



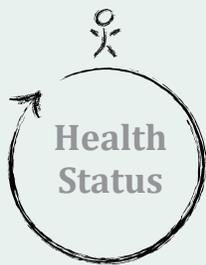
## The Child

While children's health care needs and their parents' concerns about their children's health and safety were consistent across the United States, the health issues, access barriers, and risks may vary for rural and urban children. This section presents information on the sociodemographic characteristics of children by location, health status, access to and use of health care services, and activities in and outside of school.

Children's health was measured through their parents' reports of their overall health and oral health, whether they were born prematurely, their risk of developmental delay and their parents' concerns about their development, their body mass index (based on their age and sex), whether young children were breastfed, and the presence of one or more chronic conditions.

Children's access to and use of health care was measured through questions about children's health insurance coverage; whether they were continually covered over the previous year; whether their insurance is adequate to meet their needs; their use of preventive health care, dental care, and mental health services; whether young children received a standard developmental screen; and whether their care meets the standards of the "medical home."

Children's participation in activities in school and in the community represents another important aspect of their well-being. The survey asked about how often young children played with their peers; children's school performance, including participation in early intervention or special education, their engagement with school, and whether they had repeated a grade; and their activities outside of school, including volunteering, working for pay, reading for pleasure, and time spent watching TV or videos.



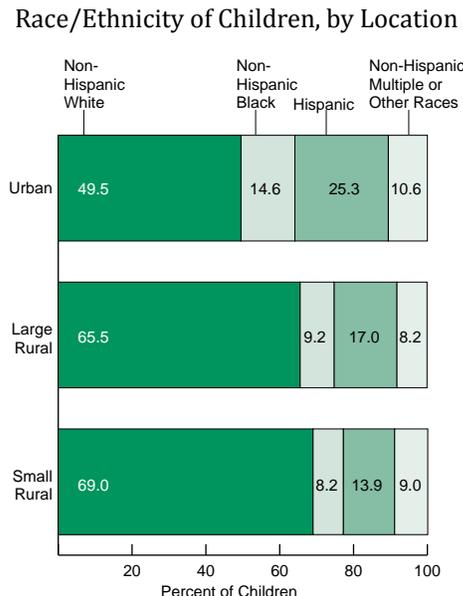
## Characteristics of Urban and Rural Children

The demographic composition of the population of children in small and large rural areas differed from that of urban children. While the age distribution was similar across the three geographic categories, rural children were significantly more likely to be non-Hispanic White and have low family incomes.

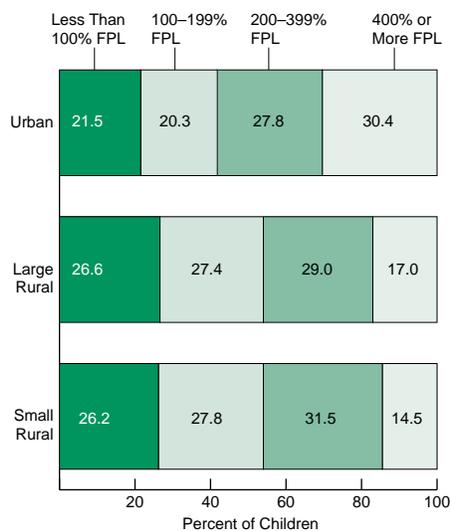
In each geographic category, about one-third of children were 0–5 years old, one-third were 6–11, and one-third were 12–17 years of age.

Fewer than half of urban children were non-Hispanic White (49.5 percent), compared to 65.5 percent of children in large rural areas and 69.0 percent of those in small rural areas. Children in urban areas were more likely to be non-Hispanic Black (14.6 percent of urban children, compared to less than 10 percent of rural children) and Hispanic (25.3 percent of urban children, compared to 17.0 percent of children in large rural areas and 13.9 percent in small rural areas).

Children in rural areas were also significantly more likely than urban children to be poor. More than 26 percent of children in both small and large rural areas had household incomes below the Federal Poverty Level (FPL), compared to 21.5 percent of urban children. In contrast, nearly one-third of urban children had

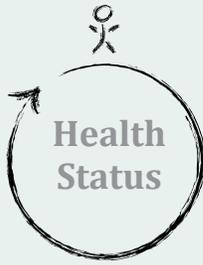


### Family Income of Children as a Percent of FPL,\* by Location



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines, poverty was \$23,050 for a family of four in 2012.

household incomes of 400 percent or more of the FPL, compared to 17.0 percent of children in large rural areas and 14.5 percent of those in small rural areas.



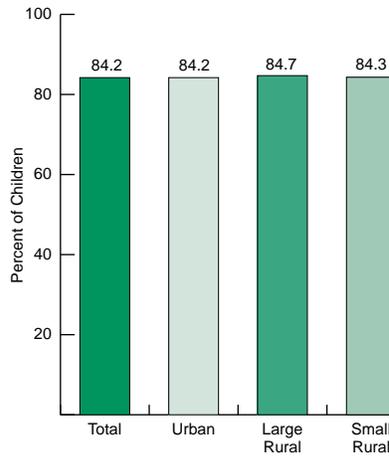
## Child Health Status

The survey asked parents to rate their children's overall health status as excellent, very good, good, fair, or poor. While this indicator does not offer a complete picture of a child's health, it gives a general sense of the child's health and well-being.

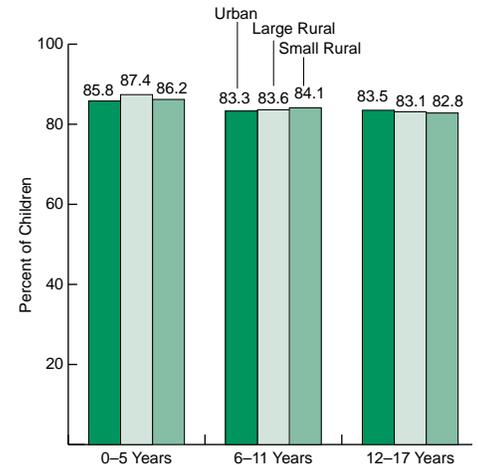
In all locations, approximately 84 percent of children were reported to be in excellent or very good health. The health status of children within each age group did not vary significantly by area of residence, and more than 80 percent of children of all ages in all locations were reported to be in excellent or very good health.

Children's health status varied more widely across locations with regard to specific racial/ethnic groups. For example, among non-Hispanic Black children, those living in urban and large rural areas were more likely to be reported in excellent or very good health than those in small rural areas (82.6 and 85.3 percent versus 73.3 percent, respectively). With regard to non-Hispanic White children, those in urban areas were more likely than both large and small rural areas to be in excellent or very good health: 91.8 percent of those in urban areas, compared to more than 88 percent of those in large and small rural areas. In all locations, Hispanic children were the least likely to be in excellent or very good health, and this percentage did not vary significantly by location.

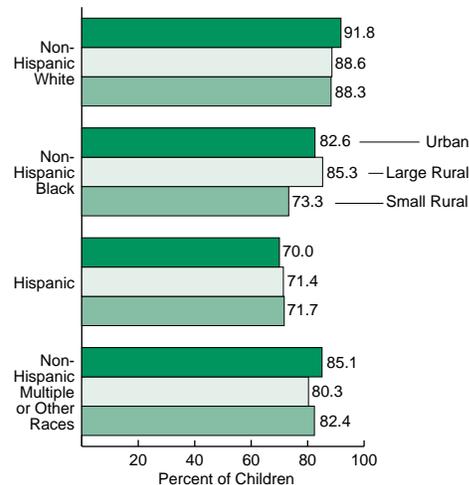
Children in Excellent or Very Good Health, by Location

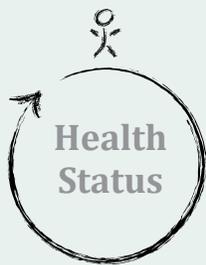


Children in Excellent or Very Good Health, by Location and Age



Good Health, by Location and Race/Ethnicity





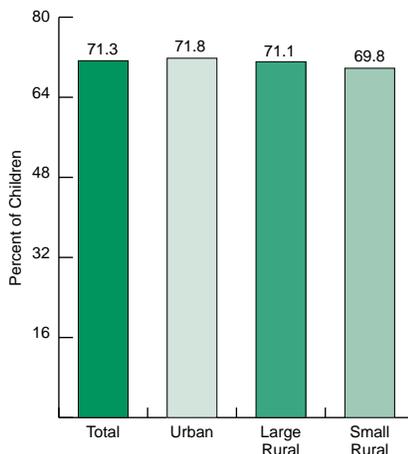
## Oral Health Status

Parents of children aged 1 year and older who had at least one tooth were asked to describe the status of their children's teeth as excellent, very good, good, fair, or poor. The percentage of children with excellent or very good oral health did not vary significantly across locations, ranging from 69.8 percent among children in small rural towns to 71.8 percent of those in urban areas.

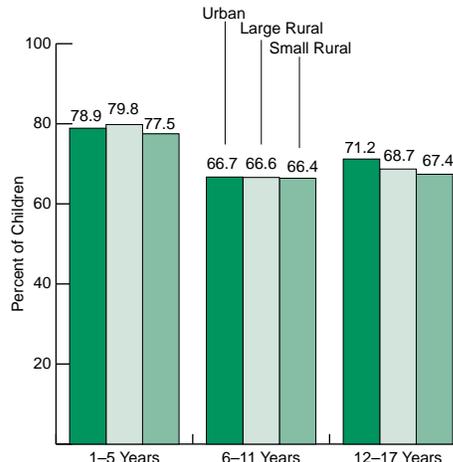
In all locations, the youngest children (aged 1-5 years) were the most likely to have excellent or very good oral health (greater than 77 percent), while approximately two-thirds of older children were reported to have excellent or very good oral health. These proportions did not vary significantly across locations.

Within each location, the condition of children's teeth varied by race and ethnicity, with non-Hispanic White children more likely than other children to have excellent or very good oral health. With regard to location, non-Hispanic White children in urban areas were more likely to report excellent or very good oral health than those in large and small rural areas (81.9 versus 76.3 and 74.6 percent, respectively). Non-Hispanic Black children in urban areas were also more likely than those in small rural areas to have excellent or good oral health (67.8 versus 55.0 percent, respectively), though there was no significant difference between urban and large rural areas (64.8 percent).

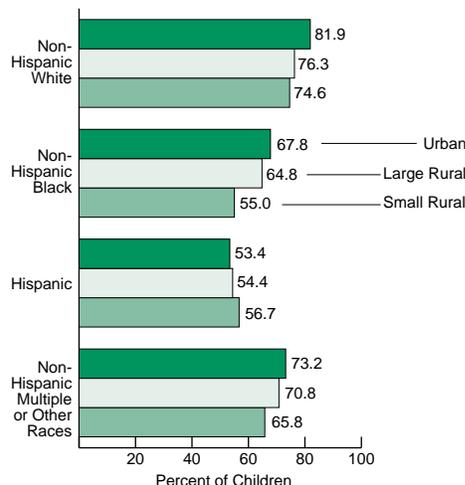
Children Aged 1-17 in Excellent or Very Good Oral Health, by Location



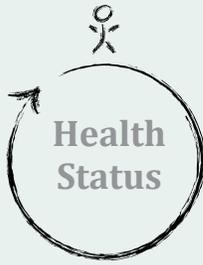
Children Aged 1-17 in Excellent or Very Good Oral Health, by Location and Age



Children Aged 1-17 in Excellent or Very Good Oral Health, by Location and Race/Ethnicity



In all locations, slightly more than half of Hispanic children were in excellent or very good oral health, and this percentage did not vary significantly by location.

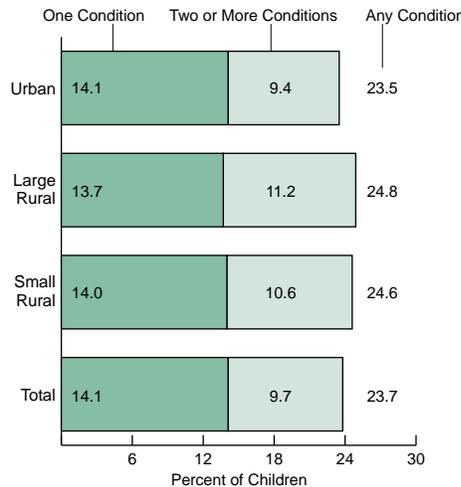


## Chronic Conditions

Children may have chronic physical or mental health problems, such as asthma or anxiety, which may have an impact on the child's well-being. The NSCH asked parents whether they had ever been told by a health care provider that their child currently had 1 of 18 specific chronic conditions. These included eight physical health conditions (asthma; diabetes; brain injury or concussion; bone, joint, or muscle problems; cerebral palsy; epilepsy or seizure disorder; hearing problems; and vision problems); eight emotional, behavioral, or developmental conditions (attention deficit disorder/attention deficit hyperactivity disorder; anxiety; autism spectrum disorder; depression; developmental delay; oppositional defiant disorder or conduct disorder; and Tourette syndrome); speech problems; and learning disabilities.

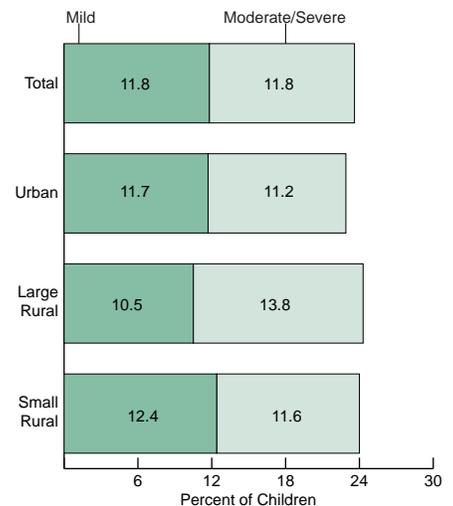
Overall, 23.7 percent of children were reported to have at least one of these conditions; this percentage did not vary by location, but children in large rural areas were more likely than those in urban or small rural areas to have at least one condition rated as moderate or severe (13.8 versus 11.2 and 11.6 percent, respectively). Children in large rural areas were also more likely to have two or more conditions than those in urban areas (11.2 versus 9.4 percent, respectively), though rates did not vary significantly from those in small rural areas.

Children With Chronic Conditions, by Number of Conditions\*



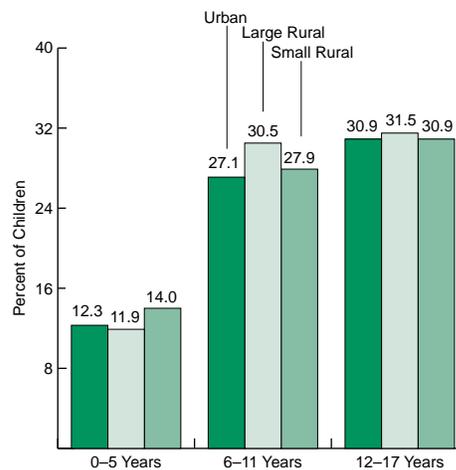
\*Among 18 chronic health conditions assessed.

Children With Chronic Conditions, by Location and Severity\*



\*Based on 17 current chronic health conditions.

Children With Chronic Conditions, by Location and Age



With regard to the child's age, the proportions of children who had at least one chronic condition did not vary across locations. Within each location, however, younger children (aged 0–5) were significantly less likely to have one or more conditions

than older children. Among children in small rural areas, for instance, 14.0 percent of 0- to 5-year-olds had at least one condition compared to 27.9 percent of children aged 6–11 years and 30.9 percent of those aged 12–17 years.

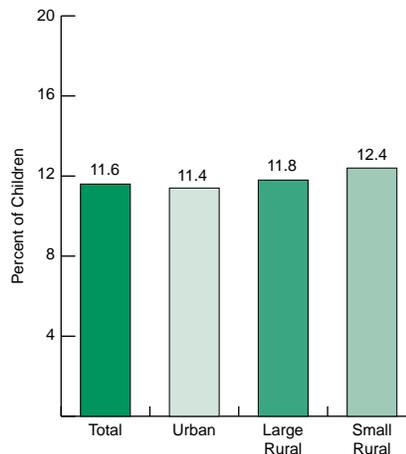


## Premature Birth

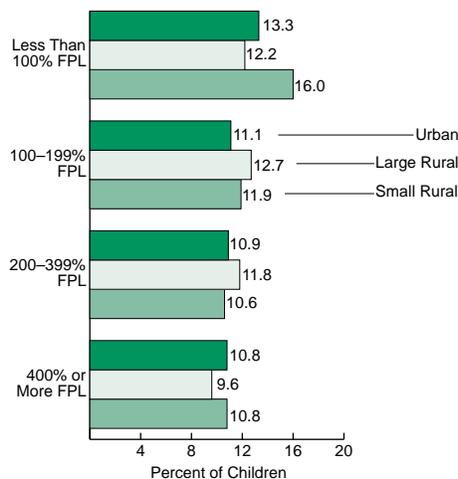
Premature birth, defined as delivery before 37 completed weeks of gestation, carries a number of risks, including immediate health problems such as respiratory distress, jaundice, and anemia, as well as longer-term health issues such as learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss.

Overall, 11.6 percent of children were reported to have been born prematurely, a percentage that did not vary significantly across locations. Within urban and small rural areas, premature birth rates were highest among children from households with incomes below 100 percent of the Federal Poverty Level (FPL). Among children in small rural areas, for example, 16.0 percent of children with household incomes below 100 percent of the FPL were born prematurely, compared to about 11-12 percent of children in higher income households. Similarly, children in urban areas with household incomes below 100 percent of the FPL were more likely to have been born prematurely than those in higher income households (13.3 versus about 11 percent, respectively). There were no differences in premature births, however, for children in large rural areas based on household income. Within each income category, the percentage of children born prematurely did not vary significantly across locations.

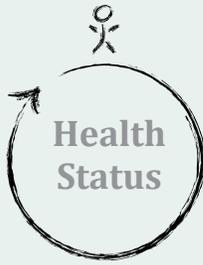
Children Who Were Born Premature, by Location



Children Who Were Born Premature, by Location and Poverty Level\*



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.



## Breastfeeding

Breast milk is widely recognized to be the ideal form of nutrition for infants. Breastfed infants are less susceptible to infectious diseases, and children who were breastfed are less likely to suffer from diabetes, overweight, obesity, asthma, lymphoma, leukemia, or Hodgkin's disease compared to children who were not breastfed. In addition, rates of post-neonatal mortality (death between the first month and the end of the first year of life) are lower among breastfed infants.<sup>1</sup> The American Academy of Pediatrics recommends that, with few exceptions, all infants be fed with breast milk exclusively for the first 6 months of life.

Overall, 79.2 percent of children aged 5 and younger were ever breastfed or fed breast milk. Urban children were significantly more likely than children in rural areas to have ever been breastfed: 81.0 percent compared to 71.2 percent of children in large rural and 70.6 percent of those in small rural areas. A much smaller percentage of children were exclusively breastfed for their first 6 months in all locations, with urban children more likely than those in small rural areas to have done so (16.5 versus 12.9 percent, respectively).

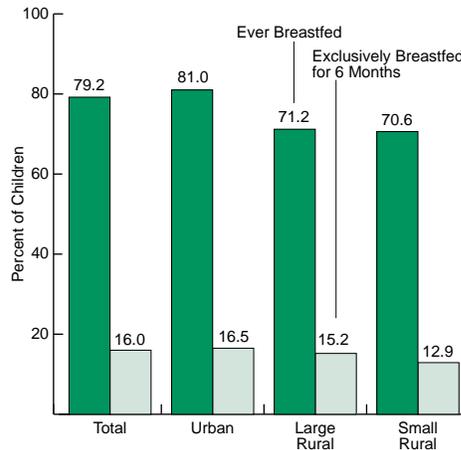
Rates of having ever been breastfed varied differentially with income and location. In all locations, children in households with incomes below 100 percent of the Federal Poverty Level (FPL) were less likely than those with

higher incomes to have ever breastfed. For instance, 60.0 percent of children in large rural areas with household incomes below 100 percent of the FPL were ever breastfed, compared to 76.6 percent of those with incomes of 200-399 percent of the FPL and 81.5

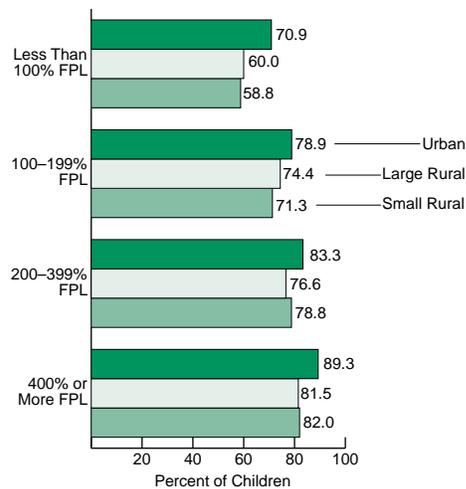
percent of those with incomes of 400 percent or more of the FPL.

Within each income level, breastfeeding rates were generally higher in urban areas compared to large and small rural areas. Children in urban areas with household incomes of 400

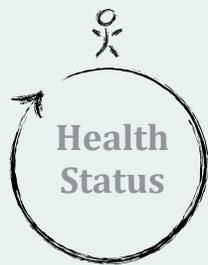
Children Aged 0–5  
Who Were Ever Breastfed,  
by Location



Children Aged 0–5  
Who Were Ever Breastfed,  
by Location and Poverty Level\*



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.



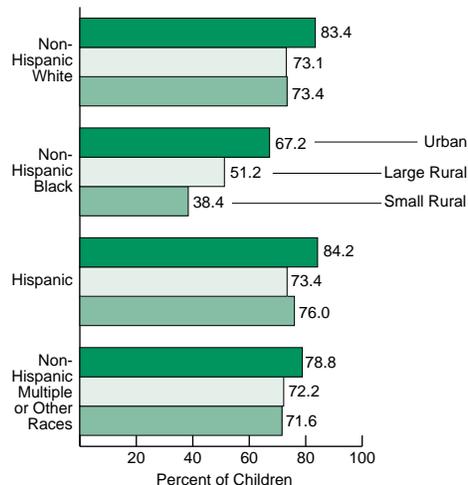
## Breastfeeding (continued)

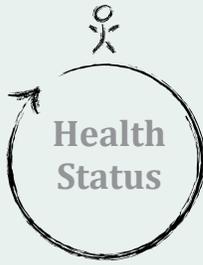
percent or more of the FPL were the most likely ever to be breastfed (89.3 percent); in rural areas, approximately 82 percent of children in the same income group were ever breastfed. Similarly, 70.9 percent of children in urban areas with household incomes below 100 percent of the FPL were ever breastfed, compared to 58.8 percent in small rural areas and 60.0 percent in large rural areas.

Breastfeeding also varied by location with regard to certain racial and ethnic groups. Among both non-Hispanic White and non-Hispanic Black children, those in urban areas were more likely than those in either large or small rural areas ever to be breastfed. Within each location, non-Hispanic Black children were significantly less likely to have ever been breastfed compared to all other racial and ethnic groups.

1 American Academy of Pediatrics, Section on Breastfeeding. *Breastfeeding and the use of human milk. Pediatrics. 2005;115(2):496-506.*

Children Aged 0-5  
Who Were Ever Breastfed,  
by Location and Race/Ethnicity





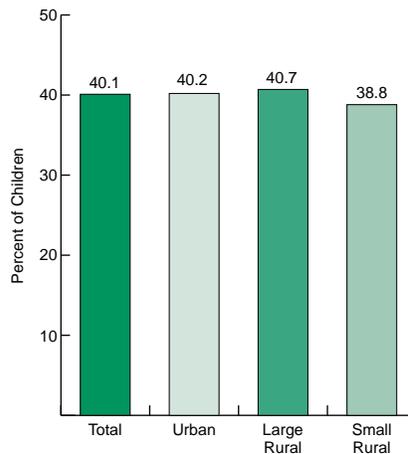
## Parental Concerns About Child Development and Risk of Developmental Delay

Parental concerns and observations about their child's development and behavior are an important indication of a child's potential risk for developmental, behavioral, and/or social delays. Parents of young children (aged 4 months to 5 years) were asked about eight specific concerns they may have about their child's learning, development, or behavior that can predict risk of developmental issues. These eight items were based on the Parent's Evaluation of Developmental Status (PEDS)®.<sup>1</sup> The parents of 40.1 percent of children in this age group reported at least one concern from this list, and this percentage did not vary significantly across locations.

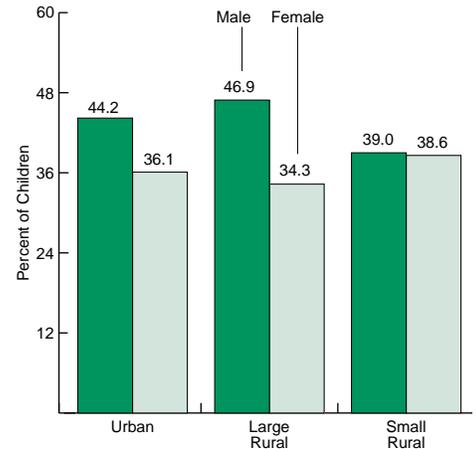
In urban and large rural areas, parents of boys were more likely to report concerns about their learning, development, or behavior than the parents of girls; however, there was no difference for children in small rural areas. Parents of boys in small rural areas were also significantly less likely to report concerns than those in large rural and urban areas (39.0 versus 46.9 and 44.2 percent, respectively). Concerns did not vary for girls across locations.

With regard to race and ethnicity, Hispanic children in all locations were

Children Aged 4 Months–5 Years Whose Parents Reported One or More Concerns About Their Development, by Location



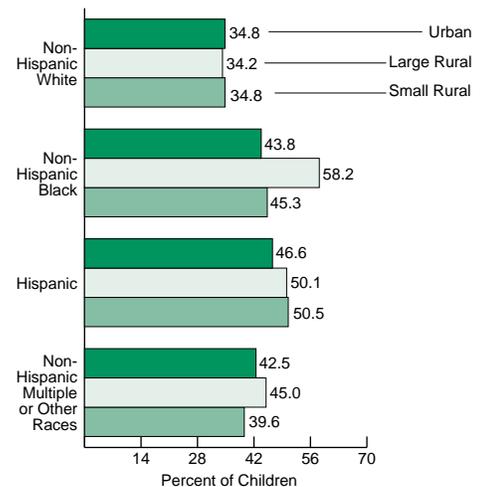
Children Aged 4 Months–5 Years Whose Parents Reported One or More Concerns About Their Development, by Location and Sex



### Parents were asked if they had concerns about...

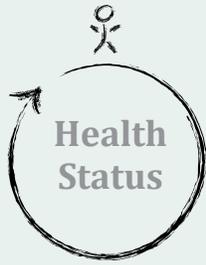
- How child talks and makes speech sounds;
- How child understands what you say;
- How child uses his/her hands and fingers to do things;
- How child uses his/her arms and legs;
- How child behaves;
- How child gets along with others;
- How child is learning to do things for himself/herself; and
- How child is learning preschool or school skills.

Children Aged 4 Months–5 Years Whose Parents Reported One or More Concerns About Their Development, by Location and Race/Ethnicity



more likely than non-Hispanic White children to have their parents report one or more concerns. In urban and large rural areas, parents of non-Hispanic White children were also less likely to report concerns than those of non-Hispanic Black and non-

Hispanic children of multiple or other races. This racial and ethnic difference was not apparent in small rural areas. Parental concerns did not vary significantly by location for any racial or ethnic group.

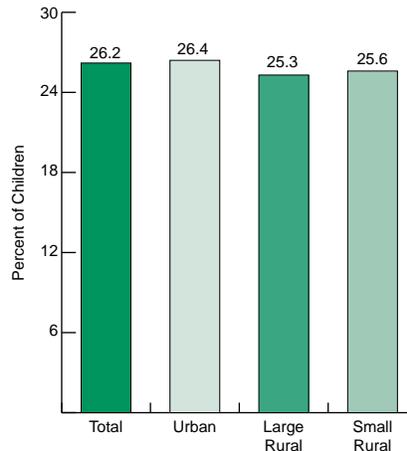


## Developmental Delay (continued)

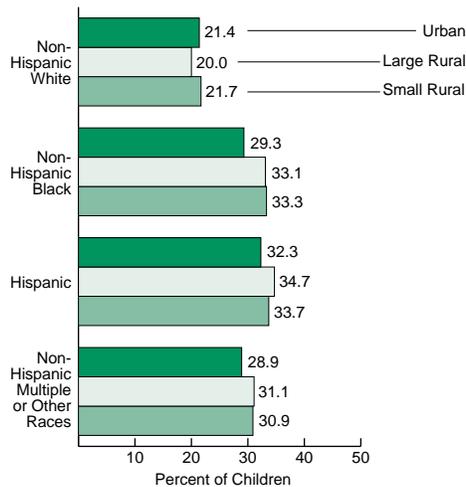
Parents' responses to concerns about their children's development were also used to assess the child's risk for behavioral, developmental, or social delays. Depending on the child's age, parents' concerns in specific areas most likely to predict delays are used to determine a child's level of risk for future delays. Children whose parents have concerns in one area that is predictive of a delay are considered to be at moderate risk, and children whose parents have concerns in two or more areas are considered to be at high risk. Children whose parents have concerns not predictive of delays or no concerns are classified as low risk. The concerns of the parents of 26.2 percent of children were significant enough to indicate that their child is at moderate or high risk of delay; this percentage does not vary significantly by location.

With regard to race and ethnicity, rates did not vary by location for any specific group. The percentage of children at moderate or high risk of developmental delay was lowest among non-Hispanic White children in every location, compared to all other racial and ethnic groups. About one-fifth of non-Hispanic White children in each location were at moderate or high risk for developmental delay, compared to about a third of Hispanic children and approximately 30 percent or more of non-Hispanic Black and non-Hispanic children of multiple or other races.

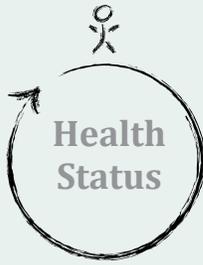
Children Aged 4 Months-5 Years at Moderate or High Risk of Developmental Delay, by Location



Children Aged 4 Months-5 Years at Moderate or High Risk of Developmental Delay, by Location and Race/Ethnicity



1 Glascoe FP. *Parents' Evaluation of Developmental Status*. Nashville, TN: Ellsworth & Vandermeer Press LLC, 2006.



## Overweight and Obesity

Overweight and obesity in children, as in adults, are assessed based on Body Mass Index (BMI), or the ratio of weight to height. For children, the standards for overweight and obesity are relative; that is, they are based on the child's percentile rank compared to others of the same age and sex. Children whose BMI falls between the 85th and 95th percentile on national growth charts for their age and sex are considered to be overweight, and those whose BMI falls at or above the 95th percentile are considered to be obese. The NSCH asked parents for the height and weight of their children, from which the BMI was calculated and weight status assessed based on age and sex for children aged 10–17 years. Overall, 31.3 percent of children met the criteria for overweight or obesity based on their parent-reported weight and height.

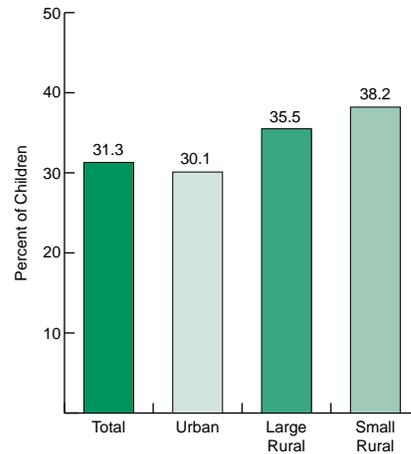
Children living in rural areas were significantly more likely than urban children to be overweight or obese. More than 35 percent of children in both large and small rural areas had a BMI at or above the 85th percentile for their age and sex, compared to 30.1 percent of urban children.

Boys were significantly more likely than girls to be overweight or obese in urban areas, though there was no difference in rates in large and small rural areas. Among both sexes, children living in rural areas were more likely to be overweight or obese

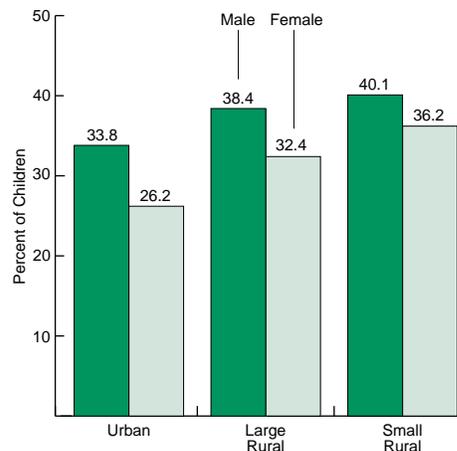
than their urban counterparts. Among boys, 33.8 percent of those in urban areas were overweight or obese, compared to 40.1 percent of boys in small rural and 38.4 percent in large rural areas. For girls, 26.2 percent of those in urban areas were overweight or obese, compared to 36.2 percent of those in small rural and 32.4 percent in large rural areas.

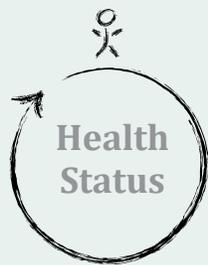
In all locations, children with lower household incomes were significantly more likely to be overweight or obese than those with higher incomes. The rate of overweight and obesity among children in households with incomes below 100 percent of the Federal Poverty Level (FPL) was approximately twice that of children

Children Aged 10–17 Who Are Overweight or Obese, by Location



Children Aged 10–17 Who Are Overweight or Obese, by Location and Sex



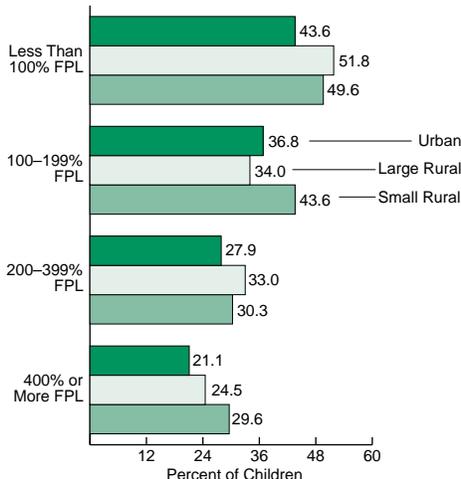


## Overweight and Obesity (continued)

with household incomes of 400 percent or more of the FPL. For example, among children in large rural areas, 51.8 percent of those in poverty were overweight or obese, compared to 24.5 percent of those with household incomes of 400 percent or more of the FPL. Within each income group there were few differences by location with no clear patterns presenting themselves. For instance, among the lowest income households, children in urban areas were significantly less likely to be overweight or obese than children in large rural areas (43.6 versus 51.8 percent, respectively), but rates did not vary significantly from those in small rural areas.

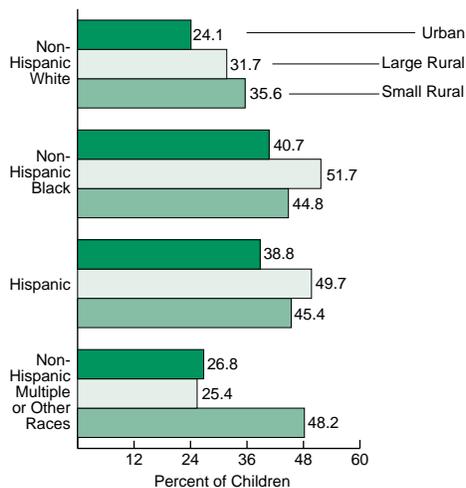
In urban and large rural areas, non-Hispanic Black and Hispanic children were more likely than non-Hispanic White children to be overweight or obese. Less than one-quarter of non-Hispanic White children in urban areas and 31.7 percent of those in large rural areas were overweight or obese, compared to more than 40 percent of non-Hispanic Black children and at least 38 percent of Hispanic children in both areas. In small rural areas, racial and ethnic differences in the proportion of children who were overweight or obese were not statistically significant.

Children Aged 10-17 Who Are Overweight or Obese, by Location and Poverty Level\*



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.

Children Aged 10-17 Who Are Overweight or Obese, by Location and Race/Ethnicity

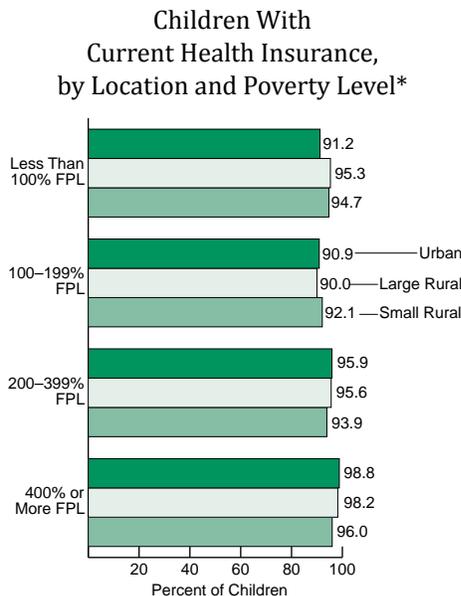
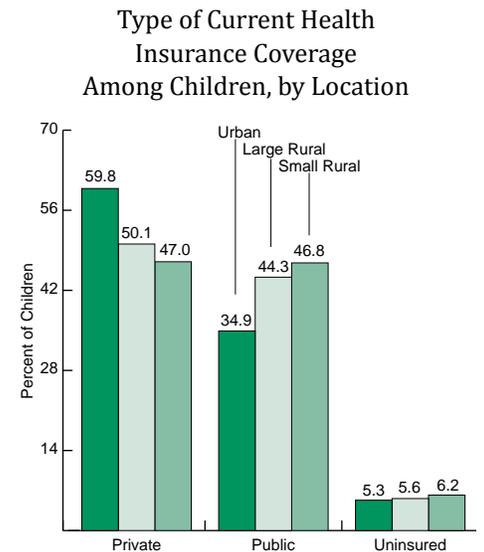
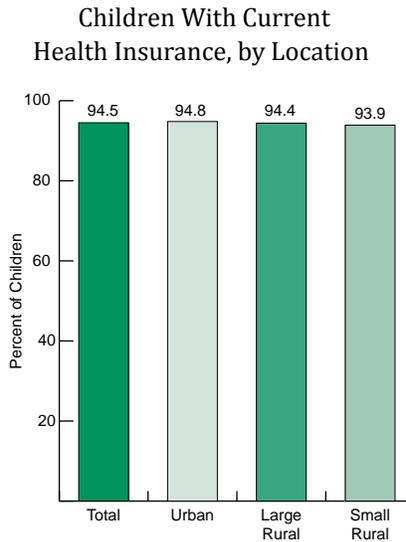




## Current Health Insurance

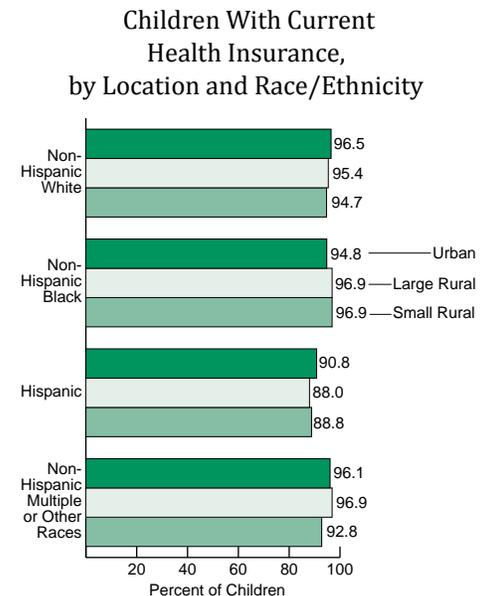
Parents were asked if their child currently had any kind of health insurance, including private/employment-based insurance or government plans such as Medicaid or CHIP. Overall, 94.5 percent of children had health insurance coverage at the time of the survey: 57.4 percent had private health insurance coverage, 37.1 percent had public coverage, and 5.6 percent were uninsured (data not shown). The percentage of children with some type of insurance did not vary significantly by location; however, the types of insurance reported did vary. Children in rural areas were more likely than urban children to have insurance through public or government programs: approximately 45 percent of children in both large and small rural areas had public insurance, compared to 34.9 percent of urban children. Children in urban areas were most likely to have private insurance (59.8 percent), followed by those in large rural areas (50.1 percent), while children in small rural areas were least likely to have private insurance (47.0 percent).

In urban and large rural areas, children with the lowest household incomes were the less likely to have health insurance than their peers in the highest income categories. For instance, 95.3 percent of children in large rural areas with household incomes below 100 percent of the Federal Poverty Level (FPL) had current health insurance, compared to



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.

98.2 percent of those with household incomes of 400 percent or more of the FPL. Among children with incomes below 100 percent of the FPL, children in small and large rural areas were significantly more likely to have health insurance than those in urban areas (94.7 and 95.3 versus 91.2 percent, respectively).



Regardless of location, Hispanic children were significantly less likely than non-Hispanic White and non-Hispanic Black children to have current health insurance. Generally, the percentage of children with insurance in each racial and ethnic group did not vary by location.

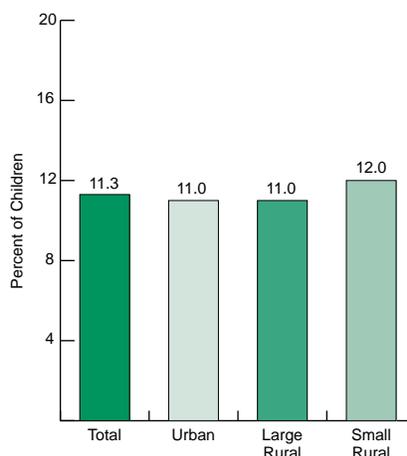


## Insurance Coverage Continuity

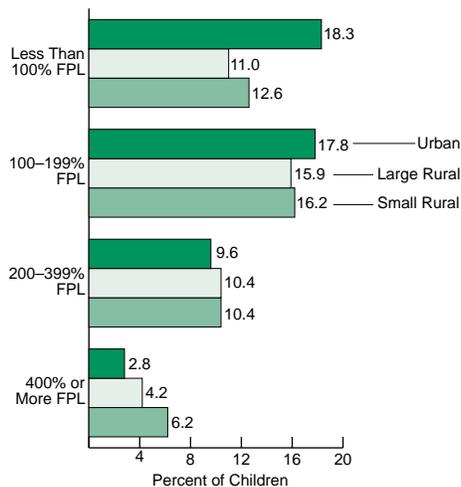
Although most children have health insurance, many experience a time when they are not covered over the course of a year. Overall, 11.3 percent of children had a gap in coverage in the previous year or were uninsured at the time of the survey. This percentage did not vary significantly by location.

Children with household incomes below 200 percent of the Federal Poverty Level (FPL) were generally more likely than children in higher-income households to experience a gap in their insurance coverage over the course of a year regardless of location. Among low-income children, whose household income was below 100 percent of the FPL urban children were more likely to have a coverage gap than those in small and large rural areas (18.3 versus 12.6 and 11.0 percent, respectively). Among children with household incomes of 400 percent or more of the FPL those living in small rural areas were significantly more likely than their urban peers to have a gap in coverage (6.2 versus 2.8 percent, respectively).

Children Lacking Continuous Coverage in the Previous Year, by Location



Children Lacking Continuous Coverage in the Previous Year, by Location and Poverty Level\*



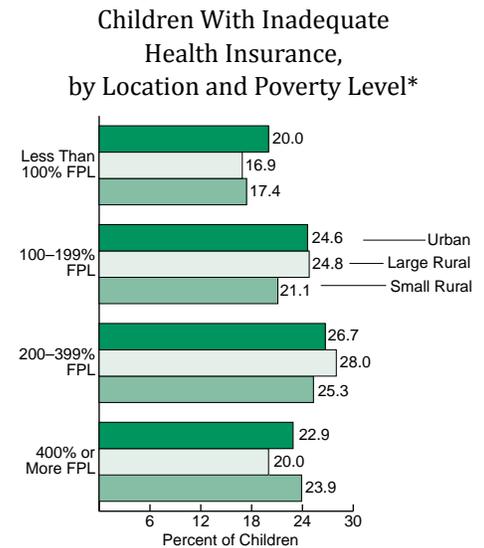
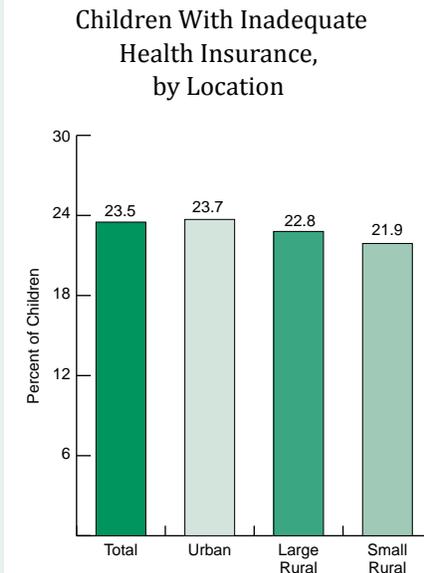
\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.



## Adequacy of Health Insurance

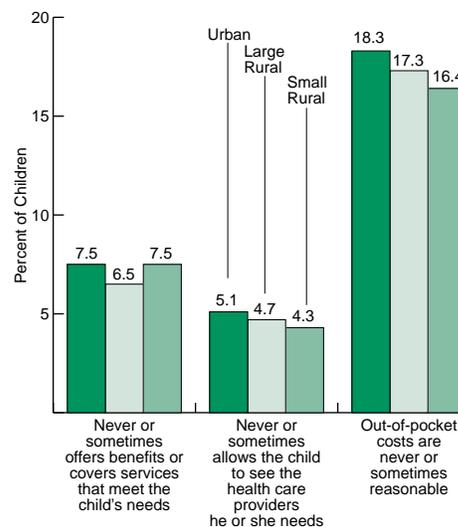
While most children had health insurance coverage at the time of the survey, insurance coverage may not always be adequate to meet their needs. Parents whose children were currently insured were asked three questions regarding the services and costs associated with their child's health insurance: whether the out-of-pocket costs were reasonable, whether the plan offered benefits or covered services that meet their child's needs, and whether the plan allowed them to see the health care providers they needed. Children were considered to have inadequate health insurance coverage if their parents did not answer "usually" or "always" to all three questions. Overall, 23.5 percent of children who were currently insured had inadequate insurance; this percentage varied slightly by location with children in small rural areas less likely to have inadequate insurance compared to their urban peers (21.9 versus 23.7 percent, respectively).

The percentage of children whose insurance was inadequate was highest among children with household incomes above 100 percent of the Federal Poverty Level (FPL). Approximately one-quarter of insured children in households with incomes of 100–399 percent of the FPL in urban and large rural areas had inadequate insurance, compared to one-fifth or fewer children with household incomes below 100 percent of pov-



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.

### Children with Inadequate Health Insurance, by Location and Adequacy Criteria



erty. With regard to location, rates of inadequate insurance did not differ significantly for children in each income category.

With regard to the three specific criteria for insurance adequacy, parents most often reported that out-of-pocket costs were never or sometimes reasonable (18.0 percent; data not shown). This percentage was slightly

higher in urban areas (18.3 percent) than small rural areas (16.4 percent). The parents of a smaller percentage of children reported that their child's insurance never or sometimes covered the services their child needed (7.5 percent) or allowed their child to see the providers they needed (5.1 percent; data not shown). These rates did not vary by location.



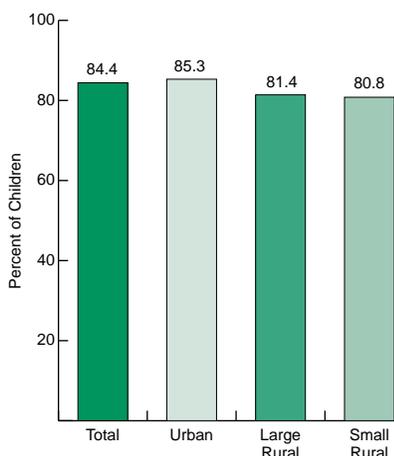
## Preventive Medical Care Visits

The Bright Futures guidelines for health supervision of infants, children, and adolescents recommend that children visit a physician six times during the first year, three times in the second year, and annually thereafter for preventive health care visits.<sup>1</sup> An annual preventive health care visit provides an opportunity to monitor a child's growth and development, assess his or her behavior, provide appropriate immunizations, discuss important issues regarding nutrition and prevention of injury and violence, and answer parents' questions about their children's health and care.

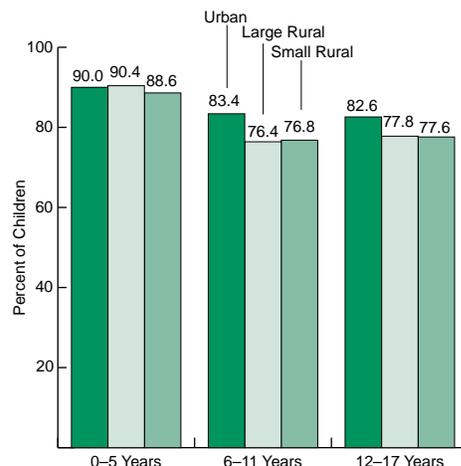
Overall, 84.4 percent of children received a preventive medical care visit in the past year. This percentage was significantly higher in urban areas (85.3 percent) than in both large and small rural areas (81.4 and 80.8 percent, respectively).

Urban children aged 6–11 and 12–17 years were more likely to have received a preventive medical visit in the past year compared to their peers in both large and small rural areas. Among children aged 6–11 years, 83.4 percent of urban children had a visit in the past 12 months, compared to less than 77 percent of those in rural areas. Among adolescents, 82.6 percent of those in urban areas had a preventive visit in the past 12 months, compared to approximately 78 percent of 12- to 17-year-olds in rural areas. Among children aged 0–5 years, the percent-

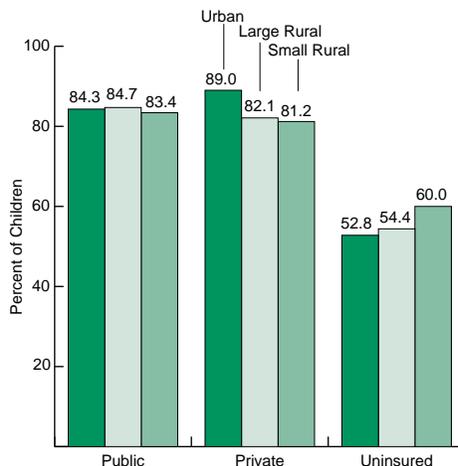
Children Receiving a Preventive Medical Care Visit in the Previous Year, by Location



Children Receiving a Preventive Medical Care Visit in the Previous Year, by Location and Age



Children Receiving a Preventive Medical Care Visit in the Previous Year, by Location and Insurance Type



age with at least one preventive visit in the past year did not vary significantly by location.

In all locations, uninsured children were considerably less likely than those with insurance to receive a preventive medical visit in the previous year, and rates among the uninsured did not vary by location. Among children with private health

insurance, those in urban areas (89.0 percent) were more likely to receive a preventive visit than their large rural and small rural peers (82.1 and 81.2 percent, respectively).

<sup>1</sup> Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: guidelines for health supervision of infants, children, and adolescents*, 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.



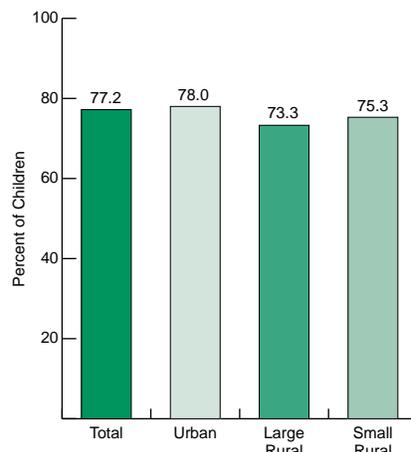
## Preventive Dental Care Visits

In addition to an annual preventive medical care visit, it is recommended that children see a dentist every beginning as soon as their first tooth erupts, or by age 1 at the latest.<sup>1</sup> The majority of children aged 1–17 years (77.2 percent) received at least one preventive dental visit in the past year. Children in urban areas were significantly more likely to have received a preventive dental visit in the past year (78.0 percent) than children in rural areas (73.3 percent of children in large rural areas and 75.3 percent of those in small rural areas).

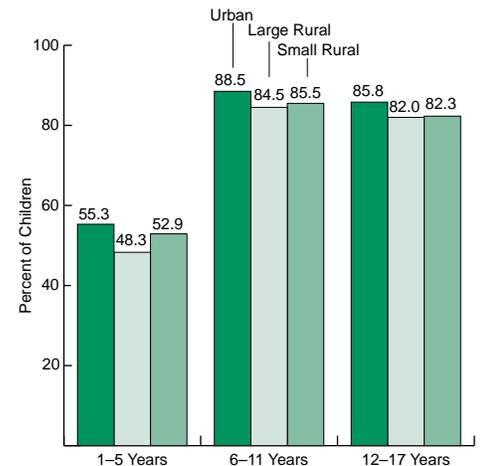
In all locations, children aged 1–5 years were less likely than older children to have had a preventive dental visit in the past 12 months, with only about half doing so. Among children aged 6–11, rural children were less likely to have had a preventive visit than those in urban areas: 88.5 percent of urban children in this age group had a dental checkup, compared to 84.5 percent of children in large rural areas and 85.5 percent of those in small rural areas. The same pattern was evident for adolescents: 85.8 percent of children aged 12–17 years in urban areas had a dental visit, compared to 82.0 percent of those in large rural areas and 82.3 percent of those in small rural areas.

In all locations, less than half of children without general health insurance had a preventive dental visit, although this percentage did not vary

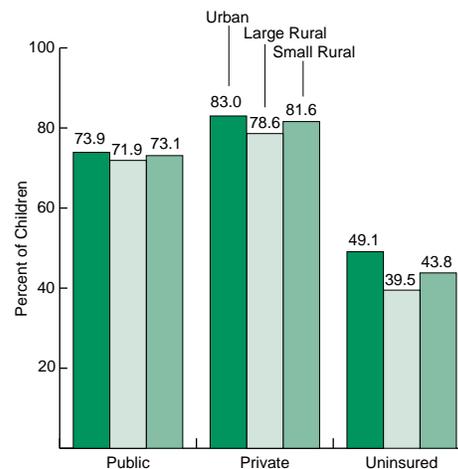
Children Aged 1–17 Receiving a Preventive Dental Visit in the Previous Year, by Location



Children Aged 1–17 Receiving a Preventive Dental Visit in the Previous Year, by Location and Age



Children Aged 1–17 Receiving a Preventive Dental Visit in the Previous Year, by Location and Health Insurance Type\*



\*Refers to general medical health insurance; public and private health insurance may not cover dental benefits.

significantly across locations. Children with private insurance were the most likely to have had a dental checkup in all locations, and those in urban areas were slightly more likely to have had a dental visit than those in large rural areas (83.0 and 78.6 percent, respectively).

*1 American Academy of Pediatric Dentistry. Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents. Chicago, IL: AAPD; 2013.*



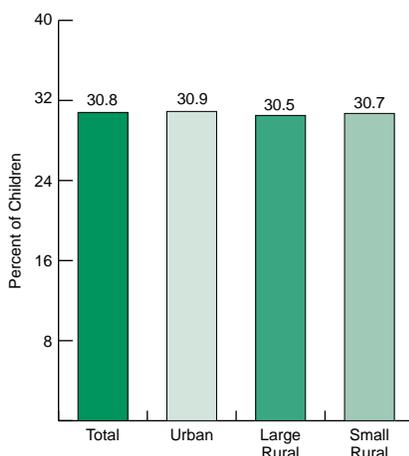
## Developmental Screening

Assessing children's development is one of the most important and valuable aspects of well-child care. Both the American Academy of Pediatrics and Bright Futures guidelines call for routine screening by pediatric health care providers for developmental and behavioral problems and delays using standardized developmental screening tools.<sup>1,2</sup> Parents were asked a series of questions to assess whether children received basic developmental assessments and to measure whether a parent completed a developmental and behavioral screening tool. Specifically, parents were asked: (1) whether the child's doctors or other health care providers asked the parent if he/she had concerns about the child's learning, development or behavior; and (2) whether parents filled out a questionnaire about specific concerns and observations they had about their child's development, communication or social behavior. These items were based on the Promoting Healthy Development Survey.<sup>3</sup>

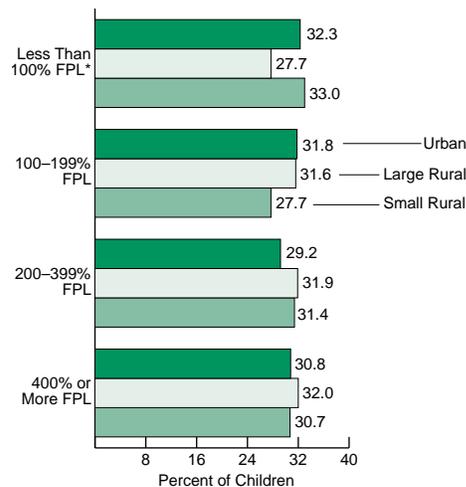
Parents of about 30 percent of children aged 10 months–5 years reported that their children had received both components of the standard developmental screen. This percentage did not vary by location.

The proportion of young children who received a standard developmental screen did not vary significantly across income groups or insurance types.

Children Aged 10 Months–5 Years Receiving a Standard Developmental Screening, by Location

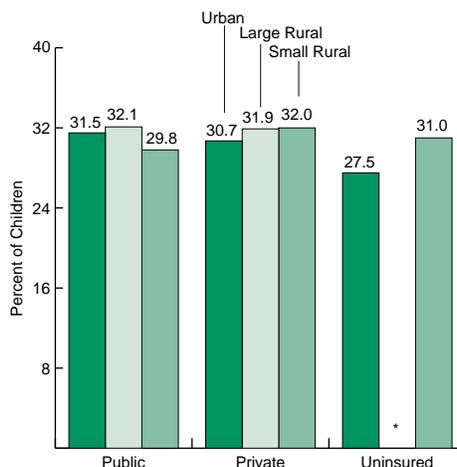


Children Aged 10 Months–5 Years Receiving a Standard Developmental Screening, by Location and Poverty Level\*



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.

Children Aged 10 Months–5 Years Receiving a Standard Developmental Screening, by Location and Insurance Type



\*Estimate does not meet standards of precision or reliability; based on fewer than 20 cases or relative standard error > 30%.

- Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: guidelines for health supervision of infants, children, and adolescents*, 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.
- American Academy of Pediatrics. Statement on identifying infants and young children with developmental disorders in the medical home. In: Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.
- Bethell C, Reuland C, Schor E. Assessing health system provision of well-child care: the Promoting Healthy Development Survey. *Pediatrics*. 2001;107(5):1084–1094.



## Mental Health Care

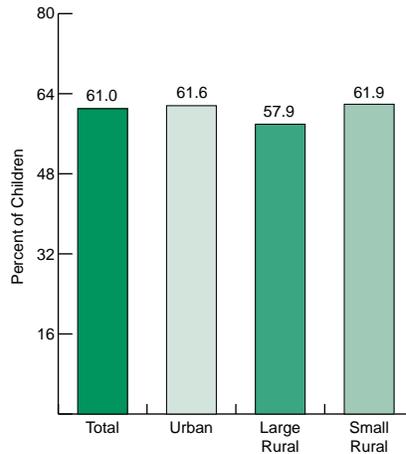
Mental health services, including counseling, medications, or specialized therapies, may be beneficial for children with behavioral or emotional problems. However, these services may not be readily available to all children who need them.

Among children aged 2–17 years who had an ongoing emotional, developmental, or behavioral problem that required treatment or counseling, 61.0 percent received mental health care or counseling in the past year. This percentage did not vary significantly across locations.

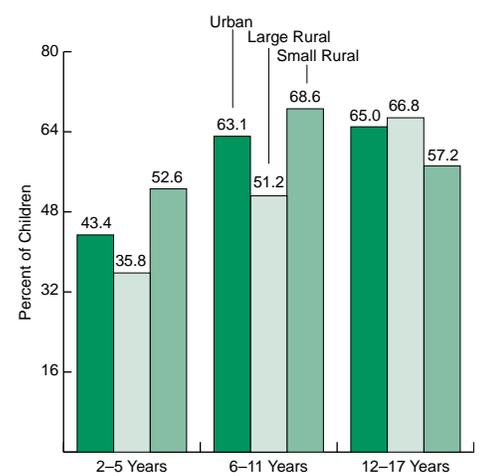
Receipt of services varied differentially with age groups across locations. In urban areas, children aged 6–11 and 12–17 years were more likely than younger children to receive needed mental health services, while children in large rural areas aged 12–17 years were more likely than both of the younger age groups to have done so. In small rural areas, however, children aged 6–11 years were more likely than both younger and older children to have received mental health services: 68.6 percent of 6- to 11-year-olds versus 52.6 and 57.2 percent of those aged 2–5 and 12–17 years, respectively.

Among children aged 2–5 years, those in large rural areas (35.8 percent) were significantly less likely than children in small rural (52.6 percent) and urban areas (43.4 percent) to have received needed mental health services in the previous year. The pro-

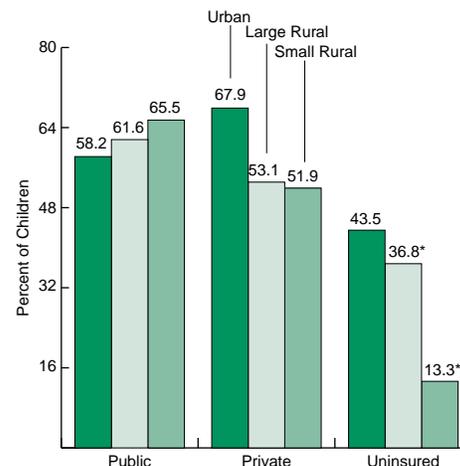
Children Aged 2–17 With Emotional, Behavioral, or Developmental Problems Receiving Mental Health Services in the Previous Year, by Location



Children Aged 2–17 With Emotional, Behavioral, or Developmental Problems Receiving Mental Health Services in the Previous Year, by Location and Age



Children Aged 2–17 With Emotional, Behavioral, or Developmental Problems Receiving Mental Health Services in the Previous Year, by Location and Insurance Type



\*Estimate does not meet standards of precision or reliability; based on fewer than 20 cases or relative standard error > 30%.

portions of older children receiving services did not vary by location.

In urban areas, uninsured children and those with public insurance were far less likely than those with private insurance to receive the mental health

services they needed (43.5 and 58.2 versus 67.9 percent, respectively). There were no significant differences in the receipt of mental health services among publicly and privately insured children in rural areas.



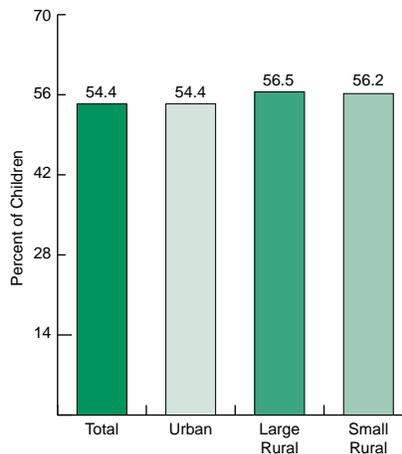
## Medical Home

A number of characteristics of high-quality health care for children can be combined into the concept of the medical home. As defined by the American Academy of Pediatrics, children's medical care should be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. A child's health care was considered to meet this standard if:

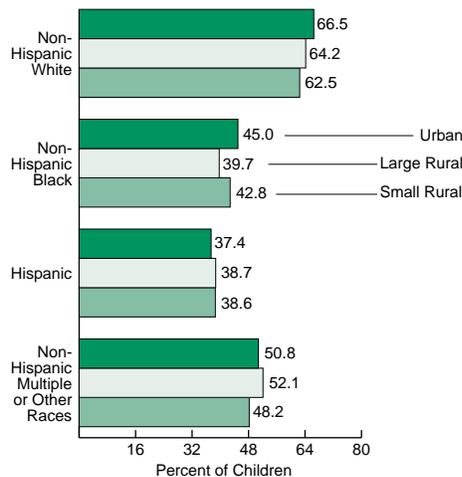
- The child has at least one personal doctor or nurse who knows him or her well and a usual source of sick care
- The child has no problems gaining referrals to specialty care and access to therapies or other services or equipment
- The family is very satisfied with the level of communication among their child's doctors and other programs
- The family usually or always gets sufficient help coordinating care when needed and receives effective care coordination
- The child's doctors usually or always spend enough time with the family, listen carefully to their concerns, were sensitive to their values and customs, provide any information they need, and make the family feel like a partner in their child's care.

A child is defined as having a medical home if his or her care was reported to meet all of these criteria.

Children With a Medical Home, by Location



Children With a Medical Home, by Location and Race/Ethnicity



Overall, the care of 54.4 percent of children met this standard, and this percentage did not vary across urban and rural locations.

The proportion of children in each racial and ethnic group with a medical home did not vary significantly across

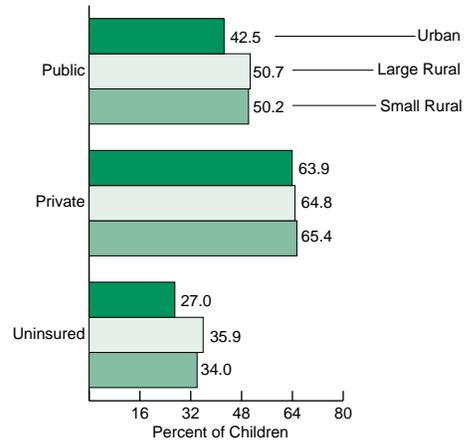
locations. However, within each location, differences between groups were evident: non-Hispanic Black, Hispanic, and children of multiple or other races in all locations were significantly less likely than non-Hispanic White children to have received care from a medical home.



## Medical Home (continued)

In all locations, uninsured children were least likely to receive care from a medical home, followed by those with public insurance, while children with private insurance were most likely to have a medical home. Among those with public insurance, urban children were less likely than children in rural areas to have a medical home (42.5 percent compared to more than 50 percent). The percentage of privately insured children who had a medical home did not vary significantly by location.

Children With a Medical Home, by Location and Insurance Type



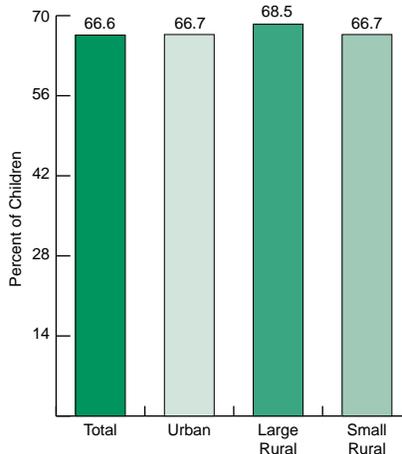


## Medical Home: Family-Centered Care

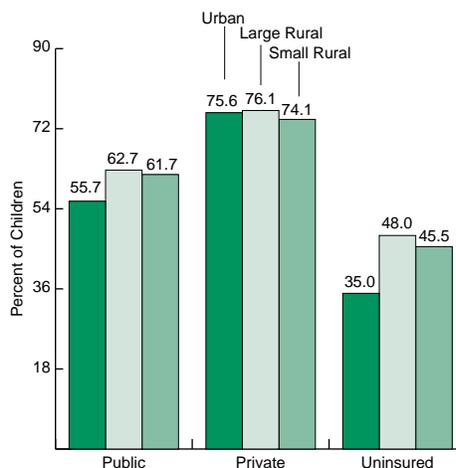
One important aspect of the medical home is whether or not children receive care that is “family-centered;” that is, whether parents report that their children’s doctors usually or always spend enough time with them, listen carefully to their concerns, are sensitive to their values and customs, provide needed information, and make the family feel like a partner in their child’s care. Together, these measures of family-centered care provide an important picture of how comfortable families feel with their children’s medical care. Overall, of the children who had at least one medical visit in the past year, two-thirds (66.6 percent) were reported to have received care that was family centered. This proportion did not vary significantly by location.

In all locations, uninsured children were least likely to receive family-centered care, followed by those with public insurance. Children with private insurance were most likely to receive family-centered care. Among uninsured children, those in urban areas were least likely to receive family-centered care: 35.0 percent of urban children did so, compared to more than 45 percent of those in both large and small rural areas. Similarly, among children with public insurance, those in urban areas were less likely to receive family-centered care than their rural peers (55.7 versus approximately 62 percent, respectively).

Children Receiving Family-Centered Care, by Location



Children Receiving Family-Centered Care, by Location and Insurance Type



On most of the individual questions that make up the family-centered care measure, the parents of more than 80

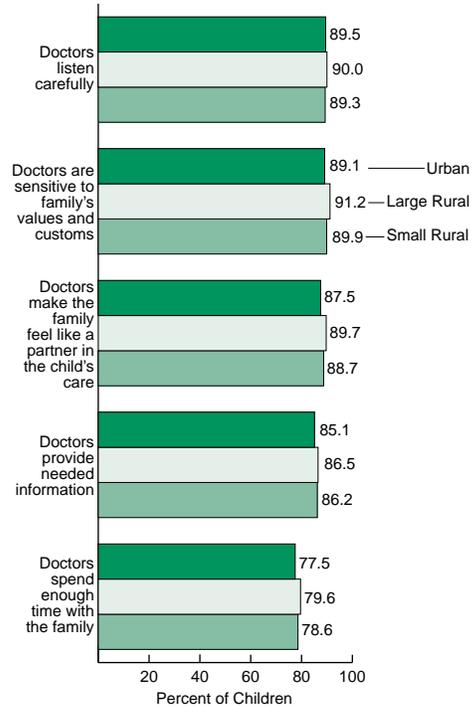
percent of children reported that their child’s provider usually or always met the standard. The only exception was



## Family-Centered Care (continued)

whether the provider spent enough time with the family, a criterion that was met for 77.5 percent of urban children, 78.6 percent of children in small rural areas, and 79.6 percent of children in large rural areas. Responses to the individual questions generally did not vary significantly by location, except that children in large rural areas were slightly more likely than their urban peers to have doctors that are sensitive to their values and customs, who make the family feel like a partner in their care, and who spend enough time with the family.

Children Who Usually or Always Receive Each Component of Family-Centered Care, by Location





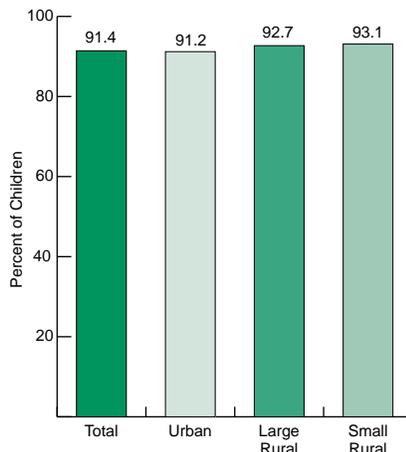
## Medical Home: Access and Care Coordination

Another important component of the medical home is children's access to primary and preventive care, consistent care when they are sick, access to referrals when they are needed, and support to help ensure that the various services they receive are coordinated.

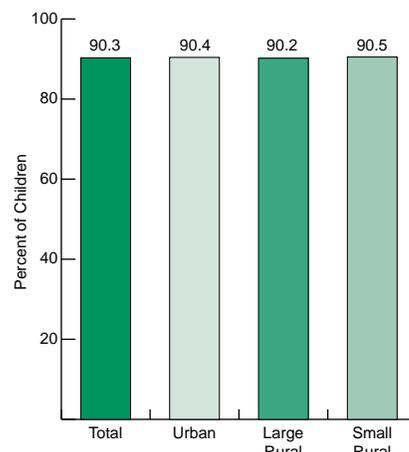
Each of the access and care coordination criteria were met for the vast majority of children. Overall, 91.4 percent of children were reported to have a regular source of sick care, 90.3 percent had a personal doctor or nurse, and 79.2 percent had no problems obtaining referrals when needed. Children were less likely to receive effective care coordination services when needed, which was reported for 66.1 percent of children.

With regard to location, children in urban areas were significantly less likely to receive effective care coordination services when needed compared to those in rural areas (65.4 versus more than 69 percent in rural areas). Urban children were also slightly less likely to have a regular source of sick care than those in rural areas (91.2 versus about 93 percent, respectively). The proportions of children with a personal doctor or nurse and who have no problems obtaining needed referrals did not differ by location.

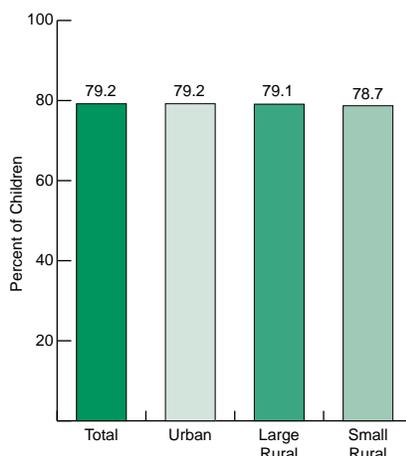
Children Who Usually or Always Have a Regular Source of Sick Care, by Location



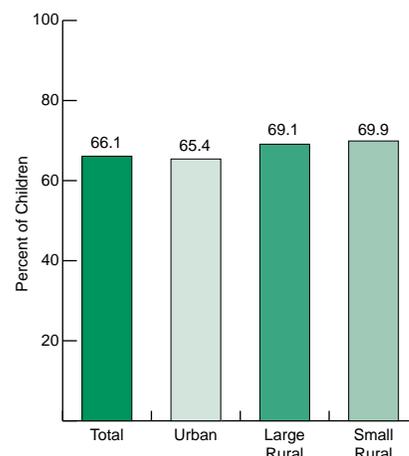
Children Who Have a Personal Doctor or Nurse, by Location



Children Who Have No Problems Obtaining Needed Referrals, by Location



Children Who Receive Effective Care Coordination Services When Needed, by Location





## Playing with Children of the Same Age

Children learn and develop social skills and behaviors through interactions with other children their own age. Parents of 1- to 5-year-olds were asked to report on how many days in the previous week their child played with other children their own age. Overall, 30.0 percent of young children played with others of the same age every day in the previous week, 61.4 percent did so on 1-6 days, and 8.6 percent had not played with others of the same age on any day in the previous week. Children in urban and small rural areas were slightly more likely to play with their peers every day than those in large rural areas, while children in both small and large rural areas were more likely than those in urban areas to have not played with others.

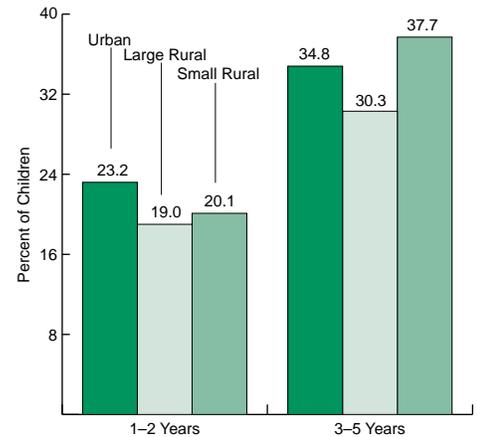
In all locations, children aged 3–5 years were more likely than younger children to play with their peers every day; approximately one-third did so, compared to less than one-quarter of children aged 1–2 years. Among 3- to 5-year-olds, the proportion playing with their peers every day differed for children in rural areas: 37.7 percent of children in small rural areas did so, compared to 30.3 percent of those in large rural areas.

Within each racial and ethnic group, the percentage of children who played with their peers every day did not vary significantly by location, except that Hispanic children in urban

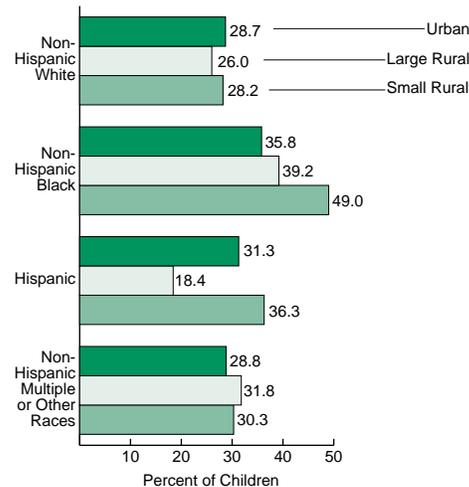
Children Aged 1–5 Who Play With Others Their Own Age, by Location



Children Aged 1–5 Who Play With Others Their Own Age Every Day, by Location and Age



Children Aged 1–5 Who Play With Others Their Own Age Every Day, by Location and Race/Ethnicity



and small rural areas were more likely to do so than those in large rural areas (31.3 and 36.3 compared to 18.4 percent, respectively). Within large rural areas, non-Hispanic Black and non-Hispanic children of multiple or other

racess (39.2 and 31.8 percent, respectively) were more likely than Hispanic children (18.4 percent) to play every day with others their own age.



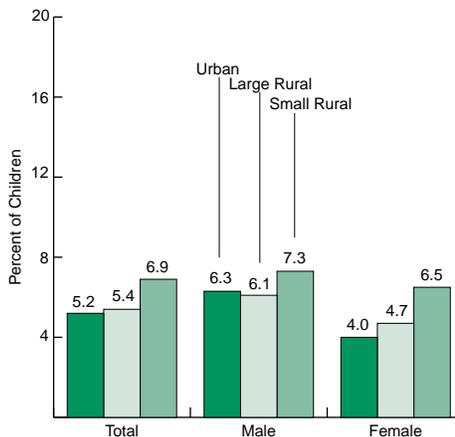
## Early Intervention and Special Education

The Individuals with Disabilities Education Act (IDEA) provides for early intervention services for young children (from birth until age 3) and special education services for older children (ages 3 and older) to minimize the effects of developmental delays and learning disabilities that could otherwise limit children's developmental and educational prospects. Early intervention can include physical, occupational, speech, and other therapies and services for young children and their families, and special education programs provide therapies and educational services. Overall, 5.3 percent of children aged 1-5 years and 11.3 percent of children aged 6-17 years received services under IDEA (data not shown). These percentages did not vary significantly by location.

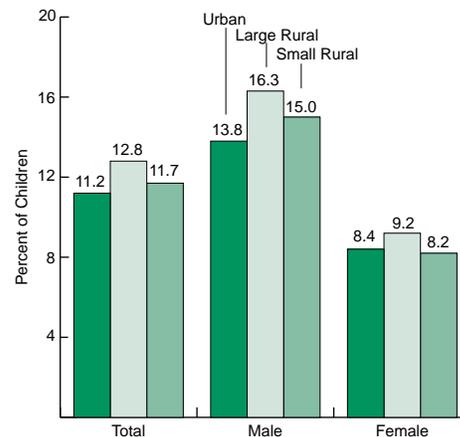
Among children aged 6-17 years in all locations, boys were more likely to receive special education services than girls. Males in urban areas were slightly more likely than girls to have received early intervention services, though there were no differences in the proportion of males and females receiving early intervention in rural areas. Receipt of early intervention and special education services did not vary across locations for older or younger children.

For younger children, receipt of early intervention and special education services did not vary with household income overall or by location. For older

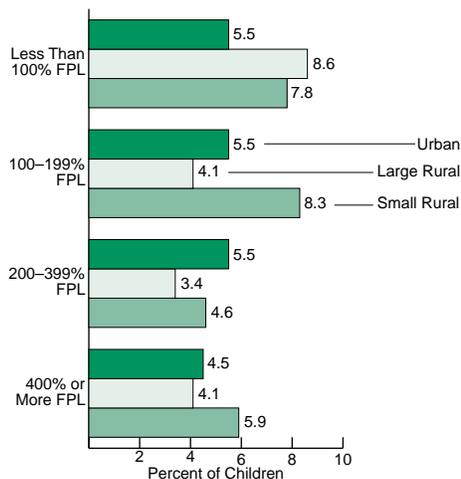
Children Aged 1-5 Receiving Early Intervention and Special Education Services, by Location and Sex



Children Aged 6-17 Receiving Special Education Services, by Location and Sex

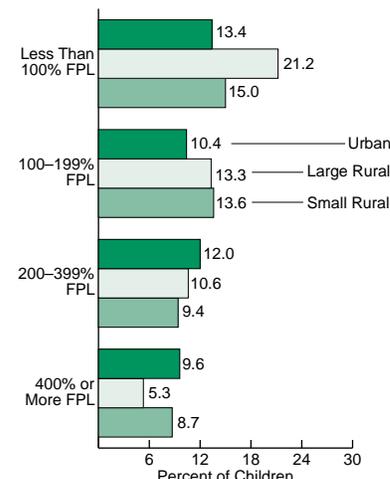


Children Aged 1-5 Receiving Early Intervention and Special Education Services, by Location and Poverty Level\*



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.

Children Aged 6-17 Receiving Special Education Services, by Location and Poverty Level\*



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.

children, however, there were some notable differences in the proportion of children receiving special education services by household income and location. Among children living in households with incomes below the Federal Poverty Level (FPL), those in urban and small rural areas were significantly less likely to receive services than children in large rural areas (13.4 and 15.0 versus 21.2 percent, respectively). The reverse was true, how-

ever, for children in households with incomes of 400 percent or more of the FPL: 9.6 percent of urban children and 8.7 percent of children in small rural areas received special education services compared to only 5.3 percent of those in large rural areas. Within each location, children with household incomes below 100 percent of the FPL were generally more likely to receive special education services than children in higher income categories.



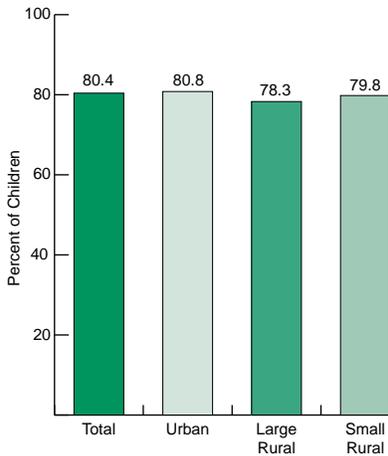
## School Engagement

Parents of school-aged children (aged 6–17 years) were asked two questions to assess their child's engagement in school: whether the child cares about doing well in school and whether the child does all required homework. Children were considered to be engaged in school if their parent responded "usually" or "always" to both of these items. Overall, 80.4 percent of children aged 6–17 years were engaged in school. Children in urban areas were only slightly more likely than those in large rural areas to be engaged in school (80.8 versus 78.3, respectively).

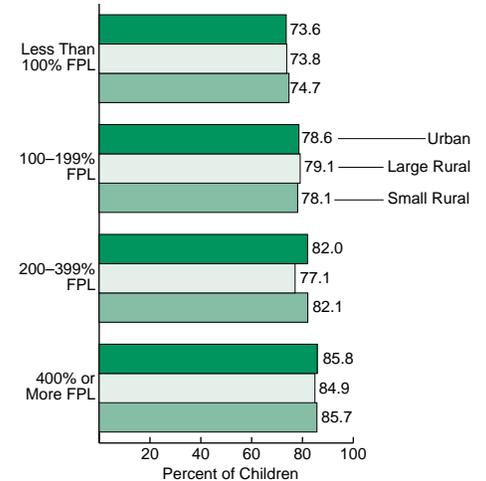
In all locations, children in the highest income categories were most likely to be adequately engaged in school than those with lower household incomes. For example, among large rural children, the percentage who were engaged in school ranges from 73.8 percent of those with household incomes below the Federal Poverty Level (FPL) to 84.9 percent of those with household incomes of 400 percent or more of the FPL. Within each income group, however, the rate of school engagement was similar across locations.

With regard to racial and ethnic groups, there were few differences in the percentage of children engaged in school across locations. The one exception was among non-Hispanic White children: those in urban areas were significantly more likely than

Children Aged 6–17 Engaged in School, by Location

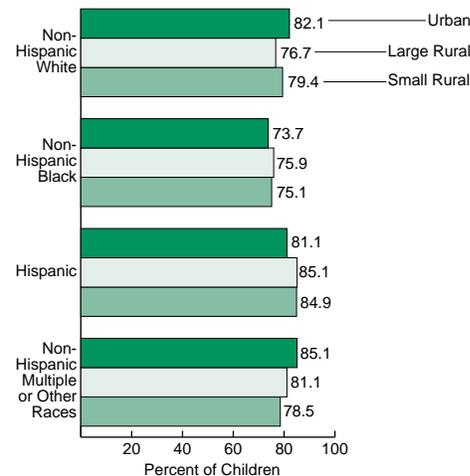


Children Aged 6–17 Engaged in School, by Location and Poverty Level\*



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.

Children Aged 6–17 Engaged in School, by Location and Race/Ethnicity



children in rural areas to be engaged in school. Within each location there were some differences across racial and ethnic groups. For instance, in both large and small rural areas non-Hispanic White and non-Hispanic

Black children were less likely than Hispanic children to be engaged in school. In urban areas, non-Hispanic Black children were less likely than all other racial and ethnic groups to be engaged in school.



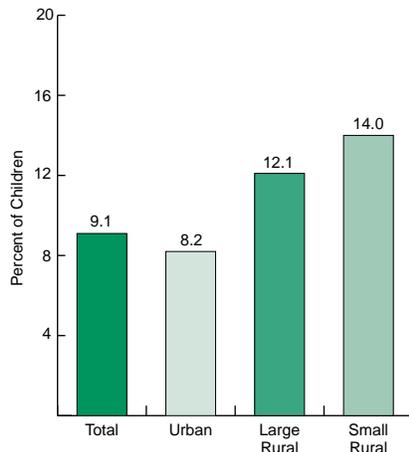
## Repeating a Grade

Parents of school-aged children (aged 6-17 years) were asked if their children had repeated one or more grades since starting school. Overall, 9.1 percent of children aged 6-17 years had repeated a grade. Repeating a grade was more common in rural areas, with 12.1 percent of school-aged children in large rural areas and 14.0 percent in small rural areas repeating a grade, compared to 8.2 percent of urban children.

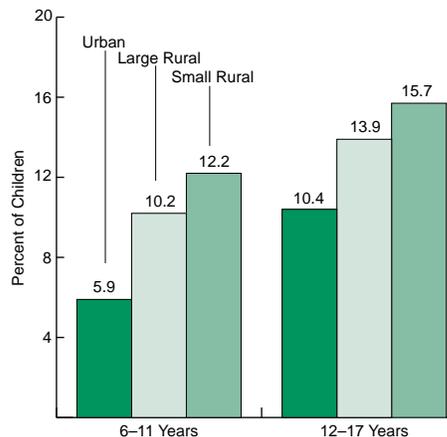
Generally, older children were more likely to have repeated a grade because they have had more opportunities to do so, and this was true for both urban and large rural areas. Within each age group, the percentage of children who had repeated a grade was significantly higher in rural than urban areas. Among children aged 12-17 years, for example, 15.7 percent of those in small rural areas and 13.9 percent of those in large rural areas had repeated a grade, compared to 10.4 percent of urban children.

In all locations, boys were more likely than girls to have repeated a grade. Again, for both sexes, the percentage of children who had repeated a grade was highest in small and large rural areas and significantly lower in urban areas.

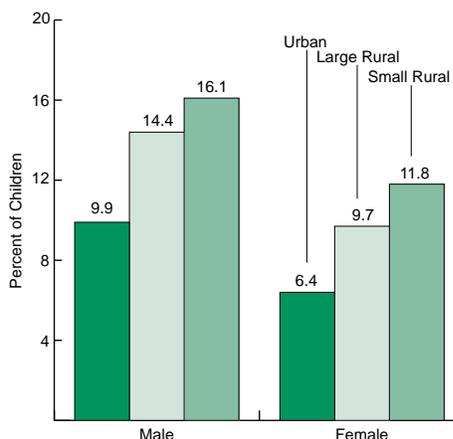
Children Aged 6-17  
Who Have Repeated a Grade,  
by Location



Children Aged 6-17  
Who Have Repeated a Grade,  
by Location and Age



Children Aged 6-17  
Who Have Repeated a Grade,  
by Location and Sex



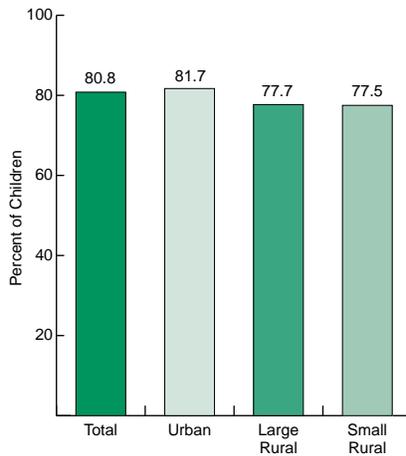


## Activities Outside of School

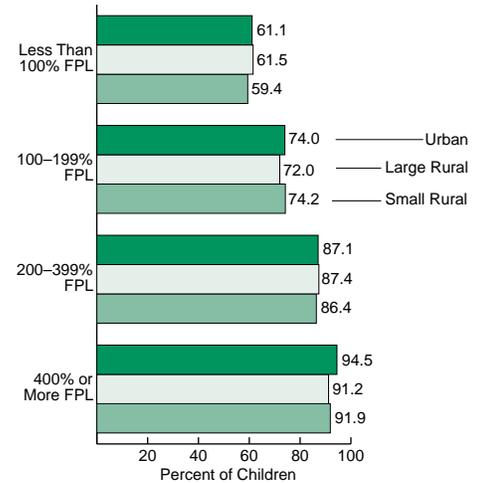
For school-aged children, participation in organized activities—such as sports teams, lessons, Scouts, religious groups, or Boys’ or Girls’ Clubs—after school or on the weekends can be an important part of overall development, provide enrichment, and contribute to the development of social skills. Parents of children aged 6–17 years were asked whether their children had participated in any of these types of activities in the previous year. Overall, 80.8 percent of school-aged children participated in at least one organized activity outside of school. This percentage was slightly higher in urban areas (81.7 percent) than in large or small rural areas (77.7 and 77.5 percent, respectively).

In all locations, children in lower-income households were significantly less likely than those in higher-income households to participate in organized activities outside of school. For instance, among children in small rural areas, 59.4 percent of children with household incomes below 100 percent of the Federal Poverty Level (FPL) participated in activities outside of school, as did 74.2 percent of those with incomes of 100–199 percent of the FPL, and 91.9 percent of those with incomes of 400 percent or more of the FPL. In general, the percentage of children who participate in activities does not vary significantly across locations, except that urban children with household incomes of 400 per-

Children Aged 6–17  
Who Participate in Activities Outside of School, by Location

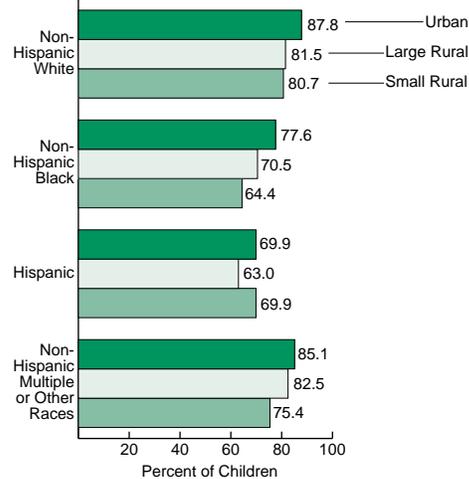


Children Aged 6–17  
Who Participate in Activities Outside of School, by Location and Poverty Level\*



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.

Children Aged 6–17  
Who Participate in Activities Outside of School, by Location and Race/Ethnicity



cent or more of the FPL (94.5 percent) were more likely to do so than their peers in large or small rural areas (91.2 and 91.9 percent, respectively).

In all locations, non-Hispanic Black and Hispanic children were less likely to participate in activities outside of

school than non-Hispanic White children. Among non-Hispanic children of each race, those in small rural areas were significantly less likely to participate in activities than their peers in urban areas.



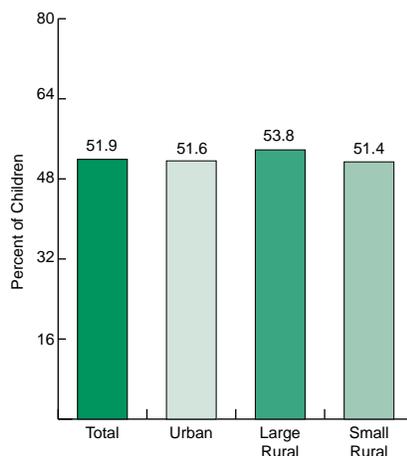
## Screen Time

The *Bright Futures* guidelines for infants, children, and adolescents recommend that parents limit children's screen time to 1–2 hours per day for children aged 1–5 years. Parents of children aged 1–17 years were asked how many hours children spent watching TV or videos on weekdays. Overall, more than half of children watched TV or videos for more than 1 hour per weekday; this percentage did not vary by location.

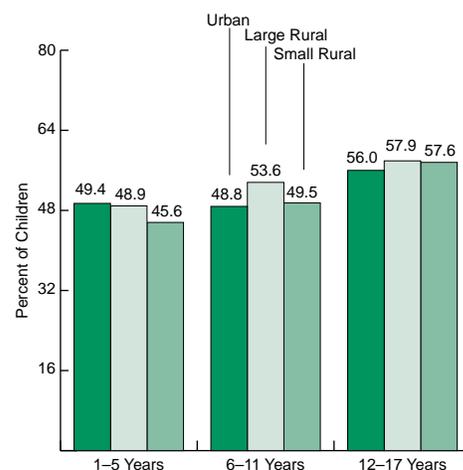
Older children were more likely than younger children to watch TV or videos for more than 1 hour per weekday. In general, the percentage of children within each age group who had more than an hour of screen time per day did not vary by location, except among children aged 6–11 years. In that age group, those in large rural areas were more likely than those in urban areas to have more than an hour of screen time per day (53.6 versus 48.8 percent, respectively).

In general, children with higher household incomes were less likely to watch more than an hour of TV or videos a day. However, this difference was smallest in small rural areas, where the percentage of children with more than an hour of screen time a day ranged from 55.9 percent among children with household incomes below 100 percent of the Federal Poverty Level (FPL) to 46.7 percent among those with incomes of 400 percent or more of the FPL. In urban

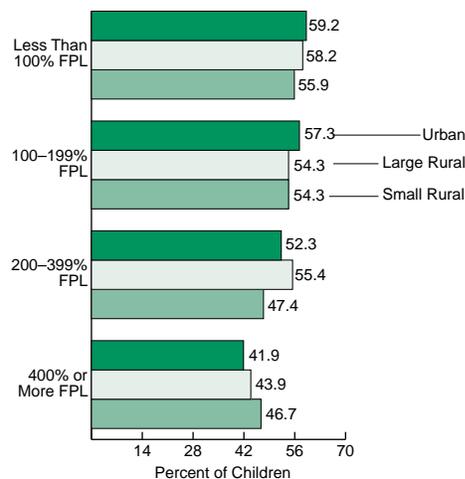
Children Aged 1–17 Who Watch More Than 1 Hour of TV or Videos per Weekday, by Location



Children Aged 1–17 Who Watch More Than 1 Hour of TV or Videos per Weekday, by Location and Age



Children Aged 1–17 Who Watch More Than 1 Hour of TV or Videos per Weekday, by Location and Poverty Level\*



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.

areas, by contrast, only 41.9 percent of children with household incomes of 400 percent or more of the FPL watched more than an hour of TV or videos a day, compared to 59.2 percent of those with household incomes

of less than 100 percent of the FPL. In general, within each income group, there were few significant differences by location in the percentage of children with more than an hour of screen time per day.



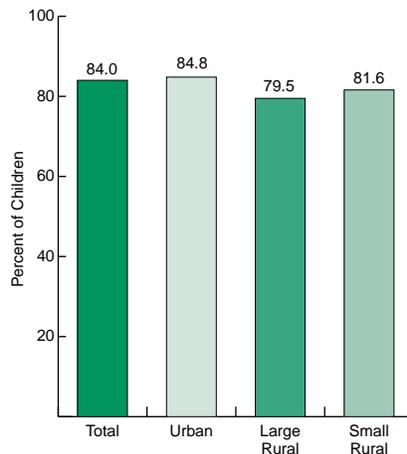
## Reading for Pleasure

Parents of school-aged children (aged 6–17 years) were asked how much time their child spent reading for pleasure on an average school day. Overall, 84.0 percent of children in this age group read for pleasure for some amount of time. The percentage of children who read for pleasure was slightly higher in urban areas (84.8 percent) than in large and small rural areas (79.5 and 81.6 percent, respectively).

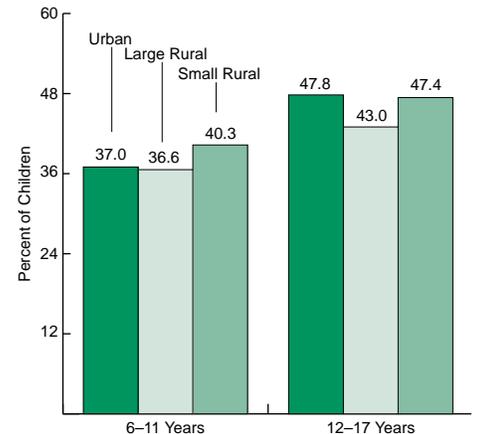
In all locations, older children (aged 12–17) were more likely to read for more than 30 minutes a day than younger children (aged 6–11). Among 12- to 17-year olds, those in urban areas were slightly more likely to read for pleasure for more than 30 minutes per day than those in large rural areas (47.8 versus 43.0 percent, respectively). There were no significant differences across locations among children aged 6–11 years.

Girls were also more likely to read for pleasure than boys in all locations. Approximately half of girls in all locations read for more than 30 minutes a day, compared to less than 36 percent of boys. Females in small rural areas were significantly more likely to read for more than 30 minutes a day compared to their large rural peers, however, no other differences were significant across locations.

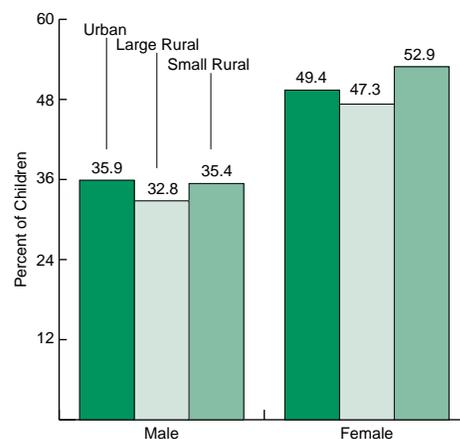
Children Aged 6–17 Who Read for Pleasure, by Location



Children Aged 6–17 Who Read for Pleasure for More Than 30 Minutes per Day, by Location and Age



Children Aged 6–17 Who Read for Pleasure for More Than 30 Minutes per Day, by Location and Sex

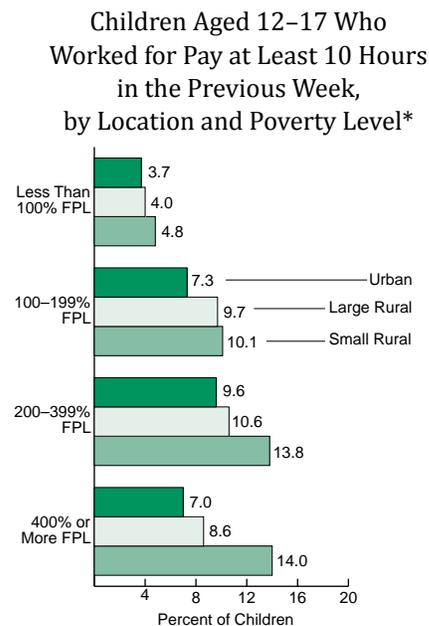
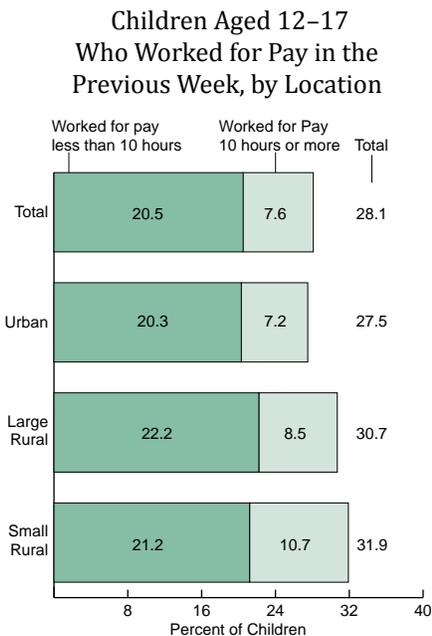




## Working for Pay

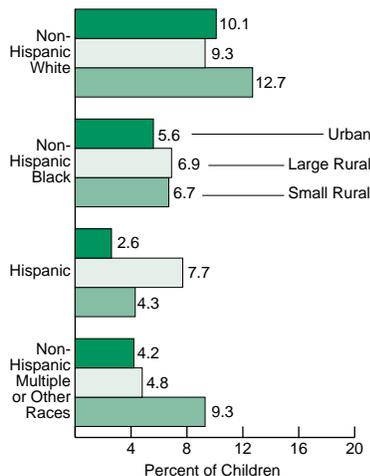
Parents of children aged 12 and older were asked whether their children worked outside the home for pay in the previous week and, if so, how many hours their children had worked for pay in the previous week. Overall, 28.1 percent of children aged 12–17 years had worked for pay in the previous week. Working for pay was more common among adolescents in small rural areas than in urban areas; 31.9 percent of those in small rural areas worked for pay, compared to 27.5 percent of urban adolescents.

The percentage of adolescents who worked at least 10 hours for pay in the previous week was lower among children in households with incomes below 100 percent of the Federal Poverty Level (FPL) compared to children from higher-income households. This difference was greatest in small rural areas where 14.0 percent of adolescents with household incomes of 400 percent or more of the FPL worked at least 10 hours compared to 4.8 percent of those with incomes below 100 percent of the FPL. Within each income category, the percentage of teens who worked for pay did not vary significantly across locations, except among adolescents with household incomes of 400 percent or more of the FPL. Among adolescents in this income category, those in small rural areas were significantly more likely to have worked for pay than those in urban and large rural areas (14.0 versus 7.0 and 8.6 percent, respectively).



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.

Children Aged 12–17 Who Worked for Pay at Least 10 Hours in the Previous Week, by Location and Race/Ethnicity



With regard to race and ethnicity, the proportion of non-Hispanic Black and non-Hispanic children of multiple or other races who worked at least 10 hours did not vary across locations. Hispanic youth in large rural areas, however, were more likely to work

than their peers in urban areas (7.7 versus 2.6 percent, respectively). Non-Hispanic White adolescents in small rural areas were significantly more likely than those in large rural and urban areas to have worked at least 10 hours for pay (12.7 versus 9.3 and 10.1 percent, respectively).



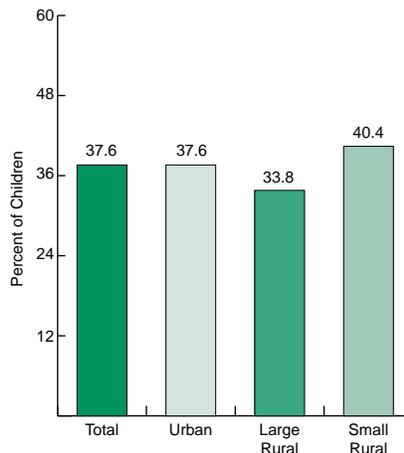
## Volunteering

Parents of children aged 12–17 years were asked how often their children had participated in community service or volunteer activities during the previous year, including activities at school, church, and in the community. Among children in this age group, 78.7 percent volunteered a few times a year or more (data not shown) and 37.6 percent volunteered a few times a month or more. The percentage of children volunteering a few times a month or more did not vary greatly across locations.

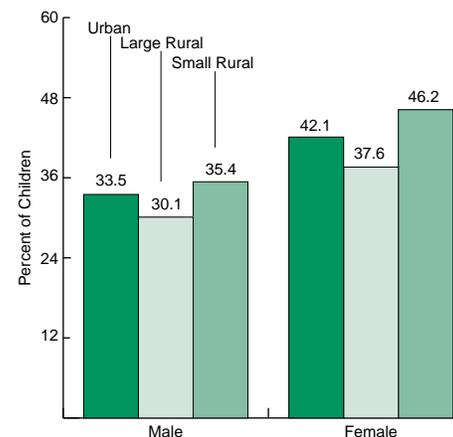
Adolescent girls were more likely than boys to volunteer a few times a month or more and this was true across all locations. The percentage of male and female adolescents who volunteered regularly did not vary greatly by location.

With regard to household income, the proportion of adolescents volunteering a few times a month or more did not vary across locations, though there were some differences within locations. Among youth in small rural areas, those with incomes 200 percent or more of the Federal Poverty Level (FPL) were more likely to volunteer than those in households with lower incomes. In urban areas, adolescents living in households with incomes of 400 percent or more of the FPL were more likely than those with incomes below 100 percent of the FPL. In large rural areas, the proportion of adolescents volunteering did not differ by household income categories.

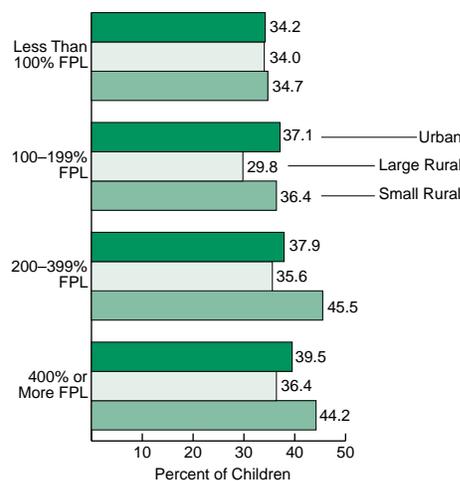
Volunteering at Least a Few Times a Month Among Children Aged 12–17, by Location



Volunteering at Least a Few Times a Month Among Children Aged 12–17, by Location and Sex



Volunteering at Least a Few Times a Month Among Children Aged 12–17, by Location and Poverty Level\*



\*Federal Poverty Level (FPL) is based on the U.S. Department of Health and Human Services poverty guidelines; poverty was \$23,050 for a family of four in 2012.