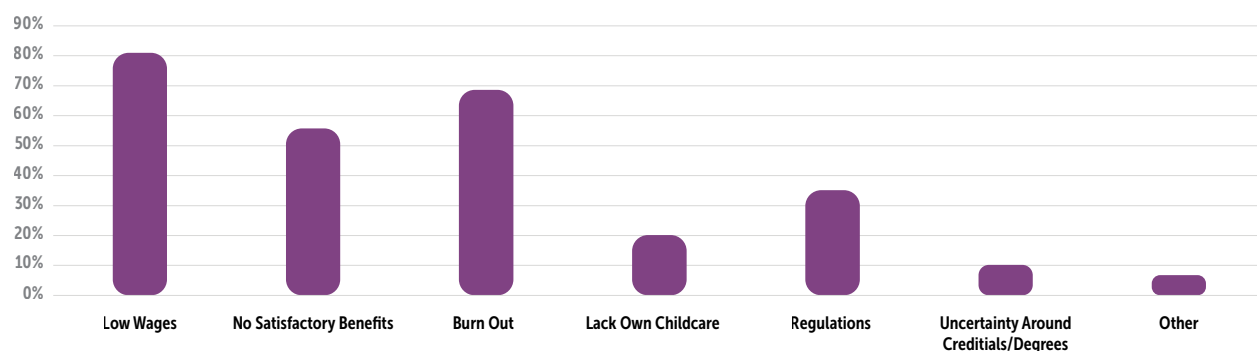
Staffing Challenges and Child Care Supply:

Ongoing child care staffing challenges both contribute to and exacerbate child care supply problems. According to the Center for the Study of Child Care Employment at UC Berkeley, employment in the child care sector remains nearly 4 percent below pre-pandemic levels.⁸ Child care is not able to attract or retain teachers, as the workforce continues to face stagnant wages that have not kept pace with increases in other sectors in the tight, post-pandemic labor market.⁹

RAPID Survey caregiver data show that low wages and burnout are the two major challenges to staff retention. And unsurprisingly, the stress of the staffing shortage is cited by providers as contributing to their burnout. (See figure 3-3). Programs serving infants and toddlers are particularly challenged, as there is often a “pay penalty” in terms of generally lower wages for working with babies, and these programs are reporting that staffing difficulties cause them to operate at less than full capacity and with longer waiting lists for parents.¹⁰ Government funding is needed to boost wages for early educators, as parents cannot afford to pay more than they already do. This will help stabilize early educator jobs and make the existing supply of child care programs available for babies and their families.

A Workforce Rapidly Burning Out: As noted above, the child care staffing shortage is increasing burnout for early educators, which in turn can undermine continuity and the ability of infant and toddler teachers to provide quality care for babies. One-half (49.6 percent) of caregivers participating in the RAPID Survey of child care providers reported burnout symptoms, describing

REASONS FOR DIFFICULTY RETAINING STAFF Figure 3-3



challenges such as feeling mentally exhausted and drained at the end of the day and difficulties with recovering energy.

The most important ingredient of quality care is the ability of early educators to establish early connections and relationships with babies and their families and to provide nurturing, developmentally and culturally responsive experiences for the children in their care. Therefore, the well-being of early educators (i.e., their mental health and economic security) is a

core component of quality care, alongside the specialized skills and knowledge required to care for babies. Urgent action is needed to address the burnout, stress and material needs of early educators. Staffing challenges and burnout, all primarily driven by low wages, must be addressed to prevent even more early educators from taking the same course as many of their colleagues and leaving the profession altogether. Compensation in particular is the linchpin that must be addressed first.

Harder than Rocket Science

Because work with infants and toddlers looks different even than work with preschool-age children, some policymakers may believe it is less intensive work or less valuable. Nothing could be further from the truth. Babies learn differently than older children, and their teachers act as facilitators of exploration, not purveyors of content.¹¹ In fact, being an early educator has been described as “harder than rocket science.”¹² Whereas traditional rocket scientists work with immutable laws of physics and chemistry,¹³ infant-toddler educators must mix an understanding of how babies learn with an ability to develop relationships and provide responsive care to children whose language is just emerging, all while calibrating these interactions to individual infants or toddlers, each of whom has their own temperament and timetable for development.

Early educators must find the mix that fuels each child toward the trajectory of confident learning. These educators understand and apply child development knowledge regularly through nurturing and responsive interactions, consistent routines and play-based activities, allowing young children to take the lead in their own learning, facilitating support for communication and language and ensuring opportunities for physical development.

Young children’s cultural and racial identity also starts to develop during their early years, which requires cultural responsiveness, training and intentional teaching practices. Early educators must partner closely with families to ensure they are supporting both their culture and their goals for their babies, as well as monitor their children’s development and care needs. Infant and toddler teachers help build babies’ brains during the most consequential period of human development, influencing cognitive and language development and social and emotional development at critical sensitive periods to help children with later school achievement and to thrive into adulthood.¹⁴ While each year and grade level of a child’s life matters, the first years are the launching pad for all that follows.

Lack of Alignment with Early Head Start Quality:

The *Yearbook* examines whether state policies support families’ access to high-quality care by setting the floor for certain structural elements of care in licensing center-based child care programs in every state. Overall, we found that very few states aspire to a high-quality floor for all center-based programs. The *Yearbook* uses Early Head Start (EHS) quality standards as the

benchmark because of the program’s proven ability to support early development for infants and toddlers. These standards should be the goal of state infant-toddler child care programs. The *Yearbook* examined state policies aligned with EHS in four key areas: staff-child ratios, group size provider qualifications, and the presence of a state infant-toddler credential.

1. **Adult-child ratio requirements:** More states met or exceeded EHS's adult-child ratio requirement (one adult for every four infants and toddlers) for infants than they did for older babies. Thirty-six states and Puerto Rico met or exceeded the standard for infants. However, only 11 of these states also achieved the standard for one-year-olds, and just three states (Alaska, Connecticut and Massachusetts), as well as Puerto Rico, achieved the standard for all infants and toddlers.
2. **Group size requirements:** Fewer states met or exceeded EHS' group size requirement (no more than eight infants or toddlers in a group) for infants than met the adult-child ratio requirement. Few states met the group size standard for older babies. Twenty-four states met or exceeded the requirement for infants, but only five states achieved the standard for infants and toddlers up to 2 years of age, and only three states achieved the standard for all infants and toddlers.
3. **Teacher qualifications:** Only five states and Puerto Rico required teachers of infants and toddlers to have a credential beyond a high school diploma—one state less than reported in our previous *Yearbook*. Puerto Rico broke new ground by requiring a bachelor's degree. The vast majority—45 states—required no credential beyond a high school diploma or equivalent. Five states required a Child Development Associate® (CDA) or equivalent state credential. Overall, state requirements fell short of EHS's standard that teachers have a minimum of a CDA or comparable credential, with training or coursework in early childhood development with a focus on infant-toddler development.
4. **Infant-toddler professional credential:** Thirty states adopted an infant-toddler professional credential, a component of early childhood workforce development that recognizes providers' achievement of the specialized knowledge and skills required to provide high-quality care for babies.



Access to Quality Care for Dual Language

Learners¹⁵: According to the Migration Policy Institute, 33 percent of children from birth to age 3 (one-third of all babies in our nation) are dual language learners (DLLs).¹⁶ The vast majority are citizens of this country and have at least one immigrant parent. Most come from homes in which the language spoken is Spanish; however, there is tremendous diversity in the languages of DLLs, with variation across and within states, as well as variations in their countries of origin, race/ethnicity, migration experience, socioeconomic status and English language use.¹⁷ This underscores the critical importance of early childhood data collection efforts and assessment of early language experiences in early childhood programs (including the health system) and in partnership with immigrant communities to ensure access and quality of services for young DLLs and their families.

While DLLs are not a homogenous group, available data point to key considerations for access to quality early care and education services for young DLLs and improvement of their comparatively lower rates of participation in early care and education programs.¹⁸ More than one-half (51 percent) of young DLLs live in families experiencing low income.¹⁹ Therefore, when navigating the child care system, a large share of families of young DLLs face child care supply and affordability barriers similar to those of other families experiencing low income. The additional burden of encountering linguistic challenges makes it even more difficult for families of young DLLs to locate quality providers. Greater attention must be given to language access and to culturally and linguistically responsive outreach in child care policy and system building efforts. Head Start policy and exemplary grantees can serve as models. Further, research has shown that country of origin, cultural and linguistic congruence and immigrant status are also factors that influence the preferences and participation in early care and education of families of young DLLs.²⁰

Current policies often identify young DLLs as “at-risk” instead of valuing the advantages of their bilingual abilities as supported by the science of early development. This bias leads to an emphasis on English language skills over children’s home languages and a lack of dual

language programming. While such identification is more common for preschool-aged DLLs, it also extends to DLLs under the age of 3. Yet, the science of early development is clear about the innate capacity of babies to develop more than one language and the cognitive benefits of learning multiple languages at an early age, such as improved executive functioning skills (the ability to think flexibly, demonstrate self-control, focus attention and develop working memory).²¹

Moreover, language is interconnected with other aspects of development, as babies’ relationships and early connections with caregivers are fundamental to social and emotional development. Here again, Head Start and Early Head Start policy and programming can serve as models for the broader field regarding support for dual language development.

To better ensure access to quality care for young DLLs and their families, greater attention and support must be provided to the teachers providing education and care to them. About 30 percent of all infant and toddler teachers speak a language other than English,²² and additional research shows that family, friends and neighbor caregivers most often share a similar language and cultural background with the children and families in their care.²³

The immigrant women in this field are a particular asset, requiring more intentional and targeted supports. In addition to the challenges facing the workforce in general, these women encounter barriers related to language, immigration and discrimination. Such challenges make it more difficult for immigrant women to participate in publicly funded programs, start or expand a child care business, engage in quality initiatives, interface with licensing and workforce development systems and obtain credentials and degrees. The linguistic and cultural diversity of this workforce is often celebrated, but this has yet to translate to tangible supports in important areas of need, such as professional learning, credential and degree programs in languages other than English, supports for learning English and improved language access services (e.g., translation and interpretation) in funding and regulatory processes.

Empowering Non-English-Speaking Providers:

ESCALERAS, which means ladders in Spanish, empowers family friend and neighbor caregivers from non-English-speaking communities by offering them a pathway to licensing and professionalization that includes digital readiness and leadership development.²⁴ ESCALERAS is a comprehensive and integrated pre-licensing course and coaching process that meets, and exceeds, state and federal requirements for licensing and/or registration and addresses the unique needs and aspirations of non-English-speaking providers.

The ESCALERAS model is implemented in partnership with a community partner familiar with local regulations in order to develop a professional development pipeline that is tailored to local communities. This synergistic pipeline advances cohorts of Spanish-speaking providers beyond licensing through a continued quality improvement process and a network. ESCALERAS introduces providers to competency and quality standards that lead and support them through more advanced training, like CDA certification, and higher education. In 2018, ESCALERAS received the first-place award from Harvard's Saul Zaentz Early Education Innovation Challenge. The program has since been piloted in several states, most recently Ohio and Maryland.

Lack of Federal Investment: Given the critical importance of access to high-quality early care and education for young children's development, and for society as a whole, we might expect a strong public role in the space similar to public investment in K-12 education, which is widely acknowledged as a public good. In reality, ongoing public investments in early care and education are extremely limited and fall far short of the need, even for families with low income who largely benefit from the major federal programs.

The largest federal sources of public funding for early childhood education and care are the Child Care and Development Block Grant (CCDBG), which provides subsidies to help defray the cost of care for working families with low incomes, and Head Start and Early Head Start, which provide comprehensive child development services and high-quality care and education to children and their families living below the federal poverty line.



The *Yearbook* shows that Early Head Start serves just 11 percent of income-eligible infants and toddlers, while CCDBG serves just 16 percent of federally eligible children.²⁵ And *Yearbook* data reveals that among families with low and moderate income (at or below 150 percent of state median income) who could particularly benefit from assistance paying for child care, only 4.7 percent received a subsidy through the Child Care and Development Fund.

Even for families that can access subsidies, states often set the value of those subsidies at rates far too low to ensure equal access to high-quality care and fair wages for early educators. In 2022, only 13 states set their subsidy reimbursement rates at or above the 75th percentile of current market rates (the federally recommended standard).²⁶ This finding was released after the 2023 *Yearbook* data collection closed and is actually a major increase over the previous year, when only two states had rates at or above the 75th percentile. This increase shows the ability of the infusion of ARPA child care funds to improve states' subsidy policies in a manner that helps both parents and providers.

Expiring COVID Funding Brings Child Care Back to the Brink: The COVID-19 pandemic represented a historic exception to traditional funding patterns for child care. Responding to the existential threat the pandemic represented to the child care system and the economy as a whole, Congress invested nearly \$40 billion in ARPA emergency relief funding through a combination of stabilization grants directly to providers to cover their fixed costs and support staff wages, as well as increased CCDBG funding to states.

Stabilization funding alone has reached more than 220,000 programs serving nearly 10 million children and has been instrumental in preventing a broad collapse of the system during the pandemic.²⁷ Of particular importance, these funds supported higher pay and hiring and retention bonuses for infant and toddler teachers. Given that public funds for early care and education for babies are significantly less than that for preschoolers, to date, fewer compensation policies have included infant and toddler teachers. As such, stabilization grants represent a significant advancement in compensation policy that is inclusive of infant and toddler teachers.

Elevating Infant-Toddler Educators in Rhode Island

Rhode Island is taking several steps to improve the financial picture for infant-toddler educators. After years of advocacy, the state used \$2 million—half of the state's latest federal fund allotment from the Preschool Development Grant Birth through Five program—to launch the Child Care WAGES model, which focuses on retaining qualified and effective infant-toddler child care educators in centers and family child care homes by improving compensation. This national model provides financial awards to eligible early childhood educators who commit to remaining in their early childhood programs for the next six months. It helps reduce staff turnover, which is good for the continuity infants and toddlers need; makes the profession more attractive; and helps stabilize programs.

The state is also continuing ARPA funding for Early Educator Pandemic Retention Bonuses through State Fiscal Year (SFY) 2024 and into SFY 2025 with a \$750 per quarter bonus for everyone who works with children in any licensed setting (e.g. child care center, family child care, Head Start/Early Head Start, preschool, etc.) Rhode Island also has committed \$3 million in Temporary Assistance for Needy Families funds to Head Start and Early Head Start (EHS)—the first time EHS has received state-managed funding—to focus on providing competitive compensation for Head Start and EHS educators so that some of the classrooms that have been closed in the 2022-2023 school year due to the staffing crisis will be reopened for 2023-2024. In addition, Rhode Island has invested in Part C early intervention (EI), implementing a 45 percent Medicaid rate increase (the first in 20 years), which will help the 60 percent of EI recipients with Medicaid coverage and have a ripple effect on other insurance providers. The state also is allocating \$11 million in ARPA funds to EI to address financial problems, the staffing crisis and waiting lists.

In addition, increased funding to CCDBG has allowed states to make structural improvements to their child care systems, including increasing provider reimbursement rates, expanding subsidy eligibility to more working families, reducing family copayments for child care assistance and making other administrative improvements, such as payments based on enrollment rather than attendance.²⁸ Unfortunately, most of this funding, including \$25 billion dedicated to child care stabilization, is set to expire at the end of fiscal year 2023, threatening additional destabilization of the system and further limiting families' access to the high-quality care their children need to thrive. According to the Century Foundation, approximately 70,000 child care programs are projected to close as a result of this expiration, with more than 3 million children potentially losing access to care nationwide.²⁹

Extending the Reach of Early Intervention (EI) Helps Ensure Developmental Needs Are Met:

An integral part of early development programs for infants and toddlers is EI services, authorized under Part C of the Individuals with Disabilities Education Act, which support the development of infants and toddlers with disabilities and enhance the capacity of families to meet the needs of their young children with disabilities. *Yearbook* data show that in 2020, 6.8 percent of infants and toddlers across the country received EI services, ranging from 1.9 percent in Arkansas to 20.2 percent in Massachusetts. Massachusetts is one of six states that include babies considered at risk for developmental disabilities in its eligibility criteria, accounting for its greater reach into the infant-toddler population. The top tier of states

all reached more than 9.2 percent of their infants and toddlers with EI services, with seven reaching more than 10 percent. Extending the reach of Part C is important, considering the magnitude of Infants and toddlers who experience stressful events such as adverse early experiences and are at risk for experiencing developmental delays or disabilities (see Urgent Policy Area #2 on IECMH for further discussion).

RAPID Survey data show that a little more than one-half (51 percent) of families with infants and toddlers have concerns about their child's development, either developmental, behavioral or both. Without receiving support during their most malleable years, children with or at risk for developmental delays or disabilities experience increased impacts on their development, learning and academic achievement. Many babies whose development may be affected will be in child care, making integration of EI with child care important. However, very few babies receive early intervention services in child care, even less after the pandemic began.³⁰ Moreover, ensuring that training for early educators in supporting children's developmental needs and other services are available in the child care setting are important for guaranteeing inclusive environments for babies in care.

Another challenge to ensuring identification of infants and toddlers who could benefit from early intervention is the lack of consistent screening for developmental concerns. The *Yearbook* shows that only one in three babies received a developmental screening in the previous year. Disparities in developmental screenings exist across racial and ethnic groups: while White babies are screened at higher rates than the national average (36.8 percent compared with 34.2 percent), Asian, Black and Hispanic babies are screened at lower rates (27.4 percent, 28.6 percent and 31.1 percent, respectively). Similar patterns are seen across income levels, with screening rates for babies in families with low income (29.5 percent) also lower than the national average. Other research has shown that babies of color are significantly less likely to receive EI services than their White peers. When babies who may be missing developmental milestones are not identified or do not qualify for or receive needed services, the result can be a need for more complex and costly services down the road.³¹





Policies That Improve the Early Care and Education System

Given that the majority of families with infants and toddlers rely on child care to work, and that access to quality early care and education plays such a critical role in shaping children's early developmental foundations, strengthening our early care and education system is an urgent policy area that must be addressed at the federal and state levels.



Most immediately, the child care sector needs continued support on a scale large enough to stabilize the current supply and address workforce shortages. In the longer term, policymakers need to reorient their thinking about how to approach early care and education policy and funding in a way that values it as a public good and eliminates disparities by race, income and geography.

The policy recommendations below offer a path forward towards a more equitable system that can truly meet the needs of infants and toddlers, their families and the early educators that support and care for them.

Sustain child care in the short term: The federal government should provide \$16 billion in emergency funding to states to disperse to providers to address critical workforce shortages that are crippling child care and to continue sustaining the child care sector overall, as tens of billions of dollars of stabilization and supplemental CCDBG funding are set to expire.

Enact a comprehensive child care program: Congress and the states must recognize that high-quality child care is a public good and fund it as such. We need a comprehensive child care

system that guarantees all families access to affordable, high-quality care across a variety of settings that meets the developmental needs of their young children and supports a well-compensated workforce of early educators. Legislation like the Child Care for Working Families Act, introduced by U.S. Senator Patty Murray (D-WA) and U.S. Representative Bobby Scott (D-VA-03), would help bring us closer to making this vision a reality for millions of infants and toddlers and their families. States can carry out this vision by contributing their own funds and aligning quality with Early Head Start standards.

Invest in and elevate infant-toddler educators: Federal and state policymakers must recognize the importance of infant-toddler educators in laying critical foundations for early learning and undertake concerted efforts to develop supports for and to aggressively recruit the highly qualified workforce that families need for their babies across all aspects of early care and learning, including home- and center-based child care, Early Head Start and Early Intervention. An intentional focus on infant-toddler educators would encompass compensation and financial relief, work environments, qualifications and education supports, workforce data, and financial resources to build, support and retain the workforce over the long term.

Quality services for babies start with insisting the infant-toddler workforce receives fair compensation, benefits and work environments that recognize the value of their contributions. It additionally requires that compensation disparities within the birth to 5 early childhood care and education mixed-delivery system are addressed, with particular attention to infant-toddler educators who are typically paid less than those working with older children.

Policies and practice must also support recruiting and retaining a racially, culturally and linguistically diverse infant-toddler workforce that reflects the diversity of the early childhood population. In addition, policymakers should be cognizant of the diversity of settings in which infants and toddlers are cared for and build capacity for supporting all settings, including family, friend and neighbor care.

Early childhood systems should define core knowledge and competencies for the infant-toddler workforce, as well as career pathways,



and build the professional development, higher education and supportive structures that ensure robust content on infant-toddler development, including embedding these supports in licensing systems.

Above all, systems should ensure equitable access for infant-toddler providers to credentialing and degree paths, with financing assistance and other supports as well as offerings in multiple languages, at times and places to meet the varied needs of the early educator workforce. State-level data collection can drive these improvements by supplying key information on the size, characteristics, and working conditions of the early childhood workforce.

These improvements, on a scale large enough to impact the infant-toddler care landscape, are not feasible without robust, systems-oriented investments. Financial support to achieve such a workforce should be built into all funding streams serving infants and toddlers. Also needed is funding for specialized purposes such as developing infant-toddler content for professional development, credentialing and higher education curricula, as well as providing infant-toddler providers equitable access to higher education.

Fully fund Early Head Start: Families facing steep economic challenges and stressors need comprehensive supports to help ensure their infants and toddlers are receiving the strongest possible start in life. Early Head Start (EHS) is a proven, effective early development and family support program and should be fully funded to reach all eligible infants and toddlers, as well as significantly more pregnant people who could

benefit from its support. But, like child care, EHS is facing a workforce crisis that threatens the program's quality. Increases building toward full funding should be in increments large enough not only to expand the program, but to more immediately address the need for investment in recruiting and retaining highly qualified EHS staff.

State policymakers should also work to serve more EHS-eligible families in their states by investing in EHS expansion across program options (home-based, family child care and center-based) and EHS child care partnerships, supporting facilities' needs, and addressing infant and toddler workforce needs. Such investment is critical to supporting EHS as a model for infant and toddler early care and learning and building its capacity to grow.

Robustly fund state and federal early intervention services: Congress must expand funding for the early intervention (EI) system to help states fully meet the developmental needs of infants and toddlers. Federal funding through Part C of IDEA should be sufficient to enable states to provide developmental screenings and follow-up; increase outreach and support to families of color to improve equitable access to services; help families navigate the system; expand the EI workforce to ensure greater racial, ethnic and linguistic diversity; ensure adequate reimbursement for EI services; ensure eligibility for more children who are at risk of or could benefit from services; support inclusion of EI in early care and education settings; and incorporate more infant and early childhood mental health expertise and services.



Endnotes

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Urgent Priority #4:

The Hidden Developmental Threat of Unstable Housing

A safe, stable, affordable home provides more than just shelter: it is the emotional and social center of family life. The security and quality of a baby's earliest relationships and experiences, which their surroundings can acutely affect, molds young children's brain architecture. When babies have the security and predictability of safe places, they are better able to sleep, eat, crawl, play and develop bonds with caregivers.¹ When this central family place becomes unstable, overcrowded, unaffordable or threatened by unsafe neighborhood conditions, babies' rapid brain development is put at risk, leaving them susceptible to long-term developmental and health problems.²

State of Babies Yearbook data show a significant proportion of infants and toddlers live in housing conditions—particularly crowded housing—that pose a hidden threat to their early development that policymakers may not recognize. Living in crowded housing places infants and toddlers at risk for developmental and health consequences and, when coupled with poverty, early mortality. Housing costs create additional stress for families, associated with concerns about being able to afford other basic needs such as food, utilities, and safety. Racial disparities in access to adequate housing reflect the generations of segregation and racism in housing policy that continue to have major consequences for families of color. The nation’s history of racist policies such as redlining, in which discriminatory policies and practices prevented investments in neighborhoods with Black families and other families of color, have reinforced the unequal distribution of property ownership and wealth.

Despite understanding that the earliest years have the largest impact on long-term health and well-being, policymakers do not place enough national attention on the importance of housing for families with young children. Housing assistance remains woefully inadequate, and only one in four families eligible for rental assistance receive this support,³ which could help them provide the physical and psychological environment their babies need to thrive. During the pandemic, families felt some relief with the issuance of necessary emergency provisions like the eviction moratorium and expanded emergency rental assistance. These temporary supports kept more than 1 million people stably housed,⁴ but they have since expired, despite the fact that housing costs continue to skyrocket; this remains a major expense for most families with young children. Housing programs need to be expanded, with a special view to ensuring that families with young children are stably housed in recognition that housing is a crucial developmental support.

Neighborhood, Built Environment and Climate Change: Housing and neighborhoods play critical roles in creating a healthy living environment for babies and women and pregnant/birthing people. Even during the prenatal period, babies are exposed to environmental stressors and pollutants, which are exacerbated by climate change. Although fewer *Yearbook* indicators are related to this domain, indirectly connected health indicators (e.g., preventive medical visits) suggest some states have considerable work to do to ensure children are being screened for health hazards such as lead and air pollution. And basic need indicators (e.g., crowded housing) suggest quality, affordable, healthy housing options may not be available to many families with babies. With the record-breaking temperatures experienced during the summer of 2023, families have revealed to us that they are often forced to stay indoors, with marked impacts on the stress levels and emotional health of themselves and their babies and toddlers. Several have likened the experience of extreme heat to the isolation of COVID: they feel trapped, isolated from community and worried about keeping their children safe.

RAPID Survey data underscore parents’ concerns about climate change and the environment around their homes:

- 79 percent of parents of infants and toddlers expressed worry about climate change’s impact on their young children, including 88 percent of Latine parents.
- 57 percent of parents said their families had been exposed to an extreme weather event.
- One-third of parents reported experiencing abnormally warm weather, by far the most prevalent extreme weather event.
- Latine parents are the most worried about the environment in which their young children are growing up (70% of latine parents, compared to 55 percent overall).
- Parents with low income worry more about the environment (61 percent, compared with 51 percent of parents above low income).

FAMILY STORY

There are six people in our family, under our roof: mom, dad and four boys. We love to be outside hiking, exploring and going to the park and the beach. My three older boys watch out for and love to play with their smaller brother. The older boys love to play soccer, basketball and video games. Our youngest, barely 3 years old, loves the playground.

Twelve years ago, when I was pregnant with our second-oldest, we moved to an apartment in our city. The rent was affordable and it was close to family. I grew up a few streets away, riding bikes and playing basketball outside all summer with the other children in my neighborhood. I imagined that kind of childhood for my children too. But the last several years have been tough for our home and our neighborhood.

Our rent is cheap, but it means that the landlords do not feel they need to maintain the property. There is a crack in the tub where mold comes out if it is submerged. I cannot give my baby a bath. I've asked for two years for it to be fixed, but nothing ever gets fixed. There are pests everywhere, so I have to watch our little one closely inside. And even so, every year for the past five years, our rent has gone up \$100 a month.

Gangs have taken over our area. Last year, a few gang members—brothers—got shot down our block. One was 17 and the other one was 15. I watched them grow up. They lived close to us, and I worry about retaliation. Our children sleep just one wall away from people who might be dangerous to them. I have to teach them to be careful, that you can't trust people, that even when some kids are nice to you, it's because they will want something from you later on. Those brothers were such nice kids, but they got cruel quick. When I take our youngest to the playground, I have to keep an eye out. I watch for unfamiliar cars and wonder why they are slowing down as they pass. I feel terrible. I want my children, all of my children, to be able to be outside, to have a place to explore and play.

All babies and toddlers deserve somewhere safe and clean to live. We have tried to move, but rents are expensive and the security deposits are impossible when we live paycheck to paycheck. If we still had the enhanced Child Tax Credit, I could move my family to a safer area with that extra \$500 a month. I wish our policymakers knew that we need affordable housing. Our city's nickname is "The Caring City," but it sure seems like they don't care about families who earn low income—or our kids.

*Chloe M.
La Habra, California*



Data Raise Concern About Housing and Early Development

The *Yearbook* shows that a concerning proportion of families with babies face housing challenges (most notably crowded housing), which create instability and hardship in the earliest years, with potentially negative long-term consequences for children's development and well-being.

Racial disparities are pronounced in data on adequacy of and worries about housing. Lacking a stable home creates greater risk of food insecurity and poor health outcomes, such as developmental delays, behavioral problems and difficulty maintaining a healthy weight.⁵ Housing concerns are closely linked to poverty and income, compounding the risks for developmental consequences and even early mortality.

Crowded Housing. Crowded housing is a critical issue for infants, toddlers and their families, with nearly one in seven babies (15.2 percent) nationally experiencing overcrowded housing. Living in overcrowded housing out of necessity due to a lack of affordable housing can create stress and have a profound impact on young children's health and well-being. The stock of affordable housing is inadequate, and thousands of public housing units are lost each year to disrepair. Crowded housing due to the inability to secure safe and affordable housing has been associated with children's health problems, including respiratory conditions, injuries and infectious diseases, as well as with children's food insecurity.^{6, 7} In homes where families are crowded, parents may also have fewer opportunities to be adequately responsive to infants and toddlers, and they may be more likely to use punitive discipline.⁸ Most alarming, when children experience poverty and crowded housing, which can go hand in hand, there is an increased likelihood of early mortality.⁹

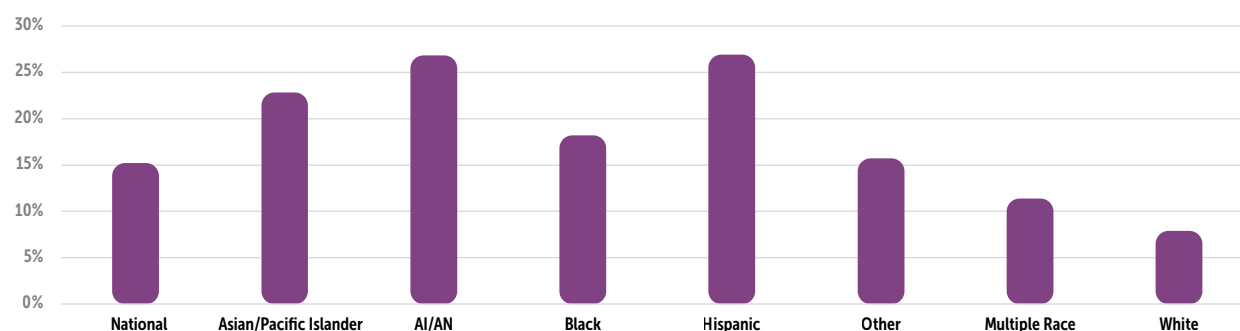
Crowded housing disproportionately affects families of color, with 26.9 percent of Hispanic and 26.8 percent of American Indian/Alaskan Native infants and toddlers living in crowded housing—nearly twice the rate of the national average of 15.2 percent. (See Figure 4-1). It is important to note that this *Yearbook* indicator

refers specifically to overcrowding out of necessity, rather than multiple generations of a family living together as a cultural choice and with adequate space (which can promote cultural well-being and safety).

Unsafe Neighborhoods. Housing and neighborhoods play critical roles in creating a healthy living environment for babies and pregnant people. A family's neighborhood determines the opportunities available to them, including proximity to grocery stores, libraries, schools, child care options, doctors' offices and other services vital to a family's well-being. Families are deeply influenced by the broader communities in which they live, and unsafe neighborhoods are a significant source of stress for families. Living in unsafe neighborhoods is associated with higher rates of infant mortality, low birth weight, child abuse and neglect, and poor motor and social development among young children.¹⁰ Further, parents living in unsafe neighborhoods may restrict children's opportunities for outdoor play out of concern for their safety.¹¹

While, nationally, a relatively low percentage of parents with babies report living in unsafe neighborhoods (5 percent), disparities by race and ethnicity are evident, with 6.9 percent of Black families and 7.2 percent of Latine/Hispanic families reporting living in unsafe neighborhoods. Among families with low income, 7.5 percent report living in unsafe neighborhoods—more than twice the rate of families above low income (3.3 percent). RAPID Survey data show that about one-third of parents with income below the poverty threshold report neighborhood concerns such as trash, poorly maintained housing, a lack of parks and neighborhood crime, compared with one-fifth or less of parents with income above poverty

INFANTS AND TODDLERS IN CROWDED HOUSING BY RACE AND ETHNICITY Figure 4-1



level. Families in poverty are also more likely to have concerns about air and water quality, with approximately one in four citing these issues

compared with about one in seven families living above poverty level.

Recent Housing Challenges

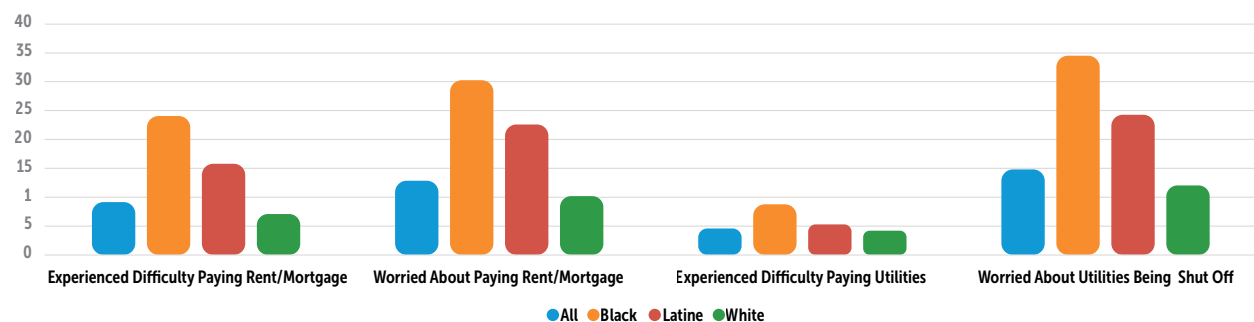
Rapid survey data show Black and Latine in particular, feel the pinch of housing costs (see Figure 4-2). Nationally, 9 percent of families reported difficulty paying their rent or mortgage, while 24 percent of Black families and 16 percent of Latine families reported difficulty meeting these expenses. But families' *worries* about whether they can meet housing and utility costs loom larger and thus are a considerable source of family stress. Nationally, 13 percent of families said they worry about paying their rent or mortgage, while 15 percent said they worry that their utilities will be cut off. Comparatively, 30 percent of Black families and 23 percent of Latine families said they worry about their housing costs. While relatively few Black or Latine families reported actually having problems paying their utility bills, a much higher percentage of these families reported worrying

about the status of their utilities (35 percent of Black families and 24 percent of Latine families).

Racial and ethnic disparities in housing and neighborhood safety demonstrate the major consequences of generations of segregation and racism, especially in housing policy for families of color. Our nation's history of systemic racism illustrated by policies such as redlining reinforce the unequal distribution of property ownership and wealth. One study found that Black residents are less likely to own homes, and when they do successfully obtain a home, it is often devalued.¹² This devaluation includes discrimination in individual appraisals, and homes located in majority-Black neighborhoods that have been chronically undervalued, exacerbating the racial wealth gap.¹³

EXPERIENCES AND WORRIES ABOUT HOUSING-RELATED HARDSHIPS BY RACE AND ETHNICITY

Figure 4-2



The Link Between Poverty and Housing Challenges

Maintaining secure housing is often a family's largest monthly expense, with extremely low-income households "hyper-allocating" spending on housing,¹⁴ meaning they spend more than 50% of their income on housing. Households with children are even more likely to be cost-burdened by housing than single individuals and couples without children.¹⁵ A growing number of families with young children, particularly those with low and moderate incomes, struggle to afford adequate housing despite working multiple jobs. *Yearbook* data show that 35 percent of babies in poverty have at least one parent working full time, further complicating the relationship between housing and income.

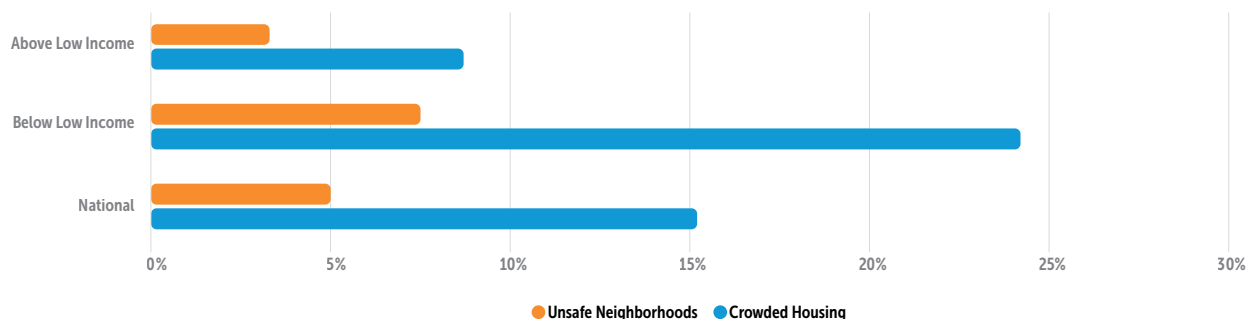
Nearly one in five babies lives in poverty (18.6 percent) while 78 percent of babies live below 150 percent of their state's median income. As noted above, *Yearbook* data show that infants and toddlers living in families with low income

(24.2 percent) are significantly more likely to live in crowded housing than babies in families above low income (8.7 percent). *Yearbook* data also reveal that 7.5 percent of parents in families with low income reported living in unsafe neighborhoods, nearly twice the rate of parents above low income (3.3 percent). (See Figure 4-3).

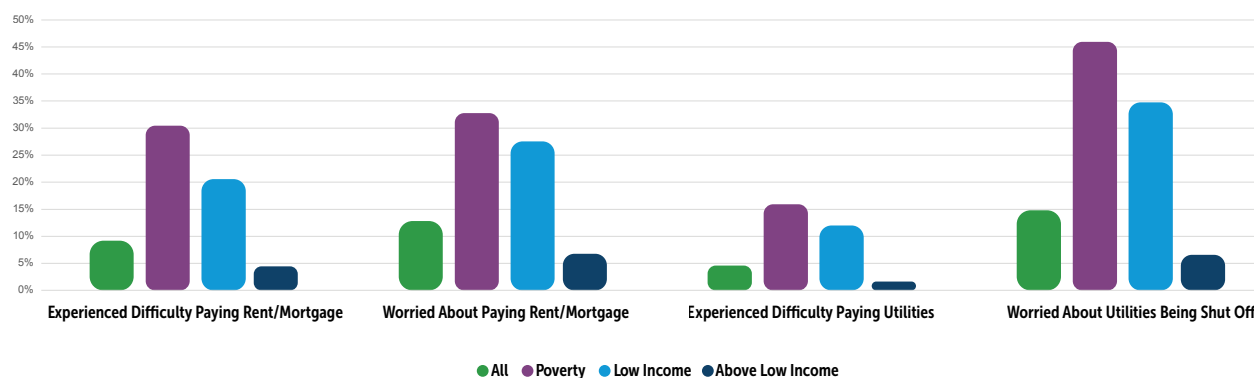
RAPID Survey data reflected a similar pattern, with 30 percent of families in poverty and 21 percent of families with low income reporting difficulty paying their rent or mortgage. And while 16 percent of families in poverty reported difficulty paying for their utilities, close to one-half (46 percent) expressed worrying about having their utilities shut off. (See Figure 4-4).

Crossover between poverty and housing is especially concerning given that one in four postpartum people experience poverty the month after giving birth.¹⁶ Increased cash assistance for

ADVERSE HOUSING EXPERIENCES BY INCOME Figure 4-3



EXPERIENCES & WORRIES ABOUT HOUSING-RELATED HARDSHIPS BY INCOME Figure 4-4



families can provide financial relief from housing costs. Housing accounted for the largest use of the expanded federal Child Tax Credit (CTC) made available through the American Rescue Plan Act (ARPA),¹⁷ but with that version of the CTC expiring in 2022, families are no longer receiving the expanded level of benefits that were so helpful in meeting their basic needs. Cash assistance provided through the Temporary Assistance for Needy Families (TANF) program can be used for basic needs such as housing costs, but this benefit only reaches a small percentage (19 percent) of

families with infants and toddlers living in poverty, according to *Yearbook* data. Direct assistance in paying for housing could alleviate the conditions that threaten to undermine the development of many infants and toddlers, yet not enough federal housing supports are targeted at families with children. An alarming 75 percent of low-income renters who are caring for a child at home and are in need of federal rental assistance do not receive such support.¹⁸

Housing and the Child Welfare System

Living in poverty or being unstably housed does not go hand in hand with child abuse or neglect, but studies have shown that housing challenges are common among families involved in the child welfare system and can become a barrier to the reunification of children who have been placed in out-of-home care. Research has shown that families experiencing homelessness or those unstably housed, as well as families experiencing poverty, are more likely to be involved with the child welfare system.¹⁹ This might be true for a variety of reasons. Families can come to the attention of child protective services because their homelessness or housing conditions pose a risk to the health and safety of their children.

While some states include a poverty exemption in their statutory definition of neglect, the circumstances under which experiencing homelessness or inadequate housing should be attributed to neglect versus poverty are not always well defined. Another connection between poverty and the child welfare system can be found when analyzing the increased surveillance of people living in poverty. For example, families living in poverty are more likely to come into contact with mandated reporters through over-policing and reliance on public supports.²⁰

Family stability, including maintaining safe and stable housing, is secured by having enough income to meet family needs. The underlying issue of inadequate or unstable housing as it relates to the child welfare system is one that requires multifaceted solutions. Housing assistance falls far short of this need, and thus

cannot reliably function as a preventive service or facilitate reunification.

The Family First Prevention Services Act (Family First) is one potential source that could help prevent families from entering the child welfare system due to housing challenges, but Family First does not currently allow use of funds for material needs such as housing or home appliances such as washing machines to avoid placement in foster care. The Safe Babies™ approach prioritizes addressing the root cause of families' entry into the child welfare system, with reliance on both a statewide coordinator and community coordinator to ensure that families are connected to necessary supports



such as mental health services, housing and other material needs. Employing a Safe Babies framework could enhance the use of Family First funds for both currently allowed services and any potential assistance such as material supports. This approach focuses on the whole family, understanding the interrelatedness of various needs, while using the community team to identify gaps in community services and strategies for filling any gaps. This type of approach could help communities work together to problem-solve in finding stable housing for families.

Homelessness

Although the *Yearbook* does not include an indicator of the number of infants and toddlers experiencing homelessness, a SchoolHouse Connection report on 20 states estimates that between 2020 and 2021, 311,961 infants and toddlers (3 percent of the infant-toddler population in those states) experienced homelessness.²¹ Experiencing homelessness can have a considerable impact on the well-being and development of a young child. Children who experience homelessness are more likely to suffer developmental delays and poor health. As with most traumatic occurrences a child endures, longer periods of experiencing homelessness are associated with more negative outcomes.²²

Many of the services to address infant well-being that are discussed in other sections of

this year's *State of Babies' Yearbook* (e.g., home visiting, locales for parent-child bonding as fostered by paid family leave and paid sick leave, and early developmental support) are difficult to provide to families facing homelessness.²³ Babies experiencing homelessness have difficulty accessing early care and learning services such as Early Head Start or child care.²⁴ However, when home visiting services are provided to families experiencing homelessness, children's social and emotional health and parents' parenting knowledge and comfort increase, suggesting that expanded and flexible home visiting services for families experiencing homelessness may help reduce some of the challenges their babies face.²⁵

Washington State's Child Welfare Housing Assistance Pilot Program

In May 2023, Washington State legislators passed Senate Bill 5256, making permanent and expanding the Child Welfare Housing Assistance Pilot Program.²⁶ The program provides services to eligible families with dependent children in foster care whose primary remaining barrier to reunification is a lack of appropriate housing. These services include housing vouchers, rental assistance, navigation and other supports.





Policies to Improve Families' Access to Stable Housing

Expand Federal Housing Programs

Increase investments in housing vouchers. The U.S. Department of Housing and Urban Development's largest rental assistance program—Housing Choice Vouchers, or tenant-based Section 8 housing—helps households with low income find housing.²⁷

Research shows that receiving a voucher can have benefits for children's mental and physical health and their later educational success. Vouchers are also powerful in the way that they allow families to choose housing in the private market, including neighborhoods that best suit their needs and those of their children. Despite research pointing to the success of vouchers, the program does not serve a significant percentage of eligible households due to funding constraints. Further investment is required to fully realize the utility of this program.

Pass the Family Stability and Opportunity Vouchers Act. This program would create 250,000 new housing vouchers specifically targeted to families with young children living with low income and provide mobility-related services (including mobility counseling) to help families move to communities of their choice, including neighborhoods with high-performing schools and/or high-quality child care and early education programs.

Increase investments in public housing operation and repairs. Congress has disinvested in public housing for decades, resulting in a backlog of capital repair needs of up to \$70 billion. This is worrisome for families with young children, as nearly one-half of tenants living in public housing have at least one child residing in the home. Nearly three-quarters of households are considered very low income or extremely low income, making less than 50 percent of the area median income, with an average annual tenant income of about \$13,400.²⁸

Invest in rental assistance programs to prevent family evictions. The economic crisis of the pandemic increased eviction risks, but even before that time tenants with children were at greater risk of an eviction judgment, and neighborhoods with more children experienced more evictions.²⁹ Emergency housing funds could prevent the disruptions in a young child's life created by losing stable housing. Enacted during COVID-19, Emergency Rental Assistance (ERA) reached the lowest-income and most marginalized



renters. The Treasury ERA program included an unprecedented amount of funding for emergency rental assistance to help renters stay stably housed. These emergency resources are being depleted, yet renters with low income continue to face high rents and increasing housing instability, with eviction filing rates reaching or surpassing pre-pandemic levels in many cities and states.³⁰ Greater access to short-term emergency funding could prevent families from experiencing homelessness and keep families together if their children are at risk of or in foster care placements.

Expand Other Supports to Assist Families with Stable Housing

Reinstate the enhanced, fully refundable Child Tax Credit (CTC). Congress allowed the enhanced CTC to expire in December 2021, including the boosted credit for young children and full refundability. Before it expired, the credit was lifting more than 3 million out of poverty every month, particularly assisting families with housing costs. Congress should restore the full value of the enhanced credit, dispensed through monthly

payments particularly helpful with housing costs and ensure that all families with children can benefit through full refundability and child eligibility. As was the case prior to the 2017 Tax Cuts and Jobs Act, the federal CTC should not exclude immigrant families who file taxes with Individual Taxpayer Identification Numbers (ITINs). States should continue the trend of adopting tax credits or other forms of allowances, including Baby Bonds, for young children.

Allow Family First Prevention Services Act programs to pay for basic needs. Given the developmental implications of child welfare involvement as discussed in Urgent Priority #2: Seizing the Opportunity to Promote Positive Infant and Early Childhood Mental Health on infant and early childhood mental health, using this source of prevention funding to keep families housed on a short-term basis and out of the child welfare system would be an impactful use of this unique funding stream. However, particularly when used for families already involved in the child welfare system, basic needs support may need to be accompanied by a holistic approach to an array of family services, such as that provided through Safe Babies.

Is Housing Health Care?

As the connection between housing and health becomes clearer, how can housing and health policy be more integrated? Action is demanded when so many babies are living in unstable housing, with a potentially detrimental impact on their early development and long-term health. One avenue would be a concerted effort to use Medicaid to help stabilize families with young children experiencing homelessness, including being doubled up with other families. Currently, Medicaid cannot be used to pay rent, and most efforts to use it for housing-related support services seem to focus on individual adults with disabilities and/or transitioning from institutions or homeless shelters.

States currently have flexibility to provide supportive services within proscribed bounds, including helping with one-time transition costs such as security deposits and essential household furnishings, assisting with housing searches and moving expenses, and providing individualized case management.³¹ Such services would be a boon for many families with young children struggling with navigating the housing market. California is pushing the federal government to go further and allow Medicaid to fund a transitional rent program of six months for people experiencing homelessness. Early health and developmental problems can lead to a lifetime of higher health and educational costs, estimated at \$110 billion over just 10 years.³² Packaging supportive services with transitional rent could go a long way toward ensuring that babies now in precarious housing situations have the security of place that helps them thrive—and likely save money in the long run.

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Urgent Priority #5: The Economic Insecurity That Engulfs Many Babies

In the United States, poverty and disparities in access to resources along racial and ethnic lines are defining features of a baby's experience. Two million infants and toddlers in America—nearly one in five—currently live in poverty. Poverty and low income are not only the most striking demographic of babies in the United States, but also the greatest indicator of risk undermining their healthy development and the nation's future. Poverty literally gets under the skin, affecting biological systems as well as neural development, with implications for future health and success in school and in life.¹

The impact of past and present systemic racism is readily apparent in the intersectionality of race/ethnicity and income. Income inequality has grown out of a long history of systems of oppression and discriminatory practices that have limited individual liberties, access to resources and opportunity, and wealth building. *The State of Babies Yearbook* finds that two-thirds of Black and Native American babies and more than one-half of Hispanic babies live in families with low income. So many babies engulfed in poverty and economic insecurity calls for urgent policy action. Earlier sections of this report examine issues such as housing, child care, maternal health, and mental health, all of which are exacerbated by economic challenges. In short, these sections illustrate disparities by income and race in access to fundamental supports and services. Moreover, the stress from inadequate housing, food insecurity and even involvement with the child welfare system can negatively impact early development. Stress that becomes chronic and unrelenting can be toxic to the developing brain, leading to delays in cognitive, social-emotional, physical and language development.

But poverty is not destiny. Strong supportive relationships with close caregivers can buffer young children from its damaging effects. Public investments can supply needed resources to mitigate material hardship at the time of development when they matter most, and work toward the creation of solutions that reduce stress for parents and other caregivers.

The most effective solution is the simplest and most direct: give families an income boost they can spend on their families' needs. The recent evidence is clear—the vast majority will spend cash aid wisely. During the pandemic, Congress temporarily enhanced the Child Tax Credit (CTC) with impressive results, dramatically reducing child poverty and helping families meet basic needs—the area where they concentrated their spending.^{2,3} The American Rescue Plan raised the CTC to \$3,000 for older children and \$3,600 for young children and allowed families to receive the credit on a monthly basis. Congress also made the CTC fully refundable so that the lowest-income families were eligible to receive the maximum credit, precisely targeting the children who could most benefit from an income increase. These aspirational reforms lifted 2.9 million children out of poverty.⁴

Ultimately, the economic hardship experienced by so many babies has implications not only for their own development, but also for our country's long-term economic well-being, underscoring the urgency for policymakers to increase available income for families with young children when it matters most. The evidence discussed below points to prime strategies such as restoring the enhanced CTC, boosting the minimum wage and making the Temporary Assistance Program for Needy Families (TANF) a true cash backstop for those families most in need. Policies should also take innovative steps toward helping close the wealth gap for babies and guaranteeing paid leave with job protection for parents. As previous sections of this report demonstrate, economic security policies are fundamental to building strong families, promoting positive development and ensuring racial equity.



FAMILY STORY

When my husband's pizza business shut down during COVID, we moved to land we owned in a rural community in Arkansas with our two children and Belgian Malinois dogs. We love the culture, peacefulness and beauty of the Ozark Mountains. First-generation college graduates, Kurtis and I both work full time, making a modest income. Our older son has autism. Unable to find appropriate services for him, I am grateful for the flexible, family-friendly job that allows me to work from home as I homeschool my son and care for my toddler.

We want our children to have the same opportunities as those in higher-income brackets and urban areas. But despite our best efforts, we live paycheck to paycheck. We don't have financial support from our family, and we are trying to scratch our way out of poverty. We don't qualify for any assistance because we make slightly too much money, including child care assistance. The closest child care program is 40 minutes from our home. It would be incredibly expensive to drive Cypress to child care every day and also have to pay \$120 a week just to attend. As gas prices have risen, we have to plan for when and how often to drive into town. In addition, our grocery budget is super-tight every month. Having a son with autism who will only eat specific foods, we do not have many options to lower that cost.

The expanded Child Tax Credit (CTC) was a huge support to us. Without that support, we had to reassess our budget. My husband had to take on an extra job. He's been working six or sometimes seven days a week to help provide for our family. Even with him doing so, we're still struggling every month. We worry about surprise costs, like a necessary car repair or a health emergency. We are trying hard to make a better future for our kids, and the CTC helped make that possible.

We want to let Members of Congress know that babies thrive best when their caregivers can nurture their children instead of stressing over meeting their basic needs. The rising costs of housing, food and other basic necessities have placed a significant strain on families like mine. The expanded CTC relieved so much stress from our household, while allowing us to thrive and focus on our children's education and development. Our families need economic security to do what's best for their babies and to ensure the success of the youngest generation of Americans.

Brandy S.
Big Flat, Arkansas

State of Babies Yearbook

Data Underscore Racial Disparities in Economic Security

Infants, toddlers and young children are at the greatest risk of experiencing poverty and low income. Economic challenges often start at the beginning: one in four mothers experience poverty the month after giving birth.⁵ And these risks are not shared equally.



Black, Native American, and Hispanic infants and toddlers are much more likely to live in poverty (100 percent of Federal Poverty Level, or FPL) and with low income (200 percent FPL) compared with compared with the national average. (See Figure 5-1). As was clear during the pandemic, these families are more vulnerable to income loss. Real hardships, such as inadequate housing and

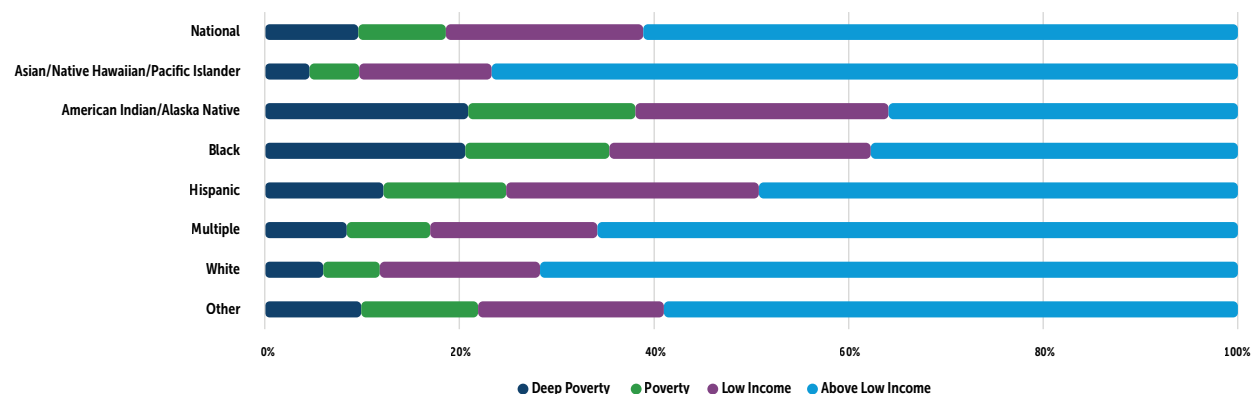
food insecurity, accompany economic insecurity, posing a risk to babies' rapidly developing brains. Families of color and those with low income are more likely to experience financial problems and strains paying for basic needs. Poverty has also become intertwined with child welfare involvement, as the lack of supports for families with few resources can lead to charges of neglect.

Disparities in Poverty and Income

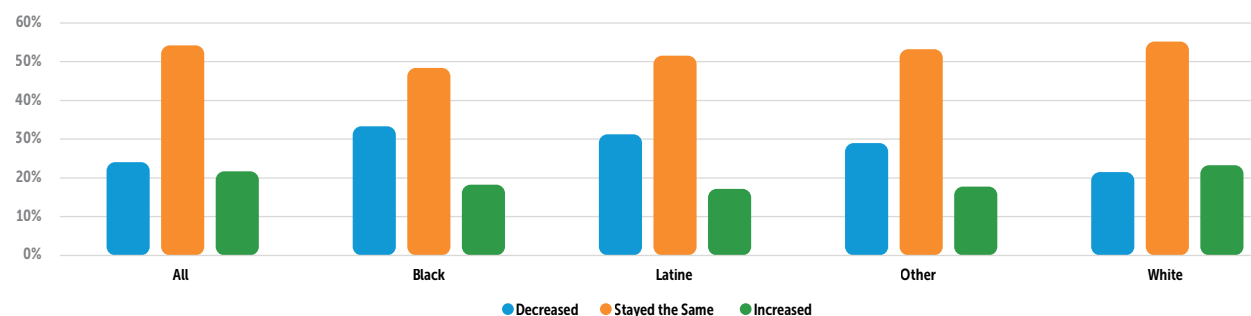
Yearbook data show that poverty and income are defining factors for the nation's babies. Nearly one in five infants and toddlers (18.6 percent) live in poverty, while one in ten (9.6 percent) live in deep poverty (defined as 50 percent below the federal poverty threshold). Poverty and low income disproportionately affect families of color, making economic insecurity the norm for many babies. This fact underscores the pernicious nature of systemic racism, as income inequality has grown

out of a long history of racial discrimination, in large part built on the legacy of slavery. The majority of Black (62.3 percent) and Native American (64.1 percent) infants and toddlers, and about one-half of Hispanic/Latine (50.8 percent) infants and toddlers, live in families with low income. Most startling, one-fifth of Black and Native American babies live in deep poverty. In 17 states, a fifth or more of Black infants and toddlers live in deep poverty.

BABIES BY FAMILY INCOME AND RACE AND ETHNICITY Figure 5-1



INCOME CHANGES BY RACE AND ETHNICITY Figure 5-2



Black and Latine families with babies, as well as all families with low income, remain the most vulnerable to economic shifts. They have been more likely to experience income decreases, as was true throughout the pandemic. RAPID Survey data for the past year show that Black and Latine families and families of other races were more likely to see an income decrease than an increase. White families were slightly more likely to see an income increase or have stable income. (See Figure 5-2). Reflecting their economic vulnerability, families with, families with low income and in poverty were much more likely to see an income decrease.

Low Income Affects Families' Experiences of Hardship

Families with low income often struggle to provide basic needs, particularly utilities, housing and food. The addition of a new family member, while a joyous occasion, can be riddled with difficulty given the added strain on previously set income, causing additional complications in meeting basic needs. For instance, half of renters with very low income spend more than half of their income on housing.¹⁰ Urgent Priority #4: The Hidden Developmental Threat of Unstable Housing, discussed in this report, illustrates this crisis, with *Yearbook* data showing that families with low income are more likely to live in crowded housing, an experience that can undermine development.

RAPID Survey data provides an extensive contemporary picture of the financial strain that families with babies have experienced in purchasing the basics for their children. More than one-third of Black (34 percent) and one-quarter of Latine (27 percent) families experienced major or extreme financial problems during 2022 and early 2023, as did almost one-half (45 percent) of families in poverty. These rates compare with 17 percent for all families participating in the survey. Families with low income and in poverty struggled the most to pay for basics like food, housing, medical care and heating, with 41 percent of families in poverty finding it hard or very hard to do so, compared with the average of all survey respondents at 15 percent. More than one-quarter of Black (28 percent) and Latine (27 percent) families found it hard or very hard to pay for the basics. (See Figure 5-3).

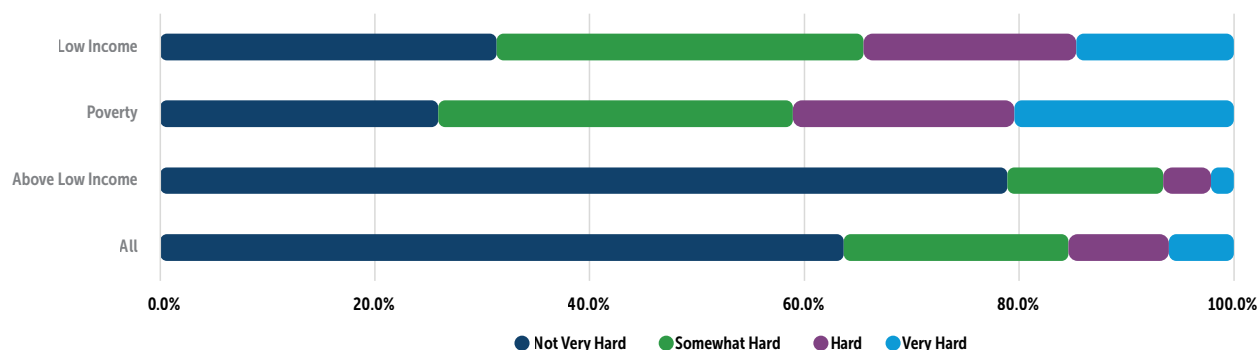
Impact of Poverty in the Early Years

Poverty experienced in the earliest years of children's lives has a greater impact on developmental trajectories than poverty experienced later in life. Early childhood poverty, especially absent the buffering effects of support from strong relationships with parents and other trusted caregivers, is associated with increased risk of toxic stress among young children (which can disrupt brain development) and increased long-term cognitive risks over the course of a child's life.⁶ These effects extend to the brain's physical structure. For example, one study found that poverty in early childhood and its associated chronic stressors decreased gray matter volume in the regions of the brain associated with school readiness and achievement by 8 to 9 percent below developmental norms.⁷ Longitudinal analyses have clearly illustrated that the negative impacts of early childhood poverty can persist well into adulthood, impacting educational attainment, later earnings, adult health, reliance on public benefits and even arrest rates.⁸

Early poverty in conjunction with adverse childhood experiences (ACEs) leads to more maladaptive child outcomes. *Yearbook* data show that 18.6 percent of babies have at least one ACE while 7.2 percent experience at least two ACEs, with higher rates for Black and Hispanic infants and toddlers and those in families with low income. Children who experience both poverty and higher levels of ACEs are more likely to suffer premature mortality or adverse adult outcomes. For instance, children who experience both poverty and parental mental illness are linked with higher rates of poor health in adulthood.⁹

Overall, paying for utilities was the most reported source of financial strain and the item that ranked first by far for families in poverty. Families with low income and in poverty also frequently reported

FINANCIAL STRAIN PAYING FOR BASICS BY POVERTY AND INCOME STATUS Figure 5-3

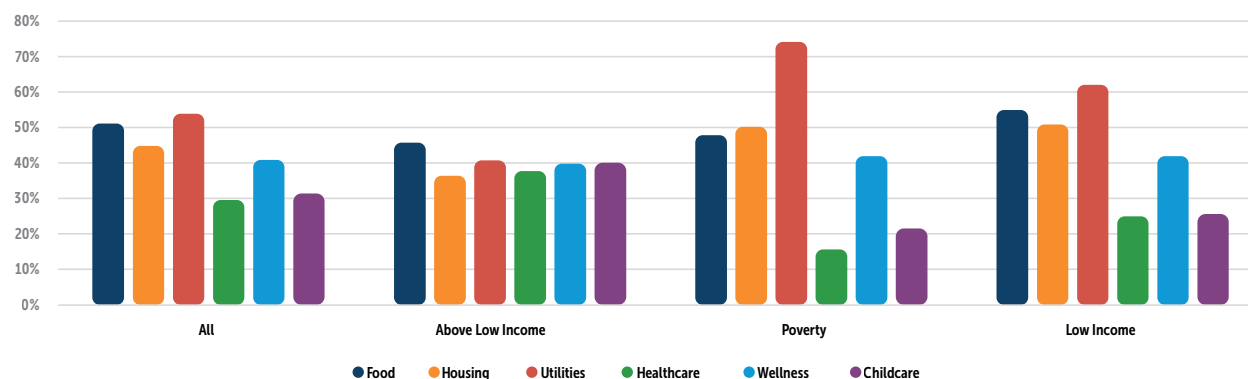


paying for food and housing as a source of strain. Black and Latine families were slightly more likely to cite utilities and housing as strains. Families of all races and ethnicities and across income levels cited food cost as a strain at somewhat similar levels, likely reflecting increased food costs from January 2022 through April 2023. Forty percent of families above low income cited child care as a financial strain, compared with 22 percent of families in poverty and 26 percent for families with low income (a figure that includes families in poverty). (See Figure 5-4). These differences could reflect a greater likelihood of families above low income using nonparental care (as discussed in Urgent Priority #3: A Commitment to Early Care and Education as a Public Good), as well as a lack of subsidies for families with moderate incomes but living above state eligibility levels.

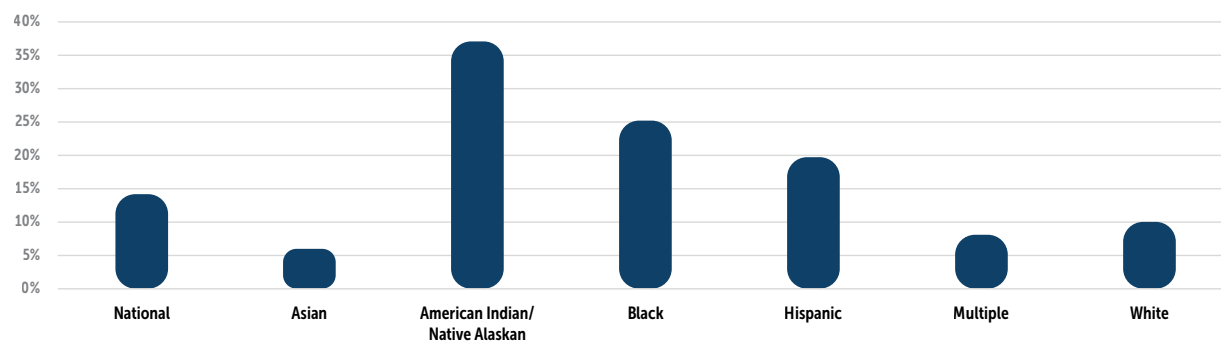
Poverty Affects Families' Ability to Provide Healthy Meals

While many families are feeling the pinch of higher food costs, actual food insecurity—where households lack sufficient nutritious food—is more prevalent among families of color and those with low income. Access to healthy and nutritious food is vital during the prenatal period and the first years of life to ensure that babies receive the nourishment they need for growth and development. A lack of sufficient nutritious food is associated with a number of serious health, behavior, and cognitive deficits in children. For infants and toddlers, even mild levels of food insecurity may result in developmental deficits during their sensitive period of rapid brain growth,¹¹ and infants who experience food insecurity are more likely to perform poorly on tests of cognitive development.¹²

SOURCES OF FINANCIAL STRAIN BY POVERTY AND INCOME STATUS Figure 5-4



HOUSEHOLDS WITH BABIES WITH HIGH OR VERY HIGH FOOD INSECURITY BY RACE/ETHNICITY Figure 5-5



The *Yearbook* shows that as many as one in six (15.9 percent) of the nation's households with babies experienced food insecurity before and during the early part of the pandemic. Most alarming were food insecurity levels among Native American and Black households with infants and toddlers (37.1 percent, although small numbers mean caution in interpreting, and 25.2 percent, respectively), compared with the national average of 14.2 percent. Hispanic households were also above the average, at a rate of 19.7 percent, while White, Asian and multiple race households with babies experienced food insecurity at rates below the average (10 percent, 6 percent and 8.1 percent, respectively). (See Figure 5-5).

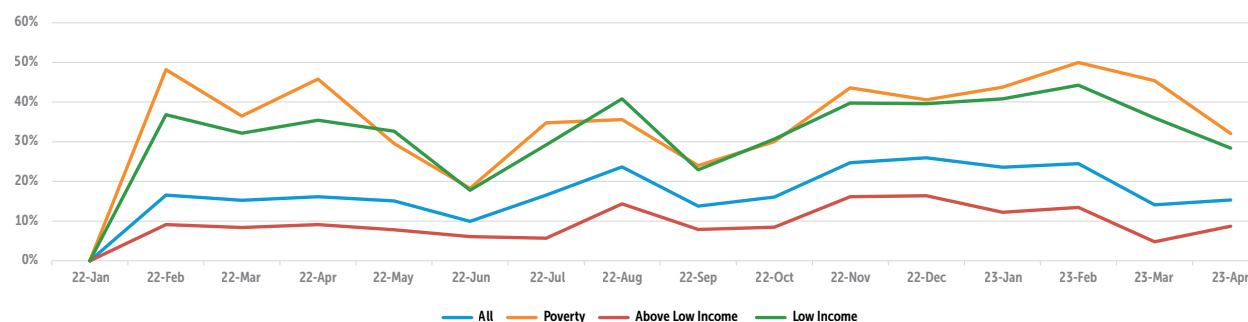
RAPID Survey data shows that families with infants and toddlers and with low income or in poverty experienced high food insecurity throughout 2022 and early 2023. These families were consistently well above both the survey average for high food insecurity and the rate reported by families with

higher incomes. On average, about one-quarter of families with low income (25 percent) and in poverty (26 percent) reported household food insecurity. (See Figure 5-6). Congress must be mindful of these high levels of food insecurity in addressing food programs in the upcoming reauthorization of the major farm and food support programs, including the Supplemental Nutrition Assistance Program.

Child Welfare and Poverty

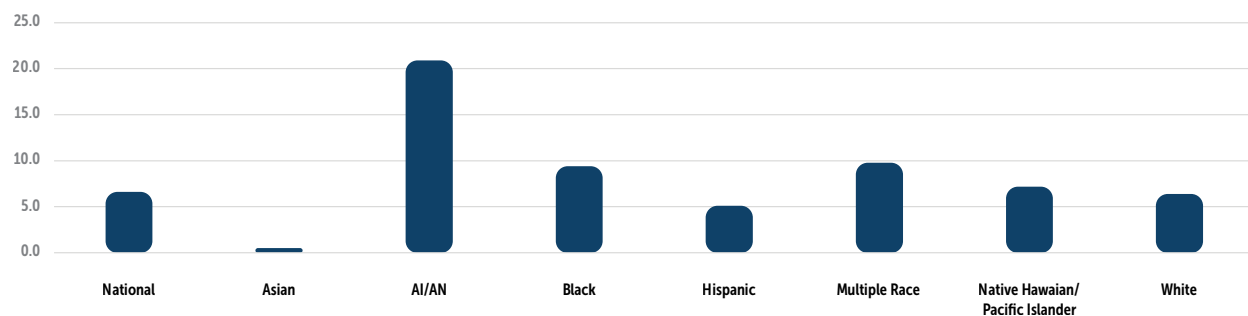
Poverty does not equal child neglect, although its accompanying hardships can create risks for neglect. Yet, living in poverty increases the risk for surveillance and involvement with the child welfare system (e.g., tripling the likelihood of substantiated maltreatment).¹³ As the *Yearbook* shows, babies of color are more likely to live in households below the poverty line. They are also disproportionately more likely to be investigated

HIGH FOOD INSECURITY TRENDS BY INCOME LEVEL Figure 5-6



INFANTS AND TODDLERS REMOVED FROM HOME & PLACED IN FOSTER CARE BY RACE AND ETHNICITY (PER 1,000 CHILDREN)

Figure 5-7



by Child Protective Services and to be placed in out-of-home care.¹⁴ American Indian/Alaska Native babies are removed from home and placed in foster care at more than three times the national rate (20.9 per 1,000 children compared with 6.6 per 1,000 children). (See Figure 5-7).

The relationship between poverty and neglect is complex: A family's inability to feed, clothe or house their children is often perceived as child neglect, even though this inability may be a result of the family experiencing poverty due to systemic factors. These needs certainly could be addressed through more concrete assistance, especially if support were available earlier. Often, the child welfare system conflates poverty and neglect, punishing families experiencing poverty

and thereby contributing to the high rates of child neglect cases and child welfare involvement for families experiencing poverty—and, therefore, for families of color.

For example, some states do not exempt financial inability to provide for a child from their definitions of maltreatment, which research has found contributes to the overrepresentation of babies of color being removed from their homes and placed in foster care.¹⁵ As discussed below, the Temporary Assistance for Needy Families program, which could help provide funds for families to meet basic needs, reaches very few families with babies in poverty, and many states transfer funds from the program to the child welfare system that may charge families with neglect.



Strategies to Increase Income and Wealth

The economic insecurity experienced by infants and toddlers in the United States—especially Black, Latine, American Indian/Alaska Native and Asian babies—has far-reaching implications for their success in life and, therefore, the country's future. The nation cannot eliminate disparities without equitable access to financial resources that help keep other hardships at bay and provide the opportunity for enriching experiences, including more time for parents to interact with their babies.



A range of strategies can help increase income and help families remain economically stable while attending to family responsibilities. Approaches to increasing cash income available to families include augmenting basic income from wages and making cash transfers available to families with young children to meet basic needs. Because of the significant wealth gap along racial

and ethnic lines, a baby-focused strategy to build wealth could help give more babies opportunities as they become young adults. Employment-related policies could also prove helpful, ensuring that employees do not lose earnings and that they maintain connection to their employment while attending to family needs, such as the birth or adoption of a child.

Increasing Basic Income and Generating Wealth

Increasing household income from wages and building generational wealth are key ways to address adverse outcomes related to poverty. Past and present systemic racism has contributed to income disparities through the overrepresentation of people of color in jobs paying low wages as well as in accruing wealth—the assets that enable families to have a cushion in times of need and to draw on for major purchases in life, such as education or homes.

Poverty among working families is both caused and exacerbated by an inadequate federal minimum wage that has failed to keep up with inflation, undermining the idea that increasing

work hours will lead to an adequate household income. The federal minimum wage was most recently increased in 2009 to \$7.25 an hour. And when adjusted for inflation, the value of the minimum wage reached a 66-year low in 2022, down 27 percent from 2009 and 40 percent from 1968.¹⁶

The *Yearbook* found that 35 percent of babies living below the poverty threshold had at least one parent working full time. Mothers in the low-wage workforce who are raising very young children (ages 3 and under) are especially economically vulnerable: one-third live in poverty, compared with about 12 percent of mothers with very young



children in the workforce overall.¹⁷ Simply raising the federal minimum wage to \$15 per hour would help low-wage working families, particularly mothers (who represent a quarter of those in the lowest-paying jobs in the U.S.¹⁸), exit poverty.

In addition to income gaps, “wealth gaps”—or a difference in family assets such as savings accounts or home equity—dramatically impact families, especially families of color. Historical and systemic racism has resulted in a higher concentration of people of color in low-paying jobs, affecting their ability to save. Further, policies such as “redlining,” which has kept people of color from certain neighborhoods, and discrimination in the valuation of homes owned by people of color have impacted families’ ability to accumulate wealth.¹⁹

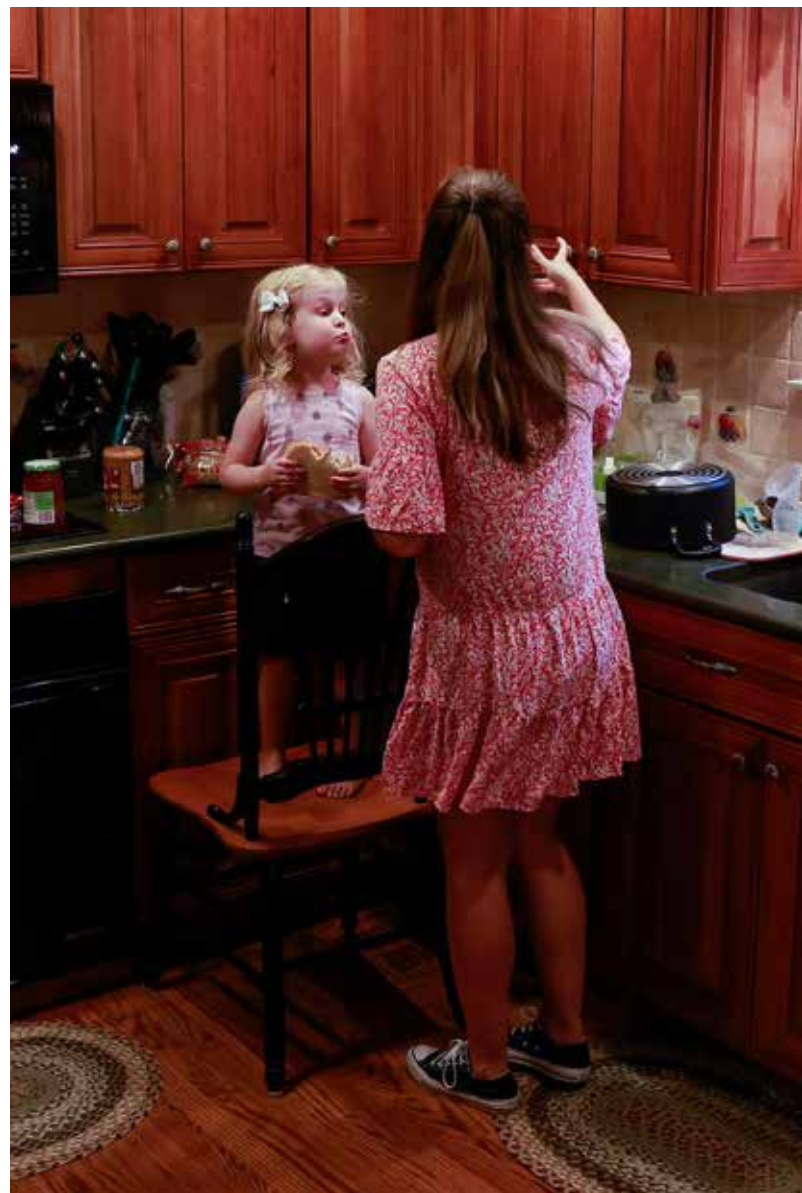
The ability or inability to accumulate wealth has an intergenerational effect, as seen in the difference in ability to transfer even relatively modest amounts of money from one generation to the next. While 38 percent of White adults report receiving \$10,000 or more from a parent or other relative, only 14 percent of Black adults, 16 percent of Latine adults and 19 percent of Native American adults report such gifts and inheritances.²⁰ In 2019, the median Black family had approximately 13 percent of the wealth of the median White family (\$24,100 compared with \$188,200). For Latine families, the median wealth was \$36,100.²¹ Lack of wealth impacts families’ ability to access opportunities for their children as they grow, including enriching activities and higher education. It can also affect the ability to take unpaid family and medical leave, as families may lack reserves to tide them over and therefore miss out on meeting critical needs.

One solution to building wealth for babies as they grow is the institution of “baby bonds,” which would involve the state or federal government placing funds in an account to start a nest egg for infants that would grow into an asset they can use later in life. While not included in *Yearbook* indicators, Connecticut is the first state to implement baby bonds. California and Washington, DC have both passed baby bond proposals, with additional proposals currently pending in eight other states and at the federal level.

Augmenting Income with Cash Transfers

Cash aid is shown to increase families’ spending on children and help them meet material needs.²²

²³ Researchers involved in the Baby’s First Years study of how unconditional cash transfers support family and infant development during the first year of life have found that with higher cash transfers, parents spend more on child-specific goods and early learning activities for their infants.²⁴ Studies of child and family tax credits show similar spending patterns. Research further shows that cash transfers made available through the Earned Income Tax Credit and Child Tax Credit have helped lower family stress, improve mental health and even promote better birth outcomes.²⁵



As the primary federal program that can provide cash assistance to eligible families during times of need, Temporary Assistance for Needy Families (TANF) is potentially a valuable resource to help overcome economic hardships and even reduce maltreatment and placement in foster care.²⁶ Overall, however, states currently use a small proportion of TANF funding for cash payments, with a corresponding shallow reach in helping families in poverty. The *Yearbook* shows that just 19 percent of families with babies in poverty

receive TANF cash assistance. States set their own income thresholds, benefit levels and other implementation policies, leading to stark differences in the utilization rate of TANF for cash assistance across states. The *Yearbook* shows that three-quarters of states reach 22.2 percent or less of infants and toddlers in poverty, suggesting that they use the majority of their funds for other allowable purposes, including funding their child welfare systems. (See Text Box on TANF and Child Welfare.)

TANF and Child Welfare

TANF cash assistance could serve as a potential backstop to help support child well-being, as well as disrupt the intersection of poverty and the child welfare system. Yet, restrictive policies and flexibility in states' use of TANF funds may place more children in jeopardy of being considered neglected and becoming entangled in the child welfare system:

- Policies implemented to restrict access to TANF, such as loss of benefits due to sanctions and time limits of less than 60 months, increase child welfare involvement, including the number of foster care placements.²⁷
- Allocation of TANF funds to cash assistance and monthly assistance payments are lowest in states with a long history of policy choices that limit access to Black families,^{28, 29} which is particularly troubling when considering that one-fifth of all Black infants and toddlers live in deep poverty.
- Child Trends reported that only about one-fifth of TANF dollars spent in fiscal year 2020 were used to provide cash assistance for families, with the remaining amount supporting other activities such as child care, work supports, refundable tax credits and administrative activities.³⁰
- Sixteen states transfer more than 20 percent of their TANF funds to child welfare services, with three states dedicating more than 40 percent of TANF funds in this manner. Arizona transfers 67 percent of TANF funds to child welfare services,³¹ but *Yearbook* data shows that only 7.9 percent of families in poverty with babies in that state receive cash assistance.

The most common reason for families coming into contact with the child welfare system continues to be neglect,³² which is frequently defined as the failure of a parent or other person with responsibility for a child to provide needed food, clothing, shelter, medical care or supervision to the degree that the child's health, safety and well-being are threatened.³³ But rather than directing TANF funds to help families meet their basic needs, many states are implementing restrictive policies that hamper families' ability to meet their babies' basic needs or even using TANF to fund a system that penalizes families for not being able to do just that.

Using Tax Credits to Provide Child Allowances

Tax benefits like the Child Tax Credit (CTC) and the Earned Income Tax Credit (EITC) are perhaps the most powerful way to augment the disposable income of families with young children. Using this avenue is well-aligned with research showing positive impacts of increasing available income and can support improved short- and long-term outcomes for young children by enhancing their families' earnings during the critical early years. For example, policies such as the CTC are linked to increased spending on basic needs (e.g., housing and food) and higher spending on children. In fact, 54 percent of both Black and low-income families who received unconditional aid through this credit reported being able to meet all their basic household expenses with the funds.³⁴

The federal CTC currently provides eligible families with children up to age 17 up to \$2,000 a year, an amount that would need to be enhanced to have real impact. Due to the lack of full refundability, families with little to no income—those whose young children could benefit most—cannot claim the full value of the credit under current law or are not eligible at all. During the pandemic, Congress made temporary changes

to the CTC to enhance its value, allowing families to receive the credit monthly, and making the credit fully refundable so that the lowest-income families could receive the maximum credit. An analysis by the U.S. Census Bureau found that more than one-third of the nearly 3 million children lifted out of poverty with help from the CTC were under age 6, with Black and Hispanic children experiencing particularly large drops in poverty. When the enhanced CTC ended, RAPID Survey data show that families lapsed back into material hardship.³⁵

The federal EITC is a refundable credit available to families with incomes up to approximately \$63,000 per year (with three or more children) that helps supplement wages for low-income workers. Research has found that people supported by the EITC during childhood are less reliant on public assistance in adulthood and less likely to experience poverty.³⁶ An analysis by the Center on Budget and Policy Priorities found that the EITC lifted nearly 3 million children out of poverty in 2018 and lessened the impact of poverty for an additional 6 million children.³⁷

In addition to federal credits, many states offer a form of a CTC or EITC. The *State of Babies Yearbook: 2023* found that 13 states offered some form of CTC, up from just six states in the 2022



Yearbook. Further, 2023 *Yearbook* data reveal that more than half of states (32) currently offer an EITC, up from 31 in the 2022 *Yearbook*. State credits can supplement or enhance the value of federal credits, further boosting family income during the years of critical brain development and helping reach additional populations who fall through the cracks in the federal system.

Instituting Employment-Related Policies: Paid Leave

Paid family and medical leave (when long-term time off is needed) and paid sick days (for short-term health needs) help ensure that employees do not face economic instability when they must attend to family needs and responsibilities, or care for themselves. These protections are particularly important for families of color, who are more likely to work in jobs where such benefits are not offered, and who are less likely to have the financial reserves to take needed time off.

Paid family and medical leave replaces wages and provides job protection to enable employees to take time off for the birth or adoption of a child, prevent financial hardship and maintain connection with their employer. Research shows

the impact of this benefit on early development and maternal health. Maternal paid leave is associated with higher infant brain function at 3 months,³⁸ as well as with increased maternal and infant physical and mental well-being,³⁹ including reduced infant mortality. Research on California's paid family leave program illustrates how paid leave promotes equity, as the program has not only increased the amount of time off taken by all women, but also has resulted in parity in the number of weeks taken by Black and White mothers/birthing parents.⁴⁰ *Yearbook* data show that only 11 states and the District of Columbia have enacted paid family medical leave. Since the *Yearbook* data were gathered, Illinois, Maine and Minnesota also have enacted paid family medical leave, bringing the total to 15.

Paid sick leave guarantees a few days for employees to use when they have a short-term illness or must attend to the health needs of their children, such as treating brief illnesses or attending health-related visits. Paid sick day policies are associated with higher job stability,⁴¹ overall population health increases⁴² and better child health.^{43, 44} The *Yearbook* shows that only 14 states currently have policies providing paid sick days that include caring for a sick child.





Policies to Improve Economic Security

Economic security—or the lack of it—has a profound influence on babies’ early development. It affects the home and neighborhood in which they live, their access to quality health care, the food they eat, their early learning opportunities, the unhurried time they are able to spend with their parents and caregivers and the family stress levels that can erode the emotional security needed for all aspects of their development.



The proportion of infants and toddlers who lack these ingredients—who live with low income, in poverty or in deep poverty—should be a source of national shame. It’s not complicated: families want to give their children the basics (and more), and policies should take the most direct path to ensuring they can do just that by including key strategies for boosting income and building wealth. Policymakers at the national and state levels should do all they can to ensure the equity of opportunities that comes with financial resources.

Reinstate the Enhanced, Fully Refundable Child Tax Credit

Congress allowed the enhanced CTC to expire in December 2021, including the larger credit for young children and full refundability. While in effect, the credit was lifting more than 3 million children out of poverty every month. Congress should restore the full value of the enhanced credit (\$3,600 a year for children under age 6 and \$3,000 a year for children ages 6 and older); restore full refundability to ensure all families can benefit; and provide monthly installments. As was the case prior to the 2017 tax reform law, the federal CTC should not exclude immigrant families who file taxes with Individual Taxpayer Identification Numbers (ITINs).

Expand State Tax Credits

States should also move to enact their own CTCs and EITCs and take steps to enhance refundability and expand access to children of immigrant families.



States Implement Tax Measures for Families

Across the country, an increasing number of states are implementing legislative measures to enhance tax credits, with the goal of supporting families and mitigating poverty. For example, Maine is making its \$300 dependent exemption tax credit refundable and adjusted for inflation. New Mexico recently passed pivotal family economic security bills, including an income-based CTC increase of up to \$600 per child. Meanwhile, South Carolina commissioned a benefit-cost analysis for a refundable EITC that demonstrated a beneficial return on investment. Minnesota established a statewide CTC of \$1,750 per child in 2023. And Maryland took steps to permanently strengthen its CTC and state EITC, which advocates estimate could benefit more than 400,000 Maryland taxpayers, with the CTC alone estimated to lift 40,000 children out of poverty. These are just a few examples highlighting the growing recognition of the power of the CTC and EITC as effective tools in the fight against poverty.

Reform TANF to Direct More Cash Assistance to Families

TANF has the potential to help promote the well-being of young children most at risk for poverty’s adverse developmental impacts. To achieve this potential, Congress must reverse policies that have led to great inequities in access to support (especially for Black infants and toddlers), including allowing states to divert funds to pay for other government functions, and move to allocating funds according to children’s economic needs. Reforms oriented around child well-being include requiring states to spend a majority of their allocations on direct cash assistance, prioritizing assistance to families most in need and revising the formula to allocate funds according to states’ proportion of children in poverty.

Adopt Baby Bonds to Build Long-term Wealth for Young Children

States and Congress should establish policies that build long-term wealth for families with young children such as the adoption of “baby bonds,” which provide savings accounts at birth that can be used once a child reaches adulthood for such investments as education, homeownership or starting a business. Policies should prioritize increased resources for children in families with low income to help reverse wealth inequity that disproportionately impacts families of color.

Connecticut: First in Implementing Baby Bonds

On July 1, 2023 Connecticut became the first state in the nation to create trusts, or “baby bonds,” for children born in the state who live in families with low income.⁴⁵ Every baby enrolled in HUSKY—Connecticut’s Medicaid program—will have \$3,200 deposited into an account at the State Treasurer’s office, creating a trust for each child to help build wealth once they become adults. These children will be able to withdraw funds between the ages of 18 and 30 for specific uses, such as to attend college or buy a home—critical steps toward ending generational poverty. The baby bonds system is designed so that eligible babies are enrolled automatically, reducing any barriers to access.

Increase the Minimum Wage

Congress should raise the federal minimum wage to at least \$15 an hour, with adjustments for inflation. Absent Congressional action, states can and do set their own minimum wages higher than the federal level, and they should strive to do so at levels that ensure working families make a living wage—at least at \$15 per hour.^{46, 47}



Institute Paid Sick Leave and Paid Family Leave

Comprehensive paid family and medical leave promotes bonding between parents and babies and enables workers to care for their family members' short-term and extended health needs. To meet the needs of all families and their young children, Congress should enact a paid family and medical leave policy (such as the FAMILY Act) that is open and accessible to all working people, offers a meaningful length of leave, is affordable and cost-effective for workers and employers, is inclusive in its definition of "family" and offers protection from employer retaliation when employees exercise their right to take leave. In addition, Congress should enact legislation such as the Healthy Families Act to provide a minimum of seven sick days for employees for short-term illnesses, including caring for family members.

Expand Food and Housing Assistance

Food/nutrition and housing assistance can be critical in helping families meet basic needs and stretch tight cash budgets. The Supplemental Nutrition Assistance Program (SNAP) automatically expands during economic downturns to accommodate more families experiencing financial hardships. During the Great Recession, as well as the pandemic, Congress authorized more generous benefits, which can boost the program's impact for young children. As the first line of defense against food insecurity, SNAP must be strengthened and protected with enhanced benefit levels to reflect today's food prices. Simultaneously, access to affordable housing must be increased, as only one in four families who are eligible for rental assistance receive it. (Policies to expand access to affordable housing are discussed in more detail in Urgent Policy Priority #4 of the *Yearbook*.)



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Appendix A: Individual Indicator Findings

| Subdomain | Indicator | Description | 2019 Yearbook | 2020 Yearbook | 2021 Yearbook | 2022 Yearbook | 2023 Yearbook |
|----------------------|-----------------------------------|--|---------------|---------------|---------------|---------------|---------------------|
| Population | Infants/toddlers (count) | Number of infants and toddlers | 11.9 million | 11.8 million | 11.5 million | 11.4 million | 11.0 million |
| | Infants/toddlers (percentage) | Percentage of infants and toddlers in the total population | 3.7% | 3.6% | 3.5% | 3.0% | 3.3% |
| | | American Indian/ Alaska Native | 0.8% | 0.8% | 0.8% | 0.8% | 0.8% |
| | | Asian | 4.9% | 4.9% | 4.8% | 5.5% | 5.5% |
| | | Black | 13.8% | 13.7% | 13.7% | 14.0% | 14.0% |
| | | Hispanic | 26.1% | 26.2% | 26.0% | 26.0% | 26.2% |
| | | Multiple race | 4.8% | 4.8% | 4.8% | 5.2% | 5.2% |
| | | Native Hawaiian/ Pacific Islander | 0.2% | 0.2% | 0.2% | 0.2% | 0.2% |
| | | White | 49.3% | 49.3% | 49.7% | 48.3% | 48.2% |
| Income Level | Above low income | Infants and toddlers living in families with incomes at or above 200 percent of the FPL | 55.4% | 57.9% | 59.7% | 59.7% | 61.1% |
| | Low income | Infants and toddlers living in families with incomes between 100-199 percent of the FPL | 22.0% | 22.3% | 21.7% | 21.7% | 20.3% |
| | Poverty | Infants and toddlers living in families with incomes below 100 percent of the FPL | 22.7% | 19.8% | 18.6% | 18.6% | 18.6% |
| | Deep poverty | <ul style="list-style-type: none"> Infants and toddlers living in families with incomes below 50 percent of the FPL | | | | | 9.6% |
| | Below 150% of state median income | Infants and toddlers living in families with incomes below 150 percent of SMI | | | | 77.3% | 78.0% |
| Urban/Rural Location | Urban | Infants and toddlers living in metro areas | 91.3% | 91.4% | 91.5% | 91.5% | 91.7% |
| | Rural | Infants and toddlers living outside of metro areas | 8.7% | 8.6% | 8.5% | 8.5% | 8.3% |

| | | | | | | | |
|------------------|---|---|-------|-------|-------|-------|--------------|
| Family Structure | Two-parent family | Infants and toddlers living in two-parent families | 76.3% | 76.7% | 77.0% | 78.9% | 77.6% |
| | One-parent family | Infants and toddlers living in one-parent families | 21.5% | 20.9% | 20.5% | 18.7% | 19.9% |
| | No parents present | Infants and toddlers living without parents | 2.2% | 2.4% | 2.5% | 2.4% | 2.5% |
| | Grandparent-headed household | Infants and toddlers living in grandparent-headed households | 9.4% | 8.5% | 8.4% | 8.2% | 8.1% |
| Employment | Working mothers | Infants and toddlers who have mothers in the labor force | 63.0% | 61.6% | 62.9% | 62.4% | 62.0% |
| | No working parents | Infants and toddlers who live with no working parents | | | 5.3% | 5.5% | 6.2% |
| | No working parents, in poverty | Infants and toddlers who live with no working parents and below 100% of the FPL | | | | 23.9% | 24.5% |
| | At least one full-time working parent* | Infants and toddlers who live with at least one full-time working parent | | | | | 75.8% |
| | At least one full-time working parent and below the poverty line* | Infants and toddlers below 100% FPL with at least one full-time working parent | | | | | 35.0% |

● New indicator in 2023

Notes: FPL = Federal Poverty Level; SMI = State Median Income

Indicators by Domain

Good Health

The Good Health domain examines indicators of mothers' and babies' physical well-being, as well as policy indicators of families' access to and coverage for health care and infant and early childhood mental health (IECMH) care, and families' access to nutrition services.

I. HEALTH CARE ACCESS AND AFFORDABILITY

1. Medicaid expansion

As of July 2022, 39 states and the District of Columbia had adopted or implemented Medicaid expansion, **reflecting no additional gains over the previous year**. Note: Since 2023 *Yearbook* data gathering closed, two additional states (North Carolina and South Dakota) have adopted expansion, leaving only 10 states without it.

2. Uninsured babies in families with low income

Despite coverage available through Medicaid and CHIP, **5.2 percent of low-income infants and toddlers still lacked health insurance**, with substantial variation continuing to be found when examined by race/ethnicity and urbanicity. Without sufficient access to health care coverage, low-income infants and toddlers may experience lasting impacts on their health and development.

Race and ethnicity. Most notably, the percentage of American Indian/Alaska Native babies in families with low income without health insurance (12.8 percent) was more than double the national average of 5.2 percent—and also above the average for Other Race (6.6 percent), White (5.8 percent) and Hispanic (5.7 percent) babies. The incidence of uninsured babies was lower than the national average for Black (3.4 percent), Asian (4.7 percent) and Multiple Race (3.6 percent) babies.

Urbanicity. The percentage of babies in families with low income without health insurance was higher than the national average for those living in rural areas (7 percent) compared with those living in urban areas (4.8 percent).

RAPID Survey data showed that 11 percent of families living with low income reported that their infants and toddlers had no health coverage.

3. CHIP Maternal Coverage for Unborn Child option

Eighteen states have implemented CHIP's Maternal Coverage for Unborn Child option, which 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.

4. Medical home

Only one-half (51 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 whom they receive coordinated, ongoing, comprehensive care.

Race and ethnicity. When examined by race, fewer Asian (41.3 percent), Hispanic (40.7 percent) and Black (39.6 percent) babies had medical homes than the national average, while White infants (58.7 percent) were more likely than the national average to have a medical home.

Income. Significantly fewer babies in families with low income had medical homes (41 percent) compared with their peers in families above low income (58.5 percent).

5. Extension of Medicaid coverage for pregnant and postpartum women and birthing people

While states provide pregnant women and birthing people with Medicaid benefits, extended for 60 days postpartum, **29 states now extend Medicaid eligibility to cover all individuals for one year postpartum.** Note: Additional states extended coverage for 12 months postpartum after 2023 *Yearbook* data collection closed, bringing the total to 46 states that have implemented or plan to implement this provision and two additional states proposing to extend coverage for a period of less than a year.

II. NUTRITION

1. Babies ever breastfed/breastfed at 6 months

The percentage of babies ever breastfed was 83.8 percent, while 55 percent of babies were still breastfed at 6 months in the 2023 *Yearbook*.

Race and ethnicity. The percentage of babies breastfed at 6 months was higher than the national average among Hispanic (61.2 percent), Black (62.5 percent) and White babies (69.3 percent). The differences in breastfeeding at 6 months may reflect the influence of cultural and historical factors, such as lasting negative connotations of forced wet nursing by Black women during slavery.

Income. At the national level, babies in families with low income are less likely to be breastfed at 6 months (57.9 percent) compared with those in families above low income (73.6 percent). These differences may indicate the structural and economic factors that influence mothers' ability to breastfeed, such as lack of workplace accommodations and time for breastfeeding in low-wage jobs.

2. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) coverage

Nationally, 98.4 percent of eligible infants participated in WIC in 2019, the most recent year available, with coverage provided to 64.5 percent of 1-year-olds and 48.1 percent of 2-year-olds.

III. MATERNAL HEALTH

1. Late or no prenatal care received

Nationally, 6.2 percent of women received late or no prenatal care.

Race and ethnicity. The percentages of Asian and White pregnant women who received late or no prenatal care (4.2 percent and 4.5 percent, respectively) were lower than the national average. Late or no receipt of prenatal care was higher than the national average among Black (9.1 percent), Hispanic (7.9 percent) and multiple race (6.8 percent) pregnant women. The percentages of Native Hawaiian/Pacific Islander and American Indian/Alaska Native pregnant women who received late or no prenatal care (19.2 percent and 12.8 percent, respectively) were strikingly high—more than twice the national average.

Urbanicity. Minimal difference was found in receipt of late or no prenatal care among urban (6.1 percent) and rural (6.7 percent) pregnant women.

2. Maternal mortality (deaths per 100,000 live births)

The maternal mortality rate was 23.8 pregnancy-related deaths per 100,000 live births in 2020. The nation's maternal (and infant) mortality rates are concerning—and 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.¹ Differences in states' definitions and reporting practices continue to prevent reporting maternal mortality rates at the state level. (Subsequent to the end of the *Yearbook* data collection, 2021 maternal mortality data showed a further increase, to 32.9 per 100,000 live births.)

Race and ethnicity. Examination of this indicator was possible for only three groups (White, Hispanic and Black mothers). The maternal mortality rates for Hispanic and White mothers (18.2 deaths and 19.2 deaths per 100,000 live births, respectively) were lower than the national average. The maternal mortality rate for Black mothers continued to be alarmingly high at 55.3 deaths per 100,000 live births—more than twice the national average.

3. Mothers reporting less than optimal mental health

The number of mothers of infants and toddlers reporting less than optimal mental health remained high, with **22.5 percent rating their mental health as worse than “excellent” or “very good.”** Caregiver and child mental health are linked; higher rates of caregiver emotional distress are directly related to increases in young children’s emotional distress.

Race and ethnicity. The percentage of White mothers reporting less than optimal mental health (23.3 percent) was higher than the survey average. However, fewer Black (20.5 percent), Hispanic (21.2 percent) and Asian (15.8 percent) mothers reported less than optimal mental health compared with the national average.

Income. Mothers of infants and toddlers in families with low income (27.4 percent) were much more likely to rate their mental health as worse than “excellent” or “very good” than mothers in families above low income (19.5 percent).

According to RAPID Survey data collected between January 2022 and April 2023, caregivers of infants and toddlers reported decreased emotional distress overall compared with earlier in the pandemic, although experiences of individual sources of emotional distress remained elevated. Parents’ emotional distress scores averaged 36.2 across surveyed parents. The parent emotional distress total score is calculated as a composite of depression, anxiety, stress and loneliness symptoms, with scores transformed to a range of 0-100. The average scores for parental symptoms of depression (23.7) and anxiety (33.8) were low, while average scores for stress (47.2) and loneliness (39.9) indicated moderate to high levels of symptoms.

4. Workplace protections for pregnant working people

31 states provide some protections or accommodations for pregnant working people. Three states cover state employees only. 23 states cover state and private employees, with some limitations. Five states cover all employees.

A new federal law, the Pregnant Workers Fairness Act, now provides a floor of protection for workers with limitations related to pregnancy, childbirth, or related medical conditions who need accommodations in the workplace. It does not replace state or local laws that are more protective. This law applies only to accommodations workers might need in the workplace. Other federal laws make it illegal to fire or otherwise discriminate against workers on the basis of pregnancy, childbirth, or related medical conditions.

IV. CHILD HEALTH

Birth Outcomes

1. Babies born preterm (births before 37 weeks of completed gestation)

Nationally, one in 10 babies (10.1 percent) were born preterm, placing them at early risk for health complications.

Race and ethnicity. The percentages of Hispanic, White and Asian babies born preterm (9.8 percent, 9.1 percent and 8.5 percent, respectively) were lower than the national average of 10.1 percent, though only slightly for Hispanic and White infants. Preterm births were significantly higher than the national average among Black (14.4 percent), American Indian/Alaska Native (11.4 percent), Native Hawaiian/Pacific Islander (11.3 percent) and multiple race (10.5 percent) babies.

Urbanicity. The incidence of preterm births was similar for infants born in urban and rural areas. Preterm births among urban babies (10 percent) occurred at the same incidence as the national average, with preterm births among rural babies (10.6 percent) only slightly higher than the average.

2. Babies with low birthweight (weight of less than 5.5 pounds at birth)

As many as one in 12 infants (8.2 percent) were born at low birthweight nationally.

Race and ethnicity. Low birthweight rates for American Indian/Alaska Native (7.7 percent), Hispanic (7.4 percent), White (6.8 percent) and Native Hawaiian/Pacific Islander (7.7 percent) infants were all lower than the national average of 8.2 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 one in seven Black babies. Low birthweight was also slightly above the national average for multiple race (9 percent) and Asian (8.5 percent) babies.

Urbanicity. The rate of infants born at low birthweight was quite similar for babies in rural and urban areas, with the percentage of urban babies (8.2 percent) equaling the national average and the percentage of rural babies (8.4 percent) slightly higher than the average.

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

The national infant mortality rate was 5.4 deaths per 1,000 live births, higher than the rates of many other high-income countries.² 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.³

Race and ethnicity. The infant mortality rates for Hispanic and White babies (5 deaths and 4.5 deaths per 1,000 live births, respectively) were lower than the national average, and slightly decreased from the previous report. The mortality rate for Asian babies (3.4 deaths per 1,000 live births) was also lower than the national average. The infant mortality rates for Black, Native Hawaiian/Other Pacific Islander and American Indian/Alaska Native babies (10.6 deaths, 8.2 deaths and 7.9 deaths per

1,000 live births, respectively) were markedly higher than the national average, with Black infant mortality nearly twice that of the national rate.

Preventive Care

4. Preventive medical visits¹

Although **nationally, a high percentage of babies (89.3 percent) had received regularly scheduled preventive medical care in the past 12 months, only 84.1 percent of babies in families with low income received a preventative medical visit** in the previous year, as **compared with 92.8 percent of those in families above low income.**

Race and ethnicity. The percentage of Black babies missing well-child visits (23.7 percent) continued to be significantly higher than the national average of 16.3 percent, while the percentage of White babies (15.9 percent) was slightly below the average and the percentage of Latine babies (16.3 percent) was equal to the national average. A similar pattern was found in missed vaccinations.

Income. The percentage of babies living below 200% of the FPL who missed well-child visits (23.3 percent) was much higher than the national average, while the percentage of babies living above 200% the FPL who missed well-child visits (12.7 percent) was lower than the average.

According to 2022-2023 RAPID Survey data, **16.3 percent of families surveyed reported that they had missed a well-baby or well-child visit.** The rate of missed visits continues to be worrisome—and nearly two times higher than the pre-pandemic level of 9 percent. As many as 55.1 percent of families reported concern about exposure to COVID-19 as the reason for missed visits, with doctors cancelling appointments (reported by 26.3 percent of families) being the second most frequent reason.

5. Vaccinations

The rate of receipt of vaccinations was relatively high, with 72.5% of babies overall having completed vaccinations according to schedule.

Race and ethnicity. Subgroup analysis indicates that more Black children missed recommended vaccinations (60.7 percent) than the national average, while less Latine children missed vaccinations (48.5 percent) than the average. The same number of White children missed vaccinations as the national average (53.3).

Income. Fewer babies in families with low income missed a recommended vaccine (51.6 percent) compared with those in families above low income (54.5 percent).

According to 2022-2023 RAPID Survey data, **53.3 percent of parents of infants and toddlers (a significant increase from 13.1 percent in 2021) reported that their children had missed a recommended vaccine.**

6. Medical home (See under Health Care Access and Affordability)

V. INFANT AND EARLY CHILDHOOD MENTAL HEALTH (IECMH)

1. Social-emotional screening of young children

The Medicaid plans of 43 states cover social-emotional screening of young children, although a survey released after the Yearbook data gathering closed shows this number is now 46.⁴

2. Medicaid coverage of IECMH services

Nearly all states' Medicaid plans cover IECMH services provided in settings most accessible to families with young children.

Forty-nine states cover IECMH services in the home, 46 states cover these services in pediatric/family medicine practices and 34 states cover these services in early care and education settings.

3. RAPID Survey findings on emotional distress

Between January 2022 and April 2023, infants' and toddlers' emotional distress slightly increased. An average score of 31.2 was seen for children's total emotional distress, which is calculated as the composite of externalizing symptoms (being fussy or defiant) and internalizing symptoms (being too fearful or anxious), with scores transformed to a range of 0-100. Children's average score for externalizing symptoms (42.7) was higher than that for internalizing symptoms (19.7).

¹ Due to a change in National Survey of Children's Health question language, this indicator was not updated for either the 2021 *Yearbook* or the 2022 *Yearbook*. Sample sizes do not support looking at subgroups beyond income.

Good Health – Summary of All Indicators

| Subdomain | Indicator | Description | 2019 Yearbook | 2020 Yearbook | 2021 Yearbook | 2022 Yearbook | 2023 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% | 200% |
| | Medicaid expansion states | Number of states adopting Medicaid expansion under the Affordable Care Act | 34 states | 37 states | 39 states | 39 states | 39 states |
| | Uninsured, low-income infants/toddlers ^a | Percentage of infants/toddlers in families with low income who are uninsured | 5.8% | 5.4% | 5.1% | 5.1% | 5.2% |
| | 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 | 18 states |
| | Medical home | Percentage of infants/ toddlers who received coordinated, ongoing, comprehensive care within a medical home | -- | -- | 50.9% | 51.5% | 51.0% |
| | Extension of Medicaid coverage for pregnant women postpartum | Status of 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 | 31 states—no law beyond mandatory 60 days; 0 states—law covering either (a) some women but not all, or (b) all women but for less than 1 year; 29 states—law covering all women for 1 year postpartum |

| Subdomain | Indicator | Description | 2019 Yearbook | 2020 Yearbook | 2021 Yearbook | 2022 Yearbook | 2023 Yearbook |
|-----------------|---|---|------------------|-------------------------------|--|---|---|
| Nutrition | Infants ever breastfed ^a | Percentage of infants ever breastfed | 83.2% | 82.9% | 83.6% | 84.2% | 83.8% |
| | Infants breastfed at 6 months ^a | Percentage of infants breastfed at 6 months | 57.6% | 54.6% | 55.1% | 56.8% | 55.0% |
| | WIC coverage – infant ^a | Percentage of eligible infants who participated in WIC | -- | 85.9% | 79.3% | 97.8% | 98.4% |
| | WIC coverage – 1 year old* | Percentage of eligible 1 year olds who participated in WIC | -- | -- | -- | -- | 64.5% |
| | WIC coverage – 2 year old* | Percentage of eligible 2 year olds who participated in WIC | -- | -- | -- | -- | 48.1% |
| | 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 | Available at state level only |
| Maternal Health | Maternal mortality rate | Number of pregnancy-related deaths per 100,000 live births | -- | 17.4 | 17.4 | 20.1 | 23.8 |
| | Late or no prenatal care received | Percentage of women receiving late or no prenatal care | 6.2% | 6.2% | 6.2% | 6.4% | 6.2% |
| | 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 | 44 sates |
| | 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% | 22.5% |
| | 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) | 31 states (3–state employees only; 23–state and private with limitations; 5– all employees) |

| Subdomain | Indicator | Description | 2019 Yearbook | 2020 Yearbook | 2021 Yearbook | 2022 Yearbook | 2023 Yearbook |
|--|--|---|------------------|------------------|------------------|------------------|------------------|
| Child Health | Infant mortality rate | Deaths per 1,000 live births | 5.9 | 5.8 | 5.7 | 5.6 | 5.4 |
| | Low birth weight | Percentage of babies with low birth weight | 8.2% | 8.3% | 8.3% | 8.3% | 8.2% |
| | Preterm birth | Percentage of babies born preterm | -- | 10.0% | 10.0% | 10.2% | 10.1% |
| | 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% | 89.3% |
| | 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% | 33.5% |
| | Recommended vaccines received | Percentage of infants/toddlers who had the recommended doses of DTaP, polio, MMR, Hib, HepB, varicella and PCV vaccines by age 19–35 months | 70.7% | 70.4% | 72.8% | 72.7% | 72.5% |
| Infant and Early Childhood Mental Health | Medicaid plan covers social-emotional screening for young children | State Medicaid plan covers social-emotional screening for young children (birth–6 years old) with a tool specifically designed for this purpose | 41 states | 43 states | 43 states | 43 states | 43 states |
| | Medicaid plan covers IECMH services—at home ^b | Medicaid plan covers services in home settings | 46 states | 49 states | 49 states | 49 states | 49 states |
| | Medicaid plan covers IECMH services—in medical settings ^b | Medicaid plan covers services in pediatric/ family medicine practices | 45 states | 46 states | 46 states | 46 states | 46 states |
| | Medicaid plan covers IECMH services—in ECE settings ^b | Medicaid plan covers services in early care and education program settings | 34 states | 34 states | 34 states | 34 states | 34 states |

*New indicator in 2023

Notes: CHIP = Children's Health Insurance Program; ECE = early childhood education; FPL = federal poverty level; IECMH = infant and early childhood mental health; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children

^a Due to changes in data reporting and/or changes to the methods for calculating this indicator, we caution against directly comparing estimates from the 2019 *Yearbook* with those from the 2020–2023 *Yearbooks*. For a more detailed discussion, see the indicators and methodological appendices (Appendix B and Appendix C).

^b The Infant and Early Childhood Mental Health Medicaid Survey was updated subsequent to the end of data gathering for the 2023 *Yearbook*, and some questions apparently were not repeated. Available updates are indicated in the indicator discussion.

Strong Families

Indicators of well-being in this domain examine the economic and environmental contexts in which babies develop, as well as the extent to which infants and toddlers experience adverse events or maltreatment. We also present the experience of infants and toddlers involved in the child welfare system. Policy indicators in this domain address the degree to which families are assisted by supportive policies, such as home visiting, paid family leave and sick time, and to which they benefit from the financial boosts offered through the direct assistance of Temporary Assistance for Needy Families (TANF) or tax credits.

VI. BASIC NEEDS SUPPORT

1. TANF benefits receipt among families in poverty

The latest *Yearbook* data show that **less than one in five (19.5 percent) of families with infants and toddlers living below the poverty line receive cash assistance through TANF.**

2. Crowded housing

Nearly one in seven babies (15.2 percent) were living in crowded housing, homes in which numerous people live in close quarters.

Race and ethnicity. Notably, the percentage of Hispanic infants and toddlers living in crowded housing (26.9 percent) was nearly twice the national average. The incidence of crowded housing for American Indian/Alaska Native and Asian babies (26.8 percent and 22.8 percent, respectively) was also markedly higher than the average, followed by Black babies (18.2 percent) and those of other race (15.7 percent). The rate of crowded housing for White infants and toddlers (7.9 percent) was close to one-half of the national average.

Income. Infants and toddlers living in families with low incomes (24.2 percent) were more likely to live in crowded housing than babies in families above low income (8.7 percent).

Urbanicity. Infants and toddlers living in metro areas (16.1 percent) were more likely to live in crowded housing than babies living in rural areas (12.1 percent).

3. Unsafe neighborhoods

Nationally, 5 percent of parents of infants and toddlers reported living in neighborhoods that are not safe.

Race and ethnicity. A greater percentage of Black parents reported living in unsafe neighborhoods (6.9 percent) than the national average, as did Hispanic parents (7.2 percent). Asian and White parents reported living in unsafe neighborhoods at rates below the national average (4.7 percent and 3.6 percent, respectively).

Income. Parents in families with low income reported living in unsafe neighborhoods at more than twice the rate of parents above low-income (7.5 percent, compared with 3.3 percent).

4. Low or very low food security

As many as **one in six (14.2 percent) of the nation's households with babies reported experiencing low or very low food security.**

Race and ethnicity. American Indian/Alaska Native and Black households with babies experienced food insecurity at rates significantly higher than the national average (37.1 percent and 25.2 percent, respectively). Hispanic households were also above the average, at a rate of 19.7 percent. White, Asian and multiple race households with babies experienced food insecurity at rates below the average (10 percent, 6 percent and 8.1 percent, respectively).

Urbanicity. At the national level, households in urban areas with infants and toddlers (14.1 percent) experienced food insecurity at a rate similar to and only fractionally below the national average, while those in rural areas (15.1 percent) were more likely to have had food insecurity.

5. RAPID Survey data on basic needs

According to RAPID Survey data collected between January 2022 and April 2023, the largest group of families (48.3 percent) reported *minor financial problems*, while 34.7 percent reported *no problems*, 13.1 percent reported *major problems* and 4 percent reported *extreme problems*.

Race and ethnicity. Disparities in the reporting of financial problems were seen across racial and ethnic groups, with more Black and Latine families reporting major problems (24.9 percent and 20.7 percent, respectively) and extreme problems (9.3 percent and 6.2 percent, respectively) than the national average. Fewer Black and Latine families reported no problems compared with the total survey average (18.9 percent and 22.1 percent, respectively). More White families (38.2 percent) reported no problems than the national average, while less White families reported major problems (10.6 percent) and extreme problems (2.6 percent) than the national average.

The RAPID Survey also provided information on families' self-reported financial problems. While 63.7 percent of families surveyed reported that it was *not very hard* to pay for their families' basic needs, 20.9 percent reported it was *somewhat hard*, 9.4 percent reported it was *hard*, and 6.0 percent reported it was *very hard*. The most commonly reported sources of financial strain were utilities (53.8 percent), followed by food (51.2 percent), housing (44.8 percent), wellness (40.9 percent) and child care (31.4 percent).

Race and ethnicity. When stratified by race and ethnicity, the data indicate that more Black and Latine families than the survey average reported paying for their families' needs as being somewhat hard (29.4 percent and 24.4 percent, respectively); hard (14.1 percent and 17.2 percent, respectively); or very hard (14.1 percent and 10.3 percent, respectively). Comparatively, White families reported paying for family needs as being somewhat hard, hard and very hard at rates of 19.7 percent, 7.7 percent and 4.3 percent, respectively. Black families more often reported the source of their financial strain to be utilities (58.5 percent), housing (48.9 percent) or child care (33.5 percent). Latine families reported the top sources of their financial strain to be utilities (58.5) and housing (56.5 percent).

VII. CHILD WELL-BEING AND RESILIENCE

1. Family resilience

Nationally, 85.6 percent of families with infants and toddlers reported resilience—the capacity when faced with problems to talk together about what to do, work together to solve problems, to be aware that they have strengths to draw upon and to stay hopeful even in difficult times.

Race and ethnicity. The percentage of White families with babies who reported resilience (89.1 percent) was higher than the national average, while the percentages reported by Hispanic (82.2 percent) Asian (80.6 percent) and Black (79.7 percent) families were lower than the national average.

Income. Babies living in families above low income have a higher percentage of families reporting family resilience (88.9 percent) than the national average, while families with infants and toddlers with low income have a lower reported percentage of family resilience (80.7 percent) than the national average.

2. One, or Two or more Adverse Childhood Experiences (ACE)

Nationally, one in five babies (18.6 percent) has already experienced one ACE, while nearly one in 12 (7.2 percent) has experienced two or more ACEs.

Race and ethnicity. Among those groups for which data are available, the incidence of Black babies who experienced two or more ACEs (11.2 percent) was markedly higher than the national average; the incidence was also above the average for Hispanic babies (8.5 percent). The number of White babies who experienced two or more ACEs (5.7 percent) was below the national average, while the number of Asian babies experiencing two or more ACEs (1.3 percent) was significantly lower than the average. Among babies who had experienced a single ACE, 24.5 percent of Black infants and toddlers and 21.8 percent of Hispanic infants and toddlers had the highest rates.

Income. Infants and toddlers in families with low income (12.4 percent) were significantly more likely than those in families above low income (3.4 percent) to have experienced two or more ACEs, with a rate nearly four times higher. Among babies who had experienced a single ACE, 27.4 percent of babies in families with low income had such an experience, more than double the rate of babies in families with above low income (12.7 percent).

3. Maltreatment

2023 *Yearbook* findings show **the national rate of maltreatment of babies was 15.5 per 1,000 infants and toddlers.**

4. Removed from home

Nationally, 6.6 babies per 1,000 were removed from their homes and placed in foster care.

Race and ethnicity. Strikingly, the number of American Indian/Alaska Native babies removed from home (20.9 per 1,000) was three times the national average. Removal rates were also above the average for multiple race (9.8), Native Hawaiian/Pacific Islander (7.3) and Black (9.4) infants and toddlers. The removal rates of White (6.4), Hispanic (5.1) and Asian (0.6) infants and toddlers were lower than the national average.

5. Duration of out-of-home placement

At the national level, only one in three babies (33.9 percent) in out-of-home placement exited foster care in less than 12 months.

Race and ethnicity. The percentage of babies in out-of-home placement who were in care for less than 12 months was higher than the national average for Asian (49.7 percent), Native Hawaiian/Pacific Islander (38.2 percent), American Indian/Alaska Native (36.1 percent) and White (34.2 percent) babies. Shorter stays in care were slightly below the national average for Hispanic (33.3 percent), Black (32.7 percent) and multiple race (32.6 percent) babies.

6. Types of permanency achieved

The 2023 *Yearbook* findings provide a view of the types of permanency babies achieved. **The largest proportion of babies exiting care are reunified with their families (49.8 percent) or adopted (34.2 percent); fewer babies achieve permanency with a guardian (7.9 percent) or relative (7 percent).**

7. Race and ethnicity

Reunification. The percentage of babies who were reunified with their families was higher than the national average for Asian (59.9 percent), Native Hawaiian/Pacific Islander (51.1 percent), Hispanic (54 percent), American Indian/Alaska Native (51.9 percent) and Black (51.5 percent) babies. The percentage of babies reunified was less than the national average for multiple race (46.7 percent) and White (47.3 percent) babies.

Adoption. The percentage of babies exiting foster care who were adopted was higher than the national average for White (36.8 percent) and multiple race (36.6 percent) babies. The percentage of babies adopted was lower than the national average for Native Hawaiian/Pacific Islander (34.1 percent), Black (29.2 percent), Asian (33.2 percent), Hispanic (33.8 percent) and American Indian/Alaska Native (23.2 percent) babies.

Guardian. The percentage of babies exiting foster care who were placed permanently with a guardian was higher than the national average for American Indian/Alaska Native (12.9 percent), Black (9.7 percent) and Hispanic (7.9 percent) babies. The percentage of babies placed with a guardian was lower than the national average for White (7.1 percent), multiple race (7.5 percent) and Asian (4.5 percent) babies. Data for guardian placement were not available for Native Hawaiian/Pacific Islander babies.

Relative. The percentage of babies exiting foster care who were placed permanently with a relative was higher than the national average for White (8 percent), Black (8.3 percent) and multiple race (7.9 percent) babies. The percentage of babies placed with a relative was substantially lower than the national average for Hispanic (3.3 percent) and American Indian/Alaska Native (3.2 percent) babies. Data for relative placement were not available for Asian and Hawaiian/Pacific Islander babies.

VIII. SUPPORTIVE POLICIES

Paid Leave

1. Paid family leave

At the time of the 2023 Yearbook, only 12 states had enacted paid family medical leave. Since the data collection cutoff for the *State of Babies Yearbook: 2023*, three additional states (Maine, Illinois and Minnesota) have passed paid family leave policies.

2. Paid sick time that covers care for children

Only 14 states require employers to provide paid sick days that cover care for a child.

Economic and Tax Supports

3. TANF work exemption

Less than one-half of states (24) exempt a single-parent head of household from work-related activity if caring for a child under 12 months old.

4. State Child Tax Credit (CTC)

At the time of the Yearbook, only 13 states had offered a CTC. This number represents an increase of seven states from previous years' reports.

5. State Earned Income Tax Credit (EITC)

More than one-half of states (32) offer a state EITC.

Strong Families – Summary of All Indicators

| Subdomain | Indicator | Description | 2019 Yearbook | 2020 Yearbook | 2021 Yearbook | 2022 Yearbook | 2023 Yearbook |
|-------------|--|--|------------------|------------------|------------------|------------------|------------------|
| Basic Needs | TANF benefits receipt among families in poverty ^a | Percentage of families with infants/toddlers living below 100% of the federal poverty line who receive TANF benefits | 20.6% | 21.7% | 21.7% | 18.5% | 19.5% |
| | Low or very low food security | Percentage of households with infants/toddlers experiencing low or very low food security | 16.5% | 15.9% | 13.7% | 14.9% | 15.3% |
| | Housing instability ^a | Percentage of infants/toddlers who have moved three or more times since birth | 2.5% | 2.7% | 2.6% | 2.9% | 2.9% |
| | Crowded housing | Percentage of infants/toddlers who live in crowded housing | 15.6% | 15.5% | 15.5% | 15.4% | 15.2% |
| | Unsafe neighborhoods ^a | Percentage of infants/toddlers living in unsafe neighborhoods, as reported by parents | 6.3% | 5.8% | 4.9% | 5.2% | 5.0% |

| Subdomain | Indicator | Description | 2019 Yearbook | 2020 Yearbook | 2021 Yearbook | 2022 Yearbook | 2023 Yearbook |
|--------------------------------------|--|--|------------------|------------------|------------------|------------------|------------------|
| Child Wellbeing and Resilience | Family resilience ^a | Percentage of infants/toddlers who live in families who report "family resilience" | 82.6% | 85.2% | 85.3% | 84.9% | 85.6% |
| | ACEs – 1 ^a | Percentage of infants/toddlers who have experienced one adverse childhood experience | 21.9% | 22.4% | 20.7% | 19.6% | 18.6% |
| | ACEs – 2 or more ^a | Percentage of infants/toddlers who have experienced two or more adverse childhood experiences | 8.3% | 8.6% | 7.7% | 7.3% | 7.2% |
| | Infant/toddler maltreatment rate ^{a, b} | Maltreatment rate per 1,000 children ages 0-2 | 16.0 | 15.9 | 16.4 | 15.9 | 15.5 |
| | Infants and toddlers removed from home | Number per 1,000 infants and toddlers who have been removed from home and placed in foster care | | | 7.1 | 7.1 | 6.6 |
| | Time in out-of-home placement | Percentage of infants/toddlers in out-of-home placement who exited care in less than 12 months | -- | 20.2% | 18.7% | 18.7% | 33.9% |
| | Permanency – Adopted | Percentage of infants/toddlers exiting foster care who are adopted | -- | -- | 34.6% | 34.6% | 34.2% |
| | Permanency – Reunified | Percentage of infants/toddlers exiting foster care who are reunified | | | 48.1% | 48.1% | 49.8% |
| | Permanency – Guardian | Percentage of infants/toddlers exiting foster care who are placed with a guardian | | | 8.3% | 8.3% | 7.9% |
| | Permanency – Relative | Percentage of infants/toddlers exiting foster care who are placed with a relative | | | 7.8% | 7.8% | 7.0% |
| | Potential home visiting beneficiaries served | Percentage of infants/toddlers who could benefit from evidence-based home visiting and are receiving such services | 1.9% | 1.9% | 2.0% | 2.1% | 2.1% |

| Subdomain | Indicator | Description | 2019 Yearbook | 2020 Yearbook | 2021 Yearbook | 2022 Yearbook | 2023 Yearbook |
|---------------------|---|--|------------------|--|--|--|--|
| Supportive Policies | Paid sick time that covers care for child | State requires employers to provide paid sick days that cover care for children | 11 states | 11 states | 12 states | 14 states | 14 states |
| | Paid family leave | State has a paid family leave program | 7 states | 9 states | 10 states | 10 states | 12 states |
| | TANF work exemption | Single-parent head of unit over 21 years old is exempt from TANF work-related activity if caring for a child under 12 months | -- | 24 states (11 of which exempt for one single child only) | 24 states (11 of which exempt for one single child only) | 24 states (11 of which exempt for one single child only) | 24 states (11 of which exempt for one single child only) |
| | State Child Tax Credit (CTC) | State offers a CTC | -- | 6 states | 6 states | 6 states | 13 states |
| | State Earned Income Tax Credit (EITC) | State offers an EITC | -- | 30 states | 30 states | 31 states | 32 states |
| | | | | | | | |

Notes: ACE = adverse childhood experience; CTC = Child Tax Credit; EITC = Earned Income Tax Credit; TANF = Temporary Assistance to Needy Families

^a Due to changes in data reporting and/or changes to the methods for calculating this indicator, we caution against directly comparing estimates from the 2019 *Yearbook* with those from the 2020-2023 *Yearbooks*. For a more detailed discussion, see the indicators and methodological appendices (Appendix B and Appendix C).

Positive Early Learning Experiences

Infants and toddlers learn through interactions with the significant adults in their lives and active exploration of enriching environments. Indicators in this domain address infants' and toddlers' exposure to learning experiences at home, families' access to child care (including costs and the reach of assistance to families) and Early Head Start, and the extent to which babies receive developmental screening and early intervention services. Policies examine structural quality factors included in licensing for center-based programs, including adult-child ratios, group sizes and teacher qualifications, child care reimbursement, and serving children considered at risk under Part C of the Individuals with Disabilities Education Act.

IX. ELEMENTS THAT SUPPORT CHILD CARE QUALITY

State Standards for Infant and Toddler Care

States set standards for licensed or regulated child care. Given the importance of quality in supporting strong early development, the *Yearbook* includes indicators related to licensing requirements center-based programs must meet in areas that promote structural aspects of quality, using Early Head Start (EHS) performance standards as a benchmark. The indicators measure how states' standards compare to EHS performance standards for adult-child ratios, group sizes and teacher qualifications.

1. Adult-child ratio requirements

More states meet or exceed Early Head Start's adult-child ratio requirement (one adult for every four infants and toddlers) for infants than for older babies. Thirty-six states and Puerto Rico meet or exceed this adult-child ratio standard. Of these states and Puerto Rico, 22 meet or exceed the standard for one age group (infants at 11 months old), 11 states achieve it for two age groups (infants and 1-year-olds) and three states (Alaska, Connecticut and Massachusetts) and Puerto Rico achieve it for all three age groups, including 2-year-olds.

2. Group size requirements

More states meet or exceed EHS' group size requirement (no more than eight infants or toddlers in a group) for infants than for older babies. Twenty-four states meet or exceed the requirement for one age group (infants), five states achieve it for two age groups (infants and toddlers) and only three states achieve it for all three age groups.

3. Teacher qualifications

Only five states require teachers of infants and toddlers to have either a Child Development Associate (CDA) credential or state equivalent—one state fewer than in the last Yearbook. In fact, a vast majority of states (45) require no credential beyond a high school diploma. Puerto Rico requires a bachelor's degree.

4. Infant/toddler professional credential

Thirty states have adopted an infant-toddler professional credential. Such a credential provides a formal recognition that early educators have met requirements such as training, course work, and/or experience for working with infants and toddlers.

X. ACTIVITIES THAT SUPPORT EARLY LEARNING

1. Parent reads to baby every day

Nationally, only 37.4 percent of babies are read to daily.

Race and ethnicity. The percentage of White parents who reported reading to their babies daily (45.6 percent) was higher than the national average, while the percentages of Asian, Black and Hispanic parents who reported reading to their babies daily (35.4 percent, 25.5 percent and 23.5 percent, respectively) were lower than the national average.

Income. Parents in households with low income were significantly less likely to read to their infants/toddlers every day (27.5 percent) than those in households above low income (44.1 percent).

2. Parent sings or tells stories to baby every day

Nationally, more than one-half (58.1 percent) of parents sing or tell stories to their infants or toddlers every day.

Race and ethnicity. The percentage of White parents who reported singing or telling stories to their babies every day (64.5 percent) was higher than the national average, while the percentages of Black, Asian and Hispanic parents who reported singing or telling stories daily to their babies (48.8 percent, 48 percent and 47.2 percent, respectively) were lower than the national average.

Income. Nationally, the percentage of parents with low income who reported singing or telling stories to their babies every day (49.9 percent) was about three-quarters of the rate of families above low-income (63.5 percent).

XI. ACCESS TO EARLY LEARNING PROGRAMS

1. Income-eligible infants/toddlers with Early Head Start (EHS) access

The EHS program had spaces for only 11 percent of eligible infants and toddlers.

2. Infants/toddlers in Child Care and Development Fund (CCDF)-funded care

Fewer than one in seven families with low or moderate income (4.7 percent), who could benefit from assistance, receive help paying for child care under CCDF.

3. State sets child care subsidy eligibility level for infant care above 200 percent of FPL

18 states make families with incomes above low income eligible for subsidies.

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

At the time of *Yearbook* data collection, only 2 states set their reimbursement rates for infants at or above the 75th percentile of current market rates (the federally recommended standard). Subsequently, new data was published showing that this number had increased to 13.⁶

5. Use of nonparental child care

RAPID Survey findings for January 2022 to April 2023 show the continued impacts of chaotic child care situations on families and providers. Overall, **household use of some nonparental child care (center-based or non-center-based) substantially increased over the course of the year, from 71.4 percent of surveyed families in January 2022 to 87.8 percent in April 2023.**

Race and ethnicity. The RAPID Survey findings reveal disparities in the return to nonparental child care across families of different racial/ethnic backgrounds. In January 2022, 69.3 percent of Black families and 61.7 percent of Latine families used nonparental care, compared with 71.2 percent of White families. By April 2023, however, these disparities leveled out, with 84.7 percent of Black families, 86.5 percent of Latine families and 87.6 percent of White families using center-based and non-center-based care.

Income. The return to nonparental care was lower among families with low income (ranging from 45.6 percent in January 2022 to 68.2 percent in April 2023) than among families above low income (ranging from 78.9 percent to 98.1 percent for the same time periods).

XII. EARLY INTERVENTION AND PREVENTION SERVICES

Early intervention to identify and address developmental delays is critical, but few babies reap the benefits of early intervention programs.

1. Developmental screening received

Nationally, one in three babies (34.2 percent) ages 9–35 months old received a developmental screening using a parent-completed tool.

Race and ethnicity. The percentage of White babies receiving developmental screening (36.8 percent) was higher than the national average, while the percentage of Hispanic, Black and Asian babies screened (31.1 percent, 28.6 percent and 27.4 percent, respectively) was lower than the average.

Income. Differences were also evident when examined by income, with screening of babies in families above low income (37.3 percent) being higher than the national average, and screening of babies in families with low income (29.5 percent) lower than the national average.

2. Infants/toddlers receiving services under Part C of the Individuals with Disabilities Education Act (IDEA)

The percentage of infants and toddlers with disabilities from birth to 2 years old who received early intervention services under IDEA Part C during the most recent 12-month period was 6.8 percent. Subgroup data are not available for this indicator.

3. State includes “at risk” children as eligible for IDEA Part C services or reports that they serve “at risk” children

2023 *Yearbook* data show that **only six states include children whose experiences place them at risk for disabilities as eligible for services under IDEA or report that they serve this population unless a confirmed delay emerges.**

Positive Early Learning Experiences – Summary of All Indicators

| Subdomain | Indicator | Description | 2019 Yearbook | 2020 Yearbook | 2021 Yearbook | 2022 Yearbook | 2023 Yearbook |
|--|---|---|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Early Care and Education Opportunities | Parent reads to baby every day ^a | Percentage of parents who report reading to their infants/toddlers every day | 38.2% | 37.8% | 37.2% | 36.8% | 37.4% |
| | Parent sings to baby every day ^a | Percentage of parents who report singing songs or telling stories to their infants/toddlers every day | 56.4% | 57.6% | 57.4% | 57.3% | 58.1% |
| | Income-eligible infants/toddlers with Early Head Start access | Percentage of infants/toddlers below 100% of the federal poverty line with access to Early Head Start | 7.0% | 7.0% | 11.0% | 11.0% | 11.0% |
| | Cost of care, as % of income (married families) | Average state cost of center-based infant care as a percentage of median income for married families | Not available at national level | Not available at national level | Not available at national level | Not available at national level | Not available at national level |
| | Cost of care, as % income (single parents) | Average state cost of center-based infant care as a percentage of median income for single parents | Not available at national level | Not available at national level | Not available at national level | Not available at national level | Not available at national level |
| | Families above 200% of FPL eligible for child care subsidy | Income eligibility for child care subsidy above 200% of the federal poverty line | 12 states | 13 states | 16 states | 16 states | 18 states |
| | Low-income and moderate-income infants/toddlers in CCDF-funded care | Percentage of infants/toddlers with family incomes equal to or below 150% of the state median income who are receiving a child care subsidy | 4.2% | 4.2% | 4.2% | 4.6% | 4.7% |

| Subdomain | Indicator | Description | 2019 Yearbook | 2020 Yearbook | 2021 Yearbook | 2022 Yearbook | 2023 Yearbook |
|-----------------------|--|--|------------------|--|--|--|--|
| Child Care Quality | Group size | States meeting EHS group size requirements for infants and toddlers in licensed center-based child care | -- | 23 states (16 states for one age group, six states for two age groups, one for three age groups) | 23 states (16 states for one age group, six states for two age groups, one for three age groups) | 23 states (16 states for one age group, six states for two age groups, one for three age groups) | 31 states (23 states for one age group, five states for two age groups, three for three age groups) |
| | Adult/child ratio | States meeting EHS requirements for adult-child ratio for infants and toddlers in licensed center-based child care | -- | 35 states (21 states for one age group, 12 states for two age groups, two for three age groups) | 35 states (21 states for one age group, 12 states for two age groups, two for three age groups) | 35 states (21 states for one age group, 12 states for two age groups, two for three age groups) | 36 states (22 states for one age group, 11 states for two age groups, three for three age groups) |
| | Teacher qualifications | States meeting EHS teacher qualifications for infants and toddlers in licensed center-based child care | -- | Six states—CDA/state equivalent (45 states—no credential beyond high school) | Six states—CDA/state equivalent (45 states—no credential beyond high school) | Six states—CDA/state equivalent (45 states—no credential beyond high school) | Five states—CDA/state equivalent (46 states—no credential beyond high school). Puerto Rico requires a BA |
| | Infant/toddler professional credential | The state has adopted a professional credential for infant/toddler teachers | -- | 30 states | 30 states | 30 states | 30 states |
| | State reimburses center-based child care | State reimburses center-based child care at or above the 75th percentile of current market rates | -- | 1 state | 4 states | 1 state | 2 states (See text above) |

| Subdomain | Indicator | Description | 2019 Yearbook | 2020 Yearbook | 2021 Yearbook | 2022 Yearbook | 2023 Yearbook |
|--|---|---|------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Early Intervention and Prevention Services | Developmental screening | Percentage of infants/toddlers, ages 9–35 months, who received a developmental screening using a parent-completed tool in the past year | 30.4% | 31.1% | 32.5% | 33.8% | 34.2% |
| | At-risk children included in IDEA Part C eligibility definition | State includes "at-risk" children as eligible for IDEA Part C services or reports that they serve at-risk children | -- | 5 states | 6 states | 6 states | 6 states |
| | Infants/toddlers receiving IDEA Part C services | Percentage of infants/toddlers receiving IDEA Part C services | 3.1% | 6.4% ^b | 6.8% ^b | 7.3% ^b | 6.8% ^b |
| | Timeliness of Part C services | Percentage of infants and toddlers with Individual Family Service Plans (IFSPs) who receive the early intervention services on their IFSPs in a timely manner | -- | Not available at national level | Not available at national level | Not available at national level | Not available at national level |

Notes: CDA = Child Development Associate; CCDF = Child Care Development Fund; FPL = federal poverty level; IDEA = Individuals with Disabilities Education Act

^a Due to changes in data reporting and/or changes to the methods for calculating this indicator, we caution against directly comparing estimates from the 2019 *Yearbook* with those from the 2020-2023 *Yearbooks*. For a more detailed discussion, see the indicators and methodological appendices (Appendix B and Appendix C).

^b Beginning with the 2020 calculation, a cumulative count for the most recent 12-month period has been used, whereas a snapshot was used for 2019.

Endnotes

- ¹ Centers for Disease Control and Prevention (2023, March 23). *Pregnancy Mortality Surveillance System*. <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>
- ² The World Bank. (n.d.). *Mortality rate, infant (per 1,000 live births)* [Data file]. <https://data.worldbank.org/indicator/SP.DYN.IMRT.IN>
- ³ Centers for Disease Control and Prevention (2022). *Infant mortality*. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm#print>
- ⁴ Smith, S., Granja, M. R., Burak, E. W., Johnson, K., & Ferguson, D. (2023). Medicaid Policies to Help Young Children Access Key Infant-Early Childhood Mental Health Services: Results from a 50-state Survey. National Center for Children in Poverty at Bank Street Graduate School of Education, Georgetown University McCourt School of Public Policy Center for Children and Families, and Johnson Policy Consulting. [NCCP-Medicaid-Brief_6.13.23-FINAL.pdf](#)
- ⁵ Driscoll, A. K. & Rossen, L. M. (2020). Quarterly provisional estimates for infant mortality, 2017-Quarter 4, 2019. National Center for Health Statistics, National Vital Statistics System, Vital Statistics Rapid Release Program. <https://www.cdc.gov/nchs/nvss/vsrr/infant-mortality-dashboard.htm>
- ⁶ Schulman, K. (2023). *Precarious progress: State child care assistance policies 2022*. National Women's Law Center. <https://nwlc.org/wp-content/uploads/2023/06/State-of-Child-Care-2023-FINAL.pdf>

Appendix B. Summary of Indicator Values

| Good Health | | | | |
|---|--|---|---|--|
| Subdomain | Indicator | National Average/ Policy Count (most current data available) | Range | Summary |
| Health Care Access/ Affordability | Income cutoff (percent of the FPL) for Medicaid eligibility for pregnant women | 200% (median) | 138% (ID, LA, OK & SD) – 380% (IA) | 29 states including DC above 200% |
| | State-adopted Medicaid expansion under the Affordable Care Act | 39 states | Note: Since data collection closed, NC and SD have adopted expansion. | |
| | Percentage of low-income infants/toddlers who are uninsured | 5.2% | 0.7% (VT) – 17.9% (ND) | 3 states at or above 10% (AK, ND, WY) |
| | State extends CHIP coverage to undocumented pregnant women by covering their unborn child as a targeted low-income child | 18 states | -- | -- |
| | Percentage of infants/ toddlers who received coordinated, ongoing, comprehensive care within a medical home | 51.0% | 40.5% (AZ) – 62.6% (VT) | 33 states at or above 50 |
| | State efforts to extend Medicaid coverage beyond 60 days postpartum | 29 states—covering all women for 1 year postpartum; 22 states—no law beyond mandatory 60 days; 0 states—law covering either (a) some women but not all, or (b) all women but for less than 1 year | NOTE: Since data collection closed, more states have moved to adopt coverage for 12 months postpartum: 36 implementing 10 planning to implement 2 proposing time period less than 12 months 3 with no policy or plans | |
| Nutrition | Percentage of infants ever breastfed | 83.8% | 66.0% (WV) – 94.0% (OR) | 40 states including DC at or above 80% |
| | Percentage of infants breastfed at 6 months | 55.0% | 33.4% (WV) – 70.7% (OR) | 39 states including DC at or above 50% |
| | Percentage of eligible infants who participated in WIC | 98.4% | 62.9% (UT) – 100.0% (AL, CA, CT, DC, HI, IL, IN, KS, KY, MD, MI, MN, MS, OK, OR RI, TX, VT & WI) | 40 states including DC at or above 90% |
| | Percentage of eligible 1-year-olds who participated in WIC | 64.5% | 41.5% (TN) – 91.9% (VT) | 3 states at or above 80% (MD, RI, VT) |
| | Percentage of eligible 2-year-olds who participated in WIC | 48.1% | 30.3% (TN) – 86.3% (ND) | 17 states at or above 50% |
| | Percentage of WIC recipients 3–23 months old who had high weight-for-length | Not available at the national level | 6.3% (CO) – 16.3% (KY) | 41 states including DC at or above 10% |

| Good Health | | | | |
|--|--|---|---|---|
| Subdomain | Indicator | National Average/ Policy Count (most current data available) | Range | Summary |
| Maternal Health | Number of pregnancy-related deaths per 100,000 live births | 23.8* | Available at national level only | -- |
| | Percentage of women receiving late or no prenatal care | 6.2% | 1.3% (RI) – 11.3% (NM) | 2 states at or above 10% (HI, NM) |
| | State Medicaid policy requires, recommends or allows maternal depression screenings during well-child visits | 44 states | -- | -- |
| | Percentage of mothers of infants/toddlers rating their mental health as worse than “excellent” or “very good” | 22.5% | 15.5% (DC) – 32.1% (MT) | 40 states at or above 20% |
| | Protections or accommodations are set in place for pregnant working people | 31 states (3–state employees only; 23–state and private, with limitations; 5–all employees)** | -- | -- |
| Child Health | Deaths per 1,000 live births | 5.4 | 3.5 (VT) – 8.1 (MS) | 6 states at or above 7 per 1,000 (AL, AR, LA, MS, SD, WV) |
| | Percentage of babies with low birth weight | 8.2% | 6.5% (OR) – 11.8% (MS) | 3 states at or above 10% (AL, LA, MS) |
| | Percentage of babies born preterm | 10.1% | 7.6% (VT) – 14.2% (MS) | 24 states at or above 10% |
| | Percentage of infants/toddlers who had a preventive medical visit in the past year | 89.3% | 82.6% (LA) – 98% (ME) | 22 states at or above 90% |
| | Percentage of infants/toddlers who had a preventive dental visit in the past year | 33.5% | 16.8% (ND) – 52.5% (WA) | 20 states including DC above 33.5% |
| | Percentage of infants/toddlers receiving the recommended doses of DTaP, polio, MMR, Hib, HepB, varicella and PCV vaccines by ages 19–35 months | 72.5% | 64.0% (OK) – 85.8% (CT) Puerto Rico – 47.1% (not included in rankings) | 17 states at or above 75% |
| Infant and Early Childhood Mental Health | State Medicaid plan covers social-emotional screening for young children (birth to 6) with a tool specifically designed for this purpose | 43 states | -- | -- |
| | Medicaid plan covers services in home settings | 49 states | -- | -- |
| | Medicaid plan covers services in pediatric/family medicine practices | 46 states | -- | -- |
| | Medicaid plan covers services in early care and education program settings | 34 states | -- | -- |

Notes: CHIP=Children’s Health Insurance Program

* Additional update available subsequent to *Yearbook* data collection closure. See Appendix A for details.

** A new federal law, the Pregnant Workers Fairness Act, now provides a floor of protection for workers with limitations related to pregnancy, childbirth, or related medical conditions who need accommodations in the workplace. It does not replace state or local laws that are more protective.

| Strong Families | | | | |
|------------------------|---|---|--|---|
| Subdomain | Indicator | National Average/ Policy Count (most current data available) | Range | Summary |
| Basic Needs Support | Percentage of families with infants/toddlers living below 100% of the FPL who receive TANF benefits | 19.5% | 2.1% (ID) – 75.3% (CA) | 10 states at or above 30% (no data for CO or DC) |
| | Percentage of households with infants/toddlers experiencing low or very low food security | 14.2% | 3.1% (RI) – 30.2% (ME) | 19 states at or above 15% |
| | Percentage of infants/toddlers who have moved 3 or more times since birth | 2.9% | 0.5% (CT) – 8.9% (NM) | 6 states at or above 5% |
| | Percentage of infants/toddlers who live in crowded housing | 15.2% | 7.8% (WV) – 27.6% (CA) Puerto Rico – 5.8% (not included in rankings) | 39 states including DC at or above 10% |
| | Percentage of infants/toddlers living in unsafe neighborhoods, as reported by parents | 5.0% | 1.5% (ID) – 10.8% (D.C.) | 2 states at or above 10% (DC, NM) |
| Child Welfare | Percentage of infants/toddlers who live in families that report “family resilience” | 85.6% | 80.3% (HI) – 90.9% (VT) | 101 states including DC at or above 80% |
| | Percentage of infants/toddlers who have experienced one ACE | 18.6% | 12.2% (IL) – 26.3% (OK) | 20 states at or above 20% |
| | Percentage of infants/toddlers who have experienced two or more ACEs | 7.2% | 2.1% (MA) – 13.7% (OK) | 10 states at or above 10% |
| | Maltreatment rate per 1,000 children ages 0-2 | 15.5 | 2.0 (PA) – 34.5 (WV) | 17 states at or above 20 |
| | Number per 1,000 infants and toddlers who have been removed from home and placed in foster care | 6.6 | 2.4 (VA) – 26.6 (WV) | 11 states at or above 10 |
| | Percentage of infants/toddlers in out-of-home placement who exited care in less than 12 months | 33.9% | 11.5% (IL) – 63.0% (WY) | 20 states above 33.9% |
| | Percentage of infants/toddlers exiting foster care who are adopted | 34.2% | 15.2% (WY) – 58.5% (WV) | 29 states including DC at or above 35% |
| | Percentage of infants/toddlers exiting foster care who are reunified | 49.8% | 26.6% (VA) – 72.2% (MA) | 27 states at or above 50% 2 states below 30% (AL, VA) |
| | Percentage of infants/toddlers exiting foster care who are placed with a guardian | 7.9% | 1.9% (MA) – 23.8% (NC) | 4 states at or above 15% (no data for AK, DC, ID, KS, KY, ME, MD, NE, NH, NM, ND, RI & VT) |
| | Percentage of infants/toddlers exiting foster care who are placed with a relative | 7.0% | 0.5% (AZ) – 39.5% (AL) | 6 states at or above 25% (no data for AK, CA, CT, DE, DC, FL, HI, ID, IA, KS, ME, MA, MI, MO, MT, NE, NV, NH, NM, OR, RI, SD, TX, WA, WI & WY) |

| Strong Families | | | | |
|---------------------|--|---|--|--|
| Subdomain | Indicator | National Average/ Policy Count (most current data available) | Range | Summary |
| Home Visiting | Percentage of infants/toddlers who could benefit from evidence-based home visiting and are receiving such services | 2.1% | 0.1% (VT) – 6.2% (KS) | 5 states at or above 5% (IA, IN, KS, MI, RI) |
| Supportive Policies | State requires employers to provide paid sick days that cover care for child | 14 states | -- | -- |
| | State has a paid family leave program | 12 states | NOTE: Since data collection closed, 3 more states have moved to adopt paid family and medical leave (ME, IL, MN) | |
| | Single-parent head of unit over 21 years old is exempt from TANF work-related activity if caring for a child under 12 months | 24 states (11 of which exempt for 1 single child only) | -- | -- |
| | State offers a Child Tax Credit | 13 states | -- | -- |
| | State offers an Earned Income Tax Credit | 32 states | -- | -- |

Notes: ACE=Adverse Childhood Experience;

| Positive Early Learning Experiences | | | | |
|--|--|---|--|---|
| Subdomain | Indicator | National Average/ Policy Count (most current data available) | Range | Summary |
| Early Care and Education Opportunities | Percentage of parents who report reading to their infants/toddlers every day | 37.4% | 26.8% (MS) – 55.1% (VT) | 3 states including DC at or above 50% (DC, ME, VT) |
| | Percentage of parents who report singing songs or telling stories to their infants/toddlers every day | 58.1% | 48.6% (MS) – 71.8% (VT) | 19 states including at or above 60% |
| | Percentage of infants/toddlers below 100% of the FPL with access to Early Head Start | 11.0% | 5.0% (NV & SC) – 31.0% (DC) Puerto Rico—10% (not included in ranking) | 25 states including DC at or above 11%; 5 states at or above 20% (AK, DC, ME, MT, VT) |
| | Average state cost of center-based infant care as a percentage of median income for married families | Not available at national level | 7.3% (MS) – 16.7% (CA) | 6 states at or above 15% |
| | Average state cost of center-based infant care as a percentage of median income for single parents | Not available at national level | 26.3% (SD) – 79.4% (DC) | 41 states (including DC) plus Puerto Rico at or above 33% |
| | Income eligibility level for child care subsidy above 200% of the FPL | 18 states | -- | -- |
| | Percentage of infants/toddlers with family income equal to or below 150% of the state median income who are receiving a child care subsidy | 4.7% | 2.1% (HI) – 7.9% (TN) Puerto Rico—2.3% (not included in ranking) | 20 states including DC at or above 5% (no data for GA) |

| Positive Early Learning Experiences | | | | |
|--|---|--|--|---|
| Subdomain | Indicator | National Average/ Policy Count (most current data available) | Range | Summary |
| Child Care Quality | Meeting EHS group size for infants and toddlers in licensed, center-based child care | 24 states (16 states for one age group, 5 states for two age groups, 3 states for three age groups) | -- | -- |
| | Meeting EHS adult-child ratio for infants and toddlers in licensed, center-based child care | 37 states (including DC and Puerto Rico) (22 states for one age group, 11 states for two age groups, 3 states for three age groups) | -- | -- |
| | Meeting teacher qualification requirements for infants and toddlers in licensed, center-based child care | 5 states—CDA/state equivalent; Puerto Rico—BA (46 states—no credential beyond high school) | -- | -- |
| | State has adopted a professional credential for infant/toddler teachers | 30 states | -- | -- |
| | State reimburses center-based child care at or above the 75th percentile of current market rates | 2 states* | -- | -- |
| Early Intervention and Prevention Services | Percentage of infants/toddlers, ages 9–35 months, who received a developmental screening using a parent-completed tool in the past year | 34.2% | 23.2% (NY) – 53.9% (OR) | 12 states at or above 40% |
| | State includes "at-risk" children as eligible for IDEA Part C services or reports that they serve at-risk children | 6 states | -- | CA, FL, MA, NH, NM, WV |
| | Percentage of infants/toddlers receiving IDEA Part C services | 6.8% | 1.9% (AR) – 20.2% (MA) | 8 states at or above 10% |
| | Percentage of infants and toddlers with Individual Family Service Plans (IFSPs) who receive early intervention services on their IFSPs in a timely manner | Not available at national level | 78.5% (NM) – 100.00% (AL, IL, LA, MS, NH, NJ, & Puerto Rico) | 43 states at or above 95% (including DC and Puerto Rico) |

Notes: CCDF=Child Care and Development Fund; CDA=child development associate; CHIP=Children's Health Insurance Program; FPL=federal poverty level; IDEA=Individuals with Disabilities Education Act; WIC=Special Supplemental Nutrition Plan for Women, Infants, and Children

* Additional update available subsequent to *Yearbook* data collection closure. See Appendix A for details.

Appendix C. RAPID Survey Methodology

To provide perspective on the most recent essential information about families and their infants and toddlers, the 2023 Yearbook is supplemented again by national data collected through Stanford University Center on Early Childhood's Rapid Assessment of Pandemic Impact on Development (RAPID) Survey. Initially launched on April 6, 2020, by the University of Oregon's Center for Translational Neuroscience, the RAPID Survey continues to collect online responses on a biweekly basis from a national sample of 4,966 families with young children.

We provide an update on the RAPID Survey findings that directly relate to the experience of families with babies from January 2022 through April 2023 within each Yearbook domain—Good Health, Strong Families and Positive Early Learning Experiences. Findings from the survey demonstrate the ongoing, multidimensional experiences of families post-pandemic in the form of high food insecurity, caregiver and child emotional distress, and financial hardship, as well as in declines in receipt of preventive health care and access to child care and other early learning and developmental opportunities.

Data collected from families through April 2023 have been key in helping ZERO TO THREE understand the lived experiences of infants and toddlers and their families as a result of the pandemic. Policymakers and advocates are encouraged to use this data to identify and advance policies that produce the near-term support and long-term stability that babies and families need.

Appendix D. *State of Babies Yearbook* Indicators and Ranking Methodology

About the selected indicators

The selection process

The indicators used for the *State of Babies Yearbook* provide a snapshot of the state of babies across three domains: Good Health, Strong Families, and Positive Early Learning Experiences. Demographics indicators are also included in the Yearbook but do not inform the state ranks. While there are many measures we might have included in each of these domains, in the 2023 *Yearbook*, as we did for previous editions, we limited our selection to those indicators that meet the following three criteria:

- They draw from a reliable, ongoing source that yields data for all 50 states.
- They are of central importance to the domain, either because they directly measure a component of well-being or are policy choices strongly linked to well-being.
- They can be readily understood by a broad audience.

The resulting set of 90 indicators address the following topics, by domain and subdomain:

| Domain | Subdomain Topics Covered by the Selected Indicators |
|-------------------------------------|---|
| Demographics | No demographics subdomains |
| Good Health | Health Care Coverage and Affordability Nutrition Maternal Health Children's Health Children's Mental Health Services |
| Strong Families | Basic Needs Child Well-being and Resilience Supportive Policies |
| Positive Early Learning Experiences | Elements that Support Child Care Quality Activities that Support Early Learning Access to Early Learning Programs Early Intervention |

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

As new data become available, we continue to refine indicators and incorporate additional indicators. In the second edition of the report, we added more than a dozen additional policy indicators. In the third edition, we added four additional indicators focusing on the Good Health domain. In the fourth edition, we added one additional indicator focusing on the Good Health domain and two additional contextual indicators in the Demographics domain. In this fifth edition we have added three indicators focusing on the Good Health domain and four Demographics indicators. We also removed an indicator from the Positive Early Learning domain. See the Indicator Dictionary in Appendix E for a list of changes to indicators between reports, and the full list of indicators.

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

In making our final indicator selection, ZERO TO THREE and Child Trends again obtained input from a panel of experts in the field. Panelists also provided feedback on our approach to ranking states. We know some important topics are absent here, especially measures of positive social-emotional development. In these cases, we still have to acknowledge that available data do not meet our criteria.¹ Other topics may have to wait until improvements are made in measures used to collect data about young children. As noted above, the *State of Babies Yearbook: 2019* was a starting place and we intend to continue to refine indicators in future editions and consider creative ways to measure state policies.

1 For more information on what data are and are not available, see Ryberg, R., Wiggins, L., Moore, K. A., Daily, S., Piña, G., & Klin, A. (2022). *Measuring state-level infant and toddler well-being in the United States: Gaps in data lead to gaps in understanding*. *Child indicators research*, 15(3), 1063-1102. <https://link.springer.com/article/10.1007/s12187-021-09902-4>

Subgroup analyses

We have deepened our emphasis on equity throughout the Yearbook, and present results disaggregated by race/ethnicity, urbanicity, and family income, wherever data allow. Beginning with indicator updates for the 2021 Yearbook, we are presenting data for all of the racial and ethnic subgroups that each data source allows. We are now including estimates for American Indian and Alaska Native, Native Hawaiian and Pacific Islander, and multiracial groups wherever possible instead of aggregating them into an “Other” category. These upgrades are an iterative process over time. As new data become available and we update indicators, we are incorporating these improvements.

Incorporating information on territories

Starting with the 2022 Yearbook, we took steps towards incorporating information on US territories and added data for Puerto Rico where it is available. Unless otherwise specified, national totals represent the continental United States, Alaska, and Hawaii. Because many data sources do not contain information on Puerto Rico, it is excluded from the ranking process.

Cautions for interpretation of the data

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

The state ranking process

Indicators used in the ranking

| Good Health | | Included in ranking |
|--|--|---------------------|
| Health Care Coverage and Affordability subdomain | Children’s Health Insurance Program (CHIP) unborn child option | |
| | Eligibility limit (% FPL) for pregnant women in Medicaid | ✓ |
| | Uninsured low-income infants and toddlers | ✓ |
| | Medicaid expansion state | ✓ |
| | Medical home | ✓ |
| | Postpartum extension of Medicaid coverage | |
| Nutrition subdomain | Infants ever breastfed | |
| | Infants breastfed at 6 months | ✓ |
| | High weight-for-length in WIC | |
| | WIC coverage – infants | ✓ |
| | WIC coverage – one-year-olds | ✓ |
| | WIC coverage – two-year-olds | ✓ |
| Maternal Health subdomain | US abortion policies and access | |
| | Late or no prenatal care received | ✓ |
| | Maternal mortality (deaths per 100,000 live births) | |
| | Mothers reporting less than optimal mental health | ✓ |
| | Accommodations for pregnant workers, protection from job loss | ✓ |
| | State Medicaid policy for maternal depression screening in well-child visits | ✓ |
| Children’s Health subdomain | Babies born preterm | ✓ |
| | Babies with low birthweight | ✓ |
| | Infant mortality rate (deaths per 1,000 live births) | ✓ |
| | Preventive dental care received | ✓ |
| | Preventive medical care received | ✓ |
| | Received recommended vaccines | ✓ |

| | | |
|--|--|---|
| Children's Mental Health Services subdomain | Medicaid plan covers IECMH services at ECE programs | ✓ |
| | Medicaid plan covers IECMH services at home | ✓ |
| | Medicaid plan covers IECMH services at pediatric/family medicine practices | ✓ |
| | Medicaid plan covers social-emotional screening for young children | ✓ |

| Strong Families | | Included in ranking |
|--|--|----------------------------|
| Basic Needs subdomain | TANF benefits receipt among families in poverty | |
| | Housing instability | ✓ |
| | Crowded housing | ✓ |
| | Unsafe neighborhoods | ✓ |
| | Low or very low food security | ✓ |
| Child Well-being and Resilience subdomain | Family resilience | ✓ |
| | One adverse childhood experience | |
| | Two or more adverse childhood experiences | ✓ |
| | Infant/toddler maltreatment rate (per 1,000 children ages 0-2) | |
| | Permanency: Adopted | |
| | Permanency: Guardian | |
| | Permanency: Relative | |
| | Permanency: Reunified | |
| | Removed from home | |
| | Time in out-of-home placement | |
| | Potential home visiting beneficiaries served | ✓ |
| Supportive Policies subdomain | Paid family leave | ✓ |
| | Paid sick time that covers care for child | ✓ |
| | State child tax credit | ✓ |
| | TANF work exemption | ✓ |
| | State earned income tax credit | ✓ |

| Positive Early Learning Experiences | | Included in ranking |
|---|---|----------------------------|
| Elements that Support Child Care Quality subdomain | Adult/child ratio | ✓ |
| | Teacher qualifications | ✓ |
| | Group size | ✓ |
| | Infant/toddler professional credential | |
| Activities that Support Early Learning | Parent reads to baby every day | ✓ |
| | Parent sings to baby every day | ✓ |
| Access to Early Learning Programs subdomain | % Income-eligible infants/toddlers with Early Head Start access | ✓ |
| | Families above 200% of FPL eligible for child care subsidy | ✓ |
| | State reimburses center-based child care | ✓ |
| | Low/moderate income infants/toddlers in CCDF-funded care | ✓ |
| | Cost of care, as % of income married families | |
| | Cost of care, as % of income single parents | |
| Early Intervention subdomain | Developmental screening received | ✓ |
| | At-risk children included in Part C eligibility definition | |
| | Percentage of infants/toddlers receiving IDEA Part C services | ✓ |
| | Timeliness of Part C services | ✓ |

Changes to the ranking in the *State of Babies Yearbook 2023* version

The domain and overall ranks in the 2022 and 2023 Yearbooks are not directly comparable to the ranks in earlier versions of the Yearbook due to updates made to the ranking process. The updated ranking process allows for updates to the indicators included in the ranking subdomains. See the 2022 *Yearbook*² Methodology for additional details. For the 2023 *Yearbook* we made the following changes:

1. Added new indicators to the ranking. By domain, the new indicators included in the ranking were:

Good Health: We included indicators of WIC coverage for 1 year olds and 2 year olds to the Nutrition ranking subdomain to provide a more complete measure of coverage during the infant and toddler years.

2. Removed indicators from the rankings. By domain, the indicators removed from the ranking were:

Strong Families: We removed TANF benefits receipt among families in poverty from the Basic Needs ranking subdomain because indicator unreliability makes it unclear how to interpret comparisons between states.

Positive Early Learning Experiences: We omitted the Allocated CCDBG funds indicator from the 2023 Yearbook because the data informing this indicator did not capture changes made in 2020 in response to the COVID-19 pandemic.

Rescaling the indicators

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

The performance of each state on a given indicator is compared with the highest and lowest values, to create a score ranging from 0 to 100³:

Score (Rescaled Value) =

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

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

Policy indicators with “yes” or “no” values (e.g., whether the state has expanded Medicaid), are grouped within a subdomain, and we compute a composite index measuring the percentage of policies a state has enacted. For example, we counted the number of affirmative scores related to the states’ provision of mental health services at home, at pediatric/family practices, and at early care and education programs, and expressed the total as a percentage of the possible maximum (three, in this example). A few indicators were coded as a scale, for instance for “state Medicaid policy for maternal depression screening in well-child visits,” we created a scale from 1 to 4, with scores depending on whether such screening was “not covered,” “allowed,” “recommended,” or “required.” These values were then transformed to a 0 to 100 scale, as with the other indicators.

Calculating domain scores

To create state-level composite scores for each of the three domains (Good Health, Strong Families, and Positive Early Learning Experiences), we first compute an unweighted average of the scores of the component indicators for each subdomain. We then compute an unweighted average of the subdomain-level scores to obtain the domain score. Likewise, to compute overall state scores, we used an unweighted average of the domain-level scores.

Assigning states to tiers

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

[Insert top-tier graphic] (“G,” “R,” “O,” and “W”) for **Working Effectively**

[Insert tier graphic] (“G,” “R,” and “O”) for **Improving Outcomes**

[Insert tier graphic] (“G” and “R”) for **Reaching Forward**

[Insert tier graphic] (“G”) for **Getting Started**

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

2 Keating, K. & Heinemeier, S. (2022). *State of babies yearbook: 2022*. Washington, DC: ZERO TO THREE. <https://zerotothree.wpenginepowered.com/wp-content/uploads/2022/04/State-of-Babies-2022-Yearbook.pdf>

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

Appendix E. State of Babies Yearbook: 2023 Indicator Dictionary

| | |
|--|------|
| Good Health | E.3 |
| Health Care Coverage and Affordability | E.3 |
| Children’s Health Insurance Program (CHIP) unborn child option | E.3 |
| Eligibility limit (percentage of the federal poverty line) for Medicaid eligibility for pregnant women | E.3 |
| Percentage of low-income infants/toddlers who are uninsured | E.3 |
| State adopted Medicaid expansion under the Affordable Care Act | E.4 |
| Percentage of infants/toddlers who received coordinated, ongoing, comprehensive care within a medical home | E.4 |
| State efforts to extend Medicaid coverage beyond 60 days postpartum | E.5 |
| Nutrition | E.5 |
| Percentage of infants who are ever breastfed, breastfed at 6 months | E.5 |
| Percentage of WIC recipients, age 3-23 months, who have high weight-for-length | E.6 |
| Percentage of eligible infants, one-year-olds, and two-year-olds who participated in WIC | E.6 |
| Maternal Health | E.7 |
| US Abortion Policies and Access | E.7 |
| Late or no prenatal care | E.7 |
| Maternal mortality rate (pregnancy-related deaths per 100,000 live births) | E.7 |
| Percentage of infants/toddlers whose mothers rate their mental health as worse than “excellent” or “very good” | E.7 |
| Accommodations for pregnant workers, protection from job loss | E.8 |
| State Medicaid policy requires, recommends, or allows maternal depression screening during well-child visits | E.9 |
| Children’s Health | E.9 |
| Percentage of babies born preterm (before 37 completed weeks of gestation) | E.9 |
| Percentage of babies with low birthweight (less than 5.5 pounds) | E.9 |
| Infant mortality rate (deaths per 1,000 live births) | E.10 |
| Percentage of infants/toddlers who had a preventive dental care visit in the past year | E.10 |
| Percentage of infants/toddlers who had a preventive medical care visit in the past year | E.11 |
| Percentage of infants/toddlers receiving the recommended doses of DTaP, polio, MMR, Hib, HepB, varicella and PCV vaccines by age 19 through 35 months | E.12 |
| Children’s Mental Health Services | E.12 |
| Medicaid plan covers infant and early childhood mental health services | E.12 |
| State Medicaid plan covers social-emotional screening for young children (ages 0 through 6 years) with a tool specifically designed for this purpose | E.12 |
| Strong Families | E.13 |
| Basic Needs | E.13 |
| Percentage of families with infants/toddlers living below 100 percent of the federal poverty line that receive TANF benefits | E.13 |
| Housing instability (percentage of infants/toddlers who have moved three or more times since birth) | E.13 |
| Crowded housing (percentage of infants/toddlers who live in crowded housing) | E.14 |
| Percentage of infants/toddlers living in unsafe neighborhoods, as reported by parents | E.14 |
| Percentage of households with infants/toddlers experiencing low or very low food security | E.15 |
| Child Well-being and Resilience | E.16 |
| Percentage of families with infants/toddlers who report “family resilience” | E.16 |
| Percentage of infants/toddlers who have experienced one adverse childhood experiences: two or more adverse childhood experiences | E.17 |
| Maltreatment rate per 1,000 infants/toddlers | E.18 |
| Percentage of infants/toddlers exiting foster care achieving permanency who are reunified, placed with guardian, placed with non-guardian relative, or adopted | E.18 |
| Number of infants/toddlers who have been removed from home and placed in foster care, per 1,000 | E.19 |
| Percentage of infants/toddlers in out-of-home placement who exited care in less than 12 months | E.19 |
| Percentage of infants/toddlers who could benefit from evidence-based home visiting services and are receiving those services | E.19 |
| Supportive Policies | E.20 |
| State has a paid family leave program | E.20 |
| State requires employers to provide paid sick days that cover care for child | E.20 |

| | |
|--|------|
| State offers a child tax credit | E.20 |
| TANF work exemption for single parents of infants | E.21 |
| State offers an earned income tax credit | E.21 |
| Positive Early Learning Experiences | E.21 |
| Elements that Support Child Care Quality | E.21 |
| Adult/child ratio for infants and toddlers in CCDF licensed center-based child care | E.21 |
| Teacher qualifications for infants and toddlers in CCDF licensed center-based child care | E.22 |
| Group size for infants and toddlers in CCDF licensed center-based child care | E.22 |
| State has adopted a professional credential for infant/toddler teachers | E.22 |
| Activities that Support Early Learning | E.22 |
| Percentage of parents who report reading to their infants/toddlers every day | E.22 |
| Percentage of parents who report singing songs or telling stories to their infants/toddlers every day | E.23 |
| Access to Early Learning Programs | E.24 |
| Percentage of infants/toddlers below 100 percent of the federal poverty line with access to Early Head Start | E.24 |
| Income eligibility level for child care subsidy is at or above 200 percent of the federal poverty line | E.24 |
| State child care subsidy system reimburses center-based child care at or above the 75th percentile of current market rates | E.25 |
| Percentage of infants/toddlers with family incomes equal to or below 150 percent of the state median income who are receiving a child care subsidy | E.25 |
| Average state cost of center-based infant care as a percentage of median income for married families/single parents | E.26 |
| Early Intervention | E.26 |
| Percentage of infants/toddlers, ages 9 through 35 months, who received a developmental screening using a parent-completed tool in the past year | E.26 |
| State's Part C eligibility criteria include infants and toddlers who are at risk of having substantial developmental delays | E.27 |
| Percentage of infants/toddlers receiving services under the Individuals with Disabilities Education Act Part C | E.27 |
| Timeliness of Part C services | E.27 |
| Demographics | E.28 |
| Number of infants/toddlers | E.28 |
| Percentage of infant/toddler population | E.28 |
| Percentage of infants/toddlers who are Hispanic | E.28 |
| Percentage of infants/toddlers who are non-Hispanic White | E.28 |
| Percentage of infants/toddlers who are non-Hispanic Black | E.29 |
| Percentage of infants/toddlers who are non-Hispanic Asian | E.29 |
| Percentage of infants/toddlers who are non-Hispanic American Indian and Alaska Native | E.29 |
| Percentage of infants/toddlers who are Hispanic American Indian and Alaska Native | E.29 |
| Percentage of infants/toddlers who are non-Hispanic Native Hawaiian and Pacific Islander | E.29 |
| Percentage of infants/toddlers who are non-Hispanic multiple races | E.30 |
| Percentage of infants/toddlers living in two-parent families | E.30 |
| Percentage of infants/toddlers living in one-parent families | E.30 |
| Percentage of infants/toddlers living with no parents | E.31 |
| Percentage of infants/toddlers living in grandparent-headed households | E.31 |
| Percentage of infants/toddlers that have mothers in the labor force | E.31 |
| Percentage of infants/toddlers who live with no working parents | E.32 |
| Percentage of infants/toddlers below the poverty line who live with no working parents | E.32 |
| Percentage of infants/toddlers who live with at least one parent working full time | E.33 |
| Percentage of infants/toddlers below the poverty line who live with at least one parent working full time | E.33 |
| Percentage of infants/toddlers living below 50 percent of the federal poverty line | E.34 |
| Percentage of infants/toddlers living in families with incomes below 100 percent of the federal poverty line | E.34 |
| Percentage of infants/toddlers living in families with incomes between 100-199 percent of the federal poverty line | E.35 |
| Percentage of infants/toddlers living in families with incomes at or above 200 percent of the federal poverty line | E.35 |
| Percentage of infants/toddlers living in families with incomes below 150 percent of state median income | E.35 |
| Percentage of infants/toddlers living outside of metro areas | E.36 |

Health Care Coverage and Affordability

Children's Health Insurance Program (CHIP) unborn child option

States take different approaches to providing health coverage to children of immigrants. Below we provide an overview of these options, and then detail the approach that we are tracking with this indicator, the “unborn child option.” Medicaid and the Children’s Health Insurance Program (CHIP) also provide health coverage for immigrants based on what may be matched with federal Medicaid funds. Some states have chosen to use state-only funds to provide health coverage to children or other groups regardless of immigration status and use state funds to pay when a federal match is unavailable. There are two state options to receive federal matching funds for covering immigrant children and pregnant women in Medicaid and CHIP. More than half of states have opted to draw down federal matching funds in Medicaid or CHIP to cover lawfully residing immigrant pregnant women and/or children during their first five years residing in the U.S.¹

States also have an option in CHIP to cover an unborn child once a pregnancy is confirmed through the “unborn child option.” This option extends coverage to undocumented pregnant people 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 ends with the birth of the child.² The data here reflect rules in effect as of January 2022, as reported by the Kaiser Family Foundation.

Source: Brooks, T., Gardner, A., Osorio, A., Tolbert, J., Corallo, B., Ammula, M. & Moreno, S. (2022). *Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey*. Kaiser Family Foundation. <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/>

Eligibility limit (percentage of the federal poverty line) for Medicaid eligibility for pregnant women

Caring well for infants and toddlers begins with prenatal care. Medicaid and the Children’s Health Insurance Program (CHIP) help 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 eligibility limits for each state reflect rules in effect as of January 2022, as reported by the Kaiser Family Foundation. For *State of Babies Yearbook: 2023*, we have included CHIP eligibility thresholds when they are higher than Medicaid thresholds. The national average presents the national average for Medicaid only, as CHIP does not cover pregnant individuals in all states.

Source: Brooks, T., Gardner, A., Osorio, A., Tolbert, J., Corallo, B., Ammula, M. & Moreno, S. (2022). *Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey*. Kaiser Family Foundation. <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/>

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.

The denominator is the number of children ages 0-2 living below 200 percent of the federal poverty line. The numerator is the number of children ages 0-2 living below 200 percent of the federal poverty line that did not have health insurance at the time of the interview.

This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: Survey respondents report the infant or toddler’s race and ethnicity. Respondents can select one or more of many racial categories or fill in their race. The Census Bureau then assigns each respondent into one of nine categories (American Indian and Alaska Native, Black/African American, Chinese, Japanese, Other Asian or Pacific Islander, Other race, Two major races, Three or more major races, and White). 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. With these categories and ethnicity, we created seven mutually exclusive race/ethnicity categories: Hispanic, Non-Hispanic Asian/PI, Non-Hispanic Black, Non-Hispanic American Indian and Alaska Native, Non-Hispanic Other, Non-Hispanic

Multiple Races, and Non-Hispanic White. *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. Non-metropolitan areas are areas outside of metropolitan areas. Cases whose metropolitan status is indeterminable or mixed are excluded from the urbanicity subgroup analysis. We relied on ACS data that do not include estimates for Puerto Rico for the urbanicity indicator subgroups.

Source: Ruggles, S., Flood, S., Sobek, M., Brockman, D., Cooper, G., Richards, S., & Schouweiler, M. (2023). *American Community Survey 2020, five-year estimates*. (IPUMS USA: Version 13.0) [Data set]. <https://doi.org/10.18128/D010.V13.0>

State adopted Medicaid expansion under the Affordable Care Act

Under the Affordable Care Act, states have the option of expanding Medicaid eligibility criteria to a broader group of people. By adopting Medicaid expansion, more children and families become eligible for Medicaid, and more children and families are covered by health insurance. Expanded eligibility for Medicaid coverage has been shown to improve children's use of preventive care,³ reduce infant mortality,⁴ lower families' out-of-pocket medical expenditures,⁵ and reduce the amount of their unpaid medical bills.⁶

Medicaid expansion status for each state is based on the Kaiser Family Foundation's tracking and analysis of state expansion activity. States' decisions about adopting Medicaid expansion are as of September 20, 2022. States that have adopted but not yet implemented Medicaid expansion are included as being Medicaid expansion states. Additional state-specific notes are provided in the data source.

Source: Kaiser Family Foundation. (2022). Status of state action on the Medicaid expansion decisions: Interactive table. <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

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

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."⁷ 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.⁸ Medical homes are also linked to better health status and increases to family functioning for children with special health care needs.⁹

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: 2022 are based on a four-year (2016-2019) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in the 2021 yearbook, which were based on three years of NSCH data (2016-2018). They should be considered improved estimates, not new estimates that can be compared directly to previous yearbook estimates.

This indicator can be disaggregated by race/ethnicity and 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 since these categories are not controlled independently: American Indian and Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. In 2019, the "some other race" race category was removed from the questionnaire. Missing responses were imputed and categorized into existing race groups. *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 2016-2020 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 considered 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). 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). 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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2020). 2019 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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2021). 2020 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). www.childhealthdata.org

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 people 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.¹⁰

The data source categorized states into categories describing the current status of state efforts to extend Medicaid coverage beyond 60 days postpartum, including "enacted" if the state passed a bill and/or had money included in the state budget but is not yet implementing the policy and "implemented" if the state is 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 serving all pregnant people for at least one year.

Source: American College of Obstetricians and Gynecologists. (2023). *Status of state actions to extend postpartum Medicaid coverage*, ACOG. <https://www.acog.org/advocacy/policy-priorities/extend-postpartum-medicaid-coverage/status-of-state-actions>

Nutrition

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.¹¹ The skin-to-skin contact in breastfeeding improves oxytocin levels and breastfeeding parents report higher rates of attachment.¹² Experts recommend that babies are breastfed throughout the first year of life.¹³

For the percentage of infants who are ever breastfed, the denominator is the number of toddlers ages 19-35 months. The numerator is the number of toddlers ages 19-35 months who were ever breastfed. For the percentage of infants breastfed at 6 months, the denominator is the number of toddlers ages 19-35 months. The numerator is the number of toddlers ages 19-35 months who were breastfed any amount at or over six months of age. The estimates presented in the *State of Babies Yearbook: 2023* 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. The public-use data does not have the information needed to calculate birth cohort estimates.

This indicator can be disaggregated by race/ethnicity and income. *Race/ethnicity*: Survey respondents reported the toddler's race. The public-use file includes the following categories: Hispanic, non-Hispanic White, non-Hispanic Black, and non-Hispanic other. The non-Hispanic other category includes Asian, American Indian and Alaska Native, Native Hawaiian and 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 2018 Census poverty thresholds. The imputed income-to-poverty ratio is used for the *State of Babies Yearbook: 2023*. 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. (2022). *The 2020 National Immunization Survey – Child* [Dataset]. Centers for Disease Control and Prevention. <https://www.cdc.gov/vaccines/imz-managers/nis/datasets.html>

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.¹⁴ The American Academy of Pediatrics recommends using the weight-for-length growth standards to assess the nutritional status of children younger than two.¹⁵ These standards have been recognized internationally in efforts to prevent child malnutrition and obesity.¹⁶

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 was measured to the nearest one-quarter pound, and length to the nearest one-eighth inch by using an infant measuring board according to CDC surveillance standards. Children with missing values of sex, weight, or length, or who had a length outside the range (45–110 cm) in the WHO growth standards were excluded. In addition, children with 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. *Race/ethnicity*: The included subgroups are non-Hispanic White, non-Hispanic Black, Hispanic, Asian/Pacific Islander, and American Indian/Alaska native.

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. (2022). *Data, trends and maps*. <https://www.cdc.gov/nccdp/dnpao/data-trends-maps/index.html>

Percentage of eligible infants, one-year-olds, and two-year-olds who participated in WIC

The Special Supplemental Nutrition Program for Women, Infants, and Children (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 the age of five years.¹⁷ A woman's or child's eligibility to participate in WIC is based on the caregiver's income, as well as the child's medical or dietary status.¹⁸ Participating in WIC is associated with lower levels of infant mortality, better cognitive development for the child as well as more nutritious diets.¹⁹

This indicator documents the coverage rates for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) eligible infants, one-year-olds, and two-year-olds by state for the 2019 calendar year. In the following states: Alabama, California, Connecticut, the District of Columbia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Oklahoma, Oregon, Rhode Island, Texas, Vermont, and Wisconsin, the estimated coverage rate was greater than 100 percent for infants.

The percentage of eligible infants who participated in WIC can be disaggregated by race and ethnicity. The included subgroups are Hispanic, Non-Hispanic White, Non-Hispanic Black, and Non-Hispanic Two or More Races or Other Race.

Source: Farson Gray, K., Balch-Crystal, E., Giannarelli, L., & Johnson, P. (2022). *National- and State-level estimates of WIC eligibility and WIC program reach in 2019*. U.S. Department of Agriculture Food and Nutrition Service. <https://www.fns.usda.gov/wic/national-state-level-estimates-eligibility-program-reach-2019>

Maternal Health

US Abortion Policies and Access

Abortion is a critical component of health care that supports the health and well-being of women and children.²⁰ This indicator is new for *State of Babies Yearbook: 2023*. This indicator categorizes states on a scale of 1-7 from most restrictive to most supportive based on the abortion policies in effect as of the date the data were drawn. These policies are rapidly changing, so the data reported in *State of Babies Yearbook: 2023* may not reflect the most recent policy changes.

Source: Guttmacher Institute (2023). *Interactive Map: US Abortion Policies and Access After Roe*. <https://states.guttmacher.org/policies/>

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 people 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.²¹ In addition to receiving care early, frequency and timing of prenatal care are also important, especially for effective responses to specific maternal risk factors.²²

Data for the *State of Babies Yearbook: 2023* were calculated using data from CDC Wonder. The numerator is the number of births with prenatal care that began during the third trimester of pregnancy or an absence of prenatal care. The denominator is the total number of births for whom timing of prenatal care is known. The total/national average is out of presented states, rather than all states. This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: The included subgroups are non-Hispanic American Indian and Alaska Native, non-Hispanic Asian, non-Hispanic Black, non-Hispanic more than one race, non-Hispanic native Hawaiian or other Pacific islander, non-Hispanic White, and Hispanic of all races. The pregnant person's race was used for the subgroup calculations. Births where the origin of the mother was unknown were included with non-Hispanic births in the CDC Wonder data. *Urbanicity*: CDC Wonder classifies each person as living in a metro or nonmetro area according to 2013 designations. The Metro group includes counties in these Urbanization categories: Large Central Metro, Large Fringe Metro, Medium Metro, and Small Metro. The Nonmetro group includes counties in these Urbanization categories: Micropolitan (non-metro) and noncore (non-metro).

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. (2022). *About Natality, 2016-2021 expanded*. <http://wonder.cdc.gov/natality-expanded-current.html>

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

Maternal mortality can be defined as the death of a parent that takes place during pregnancy, childbirth or post-partum.²³ A parent's death is detrimental to the development of the newborn child and poses a great hardship to the affected household.

This indicator is available at the national level only because the CDC does not suggest comparing state-level estimates. The *State of Babies Yearbook: 2023*, 2022, and 2021 data reflect a new methodology, recently adopted by the CDC (to be called 2018 method), for coding maternal deaths, which 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 2020.

This indicator can be disaggregated by mother's race/ethnicity at the national level only. The only subgroups reported in the source document are non-Hispanic Black, non-Hispanic White, and Hispanic of all races.

Source: Hoyert, DL. (2022). *Maternal mortality rates in the United States, 2020*. NCHS Health E-Stats. <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/e-stat-maternal-mortality-rates-2022.pdf>

Percentage of infants/toddlers whose mothers 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.²⁴ The negative effects of maternal depression can begin prenatally.²⁵ 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.²⁶ Untreated depression in mothers or fathers is also associated with greater risk for delays in cognitive and motor development,²⁷ child maltreatment,²⁸ and neglectful parenting practices.²⁹ Several intervention models are effective in treating parents' depression.³⁰

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 *State of Babies Yearbook: 2023* are based on a five year (2016-2020) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in SoBY 2022, which were based on four years of NSCH data (2016 - 2019); SoBY 2021, which were based on three years of NSCH data (2016-2018); or SoBY 2020, which were based on two years of NSCH data (2016-2017). They should be considered improved estimates, not new estimates that can be compared directly to the 2022, 2021, 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and 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 since these categories are not controlled independently: American Indian and Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. In 2019, the "some other race" race category was removed from the questionnaire. Missing responses were imputed and categorized into existing race groups. *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 2016-2020 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 considered 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). 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). www.childhealthdata.org

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Child and Adolescent Health Measurement Initiative. (2020). 2019 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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2021). 2020 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). www.childhealthdata.org

Accommodations for pregnant workers, protection from job loss

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).³¹ However, despite the PDA of 1978, pregnant workers still found themselves facing workplace discrimination. To combat this, various states have made 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.

The data reflect laws passed by states that require employers to provide protections and accommodations to pregnant workers. These data are as of April 2022, 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 people that were considered "state" or "county" employees. States were classified as having protections for state employees only if the terms "public employers," "state employers," "county," or "municipal employees" were used. "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.

Source: National Partnership for Women and Families. (2022). *Reasonable accommodations for pregnant workers: State and local laws*. <https://national-partnership.org/report/reasonable-accommodations-pregnant-workers/>

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

Regular, periodic well-child visits during the first year of life are 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 guidance³² allows states to include screening for maternal depression as part of a well-child visit, and limited treatment for depressed mothers, within the context of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid program for children.

The National Academy for State Health Policy's website states that the main sources of this policy information are state Medicaid agency websites and provider guidance. Any information not cited by the National Academy for State Health Policy is from communication with the state's Medicaid agency. Information is accurate as of January 2021. This data was not updated for the *State of Babies Yearbook: 2023*, as new data were not yet available.

Source: National Academy for State Health Policy. (2021). *Medicaid policies for maternal depression screening during well-child visits, by state*. Retrieved October 12, 2022, from <https://healthychild.nashp.org/wp-content/uploads/2021/04/Maternal-Depression-Screen-updates-4-1-2021.pdf>

Children's Health

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.³³ 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.³⁴

Data for the *State of Babies Yearbook: 2023* were calculated using data from CDC Wonder. The numerator is the number of infants born preterm, which is defined by the CDC as births completed before 37 completed weeks of gestation. The denominator is the total number of infants whose completed weeks of gestation is known.

This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: CDC Wonder contains very detailed information on the pregnant parent's race/ethnicity. After examining sample sizes, we are presenting the following subgroups: non-Hispanic American Indian and Alaska Native, non-Hispanic Asian, non-Hispanic Black, non-Hispanic more than one race, non-Hispanic native Hawaiian or other Pacific islander, non-Hispanic White, and Hispanic of all races. Births where the origin of the mother was unknown were included with non-Hispanic births in the CDC Wonder data. *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). For the subgroups, the total/national average is out of states whose data is presented for that subgroup, rather than all states.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. (2022). *About Natality, 2016-2021 expanded*. <http://wonder.cdc.gov/natality-expanded-current.html>

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.³⁵ 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.³⁶ 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.

Data for the *State of Babies Yearbook: 2023* were calculated using data from CDC Wonder. The numerator is the number of infants born with low birth weight, which is defined by the CDC as less than 2,500 grams, or 5.5 pounds. The denominator is the total number of infants whose birth weights are known.

This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: CDC Wonder contains very detailed information on the pregnant parent's race/ethnicity. After examining sample sizes, we are presenting the following subgroups: non-Hispanic American Indian and Alaska Native, non-Hispanic Asian, non-Hispanic Black, non-Hispanic more than one race, non-Hispanic Native Hawaiian or other Pacific Islander, non-Hispanic White, and Hispanic of all races. Births where the origin of the mother was unknown were included with non-Hispanic births in the CDC Wonder data. *Urbanicity*: CDC Wonder classifies the pregnant parent as living in a metro (urban) or non-metro (rural) area according to 2013 designations. The metro group includes counties in these categories: large central metro, large fringe metro, medium metro, and small metro. The non-metro group includes counties in these categories: micropolitan (non-metro) and noncore (non-metro). For the subgroups, the total/national average is out of states whose data is presented for that subgroup, rather than all states.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. (2022). About Natality, 2016-2020 expanded. <http://wonder.cdc.gov/natality-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 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).³⁷

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

This indicator can be disaggregated by mother's race/ethnicity. Subgroup data are from 2020. The included subgroups are non-Hispanic White, non-Hispanic Black, non-Hispanic American Indian and Alaska Native, non-Hispanic Asian, and non-Hispanic Native Hawaiian and Pacific Islander. Mother's reported race was used for the subgroup calculations.

Sources: Centers for Disease Control and Prevention, National Center for Health Statistics. (2023). About Linked Birth / Infant Death Records, 2017-2020 Expanded. <https://wonder.cdc.gov/lbd-current-expanded.html>

Ely, D.M. & Driscoll, A.K. (2020). Infant mortality in the United States, 2018: Data from the period linked birth/infant death file. National Vital Statistics Reports, 69(7). <https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-7-508.pdf>

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,³⁸ and can negatively affect child oral health quality of life,³⁹ increase experience of dental pain, and negatively impact school performance.⁴⁰

The denominator is children ages 1-2. The numerator is children ages 1-2 who ever had one or more preventive dental visits. *State of Babies Yearbook: 2023* estimates are based on a five year (2016-2020) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in SoBY 2022, which were based on four years of NSCH data (2016 - 2019), SoBY 2021, which were based on three years of NSCH data (2016-2019), SoBY 2020, which were based on two years of NSCH data (2016-2017), or SoBY 2019, which were based on 2016 NSCH data. They should be considered improved estimates, not new estimates that can be compared directly to the 2022, 2021, 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 since these categories are not controlled independently: American Indian and Alaska Native, Hawaiian or Pacific Islander, and some “Other” and “Two or More Races” categories, so those estimates are not presented. In 2019, the “some other race” race category was removed from the questionnaire. Missing responses were imputed and categorized into existing race groups.

YearbookHousehold 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 2016–2020 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 considered 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). 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). www.childhealthdata.org

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Child and Adolescent Health Measurement Initiative. (2020). 2019 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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2021). 2020 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). 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.⁴¹ Well-child visits also allow medical providers to promote behaviors conducive to healthy development, and to share advice with the parents of infants and toddlers. For example, physician guidance increases the likelihood that parents will read to their child, or that a child will be breastfed.⁴²

The denominator is children ages 0–2. The numerator is children ages 0–2 who had one or more preventive medical visits in the past 12 months. Estimates in the *State of Babies Yearbook: 2023* are based on the 2019–2020 combined National Survey of Children’s Health (NSCH). Item language changed in the 2019 NSCH, restricting comparability to previous years.

This indicator can be disaggregated by 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 2019–2020 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 considered not low-income.

Source: Child and Adolescent Health Measurement Initiative. (2020). 2019 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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2021). 2020 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). www.childhealthdata.org

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 2019. 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. *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 and Alaska Native, Native Hawaiian and 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 2018 Census poverty thresholds. The imputed income-to-poverty ratio is used for the *State of Babies Yearbook: 2023*. 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. (2022). *The 2020 National Immunization Survey – Child* [Dataset]. Centers for Disease Control and Prevention. <https://www.cdc.gov/vaccines/imz-managers/nis/datasets.html>

Children's Mental Health Services

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.⁴³ Families with low incomes may not be able to afford these services unless they are covered by Medicaid. To provide more robust services, state Medicaid plans can cover 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 was not updated for the *State of Babies Yearbook: 2023*. A survey administered by the National Center for Children in Poverty asked participants if the state's Medicaid plan provides coverage for services to address a child's mental health needs provided by an early childhood mental health specialist in early care and education settings, pediatric settings, or family medicine settings. The data reflect policies as of 2018. Georgia's Medicaid only covers mental health services for children ages 4 and above.

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. <https://academiccommons.columbia.edu/doi/10.7916/d8-8rre-9y19>

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.⁴⁴ To fully understand social-emotional development, health care providers should use an instrument that identifies young children at risk of behavioral health problems, specifically, not just a general developmental screening.

This indicator was not updated for the *State of Babies Yearbook: 2023*. A survey administered by The National Center for Children in Poverty asked Medicaid officials if the state's Medicaid plan covers social-emotional screening for children ages 0-6 years with a tool specifically designed for the purpose of identifying young children who may need further evaluation for social-emotional and behavioral difficulties.

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. https://www.nccp.org/wp-content/uploads/2018/11/text_1211.pdf

Strong Families

Basic Needs

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. TANF's reach has declined over the years to the point where, in 2019, 23 of every 100 families living in poverty received any TANF benefits, with access being especially challenging for Black families.⁴⁵

The numerator is the number of TANF families whose youngest child was under 3 for Fiscal Year 2020 (October 2019-September 2020). The denominator is the number of families whose youngest child was under 3 and who lived below 100 percent of the Federal Poverty Line based on estimates from the 2020 - 2022 Current Population Survey (Annual Social and Economic Supplement) which spans March 2019 - February 2022. For the *State of Babies Yearbook:2023* we do not include territories in the national count. We combine 3 years of data for the denominator in order to improve indicator reliability for the *State of Babies Yearbook:2023* and 2022. This should be considered an improved estimate and not a new estimate that can be compared directly to the 2021, 2020, or 2019 yearbook estimates. Values greater than 100 percent are suppressed.

Sources: U.S. Department of Health and Human Services Administration for Children and Families, Office of Family Assistance. (2021). Characteristics and financial circumstances of TANF recipients, fiscal year 2020. [Tables]. <https://www.acf.hhs.gov/ofa/data/characteristics-and-financial-circumstances-tanf-recipients-fiscal-year-2020>

Flood, S., King, M., Rodgers, R., Ruggles, S., Warren, J.R., & Westberry, M. (2022). *Current Population Survey 2021*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

Housing instability (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 and have been linked to adverse health outcomes.⁴⁶ High rates of moving may also be indicative of economic insecurity and parents' tenuous hold on employment.

The denominator is children ages 0-2. The numerator is children ages 0-2 who moved to a new address three or more times since they were born, as reported by parents. *State of Babies Yearbook: 2023* estimates are based on a five year (2016-2020) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in SoBY 2022, which were based on four years of NSCH data (2016 - 2019), SoBY 2021, which were based on three years of NSCH data (2016-2019), SoBY 2020, which were based on two years of NSCH data (2016-2017), or SoBY 2019, which were based on 2016 NSCH data. They should be considered improved estimates, not new estimates that can be compared directly to the 2022, 2021, 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and 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 since these categories are not controlled independently: American Indian and Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races"

categories, so those estimates are not presented. In 2019, the "some other race" race category was removed from the questionnaire. Missing responses were imputed and categorized into existing race groups. *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 2016–2020 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 considered 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). www.childhealthdata.org

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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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2020). 2019 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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2021). 2020 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). 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.⁴⁷ Crowding has also been associated with children's health problems, including respiratory conditions, injuries, and infectious diseases, and with young children's food insecurity.⁴⁸

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

This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: Survey respondents report the infant or toddler's race and ethnicity. Respondents can select one or more of many racial categories or fill in their race. The Census Bureau then assigns each respondent into one of nine categories (American Indian and Alaska Native, Black/African American, Chinese, Japanese, Other Asian or Pacific Islander, Other race, Two major races, Three or more major races, and White). 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. With these categories and ethnicity, we created seven mutually exclusive race/ethnicity categories: Hispanic, Non-Hispanic Asian/PI, Non-Hispanic Black, Non-Hispanic American Indian and Alaska Native, Non-Hispanic Other, Non-Hispanic Multiple Races, and Non-Hispanic White. *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. Non-metropolitan areas are areas outside of metropolitan areas. Cases whose metropolitan status is indeterminable or mixed are excluded from the urbanicity subgroup analysis. We relied on ACS data that do not include estimates for Puerto Rico for the urbanicity indicator subgroups.

Source: Ruggles, S., Flood, S., Sobek, M., Brockman, D., Cooper, G., Richards, S., & Schouweiler, M. (2023). *American Community Survey 2020, five-year estimates*. (IPUMS USA: Version 13.0) [Data set]. <https://doi.org/10.18128/D010.V13.0>

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

Living in neighborhoods that are unsafe can be a source of stress and may pose threats—through violence or pollutants—to physical well-being. Neighborhoods that are unsafe are associated with high rates of infant mortality

and low birthweight, child abuse and neglect, and poor motor and social development among young children.⁴⁹ Parents in these neighborhoods may restrict children's opportunities for outdoor play out of concern for safety.⁵⁰

The denominator is children ages 0-2. The numerator is children ages 0-2 whose parents somewhat or definitely disagree that their children are safe in the neighborhood. *State of Babies Yearbook: 2023* estimates are based on a five year (2016-2020) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in SoBY 2022, which were based on four years of NSCH data (2016 - 2019), SoBY 2021, which were based on three years of NSCH data (2016-2019), SoBY 2020, which were based on two years of NSCH data (2016-2017), or SoBY 2019, which were based on 2016 NSCH data. They should be considered improved estimates, not new estimates that can be compared directly to the 2022, 2021, 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and 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 since these categories are not controlled independently: American Indian and Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. In 2019, the "some other race" race category was removed from the questionnaire. Missing responses were imputed and categorized into existing race groups. *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 2016-2020 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 considered 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). www.childhealthdata.org

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

A lack of sufficient nutritious food is associated with a number of serious health, behavior, and cognitive deficits in children. Children living with food insecurity have poorer health than children who are in food-secure households.⁵¹ Infants who experience food insecurity are more likely to perform poorly on tests of cognitive development.⁵² For infants and toddlers, even mild levels of food insecurity may result in developmental deficits during this period of rapid brain growth.⁵³

The denominator is the number of households with one or more children ages 0-2. The numerator is the number of households with one or more children ages 0-2 who experienced low or very low food security (not child- or adult-specific). This indicator includes three years of data (2018-2020).

This indicator can be disaggregated by race/ethnicity 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 and Alaska Native only,

Asian only, Native Hawaiian or other Pacific Islander only. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, Dominican, Salvadoran, Other Hispanic, Central American (excluding Salvadoran) and South American 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 and Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian and Pacific Islander, and Non-Hispanic two or more races. *Urbanicity*: Metropolitan areas include central cities, metro area outside of central cities, and metro areas with central city status unknown. Non-metropolitan areas are areas outside of metropolitan areas.

Source: Flood, S., King, M., Rodgers, R., Ruggles, S., Warren, J.R. & Westberry, M. (2022). *Current Population Survey*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

Child Well-being and Resilience

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.⁵⁴

The denominator is children ages 0-2. The numerator is children ages 0-2 who live in a family that responded “most of the time” or “all of the time” to all four family resilience items. The 4 family resilience items are: “When your family faces problems, how often are you likely to do each of the following?” (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 to the four items are none of the time, some of the time, most of the time, or all of the time. *State of Babies Yearbook: 2023* estimates are based on a five year (2016-2020) combined sample of the National Survey of Children’s Health (NSCH). These results are more reliable than the results presented in SoBY 2022, which were based on four years of NSCH data (2016 - 2019), SoBY 2021, which were based on three years of NSCH data (2016-2019), SoBY 2020, which were based on two years of NSCH data (2016-2017), or SoBY 2019, which were based on 2016 NSCH data. They should be considered improved estimates, not new estimates that can be compared directly to the 2022, 2021, 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and 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 since these categories are not controlled independently: American Indian and Alaska Native, Hawaiian or Pacific Islander, and some “Other” and “Two or More Races” categories, so those estimates are not presented. In 2019, the “some other race” race category was removed from the questionnaire. Missing responses were imputed and categorized into existing race groups. *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 2016-2020 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 considered 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). www.childhealthdata.org

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Percentage of infants/toddlers who have experienced one adverse childhood experiences: two or more adverse childhood experiences

Exposure to unmanageable stress can interfere with the normal development of the body's neurological, endocrine, and immune systems, leading to increased susceptibility to disease. Because their brains are developing rapidly, infants and toddlers are especially vulnerable, and the damage may be long-lasting.⁵⁵ 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.

The denominator is children ages 0-2. The numerator is children ages 0-2 with whose parent reports one adverse experience or two or more adverse childhood experiences (ACEs), respectively. There are nine ACE items in the survey: 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, or 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 insecurity item was changed in the 2018 NSCH. Data for that item is no longer comparable to earlier versions of the NSCH, however, the composite measure may continue to be compared. *State of Babies Yearbook: 2023* estimates are based on a five year (2016-2020) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in SoBY 2022, which were based on four years of NSCH data (2016 - 2019). They should be considered improved estimates, not new estimates that can be compared directly to the 2022 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 since these categories are not controlled independently: American Indian and Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. Missing responses were imputed and categorized into existing race groups. *YearbookHousehold Income*: The 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 2016-2020 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 considered 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). www.childhealthdata.org

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Child and Adolescent Health Measurement Initiative. (2020). 2019 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). www.childhealthdata.org.

Child and Adolescent Health Measurement Initiative. (2021). 2020 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). www.childhealthdata.org.

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 incidents that are formally substantiated.⁵⁶ 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.”⁵⁷ 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.⁵⁸ Note that the data source for this indicator is reports that are substantiated by the child welfare agency or a court, not actual prevalence of maltreatment.

The numerator is the number of unique maltreatment victims under 1, age 1, and age 2 as reported in the Child Maltreatment 2020 report. The denominator is the total number of children under 1, age 1, and age 2 in 2020, according to the Child Maltreatment 2020 report.

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

Source: U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). *Child Maltreatment 2020*. <https://www.acf.hhs.gov/cb/data-research/child-maltreatment>

Percentage of infants/toddlers exiting foster care achieving permanency who are reunified, placed with guardian, placed with non-guardian relative, or adopted

Young children fare best when they experience stable and consistent caregiving. One stated goal of the child welfare system is to “ensure that every child and youth has a permanent family or family connection.”⁵⁹ Multiple temporary placements, by contrast, can disrupt a young child's sense of trust and security and contribute to emotional and behavioral problems.⁶⁰ This indicator examines the types of permanency that infants and toddlers attain when leaving foster care. The most common permanency outcome is reunification with their own parents. Other types of permanency are placement with a guardian, placement with a relative, and adoption.

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 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 Native Hawaiian/Pacific Islander, Hispanic (of any race), non-Hispanic multi-racial, and non-Hispanic White.

Source: Children's Bureau Administration on Children, Youth and Families. (2021). *Adoption and Foster Care Analysis and Reporting System (AFCARS), Foster Care File 2020, Version 1* [Data set]. National Data Archive on Child Abuse and Neglect (NDACAN). <https://doi.org/10.34681/PGQ6-1Y26>

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.

The denominator is the number of infants and toddlers ages 0-2 in the population. The numerator is the number of infants and toddlers who were removed from home and placed in foster care.

These indicators 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 Native Hawaiian/Pacific Islander, Hispanic (of any race), non-Hispanic multi-racial, and non-Hispanic White.

Sources: Children's Bureau Administration on Children, Youth and Families. (2021). *Adoption and Foster Care Analysis and Reporting System (AFCARS), Foster Care File 2020, Version 1* [Data set]. National Data Archive on Child Abuse and Neglect (NDACAN). <https://doi.org/10.34681/PGQ6-1Y26>

U.S. Census Bureau, Population Division. (2021). *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, 2020 to July 1, 2021*. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-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).⁶¹ Stability and permanency are crucial for children's wellbeing.⁶² The Adoption and Safe Families Act of 1997 (ASFA) was passed to ensure timely permanency and placement for children in the child welfare system, but, the youngest infants stay in foster care longer than their counterparts ages 3-12 months.⁶³

The denominator is all infants and toddlers ages 0-2 who entered care in 2019, and who either left care in 2019 or 2020. The numerator is the number of infants and toddlers in this cohort who exited care in less than 12 months. For the *State of Babies Yearbook: 2023* we updated our methodology to improve the accuracy of the estimates. They should be considered improved estimates, not new estimates that can be compared directly to previous yearbook estimates.

These indicators 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 Native Hawaiian/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), Adoption File 2019, Version 2* [Dataset]. National Data Archive on Child Abuse and Neglect. <https://doi.org/10.34681/te2e-5s03>

Children's Bureau Administration on Children, Youth and Families. (2021). *Adoption and Foster Care Analysis and Reporting System (AFCARS), Foster Care File 2020, Version 1* [Data set]. National Data Archive on Child Abuse and Neglect (NDACAN). <https://doi.org/10.34681/PGQ6-1Y26>

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.⁶⁴ Yet, in most communities, the need for home visiting services far outpaces current capacity.⁶⁵

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 number of children ages 0-2 based on the American Community Survey. The numerator is calculated by multiplying the number of children who received home visiting by the percentage of children who received home visiting who were 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.

Source: National Home Visiting Resource Center. (2022). *2022 Home Visiting Yearbook: State & Tribal profiles*. James Bell Associates and the Urban Institute. https://nhvrc.org/state_profile/alabama-2022/

Supportive Policies

State has a paid family leave program

In the absence of a federal paid family leave policy, states vary widely on if and how they require paid family leave. 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.⁶⁶

The National Partnership for Women and Families (NPWF) produced a table summarizing state paid family and medical leave insurance laws, as of October 2022. States that have enacted a policy, but whose policy has not yet taken effect are counted as having a policy. NPWF references 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.

Source: National Partnership for Women and Families. (2022). *State Paid Family and Medical Leave Insurance Laws*. <https://nationalpartnership.org/economic-justice/state-paid-leave-laws/>

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

While the Family and Medical Leave Act provides *unpaid* sick leave for some employees,⁶⁷ there is not a national paid sick leave policy. States, therefore, vary on provisions for paid sick leave. Paid sick leave may enable working parents to take care of sick children and provide them with routine medical care. For example, parents with access to paid sick leave are more likely to take their children to the doctor than parents without access to paid sick leave.⁶⁸

This indicator documents whether the state has a policy covering paid sick time for the care of family members, including care for children, as reported by the National Partnership for Women and Families. The data reflect laws and policies as of July 2022.

Source: National Partnership for Women and Families. (2022). *Paid sick days: State and district statutes*. <https://nationalpartnership.org/wp-content/uploads/2023/02/paid-sick-days-statutes.pdf>

State offers a child tax credit

The federal Child Tax Credit (CTC) is a federal program for parents with low and moderate earnings.⁶⁹ 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). The CTC helps to pay for the cost of raising children.⁷⁰ 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.⁷¹ Some states have also implemented a child tax credit to complement the federal CTC.

This indicator documents which states have a state child tax credit. Details on states' child tax credits, including their amounts and their eligibility requirements are available in the source document. For the *State of Babies Yearbook: 2023*, we updated the source document in order to report more recently enacted state tax credits. We recoded North Carolina to "yes" to align with previous years of the Yearbook.

Source: National Conference of State Legislatures (2022). *Brief child tax credit overview*. <https://www.ncsl.org/human-services/child-tax-credit-overview>

TANF work exemption for single parents of infants

The Temporary Aid to Needy Families program (TANF) was designed to help families with low incomes with minor children by providing 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.⁷² States can determine exemptions that can be made for single-parent unit households with different household circumstances.

This indicator documents whether a state exempts a single parent “head of unit” over 21 years old from TANF work-related activity if caring for a child less than 12 months old. The source document contains details about lengths and conditions of exemptions. For some states, the exemption is only valid for a single child. Policies are current as of July 2020.

Source: Dehry, I., Knowles, S., Shantz, K., Minton, S., and Giannarelli, L. (2022). *Welfare Rules Databook: State TANF Policies as of July 2020*, OPRE Report 2021-147, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/opre/report/welfare-rules-databook-state-policies-july-2020>

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.⁷³ 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 EITCs provide an additional benefit to families by reducing their state income tax liability.⁷⁴ 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.⁷⁵

For this indicator, states that have enacted a law regarding EITC that has not yet gone into effect are counted as having the policy. Both refundable and non-refundable state EITC policies are included.

Source: Urban Institute. (2022). *State Earned Income Tax Credits*. <https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/state-and-local-backgrounders/state-earned-income-tax-credits>

Positive Early Learning Experiences

Elements that Support Child Care Quality

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

The Child Care Development Fund (CCDF) program requires states to describe their standards for child-to-provider ratios in their CCDF plans. Although each state has the ability to set their own standards for child-to-provider ratios, the Office of the Administration for Children & Families (ACF) advises states to refer to the recommended standards in the *Caring for Our Children: National Health and Safety Performance Standards*. The child-to-provider ratio states the maximum number of children that should be allowed under each adult/provider. Smaller child-to-provider ratios 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.⁷⁶

The Early Head Start (EHS) standard for adult-to-child ratio for children ages 0 to 3 years old is one teacher for every four children.⁷⁷ This indicator is a count of whether the state’s ratio requirements meet or exceed EHS standards of 1:4 at the following ages: 11 months, 19 months, and 30 months, as reported in their CCDF plans. States received one point for meeting this benchmark at each age.

Source: Administration for Children and Families, Office of Child Care. (2022). *Approved CCDF Plans (FY 2022-2024)*. <https://www.acf.hhs.gov/occ/form/approved-ccdf-plans-fy-2022-2024>

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

One of the most important factors contributing to a child's development is the care setting they are exposed to. The Child Care and Development Fund (CCDF) program requires states to develop a system for continuing professional development for teachers. Additionally, each state sets its own requirements around teacher qualifications. Teacher qualifications play a role in early childhood education quality and can help bring about the conditions for the positive interactions and experiences that are associated with positive child outcomes.⁷⁸

This indicator documents the states' teacher qualifications for infants and toddlers, as reported in their CCDF plans. We classified qualifications into five categories: No credential beyond a high school diploma; CDA or state equivalent credential; Specific infant/toddler credential or CDA with an infant/toddler credential; Associate degree; and Bachelor's degree. Most states did not differentiate requirements by age within infants and toddlers. When requirements did vary by age, we selected the lowest qualifications. If the state made a distinction between types of teachers, qualifications for the lead teacher were used. For the *State of Babies Yearbook: 2023*, we re-assessed the coding for Florida, although the wording in the new CCDF plan was identical to the old plan.

Source: Administration for Children and Families, Office of Child Care. (2022). *Approved CCDF Plans (FY 2022-2024)*. <https://www.acf.hhs.gov/occ/form/approved-ccdf-plans-fy-2022-2024>

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

The Child Care Development Fund (CCDF) program 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.⁷⁹

The Early Head Start (EHS) standard for group size for children ages 0 to 3 years old is eight children.⁸⁰ 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.

Source: Administration for Children and Families, Office of Child Care. (2022). *Approved CCDF Plans (FY 2022-2024)*. <https://www.acf.hhs.gov/occ/form/approved-ccdf-plans-fy-2022-2024>

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.⁸¹

This indicator was not updated for the *State of Babies Yearbook: 2023*. This indicator denotes whether a state has adopted a professional credential for infant and toddler teachers. There is not a consensus definition of 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. <https://www.zerotothree.org/resource/state-policy-tracker/>

Activities that Support Early Learning

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

Long before they are able to read, infants and toddlers develop literacy skills and an awareness of language.⁸² 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.⁸³ 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.⁸⁴

The denominator is children ages 0-2. The numerator is children ages 0-2 whose family members report reading to them every day. *State of Babies Yearbook: 2023* estimates are based on a five year (2016-2020) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in SoBY 2022, which were based on four years of NSCH data (2016 - 2019), SoBY 2021, which were based on three years of NSCH data (2016-2019), SoBY 2020, which were based on two years of NSCH data (2016-2017), or SoBY 2019, which were based on 2016 NSCH data. They should be considered improved estimates, not new estimates that can be compared directly to the 2022, 2021, 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and 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 since these categories are not controlled independently: American Indian and Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. In 2019, the "some other race" race category was removed from the questionnaire. Missing responses were imputed and categorized into existing race groups. *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 2016-2020 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 considered 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). www.childhealthdata.org

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

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

The denominator is children ages 0-2. The numerator is children ages 0-2 whose family members report singing or telling stories to them every day. *State of Babies Yearbook: 2023* estimates are based on a five year (2016-2020) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in SoBY 2022, which were based on four years of NSCH data (2016 - 2019), SoBY 2021, which were based on three years of NSCH data (2016-2019), SoBY 2020, which were based on two years of NSCH data (2016-2017), or SoBY 2019, which were based on 2016 NSCH data. They should be considered improved estimates, not new estimates that can be compared directly to the 2022, 2021, 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and 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 since these categories are not controlled independently: American Indian and Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. In 2019, the "some other race" race category was removed from the questionnaire. Missing responses were imputed and categorized into existing race groups. *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 2016–2020 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 considered 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). 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). 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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2020). 2019 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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2021). 2020 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). www.childhealthdata.org

Access to Early Learning Programs

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 families experiencing poverty. 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.^{85,86} 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.⁸⁷

This indicator was not updated for *State of Babies Yearbook: 2023*. The National Head Start Association reports the percentage of eligible children ages 0–2 who had access to Early Head Start during the 2018 fiscal year. Due to the pandemic, more recent data are not available. 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. (2021). *Access to Head Start in the United States state-by-state fact sheets*. Retrieved October 22, 2022, from <https://www.nhsa.org/national-head-start-fact-sheets>

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 child care without sacrificing other essentials.⁸⁸

The National Women's Law Center reports the income eligibility limits for a child care subsidy as a percentage of the 2021 federal poverty level for a family of three. The data source reflects policies as of February 2021. We recoded these data to capture eligibility limits that are equal to or above 200 percent of the federal poverty level. In Colorado, Texas, and Virginia, counties set their income limits and the median eligibility limit depending on the different regions, so it is not possible to compute this indicator for these states.

Source: Schulman, K. (2022). *At the Crossroads: State Child Care Assistance Policies 2021*. National Women's Law Center. <https://nwlc.org/wp-content/uploads/2022/06/NWLC-State-Child-Care-Assistance-Policies-2021.pdf>

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

Higher-quality child care and early education has been found to benefit low-income children in promoting positive child development outcomes to a greater extent than their more affluent peers.⁸⁹ In response to federal efforts to expand high-quality child care to more children, some states have begun to reimburse center-based child care for children receiving a child care subsidy 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 using a child care subsidy. Additionally, higher reimbursement rates allow providers to serve more families receiving a subsidy, since the cost for serving those families is covered.⁹⁰

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.

Source: Schulman, K. (2022). *At the Crossroads: State Child Care Assistance Policies 2021*. National Women's Law Center. <https://nwlc.org/resource/at-the-crossroads-state-child-care-assistance-policies-2021/>

Percentage 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. Within broad federal requirements, 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.⁹¹ This indicator captures the reach of these child care subsidies among families with incomes equal to or less than 150 percent of the state median income within states.

The denominator is the number of children ages 0–2 with family incomes less than or equal to 150 percent of the state median income. In order to calculate the denominator, we took the following steps: a) obtained the state median incomes for 4-person families by state from the Low-Income Home Energy Assistance Information Memorandum; b) multiplied those numbers by 1.5 to get 150 percent 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 Low-Income Home Energy Assistance Information Memorandum; d) applied the relevant state median income threshold to each respondent in the 2021 1-year American Community Survey (ACS), based on their state and family size. The denominator covers January 2020 – December 2021. The numerator is the number of children ages 0–2 who received CCDF-funded care in FY 2020 based on estimates from the Administration for Children and Families Office of Child Care (October 2019 – September 2020). When data were accessed Georgia had not yet reported data for FY 2020, while Alaska had submitted 10 months of data, Mississippi had submitted 11 months data, North Carolina had submitted 8 months data, and Ohio had submitted 10 months of data. For the *State of Babies Yearbook: 2023* we do not include territories in the national count.

Sources: Administration for Children and Families, Office of Child Care. (2022). *FY 2020 CCDF Data Tables (Preliminary)*. <https://www.acf.hhs.gov/occl/data/fy-2020-ccdf-data-tables-preliminary>

Administration for Children and Families, Office of Community Services. (2021). *The Low-Income Home Energy Assistance Program IM-2021-03 State Median Income Estimates for Optional Use in FY 2021*. <https://www.acf.hhs.gov/ocs/policy-guidance/liheap-im-2021-03-state-median-income-estimates-optional-use-fy-2021>

Ruggles, S., Flood, S., Sobek, M., Brockman, D., Cooper, G., Richards, S., and Schouweiler, M. (2023). *American Community Survey 2021, one-year estimates*. (IPUMS USA: Version 13.0) [Data set]. <https://doi.org/10.18128/D010.V13.0>

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.⁹² The federal standard is that families should spend no more than 7 percent of their income for child care.⁹³

This indicator was not updated for *State of Babies Yearbook: 2023*. Data were provided by Child Care Aware of America, based on their 2021 survey, through a data request process. In the calculation of cost of care for married parent families, the denominator is the median income for married parent families, the numerator is the 2020 annual cost of center-based infant care, and percentages. In the calculation of cost of care for single parent families, the denominator is the median income for single parent families, the numerator is the 2020 annual cost of center-based infant care, and percentages.

Source: Child Care Aware of America. (2021). *Child Care Prices as a Percentage of Median Household Income, 2020*. Retrieved July 23, 2021, from <https://www.childcareaware.org/our-issues/research/the-us-and-the-high-price-of-child-care-2019/>

Early Intervention

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.⁹⁴ Children who get screened are more likely to have delays identified, be referred for early intervention, and be determined eligible for early intervention services.⁹⁵ The American Academy of Pediatrics recommends that children receive developmental screening from their physicians at least three times before their third birthday.⁹⁶

The denominator is children ages 9 through 35 months. The numerator is children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year, as reported by parents. *State of Babies Yearbook: 2023* estimates are based on a five year (2016-2020) combined sample of the National Survey of Children's Health (NSCH). These results are more reliable than the results presented in SoBY 2022, which were based on four years of NSCH data (2016 - 2019), SoBY 2021, which were based on three years of NSCH data (2016-2019), SoBY 2020, which were based on two years of NSCH data (2016-2017), or SoBY 2019, which were based on 2016 NSCH data. They should be considered improved estimates, not new estimates that can be compared directly to the 2022, 2021, 2020 or 2019 yearbook estimates.

This indicator can be disaggregated by race/ethnicity and 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 since these categories are not controlled independently: American Indian and Alaska Native, Hawaiian or Pacific Islander, and some "Other" and "Two or More Races" categories, so those estimates are not presented. In 2019, the "some other race" race category was removed from the questionnaire. Missing responses were imputed and categorized into existing race groups. *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 2016-2020 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 considered 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). 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). 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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2020). 2019 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). www.childhealthdata.org

Child and Adolescent Health Measurement Initiative. (2021). 2020 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). www.childhealthdata.org

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 program that aids states' provision of early intervention services for infants and toddlers with disabilities, ages birth through 2 years.⁹⁷

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.⁹⁸ 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.

States reported whether their Part C eligibility criteria include "at-risk" children as eligible for IDEA Part C services and whether they serve "at-risk" children in their Annual Progress Reports. Section 618 data was used to cross-check whether states' eligibility criteria include "at-risk" children.

Sources: The Office of Special Education Programs (OSEP). (2022). *2022 SPP/APR and State Determination Letters PART C*. <https://sites.ed.gov/idea/spp-apr-letters>

U.S. Department of Education. (2022). *IDEA Section 618 Data Products: State Level data files: Part C: 2020-2021 Child Count and Settings*. <https://www2.ed.gov/programs/osepidea/618-data/state-level-data-files/index.html#cccs>

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.⁹⁹ 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 0-2 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 number of children ages 0-2 in the population.

Source: U.S. Department of Education. (2021). *IDEA Section 618 Data Products: Static tables. Part C Child Count and Settings*. <https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html>

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 documents the child's level of development, desired outcomes, and services to meet those goals. It 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.¹⁰⁰

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.¹⁰¹

The denominator is the number of eligible infants and toddlers evaluated and assessed for whom an initial IFSP meeting was required to be conducted. The numerator is the number of eligible infants and toddlers with IFSPs for whom an initial evaluation and assessment and an initial IFSP meeting was conducted within Part C's 45-day timeline. Infants and toddlers whose services were delayed due to exceptional family circumstances are counted as meeting the 45-day timeline.

Source: The Office of Special Education Programs. (OSEP) (2022). *2022 SPP/APR and State Determination Letters PART C*. <https://sites.ed.gov/idea/spp-apr-letters>

Demographics

Number of infants/toddlers

We use vintage 2021 population estimates for the number of infants and toddlers in the United States. The estimates are based on the 2020 Census; the Census Bureau adds births, subtracts deaths, and adds net migration to the enumerated resident population from the 2020 Census.

Source: U.S. Census Bureau, Population Division. (2021). *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, 2020 to July 1, 2021*. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-state-detail.html>

Percentage of infant/toddler population

The denominator is the total population of all ages, based on the Census Bureau's vintage 2021 population estimates. The numerator is the population ages 0-2. The estimates are based on the 2020 Census; the Census Bureau adds births, subtracts deaths, and adds net migration to the enumerated resident population from the 2020 Census.

Source: U.S. Census Bureau, Population Division. (2021). *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, 2020 to July 1, 2021*. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-state-detail.html>

Percentage of infants/toddlers who are Hispanic

The denominator is the total population of all ages, based on the Census Bureau's vintage 2021 population estimates. The numerator is the Hispanic population ages 0-2. The estimates are based on the 2020 Census; the Census Bureau adds births, subtracts deaths, and adds net migration to the enumerated resident population from the 2020 Census.

Source: U.S. Census Bureau, Population Division. (2021). *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, 2020 to July 1, 2021*. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-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 2021 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. The estimates are based on the 2020 Census; the Census Bureau adds births, subtracts deaths, and adds net migration to the enumerated resident population from the 2020 Census.

Source: U.S. Census Bureau, Population Division. (2021). *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, 2020 to July 1, 2021*. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-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 2021 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. The estimates are based on the 2020 Census; the Census Bureau adds births, subtracts deaths, and adds net migration to the enumerated resident population from the 2020 Census.

Source: U.S. Census Bureau, Population Division. (2021). 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, 2020 to July 1, 2021. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-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 2021 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. The estimates are based on the 2020 Census; the Census Bureau adds births, subtracts deaths, and adds net migration to the enumerated resident population from the 2020 Census.

Source: U.S. Census Bureau, Population Division. (2021). 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, 2020 to July 1, 2021. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-state-detail.html>

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

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2021 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. The estimates are based on the 2020 Census; the Census Bureau adds births, subtracts deaths, and adds net migration to the enumerated resident population from the 2020 Census.

Source: U.S. Census Bureau, Population Division. (2021). 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, 2020 to July 1, 2021. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-state-detail.html>

Percentage of infants/toddlers who are Hispanic American Indian and Alaska Native

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2021 population estimates. The numerator is the 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. The estimates are based on the 2020 Census; the Census Bureau adds births, subtracts deaths, and adds net migration to the enumerated resident population from the 2020 Census.

Source: U.S. Census Bureau, Population Division. (2021). 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, 2020 to July 1, 2021. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-state-detail.html>

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

The denominator is the total population ages 0-2, based on the Census Bureau's vintage 2021 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. The estimates are based on the 2020 Census; the Census Bureau adds births, subtracts deaths, and adds net migration to the enumerated resident population from the 2020 Census.

Source: U.S. Census Bureau, Population Division. (2021). 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, 2020 to July 1, 2021. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-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 2021 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. The estimates are based on the 2020 Census; the Census Bureau adds births, subtracts deaths, and adds net migration to the enumerated resident population from the 2020 Census.

Source: U.S. Census Bureau, Population Division. (2021). 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, 2020 to July 1, 2021. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-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 and Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, Dominican, Salvadoran, Other Hispanic, Central American (excluding Salvadoran) and South American 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 and Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian and Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March Annual Social and Economic (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 areas 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., Warren, J.R., & Westberry, M. (2022). *Current Population Survey 2021*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

Percentage of infants/toddlers living in one-parent families

The denominator is the total number of children ages 0-2. The numerator is the number of children ages 0-2 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 and Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, Dominican, Salvadoran, Other Hispanic, Central American (excluding Salvadoran) and South American 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 and Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian and Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March Annual Social and Economic (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 areas 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., Warren, J.R., & Westberry, M. (2022). *Current Population Survey 2021*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

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 and Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, Dominican, Salvadoran, Other Hispanic, Central American (excluding Salvadoran) and South American 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 and Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian and Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March Annual Social and Economic (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 areas 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., Warren, J.R., & Westberry, M. (2022). *Current Population Survey 2021*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

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 and Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, Dominican, Salvadoran, Other Hispanic, Central American (excluding Salvadoran) and South American 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 and Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian and Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March Annual Social and Economic (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 areas 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., Warren, J.R., & Westberry, M. (2022). *Current Population Survey 2021*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

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. Mothers are all age 16 or older.

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 of two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian and Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, Dominican, Salvadoran, Other Hispanic, Central American (excluding Salvadoran) and South American 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 and Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian and Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March Annual Social and Economic (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 areas 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., Warren, J.R., & Westberry, M. (2022). *Current Population Survey 2021*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

Percentage of infants/toddlers who live with no working parents

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 to qualify as living with disconnected parents. We combined three years of data (2020-2022) to increase the reliability of the estimates, and used weights adjusted to account for non-random non-response related to COVID-19.

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 of two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian and Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, Dominican, Salvadoran, Other Hispanic, Central American (excluding Salvadoran) and South American 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 and Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian and Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March Annual Social and Economic (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 areas 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., Warren, J.R., & Westberry, M. (2022). *Current Population Survey 2021*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

Percentage of infants/toddlers below the poverty line who live with no working parents

The denominator is the total number of children ages 0-2 below the poverty line who live with at least one parent. The numerator is the number of children ages 0-2 below the poverty line 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 to qualify as living

with disconnected parents. We combined three years of data (2020-2022) to increase the reliability of the estimates, and used weights adjusted to account for non-random non-response related to COVID-19.

This indicator can be disaggregated by race/ethnicity 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 of two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian and Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, Dominican, Salvadoran, Other Hispanic, Central American (excluding Salvadoran) and South American 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 and Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian and Pacific Islander, and Non-Hispanic two or more races. *Urbanicity*: Metropolitan (urban) areas include central cities, metro areas 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., Warren, J.R., & Westberry, M. (2022). *Current Population Survey 2021*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

Percentage of infants/toddlers who live with at least one parent working full time

This is a new indicator for the *State of Babies Yearbook: 2023*. 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 at least one parent who works full-time (at least 35 hours a week, 50-52 weeks a year). We combined three years of data (2020-2022) to increase the reliability of the estimates, and used weights adjusted to account for non-random non-response related to COVID-19.

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 of two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian and Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. Ethnicity is asked as a separate question. Responses of Mexican, Puerto Rican, Cuban, Dominican, Salvadoran, Other Hispanic, Central American (excluding Salvadoran) and South American 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 and Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian and Pacific Islander, and Non-Hispanic two or more races. *Income*: Income is asked only on the March Annual Social and Economic (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 areas 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., Warren, J.R., & Westberry, M. (2022). *Current Population Survey 2021*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

Percentage of infants/toddlers below the poverty line who live with at least one parent working full time

This is a new indicator for the *State of Babies Yearbook: 2023*. The denominator is the total number of children ages 0-2 below the poverty line who live with at least one parent. The numerator is the number of children ages 0-2 below the poverty line who live with at least one parent who works full-time (at least 35 hours a week, 50-52 weeks a year). We combined three years of data (2020-2022) to increase the reliability of the estimates, and used weights adjusted to account for non-random non-response related to COVID-19.

This indicator can be disaggregated by race/ethnicity 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 of two or three categories and unspecified combinations of the races: White only, Black or African American only, American Indian and Alaska Native only, Asian only, Native Hawaiian or other Pacific Islander only. Ethnicity is asked as a separate question. Responses of

Mexican, Puerto Rican, Cuban, Dominican, Salvadoran, Other Hispanic, Central American (excluding Salvadoran) and South American 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 and Alaska Native, Non-Hispanic Asian, Non-Hispanic Hawaiian and Pacific Islander, and Non-Hispanic two or more races. *Urbanicity*: Metropolitan (urban) areas include central cities, metro areas 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., Warren, J.R., & Westberry, M. (2022). *Current Population Survey 2021*. (IPUMS, Current Population Survey: Version 10.0) [Dataset]. IPUMS. <https://doi.org/10.18128/D030.V10.0>

Percentage of infants/toddlers living below 50 percent of the federal poverty line

This is a new indication for the *State of Babies Yearbook: 2023*. The denominator is the total number of children ages 0-2. The numerator is the number of children ages 0-2 who live below 50 percent of the federal poverty line. For the *State of Babies Yearbook: 2023* we report estimates using the 2021 ACS 1-year data because the Census Bureau did not release its standard 2020 ACS 1-year estimates due to the effects of the COVID-19 pandemic.

This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: Survey respondents report the infant or toddler's race and ethnicity. Respondents can select one or more of many racial categories or fill in their race. The Census Bureau then assigns each respondent into one of 9 categories (American Indian and Alaska Native, Black/African American, Chinese, Japanese, Other Asian or Pacific Islander, Other race, Two major races, Three or more major races, and White). 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. With these categories and ethnicity, we create the following mutually exclusive race/ethnicity categories: Hispanic, Non-Hispanic Asian/PI, Non-Hispanic Black, Non-Hispanic American Indian and Alaska Native, Non-Hispanic Other, Non-Hispanic Multiple Races, and Non-Hispanic White. *Urbanicity*: Metropolitan areas include central/principal cities, metro areas outside of central/principal cities, and metro areas with central/principal city status indeterminable. Non-metropolitan areas are areas outside of metropolitan areas. Cases whose metropolitan status is indeterminable or mixed are excluded from the urbanicity subgroup analysis. We relied on ACS data from 2021 that do not include estimates for Puerto Rico for the urbanicity indicator. Puerto Rico is not included in the urbanicity subgroup analysis for indicators derived from the Puerto Rico Community Survey.

Source: Ruggles, S., Flood, S., Sobek, M., Brockman, D., Cooper, G., Richards, S. & Schouweiler, M. (2023). *American Community Survey 2021, one-year estimates*. (IPUMS USA: Version 13.0) [Data set]. <https://doi.org/10.18128/D010.V13.0>

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 the number of children ages 0-2 who live below 100 percent of the federal poverty line. For the *State of Babies Yearbook: 2023* we report estimates using the 2021 ACS 1-year data because the Census Bureau did not release its standard 2020 ACS 1-year estimates due to the effects of the COVID-19 pandemic.

This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: Survey respondents report the infant or toddler's race and ethnicity. Respondents can select one or more of many racial categories or fill in their race. The Census Bureau then assigns each respondent into one of 9 categories (American Indian and Alaska Native, Black/African American, Chinese, Japanese, Other Asian or Pacific Islander, Other race, Two major races, Three or more major races, and White). 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. With these categories and ethnicity, we create the following mutually exclusive race/ethnicity categories: Hispanic, Non-Hispanic Asian/PI, Non-Hispanic Black, Non-Hispanic American Indian and Alaska Native, Non-Hispanic Other, Non-Hispanic Multiple Races, and Non-Hispanic White. *Urbanicity*: Metropolitan areas include central/principal cities, metro areas outside of central/principal cities, and metro areas with central/principal city status indeterminable. Non-metropolitan areas are areas outside of metropolitan areas. Cases whose metropolitan status is indeterminable or mixed are excluded from the urbanicity subgroup analysis. We relied on ACS data from 2021 that do not include estimates for Puerto Rico for the urbanicity indicator. Puerto Rico is not included in the urbanicity subgroup analysis for indicators derived from the Puerto Rico Community Survey.

Source: Ruggles, S., Flood, S., Sobek, M., Brockman, D., Cooper, G., Richards, S. & Schouweiler, M. (2023). *American Community Survey 2021, one-year estimates*. (IPUMS USA: Version 13.0) [Data set]. <https://doi.org/10.18128/D010.V13.0>

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 the number of children ages 0-2 who live at or above 100 percent and below 200 percent of the federal poverty line. For the *State of Babies Yearbook: 2023* we report estimates using the 2021 ACS 1-year data because the Census Bureau did not release its standard 2020 ACS 1-year estimates due to the effects of the COVID-19 pandemic.

This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: Survey respondents report the infant or toddler's race and ethnicity. Respondents can select one or more of many racial categories or fill in their race. The Census Bureau then assigns each respondent into one of 9 categories (American Indian and Alaska Native, Black/African American, Chinese, Japanese, Other Asian or Pacific Islander, Other race, Two major races, Three or more major races, and White). 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. With these categories and ethnicity, we create the following mutually exclusive race/ethnicity categories: Hispanic, Non-Hispanic Asian/PI, Non-Hispanic Black, Non-Hispanic American Indian and Alaska Native, Non-Hispanic Other, Non-Hispanic Multiple Races, and Non-Hispanic White. *Urbanicity*: Metropolitan areas include central/principal cities, metro areas outside of central/principal cities, and metro areas with central/principal city status indeterminable. Non-metropolitan areas are areas outside of metropolitan areas. Cases whose metropolitan status is indeterminable or mixed are excluded from the urbanicity subgroup analysis. We relied on ACS data from 2021 that do not include estimates for Puerto Rico for the urbanicity indicator. Puerto Rico is not included in the urbanicity subgroup analysis for indicators derived from the Puerto Rico Community Survey.

Source: Ruggles, S., Flood, S., Sobek, M., Brockman, D., Cooper, G., Richards, S. & Schouweiler, M. (2023). *American Community Survey 2021, one-year estimates*. (IPUMS USA: Version 13.0) [Data set]. <https://doi.org/10.18128/D010.V13.0>

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 the number of children ages 0-2 who live at or above 200 percent of the federal poverty line. For the *State of Babies Yearbook: 2023* we report estimates using the 2021 ACS 1-year data because the Census Bureau did not release its standard 2020 ACS 1-year estimates due to the effects of the COVID-19 pandemic.

This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: Survey respondents report the infant or toddler's race and ethnicity. Respondents can select one or more of many racial categories or fill in their race. The Census Bureau then assigns each respondent into one of 9 categories (American Indian and Alaska Native, Black/African American, Chinese, Japanese, Other Asian or Pacific Islander, Other race, Two major races, Three or more major races, and White). 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. With these categories and ethnicity, we create the following mutually exclusive race/ethnicity categories: Hispanic, Non-Hispanic Asian/PI, Non-Hispanic Black, Non-Hispanic American Indian and Alaska Native, Non-Hispanic Other, Non-Hispanic Multiple Races, and Non-Hispanic White. *Urbanicity*: Metropolitan areas include central/principal cities, metro areas outside of central/principal cities, and metro areas with central/principal city status indeterminable. Non-metropolitan areas are areas outside of metropolitan areas. Cases whose metropolitan status is indeterminable or mixed are excluded from the urbanicity subgroup analysis. We relied on ACS data from 2021 that do not include estimates for Puerto Rico for the urbanicity indicator. Puerto Rico is not included in the urbanicity subgroup analysis for indicators derived from the Puerto Rico Community Survey.

Source: Ruggles, S., Flood, S., Sobek, M., Brockman, D., Cooper, G., Richards, S. & Schouweiler, M. (2023). *American Community Survey 2021, one-year estimates*. (IPUMS USA: Version 13.0) [Data set]. <https://doi.org/10.18128/D010.V13.0>

Percentage of infants/toddlers living in families with incomes below 150 percent of state median income

The denominator is the total number of children ages 0-2. The numerator is the number of children ages 0-2 with family incomes less than or equal to 150 percent of the state median income. In order to calculate the numerator, we took the following steps: a) obtained the state median incomes for 4-person families by state from the Low-Income Home Energy Assistance Information Memorandum; 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 Low-Income Home Energy Assistance Information Memorandum; d) applied the relevant state median income threshold to each respondent in the 2021 1-year American Community Survey (ACS), based on their state and family size; and e) counted respondents whose family income was less than or equal to the 150 percent state median income threshold.

This indicator can be disaggregated by race/ethnicity and urbanicity. *Race/ethnicity*: Survey respondents report the infant or toddler's race and ethnicity. Respondents can select one or more of many racial categories or fill in their race. The Census Bureau then assigns each respondent into one of 9 categories (American Indian and Alaska Native, Black/African American, Chinese, Japanese, Other Asian or Pacific Islander, Other race, Two major races, Three or more major races, and White). 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. With these categories and ethnicity, we create the following mutually exclusive race/ethnicity categories: Hispanic, Non-Hispanic Asian/PI, Non-Hispanic Black, Non-Hispanic American Indian and Alaska Native, Non-Hispanic Other, Non-Hispanic Multiple Races, and Non-Hispanic White. *Urbanicity*: Metropolitan areas include central/principal cities, metro areas outside of central/principal cities, and metro areas with central/principal city status indeterminable. Non-metropolitan areas are areas outside of metropolitan areas. Cases whose metropolitan status is indeterminable or mixed are excluded from the urbanicity subgroup analysis. We relied on ACS data from 2021 that do not include estimates for Puerto Rico for the urbanicity indicator. Puerto Rico is not included in the urbanicity subgroup analysis for indicators derived from the Puerto Rico Community Survey.

Source: Ruggles, S., Flood, S., Sobek, M., Brockman, D., Cooper, G., Richards, S. & Schouweiler, M. (2023). *American Community Survey 2021, one-year estimates*. (IPUMS USA: Version 13.0) [Data set]. <https://doi.org/10.18128/D010.V13.0>

Administration for Children and Families, Office of Community Services. (2021). *The Low-Income Home Energy Assistance Program IM 2020-3 state median income estimates for optional use in FY 2020 and mandatory use in FY 2021*. <https://www.acf.hhs.gov/ocs/policy-guidance/liheap-im-2021-03-state-median-income-estimates-optional-use-fy-2021>

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. Metropolitan areas include central/principal cities, metro areas outside of central/principal cities, and metro areas with central/principal city status indeterminable. Non-metropolitan areas are areas outside of metropolitan areas. Cases whose metropolitan status is indeterminable or mixed are excluded from the urbanicity subgroup analysis. For the *State of Babies Yearbook: 2023* we report estimates using the 2021 ACS 1-year data because the Census Bureau did not release its standard 2020 ACS 1-year estimates due to the effects of the COVID-19 pandemic.

Source: Ruggles, S., Flood, S., Sobek, M., Brockman, D., Cooper, G., Richards, S. & Schouweiler, M. (2023). *American Community Survey 2021, one-year estimates*. (IPUMS USA: Version 13.0) [Data set]. <https://doi.org/10.18128/D010.V13.0>

Endnotes

- 1 This is called ICHIA. For more information, see <https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/view/print?activeTab=map¤tTimeframe=0&selectedDistributions=lawfully-residing-immigrant-children-covered-without-5-year-wait-ichia-option&print=true&selectedRows=percent7Bpercent22statespercent22:percent7Bpercent22tennesseepersent22:percent7Bpercent22percent7Dpercent7D&sortModel=percent7Bpercent22colldpercent22:percent22Locationpercent22:percent22sortpercent22:percent22ascpercent22percent7D>
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Appendix F

State Median Income (SMI) by Household Size for Optional Use in FY 2021 and Mandatory Use in LIHEAP for FFY 2022

| Geographic Level ¹ | SMI for 4-Person Family ² | 60 Percent SMI for 1-Person HHld* | 60 Percent SMI for 2-Person HHld* | 60 Percent SMI for 3-Person HHld* | 60 Percent SMI for 4-Person HHld* ³ | 60 Percent SMI for 5-Person HHld* | 60 Percent SMI for 6-Person HHld* |
|-------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|--|-----------------------------------|-----------------------------------|
| Alabama | \$80,762 | \$25,198 | \$32,951 | \$40,704 | \$48,457 | \$56,210 | \$63,963 |
| Alaska | \$104,070 | \$32,470 | \$42,461 | \$52,451 | \$62,442 | \$72,433 | \$82,423 |
| Arizona | \$82,227 | \$25,655 | \$33,548 | \$41,442 | \$49,336 | \$57,230 | \$65,124 |
| Arkansas | \$71,485 | \$22,303 | \$29,166 | \$36,028 | \$42,891 | \$49,754 | \$56,616 |
| California | \$98,644 | \$30,777 | \$40,246 | \$49,716 | \$59,186 | \$68,656 | \$78,126 |
| Colorado | \$106,120 | \$33,109 | \$43,297 | \$53,484 | \$63,672 | \$73,860 | \$84,047 |
| Connecticut | \$125,087 | \$39,027 | \$51,035 | \$63,044 | \$75,052 | \$87,060 | \$99,069 |
| Delaware | \$103,900 | \$32,417 | \$42,391 | \$52,366 | \$62,340 | \$72,314 | \$82,289 |
| District of Columbia | \$137,563 | \$42,920 | \$56,126 | \$69,332 | \$82,538 | \$95,744 | \$108,950 |
| Florida | \$81,077 | \$25,296 | \$33,079 | \$40,863 | \$48,646 | \$56,429 | \$64,213 |
| Georgia | \$84,851 | \$26,474 | \$34,619 | \$42,765 | \$50,911 | \$59,057 | \$67,203 |
| Hawaii | \$108,498 | \$33,851 | \$44,267 | \$54,683 | \$65,099 | \$75,515 | \$85,931 |
| Idaho | \$79,820 | \$24,904 | \$32,567 | \$40,229 | \$47,892 | \$55,555 | \$63,217 |
| Illinois | \$102,167 | \$31,876 | \$41,684 | \$51,492 | \$61,300 | \$71,108 | \$80,916 |
| Indiana | \$86,578 | \$27,012 | \$35,324 | \$43,635 | \$51,947 | \$60,259 | \$68,570 |
| Iowa | \$94,221 | \$29,397 | \$38,442 | \$47,488 | \$56,533 | \$65,578 | \$74,624 |
| Kansas | \$90,284 | \$28,168 | \$36,836 | \$45,503 | \$54,170 | \$62,837 | \$71,504 |
| Kentucky | \$80,407 | \$25,087 | \$32,806 | \$40,525 | \$48,244 | \$55,963 | \$63,682 |
| Louisiana | \$81,779 | \$25,515 | \$33,366 | \$41,216 | \$49,067 | \$56,918 | \$64,768 |
| Maine | \$93,560 | \$29,191 | \$38,172 | \$47,154 | \$56,136 | \$65,118 | \$74,100 |
| Maryland | \$124,807 | \$38,940 | \$50,921 | \$62,903 | \$74,884 | \$86,865 | \$98,847 |
| Massachusetts | \$131,252 | \$40,951 | \$53,551 | \$66,151 | \$78,751 | \$91,351 | \$103,951 |
| Michigan | \$93,492 | \$29,169 | \$38,145 | \$47,120 | \$56,095 | \$65,070 | \$74,045 |
| Minnesota | \$112,942 | \$35,238 | \$46,080 | \$56,923 | \$67,765 | \$78,607 | \$89,450 |
| Mississippi | \$68,871 | \$21,488 | \$28,100 | \$34,711 | \$41,323 | \$47,935 | \$54,546 |
| Missouri | \$88,519 | \$27,618 | \$36,115 | \$44,613 | \$53,111 | \$61,609 | \$70,107 |

| Geographic Level ¹ | SMI for 4-Person Family ² | 60 Percent SMI for 1-Person HHld* | 60 Percent SMI for 2-Person HHld* | 60 Percent SMI for 3-Person HHld* | 60 Percent SMI for 4-Person HHld* ³ | 60 Percent SMI for 5-Person HHld* | 60 Percent SMI for 6-Person HHld* |
|-------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|--|-----------------------------------|-----------------------------------|
| Montana | \$87,442 | \$27,282 | \$35,676 | \$44,071 | \$52,465 | \$60,859 | \$69,254 |
| Nebraska | \$93,660 | \$29,222 | \$38,213 | \$47,205 | \$56,196 | \$65,187 | \$74,179 |
| Nevada | \$82,509 | \$25,743 | \$33,663 | \$41,584 | \$49,505 | \$57,426 | \$65,347 |
| New Hampshire | \$120,821 | \$37,696 | \$49,295 | \$60,894 | \$72,493 | \$84,092 | \$95,691 |
| New Jersey | \$128,786 | \$40,181 | \$52,545 | \$64,908 | \$77,272 | \$89,636 | \$101,999 |
| New Mexico | \$67,949 | \$21,200 | \$27,723 | \$34,246 | \$40,769 | \$47,292 | \$53,815 |
| New York | \$104,972 | \$32,751 | \$42,828 | \$52,906 | \$62,983 | \$73,060 | \$83,138 |
| North Carolina | \$84,549 | \$26,379 | \$34,496 | \$42,612 | \$50,729 | \$58,846 | \$66,962 |
| North Dakota | \$104,087 | \$32,475 | \$42,467 | \$52,460 | \$62,452 | \$72,444 | \$82,437 |
| Ohio | \$91,185 | \$28,450 | \$37,203 | \$45,957 | \$54,711 | \$63,465 | \$72,219 |
| Oklahoma | \$76,142 | \$23,756 | \$31,066 | \$38,375 | \$45,685 | \$52,995 | \$60,304 |
| Oregon | \$94,050 | \$29,344 | \$38,372 | \$47,401 | \$56,430 | \$65,459 | \$74,488 |
| Pennsylvania | \$100,995 | \$31,510 | \$41,206 | \$50,901 | \$60,597 | \$70,293 | \$79,988 |
| Rhode Island | \$107,837 | \$33,645 | \$43,997 | \$54,350 | \$64,702 | \$75,054 | \$85,407 |
| South Carolina | \$80,973 | \$25,264 | \$33,037 | \$40,811 | \$48,584 | \$56,357 | \$64,131 |
| South Dakota | \$88,721 | \$27,681 | \$36,198 | \$44,716 | \$53,233 | \$61,750 | \$70,268 |
| Tennessee | \$80,773 | \$25,201 | \$32,956 | \$40,710 | \$48,464 | \$56,218 | \$63,972 |
| Texas | \$85,391 | \$26,642 | \$34,840 | \$43,037 | \$51,235 | \$59,433 | \$67,630 |
| Utah | \$90,542 | \$28,249 | \$36,941 | \$45,633 | \$54,325 | \$63,017 | \$71,709 |
| Vermont | \$99,184 | \$30,945 | \$40,467 | \$49,988 | \$59,510 | \$69,032 | \$78,553 |
| Virginia | \$108,95 | \$33,994 | \$44,454 | \$54,913 | \$65,373 | \$75,833 | \$86,292 |
| Washington | \$107,085 | \$33,411 | \$43,691 | \$53,971 | \$64,251 | \$74,531 | \$84,811 |
| West Virginia | \$77,096 | \$24,054 | \$31,455 | \$38,857 | \$46,258 | \$53,659 | \$61,061 |
| Wisconsin | \$99,688 | \$31,103 | \$40,673 | \$50,243 | \$59,813 | \$69,383 | \$78,953 |
| Wyoming | \$95,814 | \$29,894 | \$39,092 | \$48,290 | \$57,488 | \$66,686 | \$75,884 |
| Puerto Rico | \$32,843 | \$10,247 | \$13,400 | \$16,553 | \$19,706 | \$22,859 | \$26,012 |

*Household

¹ The estimated U.S. median income for 4-person families is \$94,738 for the period of October 1, 2021 through September 30, 2022.

² Prepared by the U.S. Census Bureau, U.S. Department of Commerce (Census Bureau) from the 2015 through 2019 American Community Surveys (ACS). For further information, see table B19119 for the five-year estimates of the 2015 ACS through 2019 ACS at data.census.gov or contact the Census Bureau's Social, Economic and Housing Statistics Division (SEHSD) at (301) 763-3243.

³ Prepared by the Administration for Children and Families, Office of Community Services, Division of Energy Assistance. In accordance with 45 CFR 96.85, 60 percent of each State's estimated median income for a fourperson family is multiplied by the following percentages to adjust for household size for LIHEAP: 52 percent for one person, 68 percent for two persons, 84 percent for three persons, 100 percent for four persons, 116 percent for five persons, and 132 percent for six persons. For each additional household member above six persons, add three percentage points to the percentage for a six-person household (132 percent), and multiply the new percentage by 60 percent of the State's estimated median income for a four-person household.