STUDYING AND TRACKING EARLY CHILD DEVELOPMENT FROM A HEALTH PERSPECTIVE: A REVIEW OF AVAILABLE DATA SOURCES

Brett Brown and Martha Zaslow
Child Trends

Michael Weitzman
Center for Child Health Research

February 2006

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This and other Fund publications are online at www.cmwf.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 888.

CONTENTS

ACKNOWLEDGMENTS

The authors would like to thank The Commonwealth Fund for their generous support in the preparation of this paper.

Thanks to the research support staff who collected the survey information presented in this paper including Dena Aufseeser, Pilar Marin, and Sharon Bzostek from Child Trends, and Megan Kavanaugh and Sarah Bagley from the Center for Child Health Research. Thanks also to Ed Schor of The Commonwealth Fund for his guidance and helpful comments. Finally, thanks to our panel of experts who assisted in the identification of key constructs used in this review including: Jeanne Brooks-Gunn; Frances Dunston; Joseph Hagan, Jr.; David Heppel; Michael Lopez; Paul Newacheck; Deborah Phillips; Ruth Stein; and Deborah Klein Walker.

EXECUTIVE SUMMARY

Over the last several decades, there has been a substantial increase in interest among the pediatric health policy and practitioner communities in moving beyond narrow medical models of health to promote more broadly the development of very young children including their social, emotional, intellectual, and physical well-being. In this report, we review existing national data sources in terms of their capacity to inform child health policy and practice in their efforts to promote early child development. The body of the report provides an overview of existing areas of strength, identifies gaps, and makes recommendations for future data development. Some 26 national surveys and administrative data sources are assessed for their collective ability to support research and for their adequacy as sources of descriptive social indicator data.

Equally important, and perhaps even more useful for those who wish to analyze existing public data, we provide an appendix summarizing the content of the 26 surveys and administrative databases. There is a one-page summary for each data source using a standardized checklist of measures in the areas of health, health care receipt, socioemotional and intellectual development, family functioning and parent health; community characteristics; and child care and family demographics.

Recommendations for future data development include the following:

- Protect and expand sources of federally collected state- and local-level data covering early child health and development. Increasingly, policy decisions affecting early child well-being are being made at these levels, and policymakers deserve high quality indicator data as the basis for their policy decisions. At present only the National Survey of Children's Health, and to a lesser extent the survey of Children with Special Health Care Needs, provide such data for the states.
- Expand the regular collection of data on the characteristics of the neighborhoods and communities where young children live. At present there are virtually no estimates collected on a regular basis (outside of the decennial census) that allow us to track elements of the local environment known to shape early child well-being.
- Add developmental screening assessments for children under age six to the National Health and Nutrition Examination Survey (NHANES). This will create a unique source of data to support research linking health status to early socioemotional and intellectual development.
- Include more detailed information on the content of developmental screening and well-child visits in future longitudinal surveys, to support research capable of linking specific early health care practices to better intellectual, socioemotional, and physical developmental outcomes at older ages. Existing longitudinal surveys lack such measures, though they have been fielded in cross-sectional surveys, notably the National Survey of Early Child Health (NSECH).
- Include a rich set of age-appropriate intellectual and socioemotional development measures in the National Children's Study, an extremely ambitious federally sponsored longitudinal study that intends to follow 100,000 children from birth through age 21 (still in the design phase). The planned study will also contain very detailed information on health and health care receipt.

Summary of Reviewed Data Sources for Studying Early Child Development from a Health Perspective

	Data Source	Acronym	Population	Periodicity	Geography	Notable Characteristics	Recommendations
	Longitudinal						
1	Early Child Longitudinal Study—Birth Cohort	ECLS-B	children born in 2001	one-time	national	1. Covers entire developmental range from ages zero through first grade. 2. Contains detailed measures of physical, social and intellectual development. 3. Has detailed measures of health and health care receipt.	1. Gather detailed information on the content of developmental screening and well-child visits that could inform better practice for those interventions. 2. Fully fund the first grade follow-up so that entire sample can be followed.
2	Early Child Longitudinal Study—Kindergarten Cohort	ECLS-K	children in kindergarten in 1998–1999	one-time	national	1. Will follow children from kindergarten through at least 12th grade. 2. Contains rich measures of children's development.	None
3	Panel Study of Income Dynamics—Child Development Supplement	PSID-CDS	ages 0–12 in 1997	one-time	national	1. Detailed measures of child health and development, and a rich set of contextual measures including child care, family functioning, neighborhood quality and culture. 2. Unique time diary data available. 3. Includes extensive economic and employment histories for adults in the household.	None
4	Medical Expenditure Panel Survey	MEPS	all ages	annual	national	Takes a subsample of families from the National Health Interview Survey (NHIS, see row 10 in this table) and follows them for two years, gathering additional data on health conditions, health services and costs.	None
5	Fragile Families and Child Well-Being Study	FSS	This study focuses primarily on children of unwed parents living in U.S. cities with populations over 200,000.	one-time	U.S. cities over 200,000	The survey includes regular interviews of mothers and fathers (living inside or outside the home of the child) and home assessments at ages three and five. The survey is particularly strong in measures of family functioning, parental health, community characteristics, and measures of socioemotional development. The father data and the direct assessments of the family and child care/school environments make this a uniquely valuable data source.	None

	Data Source	Acronym	Population	Periodicity	Geography	Notable Characteristics	Recommendations
6	Head Start Family and Child Experiences Survey	FACES	children entering head start at ages 3–4	new cohorts in 1997, 2000, 2003	national	1. Repeated longitudinal study with new cohorts in 1997, 2000, and 2003. 2. A very strong set of measures of physical, intellectual, and socioemotional development collected using multiple methods and multiple informants. 3. Very detailed measures of the child care and pre-kindergarten environments.	None
7	National Survey of Child and Adolescent Well-Being	NSCAW	ages 0–14 within the child welfare system	one-time	National	1. Rich set of measures of social, emotional, and intellectual development, and of family functioning, for an important high risk group of children.	None
	Cross-Sectional						
8	National Survey of Early Childhood Health	NSECH	ages 4–35 months	fielded in 2000. May be fielded in future years.	national	1. Contains the most detailed data available on the content of developmental screening and well-child visits for very young children. 2. Contains a broad set of developmental measures, though all data gathered through parent report rather than examination or formal assessment.	Recommend expansion of the survey to collect representative samples at the state level, as the NSCH and CSHCN surveys currently do.
9	National Survey of Children's Health	NSCH	ages 0–17	first fielded in 2003, schedule to be repeated about every four years.	national, state	1. This is by fare the most far-ranging source of state-level social indicator data available covering early child health and development. 2. Its large sample size (over 30,000 ages 0–5) makes it a unique data resource for studying rare populations of young children.	Maintain this critical data resource at current sample size and periodicity. If possible, collect more frequently.
10	National Health Interview Survey	NHIS	all ages	annual	national	1. The NHIS has considerable strength in the health outcome and health care receipt domains, as expected, but is also very strong on measures of early socioemotional development including measures of problem behaviors, social competence, attachment, self-regulation, and cooperativeness. 2. Measures of intellectual development are weak, however, limited mostly to whether early intervention/special services were ever given to the child. 3. Data on family functioning are also sparse, while measures of parental health that may affect development are very strong.	None

	Data Source	Acronym	Population	Periodicity	Geography	Notable Characteristics	Recommendations
11, 12, 13, 14	National Household Education Surveys (after school programs survey, early child program participation, school readiness, parental involvement surveys)	NHES	ages 0–17	special topic areas repeated every 4 to 6 years	national	1. Taken together, these topical surveys contain strong measures of intellectual development, child care, family functioning, and to a lesser extent socioemotional development and health care receipt for young children. 2.Family functioning measures in the NHES tend to reflect those most obviously related to stimulating intellectual development such as reading to children and language stimulation, though some measures related to stress and conflict are also gathered.	NCES should convene an experts panel to consider economical ways to collect special topic data more frequently than every 4 to 6 years.
15	Birth Certificate Data, Vital Statistics System	Birth Data	all ages	continuous	national, state, local	1. Provides important data on health factors and practices known to be related to later intellectual and socioemotional development including birthweight, breastfeeding, and parental educational attainment. 2. It is one of the few sources of data on young children available at the local level throughout the U.S.	None
16	National Health and Nutrition Examination Survey	NHANES	all ages	continuous	national	Contains health data on young children based on medical examination rather than parent report, making this potentially a very valuable data source for health outcomes related to development. Unfortunately, while it is very strong in health outcome data, there are almost no data collected that directly related to intellectual or socioemotional development in young children under age 6.	We recommend that NHANES consider adding age appropriate intellectual and socioemotional development assessments to their data collection efforts on young children. NHANES already collects intellectual development assessment data for children ages six through sixteen.
17	Pregnancy Risk Assessment Monitoring System	PRAMS	mothers of newborns	annual	selected states	The Pregnancy Risk Assessment Monitoring System (PRAMS), provides state-representative data on infants and their mothers in 29 states. PRAMS includes valuable state data on family violence, breastfeeding, and hearing problems of infants, all of which can affect early child development. There are no measures of infant intellectual or social development in the survey.	None

	Data Source	Acronym	Population	Periodicity	Geography	Notable Characteristics	Recommendations
18	Pregnancy Nutrition Surveillance System	PNSS	pregnant and post-partum women participating in federally funded public health programs	annual	selected states	Collects data on low-income pregnant women participating in federally funded public health programs including WIC and MCH. Data collected include maternal smoking and drinking during pregnancy, anemia, diabetes, hypertension, maternal weight gain, medical care, and multi-vitamin consumption.	None
19	Pediatric Nutrition Surveillance System	PedNSS	children ages 0–5 attending federally funded maternal and child health nutrition programs.	annual	selected states	Follows the nutritional status of children ages 0–5 in federally funded maternal and child health and nutrition programs including WIC, EPSDT, and the Title V Maternal and Child Health program (MCH). Data collected include birthweight, under- and overweight, anemia, and breastfeeding.	None
20	National Child Abuse and Neglect Data System	NCANDS	ages 0–21	continuous	national, state	1. A primary source of data on child abuse and neglect in the U.S., which are strongly related to negative early child development outcomes. 2. Lacks any measures of intellectual or socioemotional development.	None
21	Adoption and Foster Care Analysis and Reporting System	AFCARS	ages 0–19 in the foster care system	continuous	national, state	Follows children in the adoption and foster care systems, but offers no data on the health and development of children in those systems.	None
22	Children with Special Health Care Needs	CSHCN	ages 0–17	First fielded in 2001, and again in 2005. Expected to be repeated about every four years.	national, state	Extensive information is gathered on health care, access to services, and coordination of services for children with special health care needs. Measures of child intellectual and socioemotional development were absent from the initial survey in 2001, but some were added in 2005.	The survey has expanded questions on socioemotional and intellectual functioning in the 2005–06 version. We recommend that age-appropriate measures be further expanded in future versions of the survey.
23	National Survey on Drug Use and Health	NSDUH	ages 12 and older	annual	national, selected states	Most detailed source of data on drug use. Children can be identified in the household, but only basic demographic information is available.	None

	Data Source	Acronym	Population	Periodicity	Geography	Notable Characteristics	Recommendations
24	National Survey of Family Growth	NSFG	women ages 15–44	about every seven years (last fielded in 2002)	national	1. Includes detailed marital and fertility history of interviewed parent. 2. Father sample is included for the first time in 2002.	None
25	National Survey of America's Families	NSAF	all ages	1997, 1999, 2002	national, selected states	The National Survey of America's Families was a privately funded survey that tracked child and family well-being following the 1996 PRWORA welfare reform act. Surveys were taken in 1997, 1999, and 2002. It includes data on child health care coverage and receipt, as well as important parenting measures (e.g. parental mental health, aggravated parenting, outings and activities with the child), but no direct measures of intellectual or socioemotional development for children under age six.	None
26	Individuals with Disabilities Education Act Data	IDEA	ages 0–21	continuous	national, state	Administrative data on children with disabilities who are served through the Individuals with Disabilities Education Act. Data are collected for children ages 0–2 and 3–21. These are aggregate data reported by the states. Data include number of children receiving services, type of service, type of disability, the educational environment, discipline, and exits from special education.	None

STUDYING AND TRACKING EARLY CHILD DEVELOPMENT FROM A HEALTH PERSPECTIVE: A REVIEW OF AVAILABLE DATA SOURCES

INTRODUCTION

Over the last several decades, there has been a substantial increase in interest among the pediatric health policy and practitioner communities in moving beyond narrow medical models of health to promote more broadly the development of very young children including their social, emotional, intellectual, and physical well-being. Health practitioners are among the only professionals to see young children on a regular basis during the first few years of life. If children with developmental delays or those at high risk of future developmental problems can be identified early and given the help they need during this vital period, they are more likely to arrive at kindergarten ready to learn and prosper, and in some cases avoid developmental delay altogether.[1]

Survey and administrative data can play an important role in supporting such efforts by helping to identify: groups at high risk for early developmental difficulties; family, community, and environmental influences that can put children at higher risk of developmental delay; opportunities for the medical community to intervene to identify such children in practice; as well as effective strategies for early intervention once they are identified.

Over the last decade, the federal statistical system has significantly expanded the amount of developmental and social contextual data collected on children ages zero to five. Most of these advances have been driven by concerns outside the health community, such as the child care and early school readiness fields, though more recently those with a health focus have been working to incorporate a broader set of developmental measures into their surveys.[2]

In this report we review existing national data sources in terms of their capacity to inform child health policy and practice in their efforts to promote early child development. The body of the report provides an overview of existing areas of strength, identifies gaps, and makes recommendations for future data development. Equally important, and perhaps even more useful for those who wish to use existing public data, we provide an appendix summarizing the content of some 26 surveys and administrative databases that can be used to support social indicator data and research on early development. Intended audiences include Federal data collection staff; health policy planners and practitioners at the national, state and local levels; and child health researchers.

BACKGROUND

Since 1990, there has been a great deal of activity concerning early child development in policy and practice, research, and data collection. These developments are not independent, as effective policy is dependent on a solid research and data base. And, as often happens, policy interest has generated additional work in data collection and research. Ideally, over time these three activities build on each other in an iterative way to the benefit of each and to the benefit of children. Below

[1] National Research Council and Institute of Medicine. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. J.P. Shonkoff and D.A. Phillips (eds). Committee on Integrating the Science of Early Childhood Development, Board of Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, D.C.: National Academy Press.

[2] See, for example, the National Survey of Early Child Health (http://www.cdc.gov/nchs/about/major/slaits/nsech.htm) and the National Children's Study (http://www.nationalchildrensstudy.gov/).

we offer brief highlights of major activities in policy and research as background for our overview and assessment of the current data system.

Policy and Practice

National Educational Goals

The National Education Goals (NEG) effort, the major federal education policy preceding President Bush's *No Child Left Behind* initiative, had as its first goal that "all children in America shall start school ready to learn." The National Education Goals Panel, a bipartisan, executive branch agency, was established: to promote the adoption of measurable education standards among the states reflecting NEG goals; to help to develop and disseminate proper assessment tools; and to promote the sharing of best practices across the states. The Panel was very active from 1990 through its decommissioning in 2002. During that period of time the number of states that adopted specific education standards grew from a handful to 49, and a majority had also fielded assessments for at least some grades.[3]

Attention has continued to focus on the early years of development. In particular, the administration's *Good Start Grow Smart* initiative, launched in April 2002 as the companion to the *No Child Left Behind* initiative, focuses on children's early learning and seeks to improve school readiness for children participating in the full range of early care and education settings. The initiative seeks to "strengthen Head Start; bring research-based information to teachers, caregivers, and parents; and partner with states to improve early childhood education"[4]

Many states responded to the school readiness goal of the National Education Goals Panel by establishing their own state-wide early school readiness programs including California (First Five), South Carolina (First Steps), North Carolina (Smart Start), and Rhode Island. States have also worked to track children's school readiness. For example, in 2000, North Carolina conducted a study involving a representative sample of its entering kindergarten children in order to document the readiness of children for school across the multiple domains of development noted by the National Goals Panel Goal 1 working groups, and also to document the readiness of schools for the children. A seventeen state consortium has just concluded the development of indicators of children's school readiness that can be tracked on a regular basis and inform efforts to strengthen school readiness in these states. These efforts, discussed in greater detail below, were informed by the conceptualization of school readiness developed by the National Goals Panel and by the data collection guidelines it proposed as a starting point.[5]

TANF/Welfare Reform

Welfare reform in the 1990s allowed states to redirect TANF funds to support child care services for low-income families in order to facilitate work by low-income parents. There was no systematic attempt to build child development goals into this expansion, at least at the federal

[3] For a summary of NEGP activities see National Education Goals Panel. 1999. Building on the Momentum. http://govinfo.library.unt.edu/negp/reports/essays.pdf.

[4] See *The Context for Critical Issues in Early Childhood Professional Development*, in Zaslow, M and Martinez-Beck, I. (in press) Critical Issues in Early Childhood Professional Development. Baltimore: Brookes Publishing.

[5] Maxwell, K.L., Bryant, D.M., Ridley, S.M., and Keyes-Elstein, L. (2001) *North Carolina's Kindergarteners and Schools: Summary Report.* Chapel Hill: University of North Carolina, Frank Porter Graham Child Development Center.

level (Adams and Rohacek 2002). However the Child Care and Development Fund, the source of funding for child care subsidies that support low income families in working or preparing for work, requires that states set aside at least four percent of the funding to improve the quality and accessibility of care. States are engaged in a wide range of efforts to improve the quality of care.[6]

Bright Futures

In the health policy arena, in 1990 the U.S. Maternal and Child Health Bureau (MCHB) began a major effort to promote its *Bright Futures* initiative. The initiative seeks to expand the vision and the practices of the pediatric health services community to embrace a broad set of developmental outcomes for children of all ages, and to promote a strong partnership with parents and the community in pursuing those goals. These outcomes include the healthy physical, social, and intellectual development from infancy through adolescence and to age twenty-one. The project has produced and promoted the use of a number of practical tools and guidelines that allow health practitioners to screen for a wide variety of developmental problems, and to encourage practices within the family that promote healthy development.[7] This project, embraced by the American Academy of Pediatrics (AAP), is currently undergoing a thorough updating of the initiative and its supporting tools and guidelines, guided by the AAP. In response to this increased appreciation for early development outcomes within the health community, the authors recently produced *Early Child Development in Social Context: a Chartook*, a collection of social indicator data intended especially for audiences in the pediatric health field.[8]

State Early Childhood Comprehensive Systems Initiative (SECCS)

More recently (starting in 2002), the Maternal and Child Health Bureau (MCHB) has been working directly with states to weave together early childhood initiatives across state agencies (education, health, welfare) through its State Early Childhood Comprehensive Systems Initiative (SECCS).[9] This is intended to coordinate the work and the goals of early child programs within education, welfare, health, and other state agencies in order to make them more effective and efficient, resulting in improved services for young children and their families. High quality social indicator data on young children and their families are very useful in such efforts to guide planning and coordination, as well as promoting system accountability.[10]

School Readiness Indicators Initiative

This initiative was a 17-state[11] consortium that focused on the development and use of child well-being indicators to inform state and community-level policies designed to improve school

---

[6] Child Trends and Bank Street College (forthcoming). Report of a survey on state child care quality initiatives; National Association of State Child Care Administrators.

[7] For additional information, see http://www.brightfutures.org/.

[8] Child Trends and the Center for Child Health Research. (2004). *Early Child Development in Social Context: A Chartbook*. New York. The Commonwealth Fund.

[9] For additional information see the National Center for Early Childhood Health Policy, http://www.healthychild.ucla.edu/Publications/NationalCenterPubs.asp.

[10] See Friedman, M. *Results Accountability for State Early Childhood Comprehensive Systems: A Planning Guide for Improving the Wellbeing of Young Children and Their Families*. In: Halfon, N., Rice, T., and Inkeles M, eds., *Building State Early Childhood Comprehensive Systems: Series No. 4*. National Center for Infant and Early Childhood Health Policy. 2004.

[11] Participating states include Arizona, Arkansas, California, Colorado, Connecticut, Kansas, Kentucky, Maine, Massachusetts, Missouri, New Hampshire, New Jersey, Ohio, Rhode Island, Vermont, Virginia, and Wisconsin.

readiness and early school success.[12] Participating state teams included heads of departments of education, health, and human services; state data experts; child advocacy groups, researchers; and, in several cases, state legislators and staff from Governors' offices. State teams were tasked to identify policies to enhance readiness; to identify indicators that could be tracked annually at the state and local levels; to develop data systems to track those indicators; and to develop communications strategies to encourage their use. States worked together to identify a common set of indicators to be used as the core of each state's system of indicators. These included indicators of ready children, ready families, ready communities, ready services (health, child care, and education), and ready schools.[13]

The consortium was formed in 2001 and worked jointly through the end of 2004. Most of these efforts continue within the individual states.

Research

In the early 1990s the National Education Goals Panel, through its Goal 1 working group reviewed the literature on early school readiness and came to two important conclusions.[14] First, the concept of "school readiness" needed to go beyond narrowly defined cognitive development or achievement to include also physical, social and emotional well-being, and approaches toward learning. Domains of child readiness for school identified by the working group include:

- physical well-being and motor development;
- social and emotional development;
- approaches to learning;
- language and literacy development; and
- cognition and general knowledge.

Second, that those concerned with the readiness of children must also be concerned with the readiness of the social environment (schools, family, community) to support development. Key characteristics of ready schools, families, and communities were also identified. The result was an ecologically based model of early development that builds on multiple research traditions (education, health, child psychology) in order to identify important constructs within each domain of the model.

The National Academy of Sciences produced a thorough synthesis of the existing research literatures titled *From Neurons to Neighborhoods: The Science of Early Childhood Development* (National Academy of Sciences, 2000). The 18 member committee of child psychologists, physicians, economists, child services and early education specialists, offered a

[12] For additional information See Rhode Island Kids Count. 2005. *Getting Ready: Findings from the 17 State Partnership*. http://www.gettingready.org/matriarch/d.asp?PageID=303&PageName2=pdfhold&p=&PageName=Getting+Ready+%2D+Full+Report%2Epdf.

[13] Ibid, pp. 5–7.

[14] Kagan, S., Moore, E., and Bradekamp, S. (1995). Reconsidering Children's Early Development and Learning: Toward Common Views and Vocabulary. Washington, D.C.: National Education Goals Panel, Goal 1 Technical Planning Group.

thorough and well-integrated review and assessment of the current state of knowledge of early child development drawing on and integrating the research base from all relevant disciplines. In addition, they fulfilled their charge by drawing implications from this review for early childhood policy, practice, professional development, and research. Particular attention was paid to the relationship between biology and the social environment as mutually determining rather than separate influences on development.

In 2000, Child Trends' staff built on the work of the NEGP working group, producing an expansive review of the literature and a more elaborated ecological model of the determinants of readiness, written in a style and format that would be useful to communities wanting to ground their investment strategies for early school readiness in the best available research.[15] In 2002, Child Trends followed up with an exhaustive catalogue of available school readiness indicators based on reviews of national, state, and local surveys for use by communities and anyone interested in tracking key aspects of readiness.[16]

THEORETICAL MODEL

To guide our work in summarizing and assessing the content of existing national databases, we adopted a theoretical model of early school readiness developed by Zaslow, Calkins, Halle, Zaff, and Margie (2000),[17] itself based on early work by Kagan, Moore, and Bradekamp (1995).[18] (See Figure). The model is comprehensive, covering the multiple domains of well-being noted by the National Goals Panel, including intellectual and social development, approaches to learning, and health. It is developmental, recognizing that growth takes place in sequential stages, with each stage having its own goals, and with measures particular to those age-appropriate goals. Finally it is contextual, incorporating the influences of family, early care and education settings, and community known to affect early development.

Key measures for each domain within the model were identified based on a literature review by Zaslow et al, updated for this project, and augmented with research relating health care receipt to early development.[19] From these reviews we developed a checklist of key constructs which was reviewed, critiqued and extended by the project's panel of national experts. The panel included leaders in the fields of health policy, pediactrics, public health, and early child health and development.[20] The final checklist was used to summarize the content of each national database, and can be found in the appendix.

---

[15] Zaslow, M., Calkins, J., Halle, T. (2000) Background for Community-level work on School Readiness: A Review of Definitions, Assessments, and Investment Strategies. Child Trends: Washington D.C. http://www.childtrends.org/files/KEducation.pdf.

[16] Calkins, J., Ling, T., Moore, E., Halle, T., Hair, B, Moore, K., and Zaslow, M. (2002) School Readiness Indicator Items and Basic Measures of Progress. Washington, D.C.: Child Trends. http://www.childtrends.org/files/schoolreadiness&progress.pdf

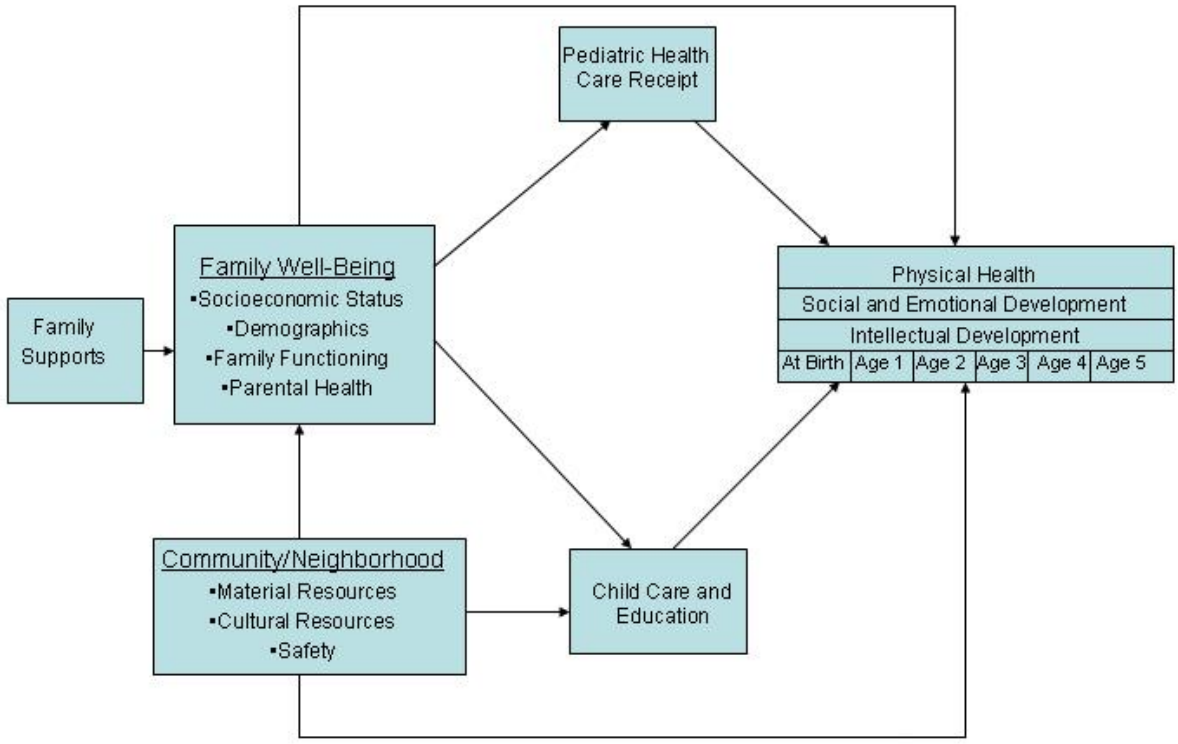
[17] See Zaslow, Calkins and Halle, 2000.

[18] Kagan, S., Moore, E., and Bradekamp, S. (1995). Reconsidering Children's Early Development and Learning: Toward Common Views and Vocabulary. Washington, D.C.: National Education Goals Panel, Goal 1 Technical Planning Group.

[19] See, for example, Hughes, D.C., and S. Ng. (2003) *Reducing Health Disparities Among Children.* In The Future of Children. 13 (Spring 2003). Available at: http://www.futureofchildren.org/usr_doc/tfoc13-1_nophoto.pdf. See also National Immunization Program. (2004). *What Would Happen If We Stopped Vaccinations*? Available at http://www.cdc.gov/nip/publications/fs/gen/WhatIfStop.htm.

[20] See Acknowledgements for a complete list of panel members.

Figure
Model of Early Child Development



Source: Child Trends, Inc.

OVERVIEW OF EXISTING NATIONAL DATA RESOURCES

Child Trends and the AAP Center for Child Health Research identified 26 public databases for this review including major national surveys, surveillance systems, and administrative data sources. They include longitudinal databases that follow respondents over time (ideal for research), periodically repeated cross-sectional databases (necessary to track indicators of well-being over time), and one-time cross-sectional databases. An attempt was made to include all major national surveys and other data collection systems that gather significant amounts of health and/or child development information on children ages 0–5 in the U.S.

A major purpose of this report is simply to catalogue the relevant content of these major data resources for the health research and policy communities interested in researching and tracking early child development. For many readers the primary value of the report will lie in the appendix which provides systematic one-page summaries of the content of each data source along with other relevant information on design and access. Users can use these summaries to identify an optimal data source or sources for particular research or data tracking projects. For example, the authors of this report used these summaries in order to identify available indicators for presentation in *Early Child Development in Social Context: A Chartbook*, also sponsored by The Commonwealth Fund.[21]

[21] See http://www.cmwf.org/publications/publications_show.htm?doc_id=237483.

In addition, however, we provide here an assessment of the data system as a whole, identifying areas of strength, and identifying gaps as well as opportunities to fill those gaps. First, we evaluate the existing data in terms of its capacity to support research that can shed new light on the relationship between traditional concerns of the health policy community over which it has some control (health service delivery, early health outcomes), and the intellectual, emotional, and social development of young children. While such data sources cannot help us to identify causal relationships with the same rigor as experimental design, proper analyses can produce information that can increase our understanding and act as valuable guides to action.

Second, we examine the data system in terms of its capacity to yield useful social indicator data to support needs assessment, identify gaps across social groups, and monitor trends in well-being at the national, state, and local levels. The criteria we use to assess existing data resources are, of course, very different for research and monitoring, and for that reason they are discussed separately.

HEALTH-FOCUSED RESEARCH ON EARLY CHILD DEVELOPMENT: AN ASSESSMENT OF CURRENT DATA RESOURCES

Desirable characteristics of data sets supporting research on early child development from a health perspective include the following:

- *Longitudinal design covering ages 0–5 and beyond*. A longitudinal design, with data collected at intervals over the early lifecourse of the child, helps us to understand the mechanisms through which early influences affect later developmental outcomes. It can aid researchers in teasing out potential causal mechanisms in a way that is not possible with cross-sectional surveys. Secondarily, it is important to periodically launch new cohort surveys, since the factors affecting early development may change over time, so that the causal mechanisms of a decade ago may no longer function the same way for today's children. If one is limited to cross-sectional data collection, then capturing retrospective data on key past influences and outcomes is an important second-best strategy.

- *Breadth of high quality and age-appropriate measures of early child development*. It is not unusual for national data collection activities to focus on a narrow set of early developmental outcomes. Health agencies tend to focus on traditional health outcomes; education agencies on collecting data on intellectual development; and so on. But the physical, social, emotional, and intellectual development of young children is interconnected, and according to the research underlying the theoretical model we have adopted, one cannot fully understand the determinants in one area without taking into consideration the other areas. In addition, one can only fully assess the overall importance of other social contextual influences in light of their relationship with the multiple aspects of early development. For those reasons, a broad selection of developmental outcomes, including major health conditions known to affect other aspects of development, is highly desirable in the ideal database for researching early child development.

- *In-depth measures of health care service receipt*. If research is to be an effective guide to action for health policymakers and practitioners, the data must include sufficient detail on

health care practices that a connection can be made between particular practices and outcomes of interest. For our purposes, we are particularly interested in practices intended to monitor and promote positive early development of all sorts: physical, social, emotional, and intellectual. Practices such as those promoted for well-child visits by the *Bright Futures* project would be important examples of this,[22] as would the degree to which the child's usual source of care adheres to the Medical Home concept, and the quality of clinician–family communication.

- *Nationally representative samples*. Surveys based on nationally representative samples assure that research findings are generalizeable to the U.S. population of young children.

- *Capacity to analyze data separately for high risk groups and major sociodemographic groups*. Factors affecting early development may differ across culturally, socio-economically, and medically defined subgroups of children. Research suggests, for example, that the quality of early care and education settings may be particular important to the development of children in low income families. In addition, the same factors sometimes work differently across these groups, which can inform the development of different intervention strategies for different groups. For this reason, it is important that datasets used for researching the mechanisms affecting early development be able to identify key population subgroups, and that they have sample sizes sufficiently large for these groups to support separate analyses. For the health policy and services community, the capacity to identify health-defined high risk groups (e.g, children with chronic disabilities) would be particularly important.

- *Measures of family, institutional and community characteristics known to affect early child development*. In order to model the determinants of early development, it is important for data to include the multiple sources of contextual influence identified in the theoretical model we have adopted. For example, institutional influences on early development (e.g. health care services, child care, pre-school) will both interact with and affect family influences, and both may function differently in different community environments.[23] Surveys are often so focused on particular aspects of social context (e.g., child care, or family functioning, or health service receipt) that they virtually ignore other important aspects of the environment. In doing so, they limit what can be understood even about those aspects of the social environment that most interest them.

Of the 26 data sets reviewed for this report, seven had a longitudinal design. Of those, four were nationally representative samples of all children in the U.S., while the others focused on special populations (children at risk of abuse and neglect; children of unmarried parents; and children in Head Start programs). This mix of general and special population surveys is a strength for the data system as a whole, as it allows researchers to build up the general knowledge base while also addressing issues particular to high risk populations.

[22] For additional information, see http://brightfutures.aap.org/web/.

[23] Brooks-Gunn, J., Duncan, G., and Aber, J. (1997) Neighborhood Poverty: Context and Consequences for Children, vols. 1 and 2. New York: Russell Sage.

The four general population longitudinal surveys are:

- The Early Childhood Longitudinal Study—Birth Cohort (ECLS-B), which started in 2001 tracking children at birth.
- The Early Childhood Longitudinal Study—Kindergarten Cohort (ECLS-K), which started tracking children at kindergarten.
- The Panel Study of Income Dynamics—Child Development Supplement (PSID-CDS), which tracks certain characteristics from birth, but begins tracking many relevant developmental and social context measures at ages 3 to 12.
- The Medical Expenditure Panel Survey—Household (MEPS), which collects detailed information on family health care expenditures, sources of payment, over a two-year period.

The Early Childhood Longitudinal Study—Birth Cohort (ECLS-B)

The ECLS-B is the closest to the ideal dataset for research as reflected in our developmental model for examining early development in the general population. Its strengths include:

- Developmental Range: Covers virtually the entire early developmental sequence from infancy through at least first grade with measures taken frequently (9 months, 2 years, 4 years, kindergarten, and first grade).
- Breadth: Nearly every aspect of our guiding model is well represented in this survey. It includes: detailed and age-appropriate measures of physical, social and intellectual development; detailed measures of the family environment and the parent/child relationship; detailed reports on health conditions relevant for development and of health care receipt; and detailed characteristics of the child care and early school environments.
- Quality: Data are collected using direct assessments and observation as well as surveys of parents, teachers, and child care providers/teachers.
- Subgroup Analyses: The survey was designed to allow for separate analyses by race and ethnicity (for white, black, Asian, Chinese, Native American, and Hispanic), for low and very low-birthweight children, and for twins.

The survey is not without its limitations, however, for general research and for those interested in researching early development from a health perspective. These include:

- Health data are largely based on parent report, not physician report or medical examination, limiting the type of medical data that could be collected and, in some cases, its accuracy.
- While data on health care receipt is considerable, the data on developmental screening is limited to parent report of whether one ever took place, and does not address particular practices.
- Due to budgetary restrictions, the current plan is to limit the follow-up at first grade to only 25 percent of the sample, limiting statistical power and possible sub-group analyses.
- Data for the 2-year-old follow-up are expected to be available in early 2006 (a limitation only in the sense that researchers are currently limited to data at birth and 9 months).

The Early Childhood Longitudinal Study—Kindergarten Cohort (ECLS-K)
The ECLS-K, older sibling to the to ECLS-B, demonstrates many of the same positive qualities in terms of the breadth and quality of its measures, the frequency of measurement, and its capacity to support subgroup analyses (in fact it has twice the sample size of the ECLS-B, with about 22,000 in the initial sample). Current plans call for regular follow-up surveys through the 12th grade, making it a remarkable data resource for those interested in examining child development from kindergarten onwards. Its main limitation is the paucity of data covering development prior to kindergarten entry. There are some retrospective data gathered regarding health conditions and health care receipt, child care, and family structure, but all in all it is not a strong survey for understanding early child development prior to kindergarten, nor is it strong in examining pre-kindergarten influences on later development.

The Panel Study of Income Dynamics—Child Development Supplement (PSID-CDS)
The third nationally representative longitudinal survey reviewed is the PSID-CDS. The PSID survey is a longitudinal survey that has been going on since 1968. Its primary focus has been the collection of detailed longitudinal information on family structure and fertility, employment and income, wealth, consumption and expenditures, and the like. In 1997, however, it launched a special Child Development Supplement, collecting very detailed data on the health and development of 3600 children ages 0–12 within those PSID households, as well as extensive information on child care, family functioning and parent/child relationships, health care receipt and coverage, and neighborhood quality and culture. There was a follow-up in 2001 where a similar breadth of data was collected, including additional information appropriate to adolescents. A revised Woodcock-Johnson assessment was used to assess intellectual development.

The survey has two outstanding strengths which make it unique for certain research interests. First, the child development data is embedded in a long-standing and detailed longitudinal history of the economic, employment and demographic characteristics of the households in which these children are growing up. For those interested in relating these characteristics to health and development outcomes in early childhood through late adolescence, the survey is without peer. Second, one of its most unique features is its use of a time diary to collect detailed activity data for a 24-hour period on one week day and one weekend day. For researchers interested in common daily activities and their relation to child development, this is a tremendous research resource.

The modest sample size of the PSID-CDS limits subgroup analyses one can perform (there are fewer than 2000 children under age 6 in the original 1997 supplement). In addition, though the health outcome and service data section covers many topics, it is largely retrospective and is based on parent report (though height and weight were measured). There is also no information on developmental screening beyond whether one ever took place.

The Medical Expenditure Panel Survey (MEPS)
The MEPS survey follows a subset of households from the National Household Information Survey (see below) over a two-year period. In addition to all of the information gathered in the NHIS survey (which includes a limited set of developmental outcomes for young children), the MEPS survey contains detailed information on medical expenditures and health care use, sources of payment, and health status. It is a valuable source of data for those wishing to investigate relationships between health care expenditure and early child health and developmental outcomes.

In addition to the nationally representative surveys described above, we reviewed three national longitudinal data resources that focus on high risk populations, whose children are particularly at risk for a variety of negative health and developmental problems. These include:

- Fragile Families and Child Well-Being Study (Fragile Families)
- Head Start Family and Child Experiences Survey (FACES)
- The National Survey of Child and Adolescent Well-Being (NSCAW)

Fragile Families and Child Well-Being Study (Fragile Families)
This study focuses on the children (beginning at birth) of mostly unwed parents living in U.S. cities with populations over 200,000. Data are collected at birth and ages one, three, and five. The survey includes regular interviews of mothers and fathers (living inside or outside the home of the child) and home assessments at ages three and five. In addition, there are direct assessments of child care quality and kindergarten assessments at ages three and five, respectively, in ten cities. The survey has a well-rounded set of measures vis-à-vis our guiding theoretical model, and is particularly strong in measures of family functioning, parental health, community characteristics, and measures of socioemotional development. Health care receipt data are substantial, though perhaps not as detailed as some other longitudinal studies described here. The father data and the direct assessments of the family and child care/school environments make this a uniquely valuable data source.

Head Start Family and Child Experiences Survey (FACES)
This is a longitudinal study of children in Head Start programs across the country. It is the only longitudinal survey reviewed here that has been repeated, with cohorts in 1997, 2000, and 2003. Children are followed from Head Start (at ages 3 to 4) through the kindergarten or first grade.

FACES possesses an extraordinary breadth and depth of data on early development and the social contexts that shape that developmental path. Measures of early child development are particularly rich in this data set covering physical well-being and motor development, language development, cognition and general knowledge, social and emotional development, and approaches to learning.[24] Data are collected from parents, teachers, by classroom observation, and from the children themselves. For some types of outcomes, such as social and emotional development, data are collected from several informants (e.g., parent, teacher, and FACES interviewer) providing rich information from multiple perspectives. The study is also strong in measures of the family environment, family functioning, and parental health (e.g. depression, overall health, and disability). Basic health care receipt data are also collected, including coverage, usual source of care, dental care, whether the child has a medical home, and whether the child has had well-child visits, though no specific information on developmental screening are collected. As one might expect given the population being studied, measures of the child care/pre-k environment are particularly detailed in this survey, providing valuable measures of quality not found in most other surveys.

[24] Halle, T., Reidy, M., Moorehouse, M., Zaslow, M., Calkins, J., & Margie, N. G. (forthcoming). Progress in the development of indicators of school readiness. In B. Brown (Ed.) *Key Indicators of Child and Youth Well-Being: Completing the Picture*. New York: Erlbaum.

The National Survey of Child and Adolescent Well-Being (NSCAW)
This is a survey with a nationally representative sample of children ages 0 to 14 judged to be at risk of abuse or neglect, or who were in the child welfare system. Abuse and neglect are strongly related to a range of health problems and developmental delays in young children.[25] This survey was mandated by Congress as part of the 1996 welfare reform legislation the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996.* Data were collected at baseline (2001) with follow-ups at 12, 18, and 36 months. The sources of data are especially rich for this survey, including interviews with the children, parents and other caregivers, teachers, and caseworks, as well as child welfare administrative data. The main focus of the survey is to map the characteristics (strengths and weaknesses) of the children and families that have contact with the child welfare system, and to examine the short and long-term impacts of the child welfare system on family functioning and child well-being.

The survey is rich with data on the social, emotional, and intellectual development of these at-risk children, and in measures of family functioning (including violence. One limitation is that access is limited to researchers and faculty at institutions that have an Institutional Review Board (IRB) in place, due to the sensitive nature of the data.

CROSS-SECTIONAL DATA SOURCES TO SUPPORT RESEARCH ON EARLY CHILD DEVELOPMENT FROM A HEALTH PERSPECTIVE
While longitudinal data sources have much greater capacity to suggest causal relationships, well designed cross-sectional data can also be useful for discovering important relationships that may be useful guides for policy and for future research using other, more definitive methods. For research that focuses on links between health status or health care receipt, on the one hand, and early development, several cross-sectional surveys stand out.

The National Survey of Early Child Health (NSECH)
NSECH, collected by the National Center for Health Statistics using the SLAITS data collection mechanism,[26] is a survey of parents with children under age three that is particularly rich in measures of health care receipt including detailed information on developmental screening and well-child visits, and of activities in the home that contribute to healthy development in young children. In addition, there are parent-report developmental measures related to problem behaviors, mastery/motivation, positive affect, fine and gross motor skills, and stammering/ stuttering as well as a number of health status measures that can affect intellectual and socioemotional development.

The National Survey of Children's Health (NSCH)
The NSCH, also collected through SLAITS, is a survey of parents of children ages zero to seventeen. While the survey does not contain as much detailed information as some of the longitudinal studies discussed above, it does contain a strong set of developmental, health, health care (including developmental screening), and family and neighborhood environment measures that can support rather sophisticated modeling of early development. And, with a sample size of

[25] For details see *Child Maltreatment*, in: Child Trends and the Center for Child Health Research. (2004) *Early Child Development in Social Context: A Chartbook*. The Commonwealth Fund.
[26] See http://www.cdc.gov/nchs/slaits.htm.

over 100,000, about a third of whom are children ages zero to five, it allows researchers to examine relationships for relatively rare populations of young children.

SOCIAL INDICATORS OF EARLY CHILD DEVELOPMENT FROM A HEALTH-FOCUSED PERSPECTIVE: AN ASSESSMENT OF CURRENT DATA RESOURCES

The task of producing high quality indicators of early child development for the health community is a different task than the production of research and places somewhat different demands on the data collection system that supports it. Social indicators are first and foremost tools for assessing needs and strengths of particular populations of interest at a given point in time, and for tracking change over time, in both direct measures of well-being (outcomes), and key elements of the social environment (family, school, community) that shape well-being. Key characteristics include:

- *Comprehensive coverage*: A high quality system of social indicators should include data for all of the key outcomes, as well as the relevant social contextual influences known through research to influence those outcomes. The Figure presents the relevant domains for our current focus (early child development), and the checklists in the Appendix list key constructs. However, unlike data for research, data for indicators need not be collected in the same survey; they can be spread out over a variety of surveys. In fact, it would be difficult if not impossible for a single data source to support all of the relevant measures needed for a complete system.

- *Age-appropriate indicators*: Between the ages of 0 and 5 children develop quickly, traversing many developmental transitions. Each subperiod (infant, toddler, pre-school) has its own set of developmental milestones and the measures appropriate to those milestones. Any system of indicators of early childhood should adequately cover each developmental subperiod with a comprehensive set of age-appropriate measures.

- *Trends over time*: While social indicators can be used for one-time needs assessments, their primary function is to track trends over time. This allows monitoring systems to identify emerging problems, track progress towards policy goals, and, when used for accountability, to assess performance over time.[27] Where longitudinal data are crucial for research, repeated cross-sectional data collection are crucial for a system of social indicators. Periodicity for regularly fielded surveys containing early child development data vary from yearly to every four to six years. Yearly estimates are optimal for many uses, especially when data are being used to guide policy decisions or assess past performance.

- *Timeliness*. The utility of social indicators to the policy process decreases asymptotically with the age of the data. It is not difficult to understand why. When planning new efforts, policymakers and program staff need to know what the current status and needs of children are, not what they were four years ago. So, not only should social indicator data

[27] See Moore, K.A., Brown, B.V., and Scarupa, H.J. (2003). The Uses (and Misuses) of Social Indicators: Implications for Public Policy. Washington, D.C.: Child Trends. http://www.childtrends.org/files/SocialIndicatorsRB.pdf.

be collected frequently and on a regular basis, it should be made available as soon as possible to those who will use it to guide their efforts in the field.

- *Geographic detail*: Policies and programs affecting early child development are carried out at the national, state, and community levels. Social indicator systems to support that work must also allow for estimates at all these geographic levels, as the condition of young children varies substantially from state to state and even from neighborhood to neighborhood. This is much less important for research, where national samples are usually sufficient.

- *Separate estimates for key population subgroups*: While there is a strong public policy interest in tracking how all children are doing, there is particular interest in identifying differences or disparities across key social groups, and in identifying the needs of children who are in some way defined as high risk. These groups may be defined demographically (sex, race, age, family structure), socio-economically (poor-nonpoor, parent education level, insurance status) medically (chronic condition, ADHD, asthma) or even geographically (lives in high poverty neighborhood). Such estimates allow users to identify the needs of the particular populations they serve, and identify those groups in greatest overall need. For a survey or other data source to perform this function it must be able to identify members of such groups, and have large enough samples of each to produce reliable estimates.

OVERVIEW OF DATA SOURCES

The Big Four

Among the periodically fielded surveys we reviewed, the four pillars of the federal statistical system for indicators of early child health and development are: The National Health Interview Survey (NHIS); the National Household Education Surveys (NHES); the new National Survey of Children's Health (NSCH); and the National Survey of Early Child Health (NSECH). Together, they provide substantial coverage of indicators within nearly all domains of our guiding developmental model. The major exception is in the area of community/neighborhood characteristics of young children, where only the NSCH provides a modest number of measures.

The NHIS has considerable strength in the health outcome and health care receipt domains, as expected, but is also very strong on measures of early socioemotional development including measures of problem behaviors, social competence, attachment, self-regulation, and cooperativeness. Measures of intellectual development are weak, however, limited mostly to whether early intervention/special services were ever given to the child. Data on family functioning are also sparse, while measures of parental health that may affect development are very strong. The NHES surveys, which include modules on early school readiness, early childhood program participation, parental involvement, and after school programs, are, taken together, strong on measures of intellectual development, child care, family functioning,[28] and to a lesser extent socioemotional development and health care receipt.

[28] Family functioning measures in the NHES tend to reflect those most obviously related to stimulating intellectual development such as reading to children and language stimulation, though some measures related to stress and conflict are also gathered.

One clear weakness of the system is the infrequency with which several of these core surveys are fielded. Only the NHIS is fielded annually. The NHES survey modules that include important data on young children are currently fielded once every four to six years, and the current plan for the NSCH, first fielded in 2003, is to repeat every four years). This means that a large proportion of the indicators relevant to early development and health, especially in the areas of intellectual development, family functioning, child care, and community/neighborhood characteristics, will only be updated at the national level about twice per decade. This is too infrequent to support effective monitoring of trends for policy purposes, and also represents a problem for simple needs assessment as estimates grow quickly out of date.

Large sample sizes are needed to support analyses of many important sub-populations of interest. Among the three major surveys, the NSCH is the largest with over 33,000 respondents for children under age six The NHIS has over 4,000 sample children that age. The NHES surveys have about 6,000–7,000 children under age six. The NSCH, with its large size, can support estimates for relatively rare populations within narrow age groups at the national level, and basic estimates down to the state level. The NHES and NHIS surveys can also support subgroup estimates for basic populations defined by race, sex, health insurance status, and income, but are not well suited for such estimates within narrow age spans, or for more narrowly defined groups. This can be particularly a shortcoming for those interested in early development among medically defined high risk groups.

The National Survey of Early Child Health (NSECH) is a nationally representative survey of children ages 4 to 35 months. Its major strengths are the detailed data it gathers on developmental screening received by the child, advice received from the doctor or other medical staff regarding parenting techniques, reading to the child, and various safety practices that can promote positive development. The survey was originally fielded in 2000. It is unclear whether it will be fielded on a regular basis. If so, it will be a very important data source for tracking developmental screening and outcomes for very young children.

Other Important Periodic Cross-Sectional Surveys and Administrative Data

Several other regularly fielded data sources which are representative of the general early child population do not have depth in the sorts of measures we are looking for, but do contain some specialized information that make them potentially important as sources of indicator data in particular areas.

- Birth Certificate data, Vital Statistics System. The major strength of birth certificate data is that it is one of the only sources of data available at the community level, providing estimates at the county and even the neighborhood level. In terms of content, it provides health data potentially related to later development including low birthweight, prenatal care, premature birth, breastfeeding, and whether the mother was smoking during pregnancy.

- The National Survey of Drug Use and Health (NSDUH) provides detailed data on the drug use habits of parents of young children not found anywhere else.

- The National Health and Nutrition Examination Survey (NHANES) contains health data on young children based on medical examination rather than parent report, making this potentially a very valuable data source for health outcomes related to development. Unfortunately, while it is very strong in health outcome data, there are almost no data collected that are directly related to intellectual or socioemotional development in young children under age 6 (though reading, math, and other intellectual assessments are, however, administered to children ages six through 16).

- The Pregnancy Risk Assessment Monitoring System (PRAMS), provides state-representative data on infants and their mothers in 29 states. PRAMS includes valuable state data on family violence, breastfeeding, and hearing problems of infants. Measures of intellectual and socioemotional development for children under age one are not well developed in general, and none are included in this survey.

- The National Survey of America's Families was a privately funded survey that tracked child and family well-being following the 1996 PRWORA welfare reform act. Surveys were taken in 1997, 1999, and 2002. It includes data on child health care coverage and receipt, as well as important parenting measures (e.g. parental mental health, aggravated parenting, outings and activities with the child), but no direct measures of intellectual or socioemotional development for children under age six. Data on disabilities of the child are also collected.

In addition, several periodically fielded data sources cover special populations. The Head Start Child and Family Experiences Survey (FACES) is a longitudinal survey of children ages 3 to 4 in Head Start programs, but one in which new cohorts have been surveyed every few years. This is a very rich data source for developmental indicators, though it is not as strong in measures of health care receipt and health outcomes (See review of longitudinal data sources, above, for details).

The National Child Abuse and Neglect Data System (NCANDS) contains data on reported cases of abuse and neglect across the 50 states and the District of Columbia. It is a good source of indicator data for measures directly related to abuse and neglect, and of parental health outcomes such as drinking, drug use, and chronic health issues. Unfortunately, it contains no measures related to child intellectual or socioemotional development. The Adoption and Foster Care Analysis and Reporting System (AFCARS), which contains data for children in the child welfare system, is similarly devoid of developmental data, and even lacks basic health and health care receipt data.

The survey of Children with Special Health Care Needs (CSHCN) collects data on children with special health care needs in each of the 50 states and the District of Columbia; about 250 children ages 0–5 for each state and the District of Columbia. The first version of the survey (2000–2002) contained no direct measures of early intellectual or socioemotional development, which was surprising given the fact that this population is generally at higher risk for developmental difficulties. The more recent version, being fielded in 2005–06, does contain selected measures of intellectual and socioemotional development.

The Pediatric Nutrition Surveillance System (PedNSS) follows the nutritional status of children ages 0–5 in federally funded maternal and child health and nutrition programs including WIC, EPSDT, and the Title V Maternal and Child Health program (MCH). Data collected include birthweight, under- and overweight, anemia, and breastfeeding.

The Pregnancy Nutrition Surveillance System (PNSS) collects data on low-income pregnant women participating in federally funded public health programs including WIC and MCH. Data collected include maternal smoking and drinking during pregnancy, anemia, diabetes, hypertension, maternal weight gain, medical care, and multi-vitamin consumption.

CONCLUSION AND RECOMMENDATIONS

Since the early 1990s, there has been tremendous growth in survey data available to research early child development and to track trends over time. None of the longitudinal data sets covered in this review existed before 1996. While the NHES surveys reviewed began in the early 1990s, the NSCH, NSECH, and CHSCN health surveys were first collected between 2000 and 2003, and the early child development information in the NHIS was not collected on a regular basis before 1997.

From the perspective of health research and health policy, the existing data offer tremendous opportunity for new research to be generated that can support better ways for the health community to promote early child development, and strong indicators for identifying areas of need and monitoring progress. A major goal of this review was to highlight these opportunities and provide a ready reference for those who wish to pursue them (See Appendix).

The second goal was to identify opportunities for future data development that will support research and indicator development in ways that better serve the health community in its quest to improve developmental outcomes for young children. These opportunities are discussed below along with recommendations on how they might be realized. Recommendations for longitudinal data, the major vehicle for research, and cross-sectional data, the major vehicle for social indicators, are presented separately.

Recommendations for Longitudinal Data

- Existing longitudinal data sets lack detail on the content of developmental screening and well-child visits that could inform better practice for those interventions. We recommend that age-appropriate questions similar in specificity to those found in the National Survey of Early Child Health (a cross-sectional survey) be developed and included in future longitudinal surveys. There may also be time to include such measures in the ECLS-B, at least for the first grade follow-up.

- Currently, health outcome and service data in the longitudinal surveys covered are based primarily on parent report rather than medical records, doctor report, or examination. While parent report is in many cases the only economically feasible way to gather such information, we recommend that some future longitudinal surveys include data from these more reliable sources. The National Children's Study may represent such an opportunity. (See below.)

- The National Children's Study (NSC) is an extremely ambitious longitudinal study designed to follow 100,000 children from before birth through age 21. It will focus on identifying the environmental influences affecting child health and development throughout the first two decades of life. Environmental factors include the external natural and man-made environments, and the social/cultural environment. Information on genetics will also be collected. The study will also be rich in health data. While the exact items to be gathered are not yet finalized, child development and mental health has been identified as a priority theme area. If developmental measures are sufficiently rich, the study could radically advance our understanding of the determinants of early development and the role that the health policy and practice communities can play in optimizing that development. We therefore strongly recommend that the design teams for this study adopt a rich set of age-appropriate intellectual and socioemotional development measures to complement the health measures to be fielded for this survey**.** The research coming out of this study should also have substantial effects on future choices of social contextual indicators affecting early development, as it may substantially alter our understanding of what and how key environmental factors affect development.

- Due to budgetary cutbacks, the current plan (as of July 2005) for the ECLS-B survey is to follow up with only one quarter of the full sample in first grade.[29] That would reduce the sample size to under 2500 children for that round, substantially weakening its ability to support subgroup analyses and reducing its statistical power overall (i.e., the ability to identify statistically significant relationships). We therefore urge the National Center for Education Statistics and key funders of the survey to reconsider their decision and find the means to fully support the first grade follow-up of the ECLS-B.

Recommendations for Periodic Cross-Sectional Data

- While trend data are available (or will be available) for a strong set of indicators of early health and development, as well as many of the social contextual factors that shape them, few indicators are available on an annual basis and many are scheduled to be updated every four to six years. This is far too infrequent to serve the needs of most policy-oriented users who require regular feedback on trends as well as needs assessments based on recent data rather than data that are five or six years old.

    - We recommend that the National Center for Education Statistics reconsider the current periodicity of its NHES surveys so that critical measures related to early child development, early child care, and early school readiness are updated on a more regular basis. Currently, NHES surveys in these areas are repeated every four to six years. An experts panel could be convened to consider alternative strategies, and weigh the costs and benefits of different approaches.

    - The NSCH, which has a sample size of over 100,000 and contains representative samples for every state and D.C, is currently expected to be fielded every four

[29] Our understanding is that only those who were held back in kindergarten rather than advancing to first grade will be surveyed in the upcoming round of data collection.

years. The NSCH is an invaluable and recent addition to the federal statistical system, providing new capacity to produce estimates for relatively rare subpopulations and estimates at the state level, both on early development and more generally on a whole host of child health and well-being outcomes. We strongly recommend that the survey be protected and nurtured in the years to come, with full funding to support its current sample size. Senator Rockefeller's State Child Well-Being Act of 2005, incorporated as an amendment into the Senate's welfare reform reauthorization bill Personal Responsibility and Individual Responsibility for Everyone (PRIDE), calls for a state-level survey of child well-being to be repeated every three years and provides the funding needed to carry it out. The NSCH is considered to be a likely vehicle for this effort if it is passed into law. While the three year cycle is less than optimal for policy purposes, it represents a significant improvement over the current four-year plan and we hope that this comes to pass whether through the PRIDE bill or through other means.

- There are a number of surveys that could be made much more useful for health-oriented early child development policy with the addition of new measures.

    - NHANES: This survey provides unique health data based on medical examination for all ages, but lacks developmental screening as part of its current data gathering plan for children under age six. The NHANES offers a great opportunity to collect developmental data based on medical examination for a nationally representative sample, which does not exist anywhere currently in the federal data collection system. We recommend that NHANES consider adding age appropriate developmental screening to their data collection efforts on young children, as they already do for children ages six and older.

    - CSHCN: When the Children with Special Health Care Needs survey was first fielded in 2000–2002, it lacked data on child intellectual, social and emotional development. This is a very important population for developmental policy, and one that the health community is particularly well positioned to support. For the 2005–06 survey some developmental measures in all these areas were added. We applaud this expansion, and recommend that additional age-appropriate developmental measures be considered for the next version of the survey.

- Increasingly, the policy decisions that affect early child health and development policy are being made at the state and local levels. Currently there are virtually no relevant data collected across all local areas with the exception of a few measures collected on the birth certificate. At the state level, the situation was only marginally better before the introduction of the NSCH in 2003. We recommend that efforts be made to continue to expand data collection at the state level. An expansion of the National Survey of Early Child Health (NSECH) from a national to a state-level survey would be an obvious and productive step in this direction, providing states with the capacity to monitor the development of very young children (ages 4 to 35 months), as well as the content and

frequency of their well-child visits in medical settings. Such data are important tools, for example, in supporting efforts to integrate state early childhood services, something that is currently being promoted by the Maternal and Child Health Bureau through its State Early Childhood Comprehensive Systems initiative (SECCS).[30] To generate data below the state level, we recommend that the responsible federal agencies consider expanding the NSCH to allow for representative samples in selected major metropolitan areas, as is currently done with the National Immunization Survey,[31] and the Youth Risk Behavior Survey.[32]

- Finally, we recommend expanding the tracking of community characteristics indicators at the national and state levels. Among the repeated cross-sectional surveys covered in this review, the major gap in data collection is in community characteristics. With the exception of a few measures in the NSCH, community indicators are virtually absent from these surveys. Such measures could include things like: the local poverty, unemployment, or crime rates; whether the neighborhood is perceived as a safe place to raise young children; and whether neighbors tend to look out for each other's children. These measures have been developed and fielded in a number of longitudinal surveys, and could be easily included in any of a number of cross-sectional surveys. These are important indicators in their own right and important also for offering the ability to track health and development among children living in high-risk neighborhoods.

The last decade has seen unprecedented development of data resources for researching and monitoring early child development and health. It is our hope that this paper will help to spur new and greater use of the rich data sources that currently exist in order to guide policy in the health community. It is also our hope that it will spur discussion within and between the health policy and data collection communities on how existing data collection efforts can be augmented and expanded to better serve the health profession in its efforts to promote healthy development for all young children.

[30] For details visit http://www.mch.dhs.ca.gov/programs/seccs/default.htm.
[31] For details visit http://www.cdc.gov/nis/.
[32] For details visit http://www.cdc.gov/HealthyYouth/yrbs/index.htm.

Appendix

1. Adoption and Foster Care Analysis Reporting System (AFCARS)
2. Survey of Children with Special Health Care Needs (CSHCN)
3. Early Childhood Longitudinal Survey, Birth Cohort (ECLS-B)
4. Early Childhood Longitudinal Survey, Kindergarten Cohort (ECLS-K)
5. Fragile Families and Child Well-Being Study (FSS)
6. Head Start Family and Child Experiences Survey (FACES)
7. Individuals with Disabilities Education Act Data (IDEA)
8. Medical Expenditure Panel Survey (MEPS) Household
9. National Survey of Children's Health (NSCH)
10. National Survey of Family Growth (NSFG)
11. National Survey on Drug Use and Health (NSDUH)
12. National Vital Statistics System: Birth Data
13. National Child Abuse and Neglect Data System (NCANDS)
14. National Health and Nutrition Examination Survey, 1999-2000 (NHANES)
15. National Household and Education Survey – After School Programs
16. National Household and Education Survey – Early Childhood Program Participation
17. National Household and Education Survey – Parental Involvement
18. National Household and Education Survey – School Readiness
19. National Health Interview Survey (NHIS)
20. National Survey of America's Families (NSAF)
21. National Survey of Child and Adolescent Well-Being (NSCAW)
22. National Survey of Early Childhood Health (NSECH)
23. Pediatric Nutrition Surveillance System (PedNSS)
24. Pregnancy Nutrition Surveillance System (PNSS)
25. Pregnancy Risk Assessment Monitoring System (PRAMS)
26. Panel Study of Income Dynamics – Child Development Supplement (PSID-CDS)

Adoption and Foster Care Analysis Reporting System (AFCARS)

Background Information

Description/Purpose: Collects state data on children in foster care and who are adopted to make better policies and programs, and in response to Title IV B/E of the Social Security Act.
Data Type: administrative reports
Population: children and youth zero to 19 + who are in the foster care system
Design: administrative case data
Periodicity: annual preliminary, interim and final reports
Sample Size: complete counts
Unit of Observation: case
Geography: state, national
Data Availability: after registering, can obtain data free online
Sponsors: Administration for Children and Families, Children's Bureau, Department of Health and Human Services
Website: http://www.acf.hhs.gov/programs/cb/dis/afcars/publications/afcars.htm

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- Stammering/stuttering
- Received early intervention or special education services

Health
- Blood lead level
- Obesity
- Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- Asthma
- Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- Unmet health needs
- TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- Developmental screening
- Health insurance coverage, and % eligible but not enrolled
- S-CHIP coverage
- Screening for hearing and vision problems
- Dental care receipt
- Office visits
- Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- Parental depression
- x Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- x Parental drug use
- Regular physical activity
- Overall health rating
- Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- x Family structure
- Income
- Income by source
- Parental employment
- x Immigrant status (1st and 2nd generation)
- Parental educational attainment
- Noresident parent information
- Poverty status
- x Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- x Births to single teen mothers
- x Children w/ parents in prison
- Food stamp receipt
- x Geographic location
- x Siblings
- TANF receipt
- WIC reChild care subsidy receipt
- Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

Survey of Children with Special Health Care Needs (CSHCN)

Background Information

Description/Purpose: Collects information on the prevalence and effects of special health care needs on children and their access to adequate medical care
Data Type: telephone survey
Population: children under age 18
Design: cross-sectional
Periodicity: 2000-2002, 2005-2006
Sample Size: 750 children with special health care needs, 2,700 children without special health care needs from each state and Washington DC
Unit of Observation: child
Geography: national, state
Data Availability: online, free
Sponsors: Maternal and Child Health Bureau of the Health Resources and Services Administration and Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.
Website: http://www.cdc.gov/nchs/about/major/slaits/cshcn.htm

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- x Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- x Expressive language
- Receptive language
- x Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- Stammering/stuttering
- Received early intervention or special education services

Health
- Blood lead level
- Obesity
- Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- x Asthma
- Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- Breastfeeding
- x Immunizations
- x Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- x Unmet health needs
- TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- Screening for hearing and vision problems
- x Dental care receipt
- x Office visits
- x Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- x Medical home

Parental Health
- Parental depression
- Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- Overall health rating
- Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- Income by source
- Parental employment
- Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- Noresident parent information
- x Poverty status
- x Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- Food stamp receipt
- Geographic location
- Siblings
- x TANF receipt
- WIC receipt
- Child care subsidy receipt
- x Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

Early Childhood Longitudinal Survey, Birth Cohort (ECLS-B)

Background Information

Description/Purpose: This is a longitudinal survey that follows children from birth through the first grade. It follows their health and development, care and education through these early years. Data are collected from the children, parents, child care providers, teachers, school administrators
Data Type: survey
Population: children born in 2001
Design: longitudinal
Periodicity: begins with children born in 2001, interviews at 9 months, 2 years, 4 years, kindergarten and first grade
Sample Size: 10,600 children
Unit of Observation: child
Geography: national
Data Availability: restricted access data available one year after wave ends, public use data available 15 months after wave ends
Sponsors: National Center for Education Statistics
Website: http://nces.ed.gov/ecls/Birth.asp

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- x Social competence
- x Attachment
- x Self-regulation
- Post-traumatic stress
- x Peer relationships
- x Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- x Verbal proficiency
- Quantitative proficiency
- x Expressive language
- x Receptive language
- x Fine and gross motor skills
- x Basic concepts mastery
- Approaches to learning
- x Pre-reading behaviors
- Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- x Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- x Failure to thrive
- x Premature birth
- x Asthma
- Iron deficiency
- x Vision problems
- x Nutritional status
- x Hearing problems
- Head injuries
- x Breastfeeding
- Immunizations
- x Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- x Parental warmth and affection
- x Language stimulation
- x Available learning materials (books computers) in the home
- x Developmentally inappropriate expectations of child's behavior
- x Harsh parenting
- Abuse/neglect of child
- x Parental stress
- x Aggravated Parenting
- x Parental domestic violence
- Regular bed time
- x Regular meal time with family
- x Regular seat belt use
- x Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- x Parenting style
- x Parental responsivity
- x Contact with noncustodial parent
- x Variety of experience
- x HOME scale
- x Parent conflict resolution styles
- Exercise
- x Unmet health needs
- x TV and video time
- x Food insecurity
- x Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- x Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- x Screening for hearing and vision problems
- x Dental care receipt
- Office visits
- x Well-child visits
- Hospitalization (accident)
- x Hospitalization (injury)
- x Hospitalization (illness)
- x Medical home

Parental Health
- x Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- x Parental drug use
- Regular physical activity
- x Overall health rating
- x Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- x Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- x Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- x Hours spent in care each week
- x Type of care
- x Teacher/child ratio
- x Primary care source
- x Use of multiple arrangements
- x Teacher education levels
- x ECE specific training or education for teachers
- x Parental involvement in care
- x Parent-caregiver/teacher communication
- x Staff years of experience
- x Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- x Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- x Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- x Poverty status
- x Children in foster care
- x Homeless children
- x Linguistic isolation
- Parental illiteracy
- x Births to single teen mothers
- x Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- x Child care subsidy receipt
- x Number of young children in family
- x Urban/rural marker
- MSA/non-MSA area

Early Childhood Longitudinal Survey, Kindergarten Cohort (ECLS-K)

Background Information

Description/Purpose: This is a longitudinal survey that follows children from kindergarten through the fifth grade. The survey includes data on the knowledge and skills of children as they enter kindergarten, and enables researchers to examine how personal, family, school, and community factors influence early school performance.
Data Type: survey
Population: children in kindergarten in 1998-1999
Design: longitudinal
Periodicity: beginning with kindergartners in 1998-1999, follows same students through fifth grade, with evaluations in first grade (1999-2000), third grade (2002) and fifth grade (2004)
Sample Size: around 22,000 children in approx. 2,000 schools, oversample of Asian children, private school children
Unit of Observation: child
Geography: national
Data Availability: kindergarten, first grade data available free, need special permission for restricted access data
Sponsors: National Center for Education Statistics
Website: http://nces.ed.gov/ecls/Kindergarten.asp

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- x Social competence
- x Attachment
- x Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- x Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- x Cooperation/compliance

Intellectual Development
- x Verbal proficiency
- x Quantitative proficiency
- x Expressive language
- Receptive language
- x Fine and gross motor skills
- x Basic concepts mastery
- x Approaches to learning
- x Pre-reading behaviors
- Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- x Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- x Premature birth
- x Asthma
- Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- x Parental warmth and affection
- x Language stimulation
- x Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- x Harsh parenting
- Abuse/neglect of child
- Parental stress
- x Aggravated Parenting
- x Parental domestic violence
- x Regular bed time
- x Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- x Parental responsivity
- x Contact with noncustodial parent
- x Variety of experience
- x HOME scale
- x Parent conflict resolution styles
- x Exercise
- Unmet health needs
- x TV and video time
- x Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- x Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- S-CHIP coverage
- Screening for hearing and vision problems
- x Dental care receipt
- Office visits
- x Well-child visits
- Hospitalization (accident)
- x Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- x Parental depression
- Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- x Overall health rating
- Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- x Violence levels
- Poverty rate
- x Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- x Crime rates
- Clean and safe playgrounds
- x Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- x Hours spent in care each week
- x Type of care
- x Teacher/child ratio
- x Primary care source
- x Use of multiple arrangements
- Teacher education levels
- x ECE specific training or education for teachers
- x Parental involvement in care
- x Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- x Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- x Poverty status
- x Children in foster care
- x Homeless children
- x Linguistic isolation
- Parental illiteracy
- x Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- x Child care subsidy receipt
- x Number of young children in family
- x Urban/rural marker
- MSA/non-MSA area

Fragile Families and Child Well-Being Study (FFS)

Background Information

Description/Purpose: Examines non-marital childbearing, welfare reform, and the role of fathers, designed to provide new information on the capabilities and relationships of unwed parents, as well as the effects of policies on family formation and child wellbeing
Data Type: survey
Population: mostly unwed parents and their children, representative sample of non-marital births in cities with populations over 200,000 in 1999
Design: longitudinal 5-year study
Periodicity: at birth and when child is 1,3,5 years old; began in 1999
Sample Size: 4,700 families; 3,600 unwed couples, 1,100 married couples
Unit of Observation: family
Geography: 20 cities, U.S. cities over 200,000 population
Data Availability: birth, 1-year data available free, online, 3-yr, 5-yr follow-up will be available
Sponsors: Princeton University's Center for Research on Child Wellbeing (CRCW) and Columbia University's Social Indicators Survey Center (SIS Center)
Website: http://crcw.princeton.edu/fragilefamilies/index.asp

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- x Social competence
- x Attachment
- x Self-regulation
- Post-traumatic stress
- x Peer relationships
- x Positive affect
- x Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- x Cooperation/compliance

Intellectual Development
- x Verbal proficiency
- Quantitative proficiency
- x Expressive language
- x Receptive language
- x Fine and gross motor skills
- Basic concepts mastery
- x Approaches to learning
- Pre-reading behaviors
- x Stammering/stuttering
- Received early intervention or special education services

Health
- x Blood lead level
- x Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- x Asthma
- Iron deficiency
- x Vision problems
- x Nutritional status
- x Hearing problems
- Head injuries
- x Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- x Parental warmth and affection
- x Language stimulation
- x Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- x Harsh parenting
- x Abuse/neglect of child
- x Parental stress
- x Aggravated Parenting
- x Parental domestic violence
- x Regular bed time
- x Regular meal time with family
- x Regular seat belt use
- x Adequate childproofing of the home
- x Health/Safety issues in home environment (lead, medicine)
- x Parenting style
- x Parental responsivity
- x Contact with noncustodial parent
- x Variety of experience
- x HOME scale
- x Parent conflict resolution styles
- Exercise
- x Unmet health needs
- x TV and video time
- x Food insecurity
- x Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- S-CHIP coverage
- Screening for hearing and vision problems
- Dental care receipt
- Office visits
- x Well-child visits
- x Hospitalization (accident)
- x Hospitalization (injury)
- Hospitalization (illness)
- x Medical home

Parental Health
- x Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- x Parental drug use
- Regular physical activity
- x Overall health rating
- x Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- x Violence levels
- Poverty rate
- x Perceived safety levels
- x Neighbors can be counted on to help
- x Neighbors intervene with children's misbehavior
- x Adult unemployment
- Crime rates
- Clean and safe playgrounds
- x Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- x Hours spent in care each week
- x Type of care
- x Teacher/child ratio
- x Primary care source
- x Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- x Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- x Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- x Family structure
- x Income
- x Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- x Poverty status
- x Children in foster care
- x Homeless children
- Linguistic isolation
- x Parental illiteracy
- x Births to single teen mothers
- x Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- x Child care subsidy receipt
- x Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

Head Start Family and Child Experiences Survey (FACES)

Background Information

Description/Purpose: Measure and research quality and effectiveness of Head Start, see what changes are needed to improve program, increase accountability, measure cognitive, emotional, social and physical development of Head Start children, and accomplishments of the Head Start families
Data Type: survey
Population: children who entered Head Start at age three or four
Design: longitudinal (but being repeated)
Periodicity: 1997, following 3- and 4-year olds to first grade. New cohorts started in 2000 and 2003.
Sample Size: around 2,800 - 3,200 children
Unit of Observation:child, parent, teacher and staff
Geography: national
Data Availability: Send requests to contact@childcareresearch.org
Sponsors: Administration for Children and Families, WESTAT
Website: http://www.acf.hhs.gov/programs/opre/hs/faces

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- x Social competence
- Attachment
- x Self-regulation
- Post-traumatic stress
- x Peer relationships
- Positive affect
- x Internalizing behaviors (sad, unhappy or depressed)
- x Mastery motivation
- x ADHD, attentional issues, hyperactivity
- x Cooperation/compliance

Intellectual Development
- x Verbal proficiency
- x Quantitative proficiency
- x Expressive language
- Receptive language
- x Fine and gross motor skills
- x Basic concepts mastery
- x Approaches to learning
- x Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- Asthma
- Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- x Head injuries
- Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- Parental warmth and affection
- x Language stimulation
- x Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- x Harsh parenting
- x Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- x Parental domestic violence
- Regular bed time
- Regular meal time with family
- x Regular seat belt use
- x Adequate childproofing of the home
- x Health/Safety issues in home environment (lead, medicine)
- x Parenting style
- Parental responsivity
- x Contact with noncustodial parent
- x Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- x Unmet health needs
- x TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- S-CHIP coverage
- Screening for hearing and vision problems
- x Dental care receipt
- Office visits
- x Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- x Medical home

Parental Health
- x Parental depression
- Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- x Overall health rating
- x Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- x Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- x Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- x Hours spent in care each week
- x Type of care
- x Teacher/child ratio
- x Primary care source
- x Use of multiple arrangements
- x Teacher education levels
- x ECE specific training or education for teachers
- x Parental involvement in care
- Parent-caregiver/teacher communication
- x Staff years of experience
- x Health and safety of care (sanitation, safe play)
- x Presence of curriculum
- x ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- x Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- Poverty status
- x Children in foster care
- x Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- x Children w/ parents in prison
- x Food stamp receipt
- Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- x Child care subsidy receipt
- Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

Individuals with Disabilities Education Act Data (IDEA)

Background Information

Description/Purpose: Data on children with disabilities has been collected since 1976 to monitor the children receiving early intervention or special education services.
Data Type: Administrative
Population: All children with disabilities under IDEA who receive services because of their disability
Design: NA
Periodicity: Annual data collection
Sample Size: complete counts
Unit of Observation: child
Geography: National
Data Availability: online and free
Sponsors: US Department of Education, Office of Special Education Programs
Website: www.ideadata.org

Available Measures for Children Ages 0 to 5

Socioemotional Development
x Problem behaviors
Social competence
Attachment
Self-regulation
Post-traumatic stress
Peer relationships
Positive affect
Internalizing behaviors (sad, unhappy or depressed)
Mastery motivation
ADHD, attentional issues, hyperactivity
Cooperation/compliance

Intellectual Development
Verbal proficiency
Quantitative proficiency
Expressive language
Receptive language
Fine and gross motor skills
Basic concepts mastery
Approaches to learning
Pre-reading behaviors
Stammering/stuttering
Received early intervention or special education services

Health
Blood lead level
Obesity
Low/very low birthweight, and medical follow-up
x Chronic illness/disability
Failure to thrive
Premature birth
Asthma
Iron deficiency
x Vision problems
Nutritional status
x Hearing problems
x Head injuries
Breastfeeding
Immunizations
x Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
Parent reads to child
Parental warmth and affection
Language stimulation
Available learning materials (books computers) in the home
Developmentally inappropriate expectations of child's behavior
Harsh parenting
Abuse/neglect of child
Parental stress
Aggravated Parenting
Parental domestic violence
Regular bed time
Regular meal time with family
Regular seat belt use
Adequate childproofing of the home
Health/Safety issues in home environment (lead, medicine)
Parenting style
Parental responsivity
Contact with noncustodial parent
Variety of experience
HOME scale
Parent conflict resolution styles
Exercise
Unmet health needs
TV and video time
Food insecurity
Family participation in religion

Health Care Receipt and Coverage
Usual source of care
Developmental screening
Health insurance coverage, and % eligible but not enrolled
S-CHIP coverage
Screening for hearing and vision problems
Dental care receipt
Office visits
Well-child visits
Hospitalization (accident)
Hospitalization (injury)
Hospitalization (illness)
Medical home

Parental Health
Parental depression
Parental drinking (pre and post-natal)
Parental smoking (pre and post-natal)
Parental drug use
Regular physical activity
Overall health rating
Parental disability or chronic health condition
Parental sense of social support

Community/Neighborhood
Violence levels
Poverty rate
Perceived safety levels
Neighbors can be counted on to help
Neighbors intervene with children's misbehavior
Adult unemployment
Crime rates
Clean and safe playgrounds
Housing stock quality
liquor licenses
Employers with maternity leave
Percentage of single mothers

Child Care Participation and Quality
Hours spent in care each week
Type of care
Teacher/child ratio
Primary care source
Use of multiple arrangements
Teacher education levels
ECE specific training or education for teachers
Parental involvement in care
Parent-caregiver/teacher communication
Staff years of experience
Health and safety of care (sanitation, safe play)
Presence of curriculum
ITERS/FDCRS/ECERS or other observational quality measures
Stability of care
Parental Satisfaction with care

Demographics
x Race and Hispanic origin
Language spoken in home
Family structure
Income
Income by source
Parental employment
Immigrant status (1st and 2nd generation)
Parental educational attainment
Noresident parent information
Poverty status
Children in foster care
Homeless children
Linguistic isolation
Parental illiteracy
Births to single teen mothers
Children w/ parents in prison
Food stamp receipt
Geographic location
Siblings
TANF receipt
WIC receipt
Child care subsidy receipt
Number of young children in family
Urban/rural marker
MSA/non-MSA area

Medical Expenditure Panel Survey (MEPS) Household

Background Information

Description/Purpose: National probability survey on the financing and utilization of medical care in the US
Data Type: Survey
Population: US civilian, non-institionalized, population
Design: Longitudinal, computer-assisted, face-to-face interview
Periodicity: Annually since 1996
Sample Size: 2002 estimate: 15,000 families; 37,000 persons
Unit of Observation: household
Geography: National
Data Availability: publically available
Sponsors: Agency for Health Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS)
Website: http://meps.ahrq.gov

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- x Social competence
- x Attachment
- x Self-regulation
- Post-traumatic stress
- x Peer relationships
- Positive affect
- x Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- x Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- x Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- x Asthma
- x Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- Breastfeeding
- x Immunizations
- x Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- x Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- x Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- x Exercise
- x Unmet health needs
- TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- x Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- x Screening for hearing and vision problems
- x Dental care receipt
- x Office visits
- x Well-child visits
- Hospitalization (accident)
- x Hospitalization (injury)
- x Hospitalization (illness)
- Medical home

Parental Health
- x Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- Parental drug use
- x Regular physical activity
- x Overall health rating
- x Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- x Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- x Stability of care
- x Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language Spoken in home
- x Family structure
- x Income
- x Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- x Poverty status
- x Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- Child care subsidy receipt
- x Number of young children in family
- x Urban/rural marker
- x MSA/non-MSA area

National Survey of Children's Health (NSCH)

Background Information

Description/Purpose: Collects information on the physical and emotional health and well-being of children and youth under age 18
Data Type: telephone survey
Population: children and youth ages 0 to 17
Design: cross-sectional
Periodicity: 2003
Sample Size: 102,000 (2,000 from each state and Washington, DC)
Unit of Observation: child
Geography: national, state
Data Availability: available free, online
Sponsors: Centers for Disease Control and Prevention, Health Resources and Service Administration's Maternal and Child Health Bureau
Website: http://www.cdc.gov/nchs/about/major/slaits/nsch.htm

Available Measures for Children Ages 0 to 5

30Socioemotional Development
- x Problem behaviors
- x Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- x Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- x Expressive language
- x Receptive language
- x Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- x Stammering/stuttering
- Received early intervention or special education services

Health
- Blood lead level
- x Obesity
- Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- x Asthma
- Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- x Breastfeeding
- x Immunizations
- x Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- x Parental stress
- x Aggravated Parenting
- Parental domestic violence
- Regular bed time
- x Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- x Contact with noncustodial parent
- x Variety of experience
- HOME scale
- x Parent conflict resolution styles
- Exercise
- x Unmet health needs
- TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- x Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- Screening for hearing and vision problems
- x Dental care receipt
- Office visits
- x Well-child visits
- x Hospitalization (accident)
- x Hospitalization (injury)
- Hospitalization (illness)
- x Medical home

Parental Health
- Parental depression
- x Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- Parental drug use
- x Regular physical activity
- x Overall health rating
- Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- x Perceived safety levels
- x Neighbors can be counted on to help
- x Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- x Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- Income by ssource
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- x Poverty status
- x Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- Geographic location
- Siblings
- x TANF receipt
- WIC receipt
- x Child care subsidy receipt
- Number of young children in family
- x Urban/rural marker
- MSA/non-MSA area

National Survey of Family Growth

Background Information

Description/Purpose: Provides information on childbearing, contraception, and related aspects of maternal and child health
Data Type: Survey
Population: Women 15-44 years of age in civilian non-institutionalized U.S. population; Survey from 2002-03 included men; nationally representative sample
Design: repeated cross-section, personal in-home interviews
Periodicity: 1973, 1976, 1982, 1988, 1990 (Cycle IV telephone reinterview), 1995, 2002
Sample Size: varying from around 8,000 to 11,000
Unit of Observation: adult
Geography: national
Data Availability: Data CDs available free of charge from NCHS
Sponsors: National Center for Health Statistics; Survey Center of University of Michigan
Website: http://www.cdc.gov/nchs/nsfg.htm

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- Stammering/stuttering
- Received early intervention or special education services

Health
- Blood lead level
- Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- x Premature birth
- Asthma
- Iron deficiency
- Vision problems
- Nutritional status
- Hearing problems
- Head injuries
- x Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- x Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- x Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- Unmet health needs
- TV and video time
- Food insecurity
- x Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- Screening for hearing and vision problems
- Dental care receipt
- Office visits
- Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- x Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- x Parental drug use
- Regular physical activity
- Overall health rating
- x Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- x Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- x Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- x Family structure
- x Income
- x Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- Poverty status
- x Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- x Births to single teen mothers
- x Children w/ parents in prison
- x Food stamp receipt
- Geographic location
- x Siblings
- TANF receipt
- x WIC receipt
- Child care subsidy receipt
- Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

National Survey on Drug Use and Health

Background Information

Description/Purpose: Provides information on the prevalence, patterns, and consequences of alcohol, tobacco, and illegal drug use and abuse. Can be used to examine substance use among parents of young children.
Data Type: nationally representative survey
Population: civilian noninstitutionalized population of the United States aged 12 years old or older
Design: repeated cross-section
Periodicity: 1971-present, yearly; 2002 and later not comparable to earlier years
Sample Size: 68,126 people, with youth and young adults oversampled
Unit of Observation: individual
Geography: national, with eight states designed as large sample states
Data Availability: data available online, free
Sponsors: US Department of Health and Human Services; Substance Abuse Services and Mental Health Administration
Website: http://www.samhsa.gov/oas/nhsda.htm#NHSDAinfo

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- Stammering/stuttering
- Received early intervention or special education services

Health
- Blood lead level
- Obesity
- Low/very low birthweight, and medical follow-up
- Chronic illness/disability
- Failure to thrive
- Premature birth
- Asthma
- Iron deficiency
- Vision problems
- Nutritional status
- Hearing problems
- Head injuries
- Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- x Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- Unmet health needs
- TV and video time
- Food insecurity
- x Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- Screening for hearing and vision problems
- Dental care receipt
- Office visits
- Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- x Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- x Parental drug use
- Regular physical activity
- x Overall health rating
- x Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- x Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- x Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- Family structure
- x Income
- x Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- Poverty status
- x Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- WIC receipt
- Child care subsidy receipt
- Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

National Vital Statistics System: Birth Data

Background Information

Description/Purpose: Federal law mandates national collection and publication of birth data-this info based on 2003 certificates
Data Type: Administrative
Population: all births
Design: Information pulled from US standard certificates of live births
Periodicity: continuous
Sample Size: full count
Unit of Observation: birth
Geography: national, state, certificates also contain county, city of birth and residence
Data Availability: publicly available
Sponsors: NCHS and states
Website: www.cdc.gov/nchs/births.htm

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- Stammering/stuttering
- Received early intervention or special education services

Health
- Blood lead level
- Obesity
- x Low/very low birthweight, and medical follow-up
- Chronic illness/disability
- Failure to thrive
- x Premature birth
- Asthma
- Iron deficiency
- Vision problems
- Nutritional status
- Hearing problems
- Head injuries
- x Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- Unmet health needs
- TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- S-CHIP coverage
- Screening for hearing and vision problems
- Dental care receipt
- Office visits
- x Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- Parental depression
- Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- Overall health rating
- Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- x Family structure
- Income
- Income by source
- Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- Noresident parent information
- Poverty status
- Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- x Births to single teen mothers
- Children w/ parents in prison
- Food stamp receipt
- x Geographic location
- x Siblings
- TANF receipt
- x WIC receipt
- Child care subsidy receipt
- Number of young children in family
- Urban/rural marker
- x MSA/non-MSA area

National Child Abuse and Neglect Data System (NCANDS)

Background Information

Description/Purpose: collects state information on abused and neglected children to better inform protective service policies and programs, in response to the Child Abuse Prevention and Treatment Act
Data Type: administrative
Population: children who have been reported abused or neglected
Design: national reporting system, detailed case component and summary case component
Periodicity: annually since 1990
Sample Size: full counts
Unit of Observation: case/report
Geography: national, state
Data Availability: may order online
Sponsors: Children's Bureau, the Department of Health and Human Services
Website: http://www.ndacan.cornell.edu/NDACAN/Datasets/Abstracts/DatasetAbstract_NCANDS_General.html

Available Measures for Children Ages 0 to 5

Socioemotional Development
x Problem behaviors
Social competence
Attachment
Self-regulation
Post-traumatic stress
Peer relationships
Positive affect
Internalizing behaviors (sad, unhappy or depressed)
Mastery motivation
ADHD, attentional issues, hyperactivity
Cooperation/compliance

Intellectual Development
Verbal proficiency
Quantitative proficiency
Expressive language
Receptive language
Fine and gross motor skills
Basic concepts mastery
Approaches to learning
Pre-reading behaviors
Stammering/stuttering
Received early intervention or special education services

Health
Blood lead level
Obesity
Low/very low birthweight, and medical follow-up
x Chronic illness/disability
Failure to thrive
Premature birth
Asthma
Iron deficiency
x Vision problems
Nutritional status
x Hearing problems
Head injuries
Breastfeeding
Immunizations
Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
Parent reads to child
Parental warmth and affection
Language stimulation
Available learning materials (books computers) in the home
Developmentally inappropriate expectations of child's behavior
Harsh parenting
x Abuse/neglect of child
Parental stress
Aggravated Parenting
x Parental domestic violence
Regular bed time
Regular meal time with family
Regular seat belt use
Adequate childproofing of the home
Health/Safety issues in home environment (lead, medicine)
Parenting style
Parental responsivity
Contact with noncustodial parent
Variety of experience
HOME scale
Parent conflict resolution styles
Exercise
Unmet health needs
TV and video time
Food insecurity
Family participation in religion

Health Care Receipt and Coverage
Usual source of care
Developmental screening
Health insurance coverage, and % eligible but not enrolled
S-CHIP coverage
Screening for hearing and vision problems
Dental care receipt
Office visits
Well-child visits
Hospitalization (accident)
Hospitalization (injury)
Hospitalization (illness)
Medical home

Parental Health
Parental depression
x Parental drinking (pre and post-natal)
Parental smoking (pre and post-natal)
x Parental drug use
Regular physical activity
Overall health rating
x Parental disability or chronic health condition
Parental sense of social support

Community/Neighborhood
Violence levels
Poverty rate
Perceived safety levels
Neighbors can be counted on to help
Neighbors intervene with children's misbehavior
Adult unemployment
Crime rates
Clean and safe playgrounds
Housing stock quality
liquor licenses
Employers with maternity leave
Percentage of single mothers

Child Care Participation and Quality
Hours spent in care each week
Type of care
Teacher/child ratio
Primary care source
Use of multiple arrangements
Teacher education levels
ECE specific training or education for teachers
Parental involvement in care
Parent-caregiver/teacher communication
Staff years of experience
Health and safety of care (sanitation, safe play)
Presence of curriculum
ITERS/FDCRS/ECERS or other observational quality measures
Stability of care
Parental Satisfaction with care

Demographics
x Race and Hispanic origin
Language spoken in home
x Family structure
Income
Income by source
Parental employment
Immigrant status (1st and 2nd generation)
Parental educational attainment
Noresident parent information
x Poverty status
x Children in foster care
Homeless children
Linguistic isolation
Parental illiteracy
Births to single teen mothers
Children w/ parents in prison
x Food stamp receipt
x Geographic location
Siblings
x TANF receipt
WIC receipt
Child care subsidy receipt
Number of young children in family
Urban/rural marker
MSA/non-MSA area

National Health and Nutrition Examination Survey

Background Information

Description/Purpose: To provide data about estimated number of people with certain diseases and risk factors, study the relationship between nutrition and diet, trends in new technologies, measure prevalence, awareness, treatment, and control of selected diseases.
Data Type: Survey, physical examination, and lab collection
Population: U.S. population
Design: Cross-sectional. Information gathered at subject's home by interviewer (Computer Assisted Personal Interviewing) and examination in a Mobile Examination Center.
Periodicity: Continuous annual survey
Sample Size: About 7000 people annually. Oversampling for blacks, Mexican Americans, adolescents, pregnant women and older persons.
Unit of Observation: Individual
Geography: National
Data Availability: On-line, free
Sponsors: CDC-National Center for Health Statistics
Website: www.cdc.gov/nchs/nhanes.htm

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- x Blood lead level
- x Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- x Premature birth
- x Asthma
- x Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- x Breastfeeding
- x Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- x Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- x Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- x Exercise
- Unmet health needs
- x TV and video time
- x Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- Screening for hearing and vision problems
- x Dental care receipt
- Office visits
- Well-child visits
- x Hospitalization (accident)
- x Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- x Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- x Parental drug use
- x Regular physical activity
- Overall health rating
- x Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- x Hours spent in care each week
- Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- x Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- Noresident parent information
- x Poverty status
- x Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- WIC receipt
- Child care subsidy receipt
- Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

National Household Education Survey-After School Programs

Background Information

Description/Purpose: provides descriptive data on the educational data of the U.S. population, with a special focus on before- and after-school activities of children, center or school based programs, self care, arrangements with relatives, and activities children participate in after school
Data Type: Survey
Population: Kindergarten through Grade 8
Design: repeated cross-section
Periodicity: 1991, 2001, and 2005
Sample Size: 9,583 completed after school program surveys, 48,385 screener interviews
Unit of Observation: adult most knowledgeable about sample child
Geography: national
Data Availability: online, free
Sponsors: National Center for Education Statistics, U.S. Department of Education
Website: http://nces.ed.gov/nhes/index.asp

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- x Approaches to learning
- Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- Obesity
- Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- Asthma
- Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- Breastfeeding
- Immunizations
- x Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- Unmet health needs
- TV and video time
- Food insecurity
- x Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- x Developmental screening
- Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- Screening for hearing and vision problems
- x Dental care receipt
- Office visits
- x Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- Parental depression
- Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- Overall health rating
- Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- x Hours spent in care each week
- x Type of care
- x Teacher/child ratio
- x Primary care source
- x Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- x Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- x Stability of care
- x Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- x Poverty status
- Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- x Child care subsidy receipt
- Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

National Household Education Survey-Early Childhood Program Participation

Background Information

Description/Purpose: provides descriptive data on the educational data of the U.S. population, with a special focus on early childhood program participation and child care
Data Type: Survey
Population: 0-6 years old who were not enrolled in Kindergarten or higher;
Design: repeated cross-section
Periodicity: 1991, 1995, 1999, 2001, and 2005;
Sample Size: 6,749 parents surveyed in 2001
Unit of Observation: adult most knowledgeable about sample child
Geography: national
Data Availability: online, free
Sponsors: National Center for Education Statistics, U.S. Department of Education
Website: http://nces.ed.gov/nhes/index.asp

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- x Verbal proficiency
- x Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- x Basic concepts mastery
- Approaches to learning
- x Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- Obesity
- Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- Asthma
- Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- Parental warmth and affection
- x Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- x Variety of experience
- x HOME scale
- Parent conflict resolution styles
- Exercise
- Unmet health needs
- TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- Developmental screening
- Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- x Screening for hearing and vision problems
- x Dental care receipt
- Office visits
- x Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- Parental depression
- Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- Overall health rating
- Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- x Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- x Hours spent in care each week
- x Type of care
- x Teacher/child ratio
- x Primary care source
- x Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- x Parental involvement in care
- x Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- x Stability of care
- x Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- x Poverty status
- Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- x Child care subsidy receipt
- x Number of young children in family
- x Urban/rural marker
- MSA/non-MSA area

National Household Education Survey-Parental Involvement

Background Information

Description/Purpose: provides descriptive data on the educational data of the U.S. population, and additional information on parental and family involvement, including involvement in homework, school events and activities, and activities outside of school.
Data Type: Survey
Population: Grades K through 12
Design: repeated cross-section
Periodicity: 1996, 1999, and 2003
Sample Size: 12,426
Unit of Observation: adult most knowledgeable about sample child
Geography: national
Data Availability: online, free
Sponsors: National Center for Education Statistics, U.S. Department of Education
Website: http://nces.ed.gov/nhes/index.asp

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- x Approaches to learning
- Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- Obesity
- Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- Asthma
- Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- Parental warmth and affection
- x Language stimulation
- x Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- x Parenting style
- x Parental responsivity
- x Contact with noncustodial parent
- x Variety of experience
- x HOME scale
- Parent conflict resolution styles
- Exercise
- Unmet health needs
- TV and video time
- Food insecurity
- x Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- Developmental screening
- Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- Screening for hearing and vision problems
- Dental care receipt
- Office visits
- Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- Parental depression
- Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- Overall health rating
- Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- x Parental involvement in care
- x Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- Poverty status
- Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- Child care subsidy receipt
- Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

National Household Education Survey-School Readiness

Background Information

Description/Purpose: Provides descriptive data on the educational data of the U.S. population, with a special focus on school readiness, including home literacy activities, school adjustment, and early school experiences
Data Type: Survey
Population: 3-7 years old or those in second grade or below;
Design: repeated cross-section
Periodicity: 1993 and 1999, will be conducted in 2007
Sample Size: 10,888
Unit of Observation: adult most knowledgeable about sample child
Geography: national
Data Availability: online, free
Website: http://nces.ed.gov/nhes/index.asp

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- x Social competence
- Attachment
- x Self-regulation
- Post-traumatic stress
- x Peer relationships
- Positive affect
- x Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- x Cooperation/compliance

Intellectual Development
- x Verbal proficiency
- x Quantitative proficiency
- x Expressive language
- Receptive language
- x Fine and gross motor skills
- x Basic concepts mastery
- x Approaches to learning
- x Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- x Premature birth
- Asthma
- Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- Breastfeeding
- Immunizations
- x Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- Parental warmth and affection
- x Language stimulation
- x Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- x Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- x Variety of experience
- x HOME scale
- Parent conflict resolution styles
- Exercise
- Unmet health needs
- x TV and video time
- x Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- Developmental screening
- Health insurance coverage, and % eligible but not enrolled
- S-CHIP coverage
- Screening for hearing and vision problems
- x Dental care receipt
- Office visits
- x Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- x Medical home

Parental Health
- Parental depression
- Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- Overall health rating
- Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- x Hours spent in care each week
- x Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- x Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- x Poverty status
- Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- Child care subsidy receipt
- x Number of young children in family
- x Urban/rural marker
- MSA/non-MSA area

National Health Interview Survey (NHIS)

Background Information

Description/Purpose: Provides a broad range of health measures for US civilian population
Data Type: Survey
Population: noninstitutionalized civilian population of the US, including sample children ages 0-17
Design: repeated cross-section
Periodicity: 1997-present, yearly, (survey collected since 1957 but using different format)
Sample Size: Sample child-13,000; Sample Adult-33,000; Family-40,000
Unit of Observation: family, child, parent
Geography: National
Data Availability: In raw form, online, free
Sponsors: National Center for Health Statistics, Center for Disease Control and Prevention
Website: http://www.cdc.gov/nchs/nhis.htm

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- x Social competence
- x Attachment
- x Self-regulation
- Post-traumatic stress
- x Peer relationships
- Positive affect
- x Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- x Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- x Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- x Asthma
- x Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- Breastfeeding
- x Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- x Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- x Exercise
- x Unmet health needs
- TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- x Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- Screening for hearing and vision problems
- x Dental care receipt
- x Office visits
- x Well-child visits
- Hospitalization (accident)
- x Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- x Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- Parental drug use
- x Regular physical activity
- Overall health rating
- x Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- x Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- x Family structure
- x Income
- x Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- x Poverty status
- x Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- Child care subsidy receipt
- x Number of young children in family
- x Urban/rural marker
- x MSA/non-MSA area

National Survey of America's Families

Background Information

Description/Purpose: gathers data on economic, health, and social characteristics of children and families, in order to estimate well-being
Data Type: Survey
Population: Non-institutionalized American children and adults under the age of 65,
Design: repeated cross-section
Periodicity: 1997, 1999, 2002
Sample Size: over 44,000 households; 34,439 children under 18 years of age
Unit of Observation: most knowledgeable adult about sample child under age six
Geography: National, oversamples from people in 13 states
Data Availability: after registering, can obtain data free online
Sponsors: The Annie E. Casey Foundation anad others.
Website: http://www.urban.org/Content/Research/NewFederalism/NSAF/Overview/NSAFOverview.htm

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- Obesity
- Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- Premature birth
- Asthma
- Iron deficiency
- Vision problems
- Nutritional status
- Hearing problems
- Head injuries
- Breastfeeding
- Immunizations
- x Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- x Parental stress
- x Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- x Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- x Unmet health needs
- TV and video time
- x Food insecurity
- x Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- Screening for hearing and vision problems
- x Dental care receipt
- x Office visits
- x Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- x Medical home

Parental Health
- x Parental depression
- Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- x Overall health rating
- x Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- x Hours spent in care each week
- x Type of care
- x Teacher/child ratio
- Primary care source
- x Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- x Family structure
- x Income
- x Income by source
- x Parental employment
- x Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- x Poverty status
- x Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- x Child care subsidy receipt
- x Number of young children in family
- Urban/rural marker
- x MSA/non-MSA area

National Survey of Child and Adolescent Well-Being (NSCAW)

Background Information

Description/Purpose: National study of children who are at risk of abuse or neglect or are in the child welfare system
Data Type: Survey
Population: Children ages 0-14 at risk of abuse or neglect or in the child welfare system who entered the system from Oct. 1999-Dec.2000. Data collected from children, parents, teachers and caseworkers.
Design: Longitudinal study to be conducted from October 1999-Sept 2003. Baseline data was collected by April 2001 will 12, 18, and 36 month follow-ups. Face to face ineterviews and some telephone follow-up
Periodicity: Carried out from October 1999 to September 2003
Sample Size: 6231 children ages 0-14 years
Unit of Observation: Children, caregiver, teacher, caseworker
Geography: National
Data Availability: All of the data is restricted to researchers and faculty at institutions with an IRB. Some of the data are restricted at a higher level, the instructions for ordering the data are found at:
http://www.ndacan.cornell.edu/NDACAN/Datasets/Order_Forms/NSCAW_Acquiring_Data.html
Sponsors: Administration for Children, Youth and Families of the Department of Health and Human Services
Website: http://www.acf.hhs.gov/programs/core/ongoing_research/afc/wellbeing_data.html

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- x Social competence
- Attachment
- x Self-regulation
- Post-traumatic stress
- Peer relationships
- x Positive affect
- x Internalizing behaviors (sad, unhappy or depressed)
- x Mastery motivation
- x ADHD, attentional issues, hyperactivity
- x Cooperation/compliance

Intellectual Development
- x Verbal proficiency
- x Quantitative proficiency
- x Expressive language
- x Receptive language
- Fine and gross motor skills
- x Basic concepts mastery
- Approaches to learning
- x Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- x Blood lead level
- x Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- x Failure to thrive
- Premature birth
- x Asthma
- x Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- x Head injuries
- Breastfeeding
- x Immunizations
- x Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- x Parental warmth and affection
- x Language stimulation
- Available learning materials (books computers) in the home
- x Developmentally inappropriate expectations of child's behavior
- x Harsh parenting
- x Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- x Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- x Parenting style
- x Parental responsivity
- Contact with noncustodial parent
- x Variety of experience
- x HOME scale
- x Parent conflict resolution styles
- Exercise
- x Unmet health needs
- TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- x Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- S-CHIP coverage
- x Screening for hearing and vision problems
- x Dental care receipt
- Office visits
- Well-child visits
- x Hospitalization (accident)
- x Hospitalization (injury)
- x Hospitalization (illness)
- Medical home

Parental Health
- x Parental depression
- Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- x Parental drug use
- Regular physical activity
- x Overall health rating
- x Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- x Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- x Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- x Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- x Language spoken in home
- x Family structure
- x Income
- Income by source
- x Parental employment
- Immigrant status (1st and 2nd generation)
- Parental educational attainment
- Noresident parent information
- Poverty status
- x Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- Food stamp receipt
- Geographic location
- x Siblings
- TANF receipt
- WIC receipt
- Child care subsidy receipt
- x Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

National Survey of Early Childhood Health (NSECH)

Background Information

Description/Purpose: Provides national baseline data on parent's perceptions of their children's pediatric care. Determine the primary concerns and issues parents of young children face and the degree to which parents believe pediatricians should address these issues
Data Type: Survey
Population: children ages 4-35 months
Design: cross-sectional; telephone survey
Periodicity: 2000
Sample Size: 2068 children
Unit of Observation: Child
Geography: National
Data Availability: SAS Data file online
Sponsors: American Academy of Pediatrics, Maternal and Child Health Bureau, AAP Friends of Children Fund, Gerber Foundation
Website: http://www.cdc.gov/nchs/about/major/slaits/nsech.htm

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- x Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- x Mastery motivation
- ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- x Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- Blood lead level
- Obesity
- x Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- x Premature birth
- x Asthma
- Iron deficiency
- Vision problems
- Nutritional status
- Hearing problems
- Head injuries
- x Breastfeeding
- x Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- Parental warmth and affection
- x Language stimulation
- x Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- x Harsh parenting
- Abuse/neglect of child
- x Parental stress
- x Aggravated Parenting
- Parental domestic violence
- x Regular bed time
- x Regular meal time with family
- x Regular seat belt use
- x Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- x Parenting style
- Parental responsivity
- Contact with noncustodial parent
- x Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- x Unmet health needs
- x TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- x Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- Screening for hearing and vision problems
- Dental care receipt
- Office visits
- x Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- x Medical home

Parental Health
- x Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- x Parental drug use
- Regular physical activity
- Overall health rating
- Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- x Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- x Family structure
- x Income
- Income by source
- x Parental employment
- Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- Noresident parent information
- x Poverty status
- Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- Food stamp receipt
- Geographic location
- x Siblings
- TANF receipt
- x WIC receipt
- Child care subsidy receipt
- x Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

Pediatric Nutrition Surveillance System (PedNSS)

Background Information

Description/Purpose: a child-based public health surveillance system that describes the nutritional status of low-income U.S. children who attend federally-funded maternal and child health and nutrition programs
Data Type: record review survey
Population: children under age 5
Design: administrative case data
Periodicity: annual
Sample Size: 2003: more than 5 million
Unit of Observation: child
Geography: 36 states, DC, Puerto Rico and 6 tribal nations in 2003
Data Availability: national data on website, stata level data for health indicators in annual report
Sponsors: United States Department of Health and Human Services, Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity
Website: http://www.cdc.gov/pednss/index.htm

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- Stammering/stuttering
- Received early intervention or special education services

Health
- Blood lead level
- x Obesity
- x Low/very low birthweight, and medical follow-up
- Chronic illness/disability
- Failure to thrive
- Premature birth
- Asthma
- x Iron deficiency
- Vision problems
- Nutritional status
- Hearing problems
- Head injuries
- x Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- Unmet health needs
- TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- Developmental screening
- Health insurance coverage, and % eligible but not enrolled
- S-CHIP coverage
- Screening for hearing and vision problems
- Dental care receipt
- Office visits
- Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- Parental depression
- Parental drinking (pre and post-natal)
- Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- Overall health rating
- Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- Family structure
- x Income
- Income by source
- Parental employment
- x Immigrant status (1st and 2nd generation)
- Parental educational attainment
- Noresident parent information
- Poverty status
- Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- Food stamp receipt
- x Geographic location
- Siblings
- TANF receipt
- WIC receipt
- Child care subsidy receipt
- Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

Pregnancy Nutrition Surveillance System (PNSS)

Background Information

Description/Purpose: Provide framework for tabulating and analyzing state-specific information on the nutritional status and behavioral risk factors of pregnant woment and their associations with birth outcomes
Data Type: record review survey
Population: low income pregnant women enrolled in public health programs in participating states
Design: cross-sectional, prenatal-postpartum data collected about women and infants from public health programs and prenatal clinics funded by the Maternal and Child Health Services Block grants
Periodicity: Annually since 1972
Sample Size: 2002: over 700,000 pregnant and postpartum women
Unit of Observation: mother
Geography: 22 states, 3 tribal governments
Data Availability: public use
Sponsors: CDC
Website: cdc.gov/nccdphp/pednss.htm

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- Stammering/stuttering
- Received early intervention or special education services

Health
- x Blood lead level
- Obesity
- x Low/very low birthweight, and medical follow-up
- Chronic illness/disability
- Failure to thrive
- x Premature birth
- Asthma
- x Iron deficiency
- Vision problems
- Nutritional status
- Hearing problems
- Head injuries
- x Breastfeeding
- Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- Parental stress
- Aggravated Parenting
- Parental domestic violence
- Regular bed time
- Regular meal time with family
- Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- Exercise
- Unmet health needs
- TV and video time
- Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- x Developmental screening
- Health insurance coverage, and % eligible but not enrolled
- S-CHIP coverage
- Screening for hearing and vision problems
- Dental care receipt
- Office visits
- x Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- x Parental drug use
- x Regular physical activity
- x Overall health rating
- Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- Type of care
- Teacher/child ratio
- Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- Family structure
- x Income
- Income by source
- Parental employment
- Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- Noresident parent information
- x Poverty status
- Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- x Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- x Geographic location
- x Siblings
- TANF receipt
- x WIC receipt
- Child care subsidy receipt
- Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

Pregnancy Risk Assessment Monitoring System

Background Information

Description/Purpose: collects state-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy, monitors changes in maternal and child health indicators
Data Type: survey
Population: all women who had a live birth recently
Design: repeated cross-section; surveys sent by mail with follow-up phone calls
Periodicity: yearly, since 1988, with four different phases
Sample Size: between 1,300 and 3,400 women for each state
Unit of Observation: mother
Geography: state (31 states and New York City participate)
Data Availability: available by emailing ccdinfo@cdc.gov and submitting a research proposal
Sponsors: Center for Disease Control and Prevention, state health departments
Website: http://www.cdc.gov/reproductivehealth/srv_prams.htm#6

Available Measures for Children Ages 0 to 5

Socioemotional Development
- Problem behaviors
- Social competence
- Attachment
- Self-regulation
- Post-traumatic stress
- Peer relationships
- Positive affect
- Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- ADHD, attentional issues, hyperactivity
- Cooperation/compliance

Intellectual Development
- Verbal proficiency
- Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- Approaches to learning
- Pre-reading behaviors
- Stammering/stuttering
- Received early intervention or special education services

Health
- Blood lead level
- Obesity
- x Low/very low birthweight, and medical follow-up
- Chronic illness/disability
- Failure to thrive
- x Premature birth
- Asthma
- Iron deficiency
- Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- x Breastfeeding
- x Immunizations
- Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- Parent reads to child
- Parental warmth and affection
- Language stimulation
- Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- Harsh parenting
- Abuse/neglect of child
- x Parental stress
- Aggravated Parenting
- x Parental domestic violence
- Regular bed time
- Regular meal time with family
- x Regular seat belt use
- Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- Parenting style
- Parental responsivity
- Contact with noncustodial parent
- Variety of experience
- HOME scale
- Parent conflict resolution styles
- x Exercise
- x Unmet health needs
- TV and video time
- x Food insecurity
- Family participation in religion

Health Care Receipt and Coverage
- x Usual source of care
- Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- x S-CHIP coverage
- x Screening for hearing and vision problems
- Dental care receipt
- Office visits
- x Well-child visits
- Hospitalization (accident)
- Hospitalization (injury)
- Hospitalization (illness)
- Medical home

Parental Health
- x Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- x Parental drug use
- x Regular physical activity
- x Overall health rating
- Parental disability or chronic health condition
- x Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- Perceived safety levels
- Neighbors can be counted on to help
- Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- Hours spent in care each week
- x Type of care
- Teacher/child ratio
- x Primary care source
- Use of multiple arrangements
- Teacher education levels
- ECE specific training or education for teachers
- Parental involvement in care
- Parent-caregiver/teacher communication
- Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic origin
- Language spoken in home
- x Family structure
- x Income
- x Income by source
- x Parental employment
- Immigrant status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- Poverty status
- Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- x Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- Geographic location
- x Siblings
- x TANF receipt
- x WIC receipt
- Child care subsidy receipt
- x Number of young children in family
- Urban/rural marker
- MSA/non-MSA area

Panel Study of Income Dynamics-Child Development Supplement

Background Information

Description/Purpose: provide researchers with a comprehensive, nationally representative, and longitudinal database of children and their families with which to study early human capital formation
Data Type: survey
Population: families with children under 12
Design: longitudinal
Periodicity: 1997, follow-up in 2001
Sample Size: 3,600 children (including about 250 immigrant children)
Unit of Observation: child
Geography: national
Data Availability: online, free
Sponsors: National Institute of Child Health and Human Development, William T. Grant Foundation, Annie E. Casey Foundation, US Department of Agriculture, US Department of Education
Website: http://psidonline.isr.umich.edu/CDS/questionnaires.html

Available Measures for Children Ages 0 to 5

Socioemotional Development
- x Problem behaviors
- x Social competence
- x Attachment
- x Self-regulation
- Post-traumatic stress
- x Peer relationships
- x Positive affect
- x Internalizing behaviors (sad, unhappy or depressed)
- Mastery motivation
- x ADHD, attentional issues, hyperactivity
- x Cooperation/compliance

Intellectual Development
- x Verbal proficiency
- x Quantitative proficiency
- Expressive language
- Receptive language
- Fine and gross motor skills
- Basic concepts mastery
- x Approaches to learning
- x Pre-reading behaviors
- x Stammering/stuttering
- x Received early intervention or special education services

Health
- x Blood lead level
- x Obesity
- Low/very low birthweight, and medical follow-up
- x Chronic illness/disability
- Failure to thrive
- x Premature birth
- x Asthma
- x Iron deficiency
- x Vision problems
- Nutritional status
- x Hearing problems
- Head injuries
- x Breastfeeding
- x Immunizations
- x Treatment for emotional/mental health problems

Family Functioning, Parent/Child Interactions, and Health Practices
- x Parent reads to child
- x Parental warmth and affection
- Language stimulation
- x Available learning materials (books computers) in the home
- Developmentally inappropriate expectations of child's behavior
- x Harsh parenting
- Abuse/neglect of child
- Parental stress
- x Aggravated Parenting
- Parental domestic violence
- x Regular bed time
- x Regular meal time with family
- Regular seat belt use
- x Adequate childproofing of the home
- Health/Safety issues in home environment (lead, medicine)
- x Parenting style
- x Parental responsivity
- x Contact with noncustodial parent
- x Variety of experience
- x HOME scale
- x Parent conflict resolution styles
- Exercise
- x Unmet health needs
- x TV and video time
- x Food insecurity
- x Family participation in religion

Health Care Receipt and Coverage
- Usual source of care
- x Developmental screening
- x Health insurance coverage, and % eligible but not enrolled
- S-CHIP coverage
- x Screening for hearing and vision problems
- x Dental care receipt
- Office visits
- x Well-child visits
- x Hospitalization (accident)
- x Hospitalization (injury)
- x Hospitalization (illness)
- Medical home

Parental Health
- x Parental depression
- x Parental drinking (pre and post-natal)
- x Parental smoking (pre and post-natal)
- Parental drug use
- Regular physical activity
- Overall health rating
- Parental disability or chronic health condition
- Parental sense of social support

Community/Neighborhood
- Violence levels
- Poverty rate
- x Perceived safety levels
- x Neighbors can be counted on to help
- x Neighbors intervene with children's misbehavior
- Adult unemployment
- Crime rates
- Clean and safe playgrounds
- x Housing stock quality
- # liquor licenses
- Employers with maternity leave
- Percentage of single mothers

Child Care Participation and Quality
- x Hours spent in care each week
- x Type of care
- x Teacher/child ratio
- x Primary care source
- x Use of multiple arrangements
- x Teacher education levels
- x ECE specific training or education for teachers
- x Parental involvement in care
- x Parent-caregiver/teacher communication
- x Staff years of experience
- Health and safety of care (sanitation, safe play)
- Presence of curriculum
- ITERS/FDCRS/ECERS or other observational quality measures
- x Stability of care
- Parental Satisfaction with care

Demographics
- x Race and Hispanic Origin
- Language Spoken in Home
- x Family Structure
- x Income
- Income by Source
- x Parental Employment
- Immigrant Status (1st and 2nd generation)
- x Parental educational attainment
- x Noresident parent information
- Poverty status
- Children in foster care
- Homeless children
- Linguistic isolation
- Parental illiteracy
- Births to single teen mothers
- Children w/ parents in prison
- x Food stamp receipt
- Geographic Location
- Siblings
- TANF receipt
- x WIC receipt
- Child care subsidy receipt
- Number of young children in family
- x Urban/rural marker
- x MSA/non-MSA area