State Quality Rating and Improvement Systems

Strategies to Support Achievement of Healthy Eating and Physical Activity Practices in Early Care and Education Settings

Nemours Children's Health System

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Executive Summary

Introduction

Childhood obesity is a national epidemic. While the prevalence of child obesity may be declining in certain age groups,[i] achieving healthy weight among young children continues to be of utmost importance. Studies have shown that approximately 23 percent of children ages 2 to 5 years old in the United States are overweight or obese.[ii] Additionally, children who are overweight or obese as preschoolers are 5 times more likely to be overweight or obese as adults.[iii] From birth to age 5 children develop skills, knowledge, and habits that are carried into adulthood.

Many children spend a significant part of their day in early care and education (ECE) programs, such as Head Start, child care, Early Head Start or pre-kindergarten. Over 6.8 million children are in center-based care alone,[iv] making ECE settings an optimal opportunity for interventions that help prevent obesity.

ECE programs are primarily regulated through federal and state laws and policies. For example, a child care center or family child care home may receive federal funding and thus be required to follow certain federal guidelines (i.e. Head Start or the Child and Adult Care Food Program). Individual states also have regulations, commonly referred to as licensing standards, that set minimum standards for child care providers to follow. Licensing regulations primarily address health and safety issues such as physical facility capacity, equipment, staff to child ratios, caregiver qualifications, etc. Some states do address healthy eating and physical activity in their licensing regulations; however, incorporating a focus on child obesity in all states is a difficult challenge. As a result, other systems, such as Quality Rating Improvement Systems (QRIS), have been used to examine healthy eating and physical activity in ECE settings.

More than 15 years ago states began developing QRIS as a structural approach to improve the quality of ECE programs, increase parent understanding of what ECE quality looks like, and supplement regulatory approaches to quality. QRIS are voluntary or required systems designed to reach large numbers of ECE providers, particularly those serving low-income children receiving child care subsidies.[1] Often, state agencies establish graduated standards of quality and use them as an incentive to get providers to go above and beyond the licensing regulations in certain areas. QRIS are often accompanied by training and technical assistance, professional development, or financial incentives to encourage providers to meet the standards.

Currently, 40 states and the District of Columbia have a statewide QRIS in place.[v] Given increasing national concerns about childhood obesity, understanding and sharing prevention strategies that are included in state QRIS will help states continue and strengthen their ECE obesity prevention efforts.

Project Overview

This report by Nemours Children's Health System focuses on four strategies to prevent childhood obesity: healthy eating, breastfeeding, physical activity, and limited screen time (referred to as "HEPA"). The goal of the study was to measure the extent to which states with QRIS are using specific implementation strategies (professional development, assessments, technical assistance, and incentives) to promote HEPA practices in ECE settings (including center-based and family child care).

The purpose of this report is to provide data, recommendations, and case study examples to state-level administrators and stakeholders (e.g., policy makers, researchers, advocates) on how to more effectively use QRIS as a lever for change in childhood obesity prevention.

This report used two research methods, a survey and case study analysis. The *Healthy Eating, Breastfeeding, Physical Activity, and Screen Time Strategies in State QRIS Implementation Survey* ("survey") was administered electronically to state QRIS leaders to learn more about their activities related to childhood obesity prevention. The survey was administered in fall 2015 to 40 states and the District of Columbia (DC) with statewide QRIS implementation. A total of 31 states and DC responded to the survey for a 76 percent response rate. Seven states—Arizona, Georgia, Idaho, Indiana, New Jersey, Oklahoma, and Wisconsin—also participated in case study analysis. One-hour phone interviews were conducted with each case study state in February 2016.

1 Low income with parents working or attending school.

Results

This report focuses on the results from the survey and findings from the case studies.

A majority of survey respondents (24 out of 31) indicated having practices[2] related to healthy eating, breastfeeding, physical activity, and/or screen time that they want to promote via QRIS. Only 11 out of those 24 states (46%) have information about the number of ECE providers meeting HEPA best practices. Similarly, only 7 out of those 24 states (29%) said they have conducted a survey to understand whether providers are meeting HEPA practices.

The table below summarizes additional information from the 24 states.

Professional Development	96% of states (23 out of 24) indicated their professional development system is linked to their QRIS.
Self-assessment	58% of states (14 out of 24) reported encouraging providers to use a self-assessment tool focused on HEPA practices.
Observational Assessment	71% of states (17 out of 24) are using observational tools as part of QRIS to provide insight into whether providers are implementing HEPA practices.
Technical Assistance	92% of states (22 out of 24) provide QRIS-connected technical assistance that supports providers meeting HEPA practices.
Incentives	77% of states (17 out of 24) are offering incentives to providers that are linked to HEPA practices.

The case studies highlight interesting strategies being implemented by states:

- Arizona: Leveraging a Cross-Agency Initiative to Support Program Quality *(Technical Assistance)*
- Georgia: Awards and Incentives to Reward Program Quality *(Incentives)*
- Idaho: Building Knowledge and Improving Practices through Essential Trainings *(Training and Technical Assistance)*
- Indiana: System-Level Supports to Enhance Program Quality *(Technical Assistance)*
- New Jersey: Integrating Let's Move! Child Care into Self-Assessment *(Self-assessment)*
- Oklahoma: Observational Assessment as a Tool for Program Improvement *(Observational Assessment)*
- Wisconsin: Cross-Sector Collaboration for Coordinated Strategies *(Technical Assistance)*

Conclusions & Policy Implications

A majority of survey respondents, 24 out of 31 (77%), indicated their state has determined there are practices related to HEPA they want to promote through QRIS. This signals states' commitment to childhood obesity prevention efforts, as well as the importance of supporting children's health and wellness as an integral aspect of ECE program quality.

The results suggest that stakeholders, especially state-level policymakers and advocates, can help improve HEPA practices in ECE settings. They can:

- Expand the use of coursework and core competencies to support ECE providers' achievement of HEPA practices. Continue to focus on healthy eating and physical activity practices, especially practices related to breastfeeding and screen time.
- Use assessment strategies to deepen ECE providers' knowledge about their program practices and to help identify opportunities for improvement.

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2 The survey did not ask states to compare the practices they are promoting to 'best practices' indicated by national standards such as Caring for our Children or *Let's Move!* Child Care. No analysis was done to compare what HEPA "bar" states are trying to get providers to meet via their QRIS system. Further analysis and research is recommended in this area.

- Embed HEPA practices into technical assistance strategies and include training for TA providers, QRIS coaches, and raters on the HEPA best practices.
- Gather information and data from providers to inform improvements to QRIS to support providers' achievement of HEPA practices.

The results also show there is a need to:

- Explore the interplay between licensing regulations and QRIS standards to more fully understand where practices related to childhood obesity prevention sit within state systems.
- Dive deeper into QRIS implementation strategies and state-level data to understand more about whether or not strategies are helping providers make progress toward and achieve specific HEPA best practices. Answer questions such as what type of data states have to track ECE program progress toward meeting HEPA best practices.
- Learn more about the organizations and individuals supporting providers in healthy eating, breastfeeding, physical activity, and screen time practices.
- Examine HEPA practices implemented in Head Start and school-based pre-kindergarten settings where federal and state funding (as well as regulations) may impact those practices more than QRIS strategies.

Introduction

Childhood obesity is a national epidemic, and while recent studies show the prevalence may be declining in certain age groups,[vi] a focus on strategies to support healthy weights for young children continues to be of utmost importance. Studies have shown that approximately 23% of children ages 2 to 5 years old in the United States are overweight or obese.[vii] It has also been reported that children who are overweight or obese as preschoolers are 5 times more likely to be overweight or obese as adults.[viii] From birth to age 5 children develop skills, knowledge, and habits that are carried into adulthood. A multi-sector prevention approach should reach young children where they live, learn, and play. It is important to consider the system of supports surrounding children and families, and early care and education (ECE) settings provide an optimal opportunity for intervention. ECE programs serve children birth to age 5 years (kindergarten entry) and may include child care centers, family child care, Early Head Start, Head Start, state pre-kindergarten, and/or other early childhood programs. Many children spend a significant part of their day in ECE programs (in centers, homes and schools) with over 6.8 million in center-based care alone.[ix]

Because of the variety of ECE programs that exist, regulation is complicated. Depending on how the ECE setting is financed, a program (i.e. a child care center or family child care home) may receive federal funding and thus be required to follow certain federal guidelines (i.e. Head Start or the Child and Adult Care Food Program). On top of that, states are responsible for establishing regulatory requirements for child care providers. These regulations, commonly referred to as licensing standards, set minimum standards for child care providers to follow. Licensing can be used to address healthy eating and physical activity, however, they primarily exist to address basic health and safety issues (e.g., facility requirements, staff to child ratios, caregiver qualifications). Incorporating a larger focus on child obesity into state licensing standards could have broader health impacts for young children, but it can be difficult to do so depending on the political and regulatory context of each state. As a result, other systems, such as Quality Rating Improvement Systems (QRIS) have been created to present additional goals (i.e. related to school readiness) to ECE providers over the years. As explored in this report, this may be a different avenue for examining healthy eating and physical activity in ECE settings.

More than 15 years ago states began developing QRIS as a structural approach to improve the quality of ECE programs, increase parent understanding of what ECE quality looks like, and to supplement regulatory approaches to quality. QRIS are voluntary or required systems designed to reach large numbers of ECE providers, particularly those serving low-income children receiving child care subsidies.[3] Often, state agencies typically establish graduated standards of quality and use them as an incentive to get providers to go above and beyond the licensing standards in certain areas. QRIS are often accompanied by training and technical assistance, professional development, or financial incentives to encourage providers to meet the standards. At the time this study was conducted (fall 2015), 40 states and the District of Columbia had a statewide QRIS in place.[x]

Given increasing national concerns about childhood obesity, it is important to understand and share state prevention strategies being included in state QRIS. Information provided in this report expands the knowledge base on childhood obesity prevention, specifically as it relates to innovative strategies states are using to support ECE providers.

3 Low income with parents working or attending school.

Project Overview

The Nemours National Office of Policy & Prevention led a study funded by Health Eating Research (HER), a national program of the Robert Wood Johnson Foundation, and ChangeLab Solutions, to learn more about state strategies to promote healthy eating, breastfeeding, physical activity, and limited screen time ("HEPA") in state QRIS implementation. The goal of the survey was to identify ways states are promoting HEPA in ECE settings (including center-based and family child care) through QRIS beyond the use of inclusion in QRIS standards.

QRIS standards[4] are important levers for program improvement, however they only tell part of the story. In states implementing a QRIS, standards are the basis of the system and serve as quality indicators for ECE programs. Standards are usually above and beyond those found in state regulations (i.e. licensing) and usually reflect a state's commitment to improving quality in ECE settings. The standards themselves may or may not reflect everything a state is interested in promoting, rating and improving however. The goal of looking closely at QRIS *implementation strategies* (e.g., training, technical assistance, incentives) was to uncover how states are supporting providers to implement practices, sustain their efforts, and continuously improve their program quality in HEPA areas. However, state licensing regulations and QRIS standards related to HEPA may help to explain some of the implementation strategies. There may be connections between the inclusion of HEPA standards in QRIS and HEPA-focused implementation strategies, though the assumption cannot be made. Appendix A: State-by-State Summary of Licensing Regulations and QRIS Standards provides summary information about whether or not states have included HEPA topics in licensing regulations and QRIS standards. Readers are also encouraged to review HEPA-related licensing standards and QRIS regulations in the *Summary of Obesity Prevention Standards in State Quality Rating and Improvement Systems (QRIS) and Licensing Regulations*[5] for lists of states' specific HEPA licensing regulations and QRIS standards.

The purpose of this report is to provide data, recommendations, and case study examples to state-level administrators and stakeholders (e.g. policymakers, researchers, advocates) on how to more effectively use QRIS as a lever for change in childhood obesity prevention.

This study was supported by insight from expert consultants and a project advisory group. Tracy Fox, MPH, RD, Food, Nutrition & Policy Consultants, and Dianne Ward, Ed.D., University of North Carolina at Chapel Hill served as expert consultants on this project and provided a wealth of knowledge related to obesity prevention in ECE settings. The project was managed by Julie Shuell, MPA, Nemours National Office of Policy and Prevention, who has over 20 years leadership and management experience in ECE, and who oversees Nemours' National Early Care and Education Learning Collaboratives project. The Institute of Medicine (IOM) Roundtable on Obesity Solutions, Innovation Collaborative on Early Care and Education, whose members include researchers, practitioners, and policy makers with expertise in ECE or childhood obesity prevention, served as the advisory group for this project. The advisory group convened quarterly and provided input on key deliverables throughout the project.

The purpose of this report is to provide data, recommendations, and case study examples to state-level administrators and stakeholders (e.g., policy makers, researchers, advocates) on how to more effectively use QRIS as a lever for change in childhood obesity prevention. It also identifies opportunities for continued research and discovery to advance childhood obesity prevention in ECE settings. The report takes into consideration the interplay between practice and policy and evolving state systems for a holistic set of reflections and recommendations.

4 QRIS standards are the criteria ECE programs must meet to attain certain levels of program quality as defined by the state.

5 https://d3knp61p33sjvn.cloudfront.net/2016/04/SummaryofObesityPreventionLicensingRegulationsandQRISStandards_040416.pdf

Research Methods

Survey Development and Administration

The cornerstone of this study was a *Healthy Eating, Breastfeeding, Physical Activity, and Screen Time Strategies in State QRIS Implementation Survey* ("survey"), which was administered to state QRIS leaders to learn more about state QRIS activities related to childhood obesity prevention. The survey was developed with input from project consultants, funders, and advisory group members.

The survey was pilot tested with three states—Arizona, New Jersey and Florida (Miami-Dade)—as well as an administrator from BUILD Initiative.[6] All pilot participants provided valuable feedback on the length, detail, format of the survey, and advice on the need for incentives for survey completion. The survey was modified to reflect the feedback. Pilot participants did not believe it would be necessary to incentivize states to complete the survey.

Prior to administration of the survey, Nemours staff consulted with BUILD Initiative regarding their efforts to compile information from state QRIS administrators. This included speaking with project managers at Child Trends, the organization helping BUILD Initiative to manage data collection and analysis for the QRIS Compendium.[7] Child Trends regularly collects information from and communicates with QRIS state administrators and was able to offer recommendations to support successful data collection. Additionally, BUILD's QRIS National Learning Network published a brief paragraph about Nemours' QRIS study in its monthly newsletter to help raise awareness among state QRIS leaders.

The survey was released and completed by states in fall 2015. The organization(s) responsible for QRIS implementation vary widely by state and the details of how QRIS are implemented are not often publically available. Therefore, the BUILD Initiative's QRIS National Learning Network contact list[xi] was used to identify survey recipients. Survey respondents were encouraged to work collaboratively with others in their state to gather information for the survey. The QRIS National Learning Network contact list was also used to identify the status of states in their QRIS implementation. The survey was sent to state QRIS administrators/directors in 40 states and the District of Columbia with statewide QRIS implementation.[8] States not included in the study and the reasons why are summarized below.

- California, Florida, and Kansas – States administer QRIS locally and implementation strategies vary by community.
- Missouri – Legislation prevents state from implementing a QRIS.
- Alaska, Connecticut, Hawaii, South Dakota, West Virginia, and Wyoming – States were in the planning phase of their QRIS.

The survey asked states to describe their QRIS professional development system and whether coursework, trainings, technical assistance, assessments, and incentives link to the QRIS to support providers' achievement of practices related to healthy eating, breastfeeding, physical activity, and screen time. The survey was administered electronically and a PDF of the survey, available in Appendix B: State Survey, was provided to states for reference. Survey respondents were promised confidentiality of responses, and individual state responses are therefore not identified in this report.

For the purpose of the survey, healthy eating, breastfeeding, physical activity, and screen time were defined as follows:

- **Healthy eating** – Family style dining, fruit and vegetable consumption, limiting fried foods, eliminating sugary drinks, limiting fruit juice, availability of drinking water, following milk guidelines, appropriate portion sizes, healthy snacking and snacks, and other focus areas in healthy eating the state has identified.

6 BUILD Initiative works with state and national leaders in early childhood to strength state systems to benefit young children.

7 The QRIS Compendium provides detail about each state's QRIS for reference and analysis (www.qriscompendium.org).

8 Alabama was in the pilot phase at the time of survey administration and was included in the survey.

- **Breastfeeding –** Availability of a private space for breastfeeding or pumping and other focus areas in breastfeeding the state has identified.
- **Physical activity –** Physical activity opportunities of significant duration inside and/or outside, staff oversight and engagement of active time, breathless play that increases children's heart rate, infant "tummy time," and other focus areas in physical activity the state has identified.
- **Screen time –** Limited or no screen time for children, media literacy education, and other focus areas in screen time the state has identified.

Findings from the survey were used to inform the data summaries and recommendations in this report.

Case Study Analysis

In addition to learning about state QRIS activities, the survey was used to identify states with unique QRIS implementation strategies for in depth interviews and case study development. Sixteen states out of 31 respondents (52%) indicated in their survey responses they would be willing to consider participation in a case study. Case study states were selected based on the following criteria:

- Willingness to participate;
- Geographic distribution; and
- QRIS implementation strategies, with a goal to include a range of strategies among case study states.

Eleven states were contacted to further explore case study development, and seven states—Arizona, Georgia, Idaho, Indiana, New Jersey, Oklahoma, and Wisconsin—participated in case study analysis. One-hour phone interviews were conducted with each case study state in February 2016. Prior to each phone interview, relevant state materials provided by the state, or through background research, (e.g., training materials, handbooks) were reviewed. Each case study state's licensing regulations and QRIS standards related to childhood obesity prevention were reviewed, as was general information about the state's QRIS from the QRIS National Learning Network's QRIS Compendium.

Limitations

While this report highlights the many ways states are using QRIS implementation strategies to support childhood obesity prevention efforts in ECE settings, there are other state systems and initiatives that work toward the same end goal. For example, many states' licensing regulations include areas related to HEPA. Though licensing and QRIS are separate systems, they are often linked by licensing being a pre-requisite for participation in QRIS or licensing serving as the first level of the QRIS. Some states choose to include HEPA in the state's licensing regulations, others in QRIS standards, and some states have them in both. State systems are evolving and many states operate on a continuous improvement cycle. Periodic review of regulations, standards, and supports to providers is common as states aim to meet the current and evolving needs of ECE providers.

In many states ECE providers are *required* to meet licensing regulations in order to operate a child care business. The degree to which QRIS standards are implemented varies:

- In some states participation in QRIS is required, and in others participation is voluntary.
- Some states operate "building block" systems in which all QRIS standards at a particular level must be met before the provider can achieve a higher rating level.
- Some states operate "points-based" systems in which providers may choose which QRIS standards they will achieve to earn points toward a rating.
- A few states operate hybrid models in which some criteria are required while others may be selected.

The type of QRIS a state operates (points-based, building block, hybrid) may impact whether HEPA strategies in QRIS are impactful, as well as how many providers those strategies reach. ECE programs participating in a points-based system may choose to work on specific standards within the system, and those standards may not include HEPA practices. The focus of this project is QRIS implementation strategies and does not account for whether the state-supported practices are required or voluntary, or are part of a building block or points-based system.

Another notable variable is QRIS participation rates among ECE programs. The number and type of ECE programs participating in QRIS are important factors when considering the use of QRIS as a childhood obesity prevention strategy. The percentage of the total ECE programs in a state participating in QRIS varies widely state by state. In states where QRIS rollout has been more limited, QRIS implementation strategies to support HEPA would be reaching fewer providers, and therefore impacting far fewer children. Alternatively, states with high participation rates will be reaching a greater number of ECE providers. All states with statewide QRIS, regardless of the number or percent of ECE programs participating, were reviewed as part of this study in an attempt to uncover innovative strategies to leverage QRIS as part of a broad childhood obesity prevention strategy.

Additionally, shifting funding streams, limited budgets, and administrative priorities impact the design and implementation of a state's QRIS strategies to support participating providers. This report represents point-in-time information gathered in fall 2015 (aggregate data) through winter 2015/2016 (case study information). During that time states may have made improvements to state systems such as enhancing QRIS standards, expanding or modifying supports to providers, and/or launching an updated QRIS.

Survey Findings

Background Information

The survey was administered to 40 states and the District of Columbia (n=41) with statewide QRIS implementation. A total of 31 out of 41 states and DC responded to the survey for a 76% response rate.

Many survey respondents (24 out of 31 states, 77%) indicated their state has identified practices related to healthy eating, breastfeeding, physical activity, and/or screen time ("HEPA") they want to promote via the state QRIS. The remaining 7 states (23%) reported they are not focused on these areas and no further information was collected.[9] **This report summarizes information learned from the 24 states that completed the survey and indicated there are practices related to HEPA they want to promote through the state QRIS.**

Among the 24 states that determined there are childhood obesity prevention practices it wants to promote via its QRIS, 22 (92%) expressed a significant or moderate commitment to strategies that help providers implement HEPA best practices.

Nearly all states (22 out of 24) indicated survey responses apply to all program types[10] included in the state QRIS. Among those that stated responses do not apply to all program types, the reasons included:

- Exclusion of state pre-kindergarten because they are not included in the state's QRIS
- Exclusion of Early Head Start and Head Start programs and programs accredited by the National Association for the Education of Young Children (NAEYC), because they have an alternative pathway to participation in the QRIS

Professional Development

A central component to many states' ECE systems is professional development. States have tried to organize and simplify the way providers (across Head Start, child care, home visiting, early intervention, pre-k) learn skills, develop knowledge and practice competencies that support their work with children. States are trying to align what is required through licensing and QRIS with what is required for certificates (i.e. Child Development Associates) and degrees. They are trying to ensure that all professionals working with young children have the basic tools to support quality regardless of where they are working. These tools include career lattices (descriptions of courses and training necessary at different levels), core competencies (what providers need to know) and connected training and coursework. **Twenty-three out of 24 states (96%) indicated the state's professional development system is linked to the state's QRIS; meaning professional development required in QRIS is supported by statewide training and coursework offerings for providers.** Many states have linked mandatory course requirements, voluntary course offerings, and core competencies to the QRIS as summarized in Table 1.

Table 1 – Number and Percent of States with Voluntary Course Offerings, Mandatory Course Requirements, and Core Competencies Linked to QRIS

	Number of States*	Percent of States
Voluntary course offerings	19	83%
Mandatory course requirements	17	74%
Core competencies	16	70%

*Not mutually exclusive. Out of 23 states with the state professional development system linked to QRIS.

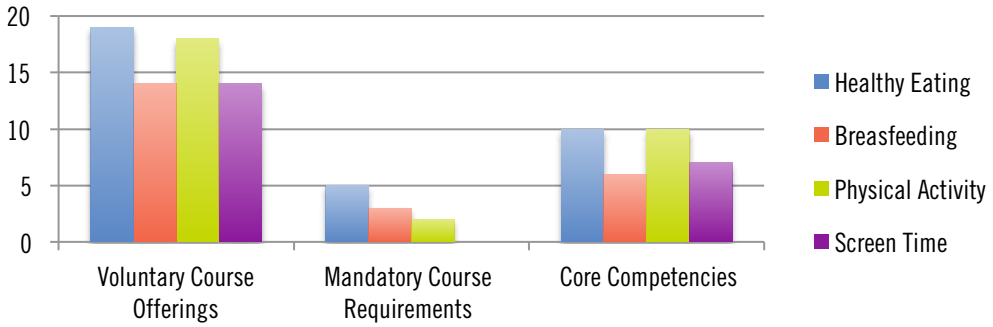
9 Among the 24 states that determined there are childhood obesity prevention practices it wants to promote via its QRIS, 22 (92%) expressed a significant or moderate commitment to strategies that help providers implement HEPA best practices.

10 The program types represented in state QRIS vary by state and may include child care centers, family child care, state pre-kindergarten, Early Head Start, Head Start, and/or other early childhood programs.

All 19 states with voluntary course offerings linked to the state's QRIS are using voluntary course offerings to support providers in one or more HEPA areas. Alternatively, of the 17 states with mandatory course requirements linked to QRIS only 6 (35%) are using mandatory course offerings to support providers in HEPA areas, and of the states with QRIS core competencies linked, 11 out of 16 (69%) are doing so.

Across all professional development strategies there is a trend toward including healthy eating and/or physical activity as focus areas. Breastfeeding and screen time are less frequently included in coursework and core competencies. For example, 19 out of 19 states (100%) with voluntary course offerings linked to QRIS are offering courses related to healthy eating and 18 out of 19 (95%) related to physical activity versus only 14 out of 19 states (74%) offering courses related to breastfeeding and 14 out of 19 states (74%) offering courses related to screen time. Similarly, 5 out of 17 (29%) of states with mandatory course requirements linked to QRIS are providing courses related to healthy eating and 6 out of 17 states (35%) related to physical activity, versus only 3 out of 17 (18%) of states offering courses related to breastfeeding and no state offering mandatory course requirements related to screen time. Table 2 further illustrates the HEPA areas included in state professional development strategies. Additional detail is provided in Appendix C: Professional Development Strategies tied to Healthy Eating, Breastfeeding, Physical Activity, and Screen Time.

Table 2 – Number of States Providing Voluntary Course Offerings, Mandatory Course Requirements, and Core Competencies Related to Healthy Eating, Breastfeeding, Physical Activity and Screen Time



Voluntary course offerings are most often used as a strategy to provide coursework to providers in HEPA practices. For example, 100% of states (19) with voluntary course offerings linked to the QRIS have course offerings to support providers related to HEPA practices, versus only 35% of states (6) with mandatory course requirements linked. Mandatory coursework is often reserved for the most foundational and necessary topics, and in a crowded landscape of QRIS standards and limited hours available to providers for training, it may not be possible to include all areas of program quality. Mandatory course requirements and core competencies, many of which are linked to state QRIS are not often used to support providers in the focus areas. Expanding the use of mandatory and core competencies to include HEPA topics is an opportunity for states to expand and reaffirm their support of ECE providers' childhood obesity prevention efforts. States may also consider identifying opportunities for the integration of childhood obesity prevention principles and overlap within existing professional development requirements, as further discussed in the Reflections and Recommendations section.

Self-Assessment

Self-assessment in ECE settings is increasingly used to help providers reflect on policies and practices, identify opportunities for growth and technical assistance, and plan program improvements. Over half of states (14 out of 24, or 58%), encourage providers to use a self-assessment tool that includes HEPA practices. Of the 14 states encouraging providers to use a self-assessment tool that includes HEPA areas, 5 (36%) have made use of a self-assessment that is *voluntary* for providers, 3 (21%) have made use of *both a required and voluntary assessment*, and 6 (43%) have *required* the use of a self-assessment.

Let's Move! Child Care (LMCC) and Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) are equally utilized tools among states that have made use voluntary for providers. One state noted anecdotally that a tool related to the focus areas was also developed and is being implemented locally in the state.

- Three states are using both LMCC and NAP SACC
- One state is using LMCC
- One state is using NAP SACC

States that have made use of both a required and voluntary self-assessment are similarly using LMCC and NAP SACC, and also a state-developed tool.

- One state is using both LMCC and NAP SACC
- One state is using NAP SACC
- One state is using a state-developed tool

Among states *requiring* use of a self-assessment, there is even greater variability in the tools used.

- Three states are using state-developed tools
- Two states are using the Environmental Rating Scales (ERS)
- One state is using LMCC and NAP SACC

Twelve out of 14 states (86%) using self-assessments related to the focus areas are using tools (e.g. LMCC and NAP SACC) that are exclusively focused on HEPA best practices. Few states are using tools (e.g., ERS) that are broad assessments of program quality and that include many other topics in addition to HEPA.

The purpose of self-assessment use varies, and many states are using self-assessment tools for multiple purposes. **Ninety-three percent of states (13 out of 14) are using self-assessment tools to help providers develop an action or program improvement plan, 71% (10 out of 14 states) are using the tools as part of the QRIS application and/or rating process, and 57% (8 out of 14 states) are using self-assessment tools to help providers determine areas of focus as part of quality improvement.** States *requiring* use of a tool are most often using it as part of the QRIS application or rating process and to help providers develop an action or program improvement plan. States allowing providers to *voluntarily* choose use of the tool are also using it for these purposes, along with more frequently using it to help providers determine areas of focus as part of their continuous program quality improvement process.

States have multiple staff reviewing the results of self-assessments. Among states using self-assessment tools related to HEPA:

- 64% (9) have results reviewed by QRIS technical assistants/coaches
- 50% (7) have results reviewed by QRIS monitors/raters
- 36% (5) use other staff (ECE program director, researchers, health specialists, portfolio assessors, CCR&R staff) to review the self-assessment
- 29% (4) have results from the self-assessment reviewed by another technical assistance provider

Self-assessment can be used as a strategy to help providers achieve practices related to HEPA. However, states are assuming that ERS self-assessment covers HEPA best practices. While it does include some HEPA topics, it does not cover specific HEPA best practices. Tools such as NAP SACC and LMCC were designed to educate providers about best practices and implementation strategies, and there is opportunity for increased use.

Observational Assessment

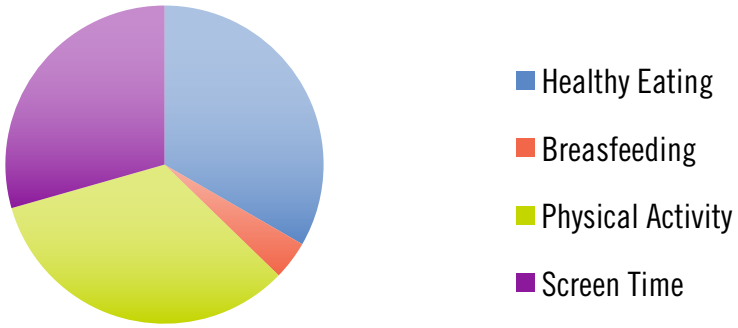
Many states are using observational assessment tools as part of QRIS to provide insight into whether providers are implementing HEPA practices. HEPA topics are often not the unique focus of the observational assessment, but rather part of a comprehensive tool that covers many areas of program quality. **Seventy-one percent of states (17 out of 24 states) are using observational tools that include HEPA topics.** Out of 17, 11 states (65%) require use of the tool(s), 1 state has made use voluntary, and 5 states use observational assessment for both required and voluntary purposes.

Most states using observational assessments that include HEPA topics are using ERS to assess program quality. Over three-quarters of states using observational tools to provide insight into the focus areas are using ERS (13 states, 76%), 3 states (18%) are using a state-developed tool, and 1 state (6%) uses the Program Quality Assessment. Three states also use the Classroom Assessment Scoring System (CLASS) in addition to ERS, and one of these states also uses the Program Administration Scale (PAS). The focus of the observational assessments by HEPA area is further described in Figure 3. ERS, the most commonly used observational assessment tool, includes some topics related to healthy eating, physical activity, and screen time. ERS is a broad observational assessment that includes many topic areas in categories including Space and Furnishings, Personal Care Routines, Listening and Talking, Activities, Interaction, Program Structure, and Parents and Staff.[11] CLASS and PAS also include some HEPA topics but weren't designed to assess best practices. Additional information is necessary from states using state-developed tools to know if the tool is specific to HEPA or part of a broader assessment. Exploration in this area may help to uncover whether states have found or developed HEPA-specific observational assessment tools that help to support changes in providers' practices. Looking across all states using observational assessment, breastfeeding is a focus significantly less often than other HEPA topics.

The Environmental Rating Scales, an observational assessment used to assess ECE program quality, includes topics related to healthy eating, physical activity and screen time. Topics covered include: providing healthy meals/snacks that meet USDA guidelines, staff modeling of healthy eating practices, providing adequate space and time for gross motor play, providing appropriate gross motor equipment, integrating music and movement as physical activity, and limiting screen time.

11 The specific components in ERS vary depending on the version used (Early Childhood, Infant/Toddler, Family Child Care, School Age). The categories listed here reflect the Infant/Toddler Environmental Rating Scale.

Figure 3 – Focus Areas of Observational Assessments Used by States

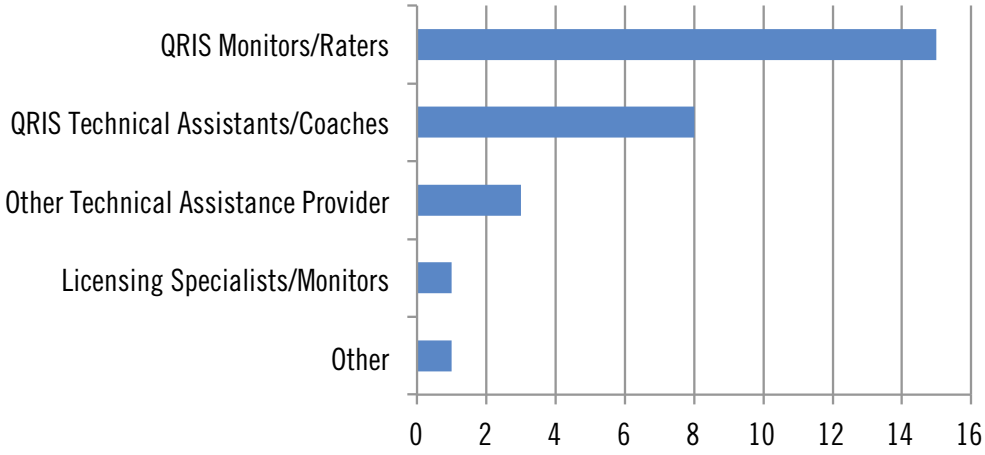


States are using observational assessment tools with providers for three primary purposes:

- For providers to develop an action or program improvement plan (14 out of 17, 82%);
- As part of the application for QRIS participation and/or as part of the rating process for QRIS (13 out of 17 states, 76%); and
- To allow providers to determine if they want to work on healthy eating, breastfeeding, physical activity, and/or screen time practices as part of their QRIS continuous improvement strategy (9 out of 17 states, 53%).

The individuals conducting the observational assessment vary by state, and, as described in Table 4, states most often use QRIS monitors and raters for this purpose.

Table 4 – Number of States Using Observational Assessment Assessors by Assessor Type



Since over three-quarters of states are using observational assessment for application/rating purposes, finding that QRIS monitors and raters are most often completing the observations is not surprising. Similarly, a majority of states also use observational assessment to support program improvement processes and thus one would expect technical assistants and coaches to be among those completing the assessments.

Technical Assistance

Technical assistance to ECE providers takes many forms, occurs at varying levels of intensity, and may be provided by a number of different individuals. Technical assistance is a strategy used widely in the ECE field to support providers' successes serving children and families. **Twenty-two out of 24 states (92%) provide technical assistance tied to QRIS that supports providers meeting HEPA practices.** States are providing technical assistance in many different ways and from different technical assistance providers, as described in Table 5 and Table 6. Often, individuals providing technical assistance linked to QRIS receive training on HEPA. **Of the 22 states providing technical assistance, 16 (73%) train their trainers in these areas.** Additional research about how specifically (e.g., by whom, what topics, and with what materials) trainers are trained on HEPA is an opportunity to learn more about the importance of these types of trainings and the impact of ECE providers' support networks.

Table 5 – Number of States Implementing Technical Assistance on HEPA Topics by Technical Assistance Provider Type

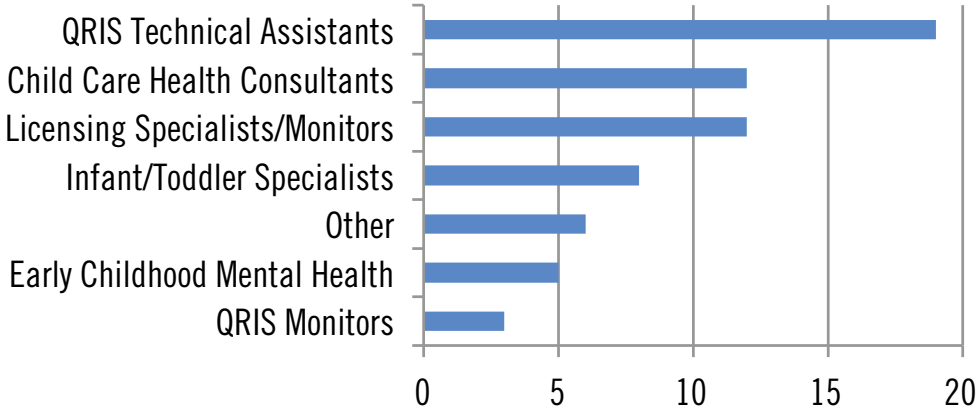
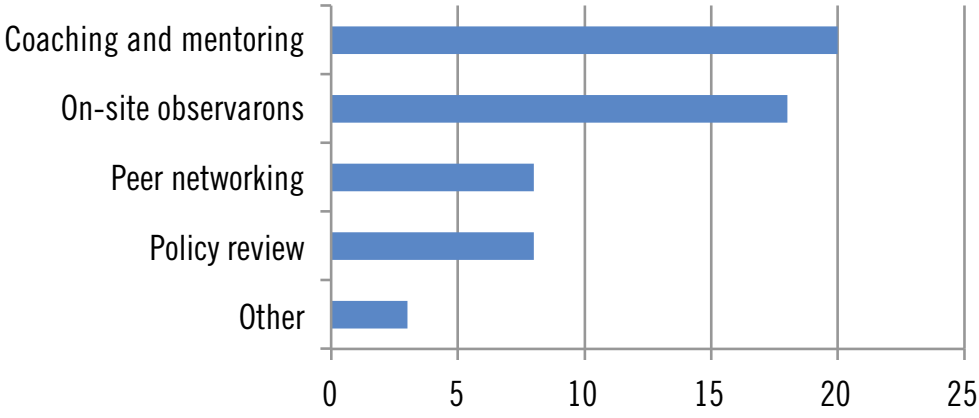


Table 6 – Number of States Implementing Technical Assistance Strategies



Almost all states providing technical assistance related to HEPA 20 (91%) are using coaching and mentoring as one of their primary strategies. Strategies identified by states as "other" include health consultation, licensing support, and professional development.

When asked if their state has information available at the state level to know how many ECE providers have received training or technical assistance or participated in a special project to help implement HEPA practices half of states indicated information is available, as described in Table 7.

Table 7 – Availability of State-Level Information about ECE Provider Access to Training and Technical Assistance Related to HEPA

	Number of States	Percent of States
Yes; Information available at the state level	12	50%
No; Information is not available at the state level	6	25%
Respondent did not know if information is available	6	25%
Total (out of 24 survey respondents)	**24**	**100%**

Additional information about how HEPA-related training and technical assistance is tracked was provided by states. Three themes emerged, including:

- Completion of training, attendance, and/or evaluation of training are often tracked through the state's professional development statewide calendar and/or registry, and data about certain trainings or types of trainings can be compiled.
- While data are not currently available, health-related pilot projects are in process, and information is being gathered about participants.
- QRIS monitoring systems capture limited information about the content of technical assistance provided. The state may know that a provider received technical assistance, but the specific content of that technical assistance—which may or may not be health-related—is not known. Drilling down to the content of technical assistance may be possible by viewing individual providers' quality improvement plans.

Incentives

Incentives are an integral component of many state QRIS, and are used as a mechanism to encourage participation and support providers' progress toward improving or maintaining quality. The type and value of incentives offered vary from state to state, and within states, according to QRIS level or participation in other initiatives. Incentives may be financial (e.g., stipends, bonuses, grants, scholarships), or non-financial (e.g., training or technical assistance, and awards/designations). **Seventeen out of 24 (77%) states are offering incentives to providers that are linked directly or indirectly to HEPA.** Table 8 provides detailed information about how incentives are tied to HEPA supports. Eleven out of 24 (58%) are implementing more than one incentive strategy related to the focus areas.

Table 8 – Number and Percent of States Awarding Incentives tied to HEPA

Incentives Offered to Providers for	Number of States*	Percent of States
Participation in HEPA focused initiatives (e.g., LMCC, or a state-specific childhood obesity program initiative)	12	50%
Use of an assessment tool focused on HEPA (e.g., LMCC, NAP SACC)	8	33%
Working toward achievement of HEPA best practices identified by the state	7	29%
Achievement of a designation identified by the state	7	29%
Full achievement of HEPA best practices identified by the state	1	4%

*Not mutually exclusive. Out of 24 state respondents.

Mechanisms by which incentives are built into QRIS vary. For example, in some states, providers might receive an incentive (e.g., stipend, training) for using the *Let's Move!* Child Care self-assessment. The incentive helps providers meet a QRIS requirement (when combined with other activities) that will allow them to move to a higher level of quality in the rating system. While HEPA topics are tied to the incentive, the HEPA areas are not the sole focus of the QRIS level or the incentive. In other instances, states might offer incentives that are specifically and exclusively tied to HEPA. For example, a provider may earn a state designation for the achievement of nutrition and physical activity best practices. Open-ended responses from survey respondents suggest that states are employing both strategies equally. States described the incentives offered—and linked to HEPA—as financial and non-financial. Financial incentives include bonuses (e.g., for achievement of a particular rating level), access to funds to purchase items to support program practice changes, scholarships for participation in HEPA-focused trainings, and access to tiered reimbursement. Non-financial incentives include earning points toward QRIS rating for participation in the Child and Adult Care Food Program (CACFP), acknowledgment on a state website, materials, and training and technical assistance. Additionally, states commented that the general achievement of points, or increase in QRIS rating level, is also an incentive.

State Level Data

Data from survey respondents—described in Table 9—suggest there are opportunities to learn more about how many providers are meeting individual best practices related to HEPA. Only 46% of states (11 out of 24) reported that information is available on the state level for this purpose.

Table 9 – Availability of State Level Information about ECE Providers' Achievement of HEPA Best Practices

	Number of States	Percent of States
Yes; Information available at the state level	11	46%
No; Information is not available at the state level	10	42%
Respondent did not know if information is available	3	13%
Total (out of 24 survey respondents)	**24**	**100%**

Three themes arose from states on how information about providers' achievement of best practices is known.

- Self-assessment and observational assessment (e.g., ERS) scores are entered into central database. While some states can access criteria-specific information from the database, others cannot. It is also unknown whether an analysis of specific standards related to HEPA has been completed.
- Some states are able to track standards met in QRIS, and the achievement of a certain level or step within QRIS would indicate that particular HEPA best practices have been met. Information provided by states indicates that the ability to disaggregate provider information from QRIS levels is possible in some states but not yet in others (e.g., due to data system limitations).
- Data about providers achieving a particular designation (e.g., an award for meeting criteria related to the focus areas) can show which providers, and how many providers, have met a certain threshold of quality in these areas.

Only 7 states of the 24 (29%) responding to the survey indicated a survey has been conducted to understand providers' needs to successfully meet HEPA practices. Table 10 describes the percent of states that have completed a survey to understand ECE providers' needs to successfully meet HEPA practices.

Table 10 – Completion of a State Survey to Understand ECE Providers' Needs to Successfully Meet HEPA Practices

	Number of States	Percent of States
Yes; Survey has been conducted	7	29%
No; Survey has not been conducted	6	25%
Respondent did not know if a survey had been conducted	11	46%

Out of the seven states that indicated a survey has been conducted, nearly half (3) indicated a university partner conducted the survey. Local and regional Child Care Resource and Referral Associations (CCR&Rs) also provided this service, as well as foundations or other state partners.

Reflections and Recommendations

While QRIS is central to supporting providers' quality improvement efforts, it is only one piece of a larger ECE system in each state. In open-ended responses states reflected on some of the contextual factors that influence how the state QRIS is used to support providers related to HEPA. The following themes emerged:

- **Licensing is a foundation.** Licensing is a base for QRIS efforts, and there may be other regulations (e.g. local) and/or supports (e.g., initiatives, trainings) outside of QRIS related to HEPA practices. States with strong HEPA licensing regulations acknowledged the importance of licensing as a foundational base for childhood obesity prevention strategies in QRIS.
- **Communication with ECE providers is essential.** Communication with providers about HEPA best practices, training, and supports available to them is an important aspect of educating providers. In QRIS, providers have choices about improvements to make, technical assistance to receive, and self-assessments to complete. Sharing information about the importance of childhood obesity prevention practices and the strategies to achieve them will help to support providers' motivation to improve in these areas.
- **Collaboration influences QRIS standards and implementation strategies.** Cross-agency advisories, committees, and initiatives, can provide both opportunities for learning and serve as a lever for change when stakeholders come to the table for the common purpose of enhancing childhood obesity prevention efforts. This also includes collecting and sharing data to understand ECE program needs and build a state system of supports for ECE providers.
- **State systems are evolving.** States commented that licensing regulations are being reviewed as a result of new requirements in the Child Care and Development Block Grant regulations, QRIS systems are being refined, and the system of supports for providers related to HEPA may evolve. Continuous improvement at the state level, and of the QRIS system, is integral to responding to and meeting the needs of ECE providers.
- **Other activities, while not exclusively linked to QRIS, are supporting providers' achievement of practices in the focus areas.** Statewide public health initiatives, local/regional pilot programs, Farm to Preschool, and trainings (e.g., Let's Move!, I Am Moving, I Am Learning) are examples provided by states of some of the other activities taking place. In some states the examples provided are linked to QRIS as well as available to providers not participating in QRIS. In other states activities are parallel to QRIS efforts, presenting an opportunity to streamline standards and supports to ensure fully engaged ECE providers.

Many states are using QRIS implementation strategies to support ECE providers' achievement of HEPA practices and to prevent childhood obesity. Even in states where QRIS standards don't include HEPA topics, there are implementation strategies to help providers achieve HEPA practices. Strategies used vary from state to state, though there are common threads among states as well as gaps in implementation that rose to the surface when survey data were analyzed.

A majority of survey respondents, 24 out of 31 (77%), indicated their state has determined there are HEPA practices the state wants to promote through QRIS. The inclusion of HEPA practices may signal states' commitment to childhood obesity prevention efforts, as well as the importance of supporting children's health and wellness as an integral aspect of ECE program quality. The observation also suggests a growing whole-child approach to school readiness. QRIS are increasingly viewed as a strategy to not only support improving ECE program quality, but also to enhance child developmental and school readiness outcomes.

Twenty-three percent of survey respondents indicated in the survey screener question that the state is not focused on strategies to support providers related to HEPA. Since no additional information was gathered from states to answer why, additional research is needed to understand the status of those states' QRIS and focus of implementation strategies. Anecdotally, it was learned that some of the states that were screened out of the survey for indicating the state is not focused in these areas are in the process of redesigning their QRIS, or will be launching new or improved supports, that do in fact include HEPA areas. Given that state systems continue to evolve and improve, a follow up survey may show a greater focus in these areas over time.

Overall, rich information was learned from survey respondents about the ways states are using QRIS implementation strategies to support ECE programs' achievement of HEPA practices. Survey findings help to expand the information base about childhood obesity prevention in ECE settings. The information gathered in this study supports a set of recommendations to help states—and stakeholders supporting states (e.g., policymakers, advocates)—reflect upon and refine state efforts to support ECE providers making progress toward implementation of HEPA practices. Analysis of study findings also point to opportunities for continued learning. State-specific recommendations and opportunities for further research are outlined below.

State-specific Recommendations

Expand the use of QRIS linked coursework and core competencies to support ECE providers achieving HEPA practices. Continue to focus on healthy eating and physical activity, and help to elevate attention paid to breastfeeding and screen time. Many states' mandatory course requirements and core competencies are linked to the QRIS but may be underutilized to support providers in the focus areas. There is significant opportunity to further utilize coursework and core competencies as mechanisms to support providers' achievement of HEPA best practices, and particularly related to screen time and breastfeeding which are less frequently a focus. As multiple states reflected on the importance of integrating HEPA concepts into daily activities, communicating with families, or educating staff, states may consider identifying opportunities for integration and overlap within existing professional development requirements. For example, considering where childhood obesity prevention principles can be woven into existing coursework or core competencies on related topics (e.g. lesson planning, family engagement, child development), whether connected to QRIS or not, could be useful.

Consider HEPA-specific self-assessment and observational assessment as strategies to deepen providers' knowledge about their program practices and to help identify opportunities for improvement. Fourteen states are using assessment tools that support providers in HEPA areas. Some self-assessments used by states (e.g. LMCC, NAP SACC) have a specific focus on HEPA practices. Alternatively, observational assessments more often include healthy eating, breastfeeding, physical activity, and/or screen time as a subset of a much broader assessment (e.g. ERS). In this case, the attention to HEPA areas is usually not as robust as tools where the specific focus is HEPA practices. While the purpose of the tools is often similar—to help providers identify areas for improvement—use varies from self-guided to being a component of the QRIS rating process. If a specific focus on HEPA best practices is desired then use of tools that exclusively address these areas (e.g., LMCC, NAP SACC) should be considered. States should also be educated that ERS does not cover HEPA best practices.

Use provider-level data to learn more about ECE providers' needs related to HEPA practices. Self-assessments more often focus on specific HEPA best practices, and thus could be a useful tool to assess provider needs and understand what specific best practice areas are most challenging for providers. Using self-assessment data as part of a statewide needs assessment is an opportunity to leverage provider-level data to support improvement of QRIS implementation strategies. Having access to this information could help states target limited technical assistance resources to high need areas, and focus training on topics that are most challenging for providers.

Embed healthy eating, breastfeeding, physical activity, and screen time into technical assistance strategies. Many states are implementing technical assistance by using multiple technical assistance providers and through multi-faceted strategies. Since many states' QRIS include technical assistance to generally support providers' improvement efforts, including healthy eating, breastfeeding, physical activity, and screen time as a subset of these efforts is perhaps one of the easier strategies for states to implement.

Gather and track information and data from providers to inform better use of QRIS to support providers' achievement of practices in the goal areas. Encourage cross-functional and cross-agency data sharing, and convene state stakeholders to develop a coordinated approach to the inclusion of HEPA in QRIS. Few states are able to clearly track training and technical assistance that providers (individuals and programs) receive specific to HEPA practices. Additional information is also needed about providers' needs in these areas. Understanding more about what providers have achieved as well as information about their needs and motivations will support states in designing QRIS implementation strategies that are relevant and attainable to providers. This will also assist in identify barriers and building implementation strategies to help providers be successful in their improvement efforts. Having data about providers' needs and achievement of HEPA practices can also be overlaid with information about the reach of a state's QRIS (i.e. how many ECE programs participating). With this information states will gain a more complete picture of the impact of HEPA focused efforts in QRIS, and can explore new ways to use existing training systems to meet providers' needs.

Opportunities for Research and Continued Learning

Explore the interplay between licensing regulations and QRIS standards to more fully understand where practices related to childhood obesity prevention sit within state systems. Link this information to what improvements are made by providers and by what strategies.

Dive deeper into QRIS implementation strategies and state-level data to understand more about whether or not strategies are helping providers make progress toward and achieve specific HEPA best practices. For example, separate out general supports (e.g., technical assistance focused on all QRIS standards) versus innovative strategies that are targeted specifically at childhood obesity prevention. Answer questions such as what type of data states have to show ECE program progress toward meeting HEPA best practices, and what strategies are most effective at supporting provider progress. Additional information is needed to understand whether including HEPA improvement as part of broader strategies (e.g., technical assistance, coursework) is effective or if a specific focus on HEPA is more effective.

Find out more about state-developed observational assessment tools to discover if and how they focus on HEPA topics (e.g., HEPA-specific tool versus principles embedded within a broader assessment). Uncover whether states have found or developed HEPA-specific observational assessment tools that help to support changes in providers' practices. Consider what other tools could be used for observational assessment of HEPA practices and if development of a new tool or modification of an existing tool would benefit the ECE field.

Learn more about the organizations and individuals who are supporting providers in healthy eating, breastfeeding, physical activity, and screen time practices. Many states are using technical assistance strategies to support providers, though the survey did not garner specific detail about trainers' expertise in these areas, how they are trained, and what the training includes. It is important to understand not just trainers' knowledge, but also their ability to assist providers with implementation of HEPA best practices. This includes the ability to coach providers on weaving HEPA best practices into other aspects of quality programming (e.g., curriculum implementation, individualized instruction) as well as knowing how to access other resources for providers related to HEPA topics.

Monitor states' continuous improvement processes to understand more about how QRIS are evolving to meet provider needs in these areas. Track QRIS standards and supports to understand more about where states are placing their efforts and how strategies to meet providers' needs are improved over time.

Examine HEPA supports in more detail as they are implemented in Head Start and school based pre-k settings. Since QRIS may not apply to these settings and/or there may be less participation by these types of providers, the embedded HEPA strategies may look different in these settings. There is also dedicated funding for these settings that may facilitate greater support for HEPA.

Case Studies

The following case studies highlight the strategies states are using to support ECE providers' childhood obesity prevention efforts. While most states are implementing multiple strategies, the case studies hone in on a diverse set of strategies to illustrate a range of real-life examples of state efforts.

- Arizona: Leveraging a Cross-Agency Initiative to Support Program Quality *(Technical Assistance)*
- Georgia: Awards and Incentives to Reward Program Quality *(Incentives)*
- Idaho: Building Knowledge and Improving Practices through Essential Trainings *(Training and Technical Assistance)*
- Indiana: System-Level Supports to Enhance Program Quality *(Technical Assistance)*
- New Jersey: Integrating Let's Move! Child Care into Self-Assessment *(Self-assessment)*
- Oklahoma: Observational Assessment as a Tool for Program Improvement *(Observational Assessment)*
- Wisconsin: Cross-Sector Collaboration for Coordinated Strategies *(Technical Assistance)*

Appendix D: Case Study Interviewees and Organizations lists contact information for the individuals interviewed as part of case study analysis. Case studies are intended to highlight interesting strategies being implemented by states and are not meant to describe the array of activities taking place in a state. Brief contextual information is provided for each case study state, however readers are encouraged to explore additional resources (e.g., QRIS Compendium[12]) to gain a full understanding about a state's QRIS. While information is provided about whether or not a state includes HEPA topics in QRIS standards, this information is provided for reference and may or may not have a direct connection to the QRIS implementation strategies highlighted.[13] Given the evolving nature of state systems, it may be useful to contact states directly for additional information.

12 www.qriscompendium.org

13 The "QRIS standards related to HEPA" line for each state's case study provides information extrapolated from the *Summary of Obesity Prevention Standards in State Quality Rating and Improvement Systems (QRIS) and Licensing Regulations*, with information current through January 2016.

Arizona: Leveraging a Cross-Agency Initiative to Support Program Quality

QRIS Implementation Strategy: Technical Assistance

QRIS Name: Quality First

Implemented Since: 2009, Revised 2011

Managing Organization: First Things First

Structure: Voluntary, points-based system

Number of ECE programs participating: 933, including licensed center-based programs (39% of total in the state) and licensed family child care providers (19% of total in the state)

QRIS Standards Related to HEPA: N/A

Background

Arizona's Empower Program has been central to the state's efforts to help ECE providers achieve HEPA best practices. Empower was developed by the Arizona Department of Health Services in 2010 as a voluntary program for ECE providers in Arizona who want to go above and beyond licensing to make improvements in health.[xiii] With licensing standards in healthy eating, breastfeeding, physical activity, and screen time, but limited QRIS standards in these areas, Empower became the logical connection to health and wellness criteria. All programs participating in Quality First must enroll in the Empower Program (participation outside Quality First is voluntary, with the benefit of reduced licensing fees). Empower is linked to QRIS to communicate the value of child health and wellness and to encourage providers to integrate Empower criteria into their program quality improvement efforts. First Things First, Arizona's state organization helping to coordinate birth to 5 services in the state and funding implementation of Quality First, has embraced child health—including obesity prevention—as one of the primary areas foundational to school readiness.

QRIS Implementation Strategies

All programs enrolled in Quality First have access to a regional Child Care Health Consultant (CCHC) to help them implement strategies and practices within Empower. Programs may receive consultation either by phone or through on-site visits, and the level of support (number and frequency) depends on a provider's tier level and ranges from sporadic support for lower tier programs to up to six or more visits per month for higher tier programs. The content of the consultation provided by the CCHC varies depending on providers' expressed needs, as well as the results of a health and safety assessment conducted by the CCHC to help identify areas for improvement. Example areas in which the CCHC may assist include the development of health and safety policies, training on implementation of family style meals, and providing guidance on how to promote physical activity indoors and outdoors. CCHCs are trained on physical activity and nutrition best practices as part of their overall CCHC training and professional development. CCHCs are trained by trainers who have been completed National Training Institute for Child Care Health Consultants trainings.

Additionally, all programs in Quality First have access to coaching through technical assistance (technical assistance professionals from Valley of the Sun United Way, a statewide sub-grantee of Quality First). While technical assistance providers do not provide direct support on health and wellness, they work collaboratively with CCHCs to help support providers with program improvement. ECE providers receive up to six hours of technical assistance per month at levels 1 and 2, and up to 4 hours per month at levels 3 through 5. Technical assistance professionals also have access to programs' Environmental Rating Scale (ERS) scores for use as a tool with providers and in consultation with CCHCs for a data-informed approach to identifying opportunities for growth.

A Deeper Dive – Building the Link to Empower

In Arizona, children's health is viewed as an important factor for supporting school readiness. Health and safety, foundational to quality in Arizona's licensing regulations, set a base for ECE focused childhood obesity prevention efforts. When designing its QRIS, the state selected the Environmental Rating Scale (ERS) as an observational tool to assess program quality. Since ERS includes criteria related to healthy eating, physical activity, and screen time, this was a way to continue to encourage improvement in these areas. However, it would only address a portion of the important health and wellness criteria the state was committed to supporting. Arizona then chose to require that all programs participating in Quality First also be enrolled in Empower. With implementation supports in place, this helped move providers from simply being enrolled in Empower to working towards achieving Empower criteria and making improvements in these areas.

State Strategies for Continuous Improvement

First Things First and supporting partners in Arizona are committed to continually reviewing Quality First and the system of supports in place for ECE providers. The model is being reviewed by an advisory group of stakeholders in Arizona to determine how to continue to increase program quality and access to the system. A validation study is also being conducted of the QRIS to determine if rating scores are accurately representing quality. Arizona is exploring updates to QRIS standards, as well as implementation strategies to help support achievement of standards.

As part of its continuous review cycle, stakeholders in Arizona are also exploring ways to overcome budget challenges. Implementation of Quality First is funded through revenue from Arizona's Tobacco Tax. With tax revenues declining, the state must find a way to fill anticipated funding gaps while also determining ways to expand access to Quality First and supports within the system. Since Quality First—and Empower—is the main lever for childhood obesity prevention efforts, it is critical to overcome budget challenges to continue to support efforts that enhance children's health and wellness.

Arizona is committed to learning and overcoming barriers to continue to support ECE providers' continuous program quality improvement efforts. First Things First is exploring strategies to increase awareness among ECE providers about the availability and value of CCHCs. Although providers must participate in Empower, they are not required to achieve the criteria. Communication efforts focus on children's health and wellness as an integral component of comprehensive program quality. As Arizona implements Quality First it will continue to gather information about the types of supports providers need and are receiving to support childhood obesity prevention efforts.

Recommendations for States from Arizona

- ✓ Include health as a *mandatory* part of the QRIS to reflect the value of its importance as an integral part of child development and school readiness. Create standards that will enhance improvement efforts. Incorporate principles related to children's wellness in messages to providers, and help staff and parents understand its importance.
- ✓ Consider the system of supports in children's lives, and specifically staff in ECE programs and children's parents. Implement QRIS strategies, like CCHC, that can help address issues such as staff modeling of behaviors, and sharing information with families about how to make changes at home.
- ✓ Strive for strong collaboration between technical assistance staff and CCHC so that all individuals supporting ECE program quality improvement in the state are talking the same language and supporting programs in a coordinated way.

For additional information Quality First: http://qualityfirstaz.com.

Georgia: Awards and Incentives to Reward Program Quality

QRIS Implementation Strategy: Incentives

QRIS Name: Quality Rated

Implemented Since: 2012, Revised 2013

Managing Organization: Bright from the Start: Georgia Department of Early Care and Learning (DECAL)

Structure: Voluntary, points-based system

Number of ECE programs participating: 2,352, including licensed center-based programs (50% of total in the state) and licensed family child care providers (34% of total in the state)[xiv]

QRIS Standards Related to HEPA: Healthy eating and physical activity

Background

When Georgia launched its QRIS, Quality Rated, in 2012 the groundwork had already been laid to support ECE providers' childhood obesity prevention efforts. As the state planned for the launch of its QRIS, part of that planning included a commitment to embedding nutrition and physical activity into the system's standards. Bright from the Start: Georgia Department of Early Care and Learning (DECAL) led the development of Quality Rated and convened stakeholders and sought expert guidance from BUILD Initiative. The state considered successes in other states as well, and was drawn to Tennessee's Gold Sneaker Initiative, which rewards child care program for implementing health and wellness policies in their program.[xv]

Additionally, Georgia had already begun to put supports into place for providers related to healthy eating and physical activity. A 2010 Team Nutrition grant from the United States Department of Agriculture (USDA) allowed implementation of a 1-year pilot to promote wellness policies in southwest Georgia. Twenty-two child care providers participated in this pilot and received training and technical assistance to support their improvement efforts. As the Team Nutrition pilot was ending, Georgia sought the next step for supporting program quality in these areas. With licensing standards in healthy eating, breastfeeding, physical activity, and screen time, the next logical step was QRIS.

QRIS Implementation Strategies

Georgia implements a range of strategies to help providers make improvements related to healthy eating, breastfeeding, physical activity, and screen time. There is a system of supports around providers—training, technical assistance, and incentives—to enhance their success. For example, participants in Quality Rated may opt to receive technical assistance (TA) provided by regional Child Care Resource & Referral Agencies (CCR&Rs). While this TA may cover any areas within Quality Rated (and not just the childhood obesity prevention focus areas), providers may choose to dive deeper into these areas. CCR&R trainers, who provide technical assistance and serve as Quality Rated's QRIS assessors, receive training on the Environmental Rating Scales (ERS). ERS is used to measure program quality across a range of criteria, which includes healthy eating, physical activity, and screen time.

Programs are required to complete a Structural Quality Assessment in which they self-assess their program across Quality Rated's five standards. The assessment is used as a tool for technical assistance and to help providers develop improvement plans. The Structural Quality Assessment includes twelve indicators for nutrition and six for physical activity as part of Standard 2 – Child Health, Nutrition, and Physical Activity. This includes topics such as breastfeeding/infant feeding, eating environments, caregiver/teacher behaviors, food and beverages, screen time, physical activity education, as well as nutrition and physical activity policies.

There is strong alignment between Georgia's assessment and best practices in *Caring for Our Children, National Health and Safety Performance Standards Guidelines for Early Care and Education Programs, 3rd Edition*. If providers meet 85% of the criteria related to Standard 2, they are eligible to receive the Georgia SHAPE Award. Programs may also access funds from a Continuous Quality Improvement (CQI) Award to support their continuous quality improvement efforts in the focus areas (Star level 1 through 2 programs are eligible for this award).

A Deeper Dive – Georgia SHAPE Award and the Continuous Quality Improvement (CQI) Award

The Georgia SHAPE Award is an initiative of the Georgia Department of Public Health and DECAL. The award recognizes ECE providers participating in Quality Rated that practice exceptional nutrition and physical activity efforts. Only ECE programs that become Quality Rated are eligible to win the award. Providers must complete the Standard 2 Structural Quality Assessment to show they have achieved at least 85% of practices related to nutrition and physical activity. If programs achieve this score they are recognized on both the Bright from the Start and Georgia SHAPE's website and receive a certificate of achievement signed by the Governor.

Quality Rated star level 1 and 2 programs may also receive a CQI award to support program improvement. CQI award may be used to support any standard, including in Standard 2 – Child Health, Nutrition and Physical Activity. ECE programs are eligible for a $1,000 award and family child care homes are eligible for a $500 award, all of which are privately funded. ECE providers must articulate how they plan to use the funds, and applications are reviewed but not scored. Examples of how programs may use a CQI award related to Standard 2 include purchasing supplies for a vegetable garden or funding supplemental trainings related to physical activity and nutrition.

State Strategies for Continuous Improvement

Georgia has found that the SHAPE Award and CQI Award are useful ways to incentivize and reward providers for achieving excellence in physical activity and nutrition standards. Currently, there is little data gathered from the process of attaining or achieving the awards, and Georgia is exploring ways to improve feedback loops. For example, if a program doesn't reach the 85% to attain the SHAPE Award they may not know where they didn't score high enough. Technical assistance staff have to review the program's online submission to get a summary of responses to review with the program.

More generally, Georgia is looking at ways to keep ECE providers engaged in Quality Rated, and how to deepen ECE providers' self-awareness about the importance of health and wellness. DECAL also continues to look at family engagement as a strategy to raise awareness and encourage change among families and caregivers to support childhood obesity prevention efforts taking place in ECE settings.

Recommendations for States from Georgia

- ✓ When designing QRIS implementation strategies to support providers, start by looking at how your state is already being intentional about children's health. Consider lessons learned, and determine where you can build on current implementation and enhance sustainability through the QRIS.
- ✓ Keep children's wellness at the forefront of conversations and planning. Give programs the opportunity to grow by establishing standards that are attainable within your system of supports. Communicate with and educate providers to help ensure they understand the importance of what they're being asked to do.

For additional information about Quality Rated: https://qualityrated.decal.ga.gov.

Idaho: Building Knowledge and Improving Practices through Essential Trainings

QRIS Implementation Strategy: Training and Technical Assistance

QRIS Name: Steps to Quality

Implemented Since: 2010, Revised 2014

Managing Organization: University of Idaho's Center on Disabilities and Human Development, Idaho Association for the Education of Young Children, and Idaho Department of Health and Welfare

Structure: Voluntary, building block system

Number of ECE programs participating: 110, including licensed center-based programs (14% of total in the state) and licensed family child care providers (4% of total in the state)[xvi]

QRIS Standards Related to HEPA: Healthy eating and physical activity

Background

In Idaho's six-level QRIS, Steps to Quality, implemented by IdahoSTARS, healthy eating and physical activity are foundational to knowledge and practice changes in Step 3 through Step 5. While participation in the voluntary system is limited, Idaho is implementing a thorough training structure that helps facilitate providers' improvement along a continuum of knowledge to practice. There are six quality standards in Steps to Quality, one of which is Health and Safety. Idaho does not currently include healthy eating, breastfeeding, physical activity, or screen time in its state licensing regulations (although some local licensing regulations do). Therefore, Steps to Quality, has been a key lever for supporting ECE providers in the state's childhood obesity prevention efforts. Steps to Quality includes standards related to healthy eating and physical activity. Healthy eating and physical activity QRIS standards at Steps 3 through 5 incorporate assessment and action planning, family engagement and information sharing, and coordination with a child health care consultant.

QRIS Implementation Strategies

Idaho has multiple QRIS strategies to support providers achieving healthy eating, breastfeeding, physical activity, and screen time practices. There is a clear link between standards, strategies, knowledge, and practice. The cornerstone of Idaho's QRIS implementation strategies in this area is its implementation of Essential Trainings, developed to align with Idaho's Essential Knowledge.[14] Essential Knowledge grew out of the Idaho Child Care Program Advisory, which has strong leadership and member commitment to supporting the healthy development of young children. Development of Essential Trainings followed, with University of Idaho designing the trainings in collaboration with IdahoSTARS. All providers participating in Steps to Quality must complete Essential Trainings at each step, and at Steps 2 and 3 there is significant focus on food, nutrition and physical activity (Essential Training 2: Food, Nutrition and Physical Activity; Essential Training 3: Food, Nutrition and Physical Activity).

A Deeper Dive – Essential Training, Follow up Technical Assistance, and Verification

IdahoSTARS designed the QRIS framework to intentionally link Essential Knowledge to evidence-based practices that can then be verified within indicators at each step. Participants can build their knowledge in six quality standards, including a health and safety standard with indicators related to healthy weight, nutrition, and active physical play. Follow up technical assistance using a coaching approach is provided after completion of Essential Trainings through one of Idaho's seven Child Care Resource and Referral (CCR&Rs) Centers to assist with implementation of the Essential Knowledge practices. Each CCR&R houses a multi-disciplinary team comprised of Resource Specialists, Quality Child Care Consultants, and Child Care Health Consultants with expertise in healthy weight and active physical play.

14 Essential Knowledges are evidence-based benchmarks and guidelines that support healthy weight in young children as identified by the American Academy of Nutrition and Dietetics, the American Academy of Pediatrics, the Institute of Medicine, the National Association for the Education of Young Children, and the U.S. Department of Agriculture. Each Essential Knowledge is crosswalked with the Idaho Early Childhood Core Competencies and the Idaho Early Learning eGuidelines.

Multiple tools were designed to support this approach. "What Will You Learn" documents describe the Essential Knowledge statements for each Essential Training, the related Essential Knowledge practices, and corresponding state and national early childhood health and nutrition standards (i.e. Idaho Early Learning eGuidelines, MyPlate, Building Mealtime Environments and Relationships (BMER) Inventory, and Idaho Early Childhood Core Competencies). The observable practices of each Essential Training are included in a "Checklist of Practice." The "Checklist of Practice" serves as both a self-assessment tool for providers to reflect on their current practices, and as a tool to assist them in identifying attainable and relevant goals for quality improvement specific to the current step of the QRIS they are working to attain. Steps 3, 4 and 5 within the health and safety quality standard include multiple indicators specific to healthy eating and active physical play.

State Strategies for Continuous Improvement

Idaho is continually seeking ways to improve its entire system of supports for ECE providers in areas related to children's health. IdahoSTARS crosswalked the Essential Trainings with higher education courses in ECE to align and support providers' achievement of college credits. In the future, ECE providers will be able to substitute Essential Trainings for higher education coursework. Not only will providers meet the requirements of participation in QRIS, they will be able to increase college credits earned on a pathway to degree attainment.

As Idaho looks to continue to improve its offerings for providers, one of the state's key considerations is the wide age range of providers and varying needs. Idaho is exploring how to engage cross-generational audiences and is considering the best strategies to support a variety of learning preferences. Additionally, on-site technical assistance that accompanies Idaho's Essential Trainings is fundamental to supporting providers' practice change; however, this is a costly model. With limited funding devoted to the state's QRIS, IdahoSTARS is seeking innovative strategies to continue to provide on-site support to current participants in Steps to Quality while expanding to serve additional providers.

IdahoSTARS has a training evaluation component to evaluate training and trainer quality, customer satisfaction, and transfer to practice. Within the next year a participant survey will be added at each QRIS step to better understand provider experience as it relates to the QRIS structure, access, quantity, and quality of Essential Trainings, QRIS coaching supports, and user resources.

Recommendations for States from Idaho

- ✓ Focus on what providers are doing, in addition to the more common focus on what providers know. Implement strategies to help providers connect knowledge to practice.
- ✓ Consider work that other initiatives or agencies may be doing in areas related to children's healthy weight in order to ensure knowledge and information given to ECE providers is consistent. Idaho's Essential Knowledge has served as a clear baseline for what ECE providers know or will learn, and has become a tool for communication across sectors.
- ✓ When talking about healthy children, also take into consideration supports for the health and wellness of the ECE workforce. Idaho's Essential Trainings build a bridge to healthier children though expanding the knowledge and practice of ECE providers.

For additional information about Steps to Quality: http://idahostars.org/?q=steps-to-quality.

Indiana: Planning QRIS Updates to Meet Provider Needs

QRIS Implementation Strategy: Technical Assistance

QRIS Name: Paths to Quality

Implemented Since: 2008

Managing Organization: Indiana Family and Social Services Administration

Structure: Voluntary, building block system

Number of ECE programs participating: 2,554, including licensed center-based programs (93% of total in the state) and licensed family child care providers (69% of total in the state)[xvii]

QRIS Standards Related to HEPA: Healthy eating, physical activity, screen time

Background

Paths to Quality builds on Indiana's child care licensing regulations by including licensing as the first level of the system. Ensuring that providers in QRIS are meeting basic health and safety standards—as defined by licensing regulations—was paramount to Indiana as it designed its system. With multiple exemptions to licensure, allowing licensure to serve as the floor of QRIS helps to raise the bar for health and safety standards. Indiana's licensing regulations include criteria related to healthy eating, breastfeeding, physical activity, and screen time, and Paths to Quality levels 2-4 builds on that base for even greater focus in these areas. Indiana is in the process of updating its QRIS and is gathering information and ideas from the broader health-focused community for how to continue to advance the state's childhood obesity prevention efforts through Paths to Quality.

QRIS Implementation Strategies

Indiana's system of supports to help providers achieve practices related to healthy eating, breastfeeding, physical activity, and screen time is diverse. As part of participation in Paths to Quality, providers have access to on-site technical assistance and coaching that helps them embed healthy changes into daily practices. Coaches provide assistance to programs as needed and in areas specific to the improvement goals identified by the program. This might, but does not always, include aspects related to healthy eating and physical activity. Coaches help providers identify barriers and overcome challenges (e.g., how to reduce screen time, increase physical activity).

Indiana is also building trainings that support topics such as breastfeeding to enhance healthy eating, and working with Child and Adult Care Food Program (CACFP) guidelines. While Paths to Quality coaches are not specifically versed in nutrition and wellness, providers may access training specific to these topics through staff trained in these areas. Increased efforts are also being made to raise awareness about CACFP, how it works, and how it can benefit ECE programs, and children and their families.

As the state considers updates for its next version of QRIS, looking at the effectiveness of training and technical assistance is central to considering if and how implementation strategies may be updated alongside standards.

A Deeper Dive – Continuous Improvement at the State and Provider Levels

As Indiana plans for its next version of Paths to Quality, the state is gathering information—formally and informally—to help plan its efforts. Recognizing that the larger Paths to Quality system is part of a continuous quality improvement process for the state, Indiana strives to learn what's working, what's not, and how the state can be more clear about expectations and supports related to program quality. Purdue University is

conducting a study of the Paths to Quality and is taking a look at factors such as barriers to participation, impact on children and families, and concrete ways the state can be clearer or improve its QRIS strategies.

Feedback from evaluators, as well as anecdotal feedback, has suggested that providers could further benefit from detailed descriptions or definitions of quality. For example, in Paths to Quality there is general language use at level 1 related to "developmentally appropriate activities." While this is commonly used language in the ECE field, it is vague. Indiana has identified that if they can further define criteria—perhaps by drilling down to a greater level of detail (e.g., implementing physical activity, offering screen time, etc.)—it will help providers achieve improved practices.

With its strong network of partners in early care and education and in the broader community health system in Indiana, the state will look to its advisory groups and initiatives to continue to design a system that meets providers where they are, while raising the bar for quality and offering targeted strategies to help providers achieve success.

Recommendations for States from Indiana

- ✓ If making changes to QRIS standards, first ensure supports are in place to help providers achieve the standards. Be cognizant of where providers are starting from when raising the bar for quality. Recognize the limited bandwidth of providers when considering in what areas and how program quality standards are required.
- ✓ It is important to take an incremental approach with providers. Asking them to take leaps to significant changes may be challenging and overwhelming.

For additional information about Paths to Quality: http://www.in.gov/fssa/2554.htm.

New Jersey: Integrating *Let's Move!* Child Care into Self-Assessment

QRIS Implementation Strategy: Self-assessment

QRIS Name: Grow NJ Kids

Implemented Since: 2015

Managing Organization: New Jersey Department of Human Services, Division of Family Development

Structure: Voluntary, building block system

Number of ECE programs participating: Initiative currently being rolled out statewide[xviii]

QRIS Standards Related to HEPA: Healthy eating, breastfeeding, and physical activity

Background

New Jersey is a recent implementer of QRIS, launching Grow NJ Kids in 2015. The state has a deep long standing commitment to preventing obesity, as evidenced in its 2008 launch of ShapingNJ. ShapingNJ, the state partnership for nutrition, physical activity, and obesity prevention, brings together cross-sector and cross-agency stakeholders to focus on obesity prevention, and includes a subgroup to address specific strategies for child care settings. NJ has historically high rates of childhood obesity in low income children which was the impetus for strengthening healthy eating and physical activity child care center regulations. Additionally, New Jersey has leveraged its strong licensing regulations in healthy eating, physical activity, and screen time to set high standards for ECE providers, and has experience offering trainings and technical assistance in these areas for years prior to the launch of Grow NJ Kids. This foundational focus on childhood obesity prevention was a driving force for the inclusion of both QRIS standards and implementation strategies to support providers' achievement of healthy eating, breastfeeding, physical activity, and screen time practices.

QRIS Implementation Strategies

A central aspect to Grow NJ Kids is the required use of the state-developed Early Care and Education Program Self-Assessment. At Level 2 in Grow NJ Kids, all programs must complete the Self-Assessment tool. Completion of the *Let's Move!* Child Care (LMCC) checklist is embedded as a requirement within the tool. Quality Improvement Specialists help programs complete the self-assessment and identify areas of focus for their quality improvement plan. Completion of the Self-Assessment also makes programs eligible to receive a Classroom Enhancement Grant. Funded through Race to the Top – Early Learning Challenge, Classroom Enhancement Grants are awarded to providers to make improvements to their classroom environments. Results of providers' self-assessments (e.g., LMCC) are used to inform requests for the Classroom Enhancement Grant.

The Environmental Rating Scale (ERS) is also used as part of the Self-Assessment at Level 2, and includes criteria related to healthy eating, physical activity, and screen time. As providers move to increasing levels of quality, ERS is then conducted by a reliable rater and is used for verification purposes.

New Jersey also implements a multi-layered technical assistance strategy. When programs enroll in Grow NJ Kids they complete an online orientation and then they receive ongoing coaching from their Quality Improvement Specialist. Once providers establish and begin to implement their quality improvement plans they may access additional technical assistance to support their quality improvement efforts. Training on nutrition and physical activity specifically is also available to programs regionally and locally.

A Deeper Dive – Using Self-Assessment to Guide Program Improvement

Embedding the LMCC checklist within the Early Care and Education Program Self-Assessment was a natural fit to align Grow NJ Kids with New Jersey's broader commitment to childhood obesity prevention.

New Jersey's Quality Improvement Specialists, who are helping providers with goal setting and establishing their quality improvement plans, have been trained on nutrition and physical activity best practices. The Quality Improvement Specialists are fully trained on all Grow NJ Kids standards and are able to help providers navigate the many areas and overlaps in program quality. For example, while LMCC is embedded specifically in the Safe, Healthy Learning Environments category of Grow NJ Kids, principles related to nutrition and physical activity are also included in Community and Family Engagement. Using results from the LMCC checklist, Quality Improvement Specialists can help programs think about practice improvements taking place in ECE settings, and how to communicate these changes to families. Education of families about nutrition and physical activity is included as part of Grow NJ Kids standards, and use of the LMCC checklist and quality improvement planning were designed to enhance these efforts.

State Strategies for Continuous Improvement

New Jersey is in the process of gathering data and feedback from providers about implementation successes and challenges of Grow NJ Kids. The state will use this information to inform the development of additional trainings and other supports for providers. The state will also reflect specifically on Grow NJ Kids standards to learn what's working and what's not, so that it can be responsive to the realities of the state's ECE providers. In particular, New Jersey will begin to collect and analyze pre/post information from a subset of providers to understand needs related to healthy eating, breastfeeding, physical activity and screen time. Anecdotal feedback from providers suggests they are eager to implement best practices in these areas, and the state plans to continue to explore ways to build upon that interest and recognize providers' successes.

Recommendations for States from New Jersey

✓ Collaboration is the key to success. While collaboration across state agencies is important and helpful, an engagement strategy that includes cross-sector stakeholders, both public and private, is essential. Particularly when early childhood services and supports are spread across multiple state agencies and partners, an intentional coordinated strategy will help to ensure input is heard, messages are consistent, and systems and supports are streamlined and efficient.

For more information on Grow NJ Kids: http://www.grownjkids.com

Oklahoma: Observational Assessment as a Tool for Program Improvement

QRIS Implementation Strategy: Observational Assessment

QRIS Name: Reaching for the Stars

Implemented Since: 1998, Revised 2012

Managing Organization: Oklahoma Department of Human Services

Structure: Voluntary, building block system

Number of ECE programs participating: 3,735, including licensed center-based programs (100% of total in the state) and licensed family child care providers (100% of total in the state)[xix]

QRIS Standards Related to HEPA: Physical activity and screen time

Background

In 1998 Oklahoma was among the first states to implement a QRIS, and the state has a long history of supporting providers' quality improvement through QRIS standards and supports. With its licensing regulations serving as the entry level for its QRIS, Reaching for the Stars, Oklahoma set a floor for participation with regulations that focus on healthy eating and physical activity. In its 2012 revisions to Reaching for the Stars Oklahoma built upon licensing regulations with QRIS standards that ask providers to take on continued improvements in these areas. When developing the state's QRIS standards, Oklahoma considered strategies to accompany standards to help ensure providers' success as they took on quality improvement activities. Oklahoma's Child Care Services office led the training of licensing staff and QRIS staff—in 2011, prior to the launch of the revised QRIS—to ensure both sides of the ECE system in Oklahoma were trained on the content, policies, and practices associated with the revised QRIS. At the same time, Oklahoma became a regional leader for Let's Move! and I Am Moving, I Am Learning by training many providers in Oklahoma and assisting other states. Oklahoma has a deep commitment to supporting the healthy development of young children, as is evident in their holistic approach to support providers.

QRIS Implementation Strategies

In Oklahoma, the use of the Environmental Rating Scales (ERS) is required for all Star 2 programs. Providers develop program improvement plans from the results of ERS, and may receive technical assistance to support implementation of their action plans.

The state also uses information learned from providers' ERS scores to refine and develop professional development opportunities to meet their needs. This is an important feedback loop, as Oklahoma requires the staff of programs participating in QRIS to receive a greater number of professional development hours than licensed programs. ECE program staff (teachers and assistant teachers) must receive at least 20 hours of professional development and program directors must receive 30 hours. Oklahoma's voluntary course offerings and core competencies include a focus on healthy eating, physical activity, and screen time. Additionally, Oklahoma's Quality Improvement Specialists provide LMCC and IMIL training specifically linked to Oklahoma's early learning guidelines to provide real examples of how knowledge translates into daily activities and lessons.

A Deeper Dive – The Use of Observational Assessment

Unlike many other states, the use of ERS in Oklahoma is not for verification purposes. Rather, the tool is used to share information with providers that will help them identify areas for program improvement. When

designing its QRIS, Oklahoma identified ERS as an important lever to help providers identify gaps in practices and work toward improved program quality.

Oklahoma Child Care Services in the Department of Human Services contracts University of Oklahoma's Center for Early Childhood Professional Development to conduct the ERS assessment. After the Center conducts an assessment results are mailed to the ECE program. Technical assistance staff from Oklahoma's child care resources and referral agencies (CCR&Rs) are available to provide assistance to ECE providers to help them establish goals from information learned from their ERS scores and implement action plans.

Additionally, staff at Oklahoma Child Care Services gather information from regional CCR&Rs about technical assistance provided. As the state learns about providers' needs it uses that information as part of continuous quality improvement at the state level to design or modify trainings and materials that will help ECE programs be successful in their quality improvement efforts.

State Strategies for Continuous Improvement

In coming years Oklahoma plans to redesign its QRIS standards and system of support to help providers meet standards. The state is in an information-gathering phase about specific practices it wants to integrate into QRIS. This includes taking a closer look at nutrition and physical activity practices, and considering whether healthy and safety practices should be minimum requirements (licensing regulations) or voluntary criteria (QRIS standards).

Budget considerations are also at the forefront for Oklahoma. In its system redesign Oklahoma will be considering modifications to its strategies to support providers' achievement of QRIS standards. As the state continues to learn about the most successful ways to support providers, it must consider the costs of efforts and what is feasible within a limited budget. Oklahoma is committed to gathering feedback, exploring new avenues for improvement, and overcoming challenges to implement a system that will best meet the needs its ECE providers.

Recommendations for States from Oklahoma

- ✓ Be willing to listen. Overseeing QRIS is also a continuous quality improvement process for states, and being responsive to providers' needs will help them be successful.
- ✓ Keep your end goal in mind, and seek partners for a collaborative effort. Leveraging the strengths of organizations and stakeholders will help to ensure progress toward what you want your state to achieve to benefit children and families.
- ✓ Maintain openness to understanding providers' needs and concerns. Be adaptable so as to support providers' progress and encourage their acceptance of any new requirements.

For additional information about Reaching for the Stars:
http://www.okdhs.org/OKDHS%20Publication%20Library/99-39.pdf.

Wisconsin: Cross-Sector Collaboration for Coordinated Strategies

QRIS Implementation Strategy: Technical Assistance

QRIS Name: YoungStar

Implemented Since: 2010

Managing Organization: Wisconsin Department of Children and Families

Structure: Voluntary, hybrid system

Number of ECE programs participating: 4,170, including licensed center-based programs (82% of total in the state) and licensed and certified family child care providers (73% of total in the state)[xx]

QRIS Standards Related to HEPA: Healthy eating and physical activity

Background

Wisconsin has a longstanding, cross-sector, commitment to public health, including obesity prevention. Through formation of the Wisconsin Partnership for Activity and Nutrition (WI PAN), formed in 1999, public and private stakeholders came together to address a concerning rise in obesity in Wisconsin.[xxi] Early care and education stakeholders have been at the table with WI PAN since 2008, at which time it became increasingly clear that early care and education was a setting that needed additional attention. Thus, in 2008, early care and education stakeholders across the state formed the Wisconsin Early Childhood Obesity Prevention Initiative. A deep, historical commitment to public health, and a strong public/private model of cross-sector collaboration has been a significant strength in Wisconsin's childhood obesity prevention efforts.

Wisconsin has licensing regulations supporting nutrition, physical activity, and limited screen time. Wisconsin also includes standards in nutrition and physical activity in its points-based quality rating and improvement system (QRIS), YoungStar. Providers earn the required nutrition point by either participating in the Child and Adult Care Food Program (CACFP) or serving meals and snacks that meet CACFP guidelines, and the program must have policies and procedures to address children's allergies and accommodate dietary restrictions. Additionally, to earn the optional physical activity point programs must provide at least 60 minutes of physical activity per day.

QRIS Implementation Strategies

Wisconsin's interagency collaboration and cross-sector engagement have translated to QRIS strategies to help providers achieve nutrition and physical activity practices. Programs participating in YoungStar are offered trainings specific to nutrition and physical activity, Active Early and Healthy Bites (programs statewide not participating in QRIS may also access these resources). Programs in YoungStar also have access to on-site technical assistance from their local child care resource and referral agency (CCR&R), of which there are 10 regional agencies statewide, and the Wisconsin Early Childhood Association (WECA) in a portion of Milwaukee. CCR&R trainers and technical consultants are supported through materials and training from Supporting Families Together Association (a statewide member organization for CCR&R and Family Resource Centers), who is contracted by the Department of Children and Families to execute YoungStar fieldwork statewide, along with WECA for a portion of Milwaukee. Approximately 90 FTE trainers and technical consultants operate out of the 10 regional CCR&Rs and WECA to provide 10 hours of technical assistance per year to each ECE programs participating in YoungStar (related to all YoungStar standards, including nutrition and physical activity). To help offset costs related to practice changes, ECE programs may earn incentives in the form of micro-grants ranging from $200-$1,000 and provided by the Department of Children and Families and distributed by WECA. Micro-grants are intentionally tied to programs' quality improvement plans and may only be accessed by programs that receive technical assistance.

A Deeper Dive – Continuing to Leverage Cross-Sector Collaboration

When Wisconsin implemented its current QRIS standards in 2010 the state found that even with a strong focus on technical assistance, some providers were hesitant to focus on optional points (rather than the required points in YoungStar's 40-point system). When the nutrition and physical activity standards in YoungStar were first implemented, both points were optional. In 2011, Wisconsin reinforced its commitment to this area by making the nutrition point only required. Further, through WECOPI the Departments of Health, Children and Families, and Public Instruction have worked with ECE stakeholders to aligned messages and outreach for coordinated communication with providers about the importance of childhood obesity prevention. WECOPI will continue to support streamlined communication strategies to reach providers in a clear and consistent manner.

State Strategies for Continuous Improvement

As Wisconsin looks to the next set of updates to YoungStar there is a shift toward a focus on the processes supporting quality improvement. Currently, providers earn points for meeting QRIS standards. In 2017, when changes to YoungStar are expected to go into effect, providers will be required to show through self-assessment and quality improvement planning that they're making inroads on practices and policies related to nutrition and physical activity (specifically related to serving nutritious foods, supporting healthy nutrition behaviors, increasing moderate to vigorous physical activity, breastfeeding, gardening, and screen time). At the same time, Wisconsin plans to further improve QRIS standards, specifically by increasing the amount of time required for physical activity from 60 minutes to 90 minutes a day.

Wisconsin also continues to explore the best way to track programs' activities in these and other YoungStar areas to determine if supports are helping providers improve their practices. Currently, the ability to track provider achievement of specific QRIS criteria is limited. Progress can be tracked by point attainment, though it is challenging to discover information about progress in these areas. As Wisconsin shifts to a system that will require providers to illustrate their improvement practices, the tracking efforts will align and tell a fuller story about providers' challenges and successes.

Recommendations for States from Wisconsin

- ✓ Engage public and private cross-sector collaboration to successfully build an infrastructure of supports to help ECE providers implement nutrition and physical activity practices.
- ✓ Ensure that QRIS criteria are mirrored in other state initiatives or supports providers are receiving so that messages and expectations about nutrition and physical activity best practices are clear and consistent.

For additional information about YoungStar: http://dcf.wisconsin.gov/youngstar/.

Appendix

Appendix A: State-by-State Summary of Licensing Regulations and QRIS Standards[15]

	Licensing Regulations				QRIS Standards			
State / DC	Healthy eating	Breastfeeding	Physical activity	Screen time	Healthy eating	Breastfeeding	Physical activity	Screen time
Alabama	■	■	■	■				
Alaska	■	■	■	■				
Arizona	■	■	■	■				
Arkansas	■	■	■	■	■		■	
California	■	■	■					
Colorado	■		■		■		■	
Connecticut	■		■					
Delaware	■		■	■	■		■	
DC	■	■	■					
Florida	■		■	■				
Georgia	■	■	■	■	■		■	
Hawaii	■		■					
Idaho					■		■	
Illinois	■		■	■				
Indiana	■	■	■	■	■		■	■
Iowa	■		■		■			
Kansas	■		■					
Kentucky	■		■	■				
Louisiana	■		■					
Maine	■		■	■			■	
Maryland	■		■		■		■	■
Massachusetts	■		■		■		■	
Michigan	■	■	■	■	■		■	
Minnesota	■		■		■		■	
Mississippi	■	■	■	■				
Missouri	■		■					
Montana	■		■		■	■		
Nebraska	■		■		■	■	■	■
Nevada	■	■	■		■	■	■	
New Hampshire	■		■					
New Jersey	■		■	■	■	■	■	
New Mexico	■		■	■	■		■	■
New York	■	■	■	■	■	■	■	■
North Carolina	■	■	■	■				
North Dakota	■	■	■		■		■	
Ohio	■	■	■					
Oklahoma	■		■				■	■
Oregon	■		■		■		■	■
Pennsylvania	■		■		■		■	
Rhode Island	■		■	■			■	
South Carolina	■		■	■	■		■	■
South Dakota	■		■					
Tennessee	■	■	■	■				
Texas	■	■	■	■	■			
Utah	■		■		■	■	■	■
Vermont	■	■	■	■				
Virginia	■	■	■					
Washington	■		■		■		■	
West Virginia	■		■	■				
Wisconsin	■		■	■	■		■	
Wyoming	■		■					
	50	19	50	24	25	6	25	9

15 Information gathered from *Summary of Obesity Prevention Standards in State Quality Rating and Improvement Systems (QRIS) and Licensing Regulations*, https://d3knp61p33sjvn.cloudfront.net/2016/04/SummaryofObesityPreventionLicensingRegulationsandQRISStandards_040416.pdf

Appendix B: State Survey

Healthy Eating, Breastfeeding, Physical Activity, and Screen Time Strategies in State QRIS Implementation

SurveyMonkey Questions (November 19, 2015)

Introduction

Background information: The Nemours National Office of Policy & Prevention is leading a QRIS Study funded by a grant from Health Eating Research (HER), a national program of the Robert Wood Johnson Foundation, to learn more about state strategies to promote healthy eating, breastfeeding, physical activity, and limited screen time in state quality rating and improvement system (QRIS) implementation. As childhood obesity continues to be a national epidemic, it is important to understand and share state prevention strategies being woven into QRIS. Strong participation in this survey will better help us gather important information to add to the body of knowledge about innovative ways states are using QRIS to support early care and education (ECE) best practices to prevent childhood obesity.

Goal of the survey: To identify how states are promoting healthy eating, breastfeeding, physical activity, and limited screen time in ECE settings ("providers," including center-based and family child care) through QRIS implementation. Strategies may range from a basic focus in a particular area to coordinated approaches to meeting best practices or emerging methods to help prevent childhood obesity. The results from this survey will also help us identify states for more in-depth case study analyses. A final report will detail survey findings (aggregated and disaggregated with state consent) and be distributed for use in the early care and education and obesity prevention fields.

Individual state responses to this survey will be kept confidential. Nemours will not share individual state information without your prior consent. Please note that contact information will be used for Nemours to contact states for additional information and/or request to participate in a case study.

Please e-mail QRISStudy@gmail.com with any questions. Thank you for your participation!

We urge you to review the survey questions—which were attached to the cover e-mail for your reference—and work with others to gather information before you input your response in the online system.

Please click next to participate in this survey.

NEXT ➔

Defining "healthy eating, breastfeeding and physical activity"

For the purpose of this survey we are collecting data on four broad categories: healthy eating, breastfeeding, physical activity, and screen time. More specifically, these categories include (note: this is not an exhaustive list):

Healthy eating – Family style dining, fruit and vegetable consumption, limiting fried foods, eliminating sugary drinks, limiting fruit juice, availability of drinking water, following milk guidelines, appropriate portion sizes, healthy snacking and snacks, and other focus areas in healthy eating the state has identified.

Breastfeeding – Availability of a private space for breastfeeding or pumping and other focus areas in breastfeeding the state has identified.

Physical activity – Physical activity opportunities of significant duration inside and/or outside, staff oversight and engagement of active time, breathless play that increases children's heart rate, infant "tummy time," and other focus areas in physical activity the state has identified.

Screen time – Limited or no screen time for children, media literacy education, and other focus areas in screen time the state has identified.

NEXT ➔

Section 1: Respondent Contact Information / State Identifying Information

Please note, at the end of this section you will have the opportunity clarify or provide additional information about your responses to the questions in this section. An optional open-ended comment box will be provided.

1. Respondent Contact Information (response required)

   Name
   Title
   Organization
   Role as it relates to your state's QRIS implementation
   State (dropdown)
   E-mail Address
   Phone Number

2. Has your state determined there are practices related to healthy eating, breastfeeding, physical activity and/or screen time that it wants to promote via its QRIS?
   a. (Check one) [Y/N]
      i. If no, SKIP to end of survey

3. In which areas has your state determined there are practices related to healthy eating, breastfeeding, physical activity and/or screen time that it wants to promote via its QRIS?
   a. (Check all that apply) [healthy eating; physical activity; breastfeeding; screen time]

4. Do survey responses apply to all program types included in your QRIS?
   a. (Check one) [Y/N]
      i. If yes, SKIP to Section 2

5. Please check all program types that survey responses apply to.
   a. (Check all that apply) [State pre-kindergarten, Head Start, Early Head Start, center-based child care, family child care, other [open-ended]]

6. **OPTIONAL:** Please use the box below to clarify or provide additional information about your responses to the questions in this section.
   a. [Open-ended]

Section 2: Professional Development System

Please note, at the end of this section you will have the opportunity clarify or provide additional information about your responses to the questions in this section. An optional open-ended comment box will be provided.

7. Does your state's professional development system link to your state's QRIS?
   a. (Check one) [Y/N]
      i. If no, SKIP to Section 3

8. How does the professional development system link to your state's QRIS? (Check all that apply)
   a. Mandatory course requirements (e.g. for facility licensure)
   b. Voluntary course offerings (e.g. from a menu of options which providers may choose to meet annual professional development requirements)
   c. Core competencies
   d. Other [Open-ended]

9. Please indicate if mandatory course requirements (e.g. facility licensure), voluntary course offerings, and/or core competencies include a focus on healthy eating, breastfeeding, physical activity, and/or screen time.
    a. [Matrix of responses for each row – Healthy eating, breastfeeding, physical activity, screen time (Check all that apply)]

	Healthy eating	Breastfeeding	Physical activity	Screen time
Mandatory course requirements				
Voluntary course offerings				
Core competencies				

10. **OPTIONAL:** Please use the box below to clarify or provide additional information about your responses to the questions in this section.
    a. [Open-ended]

Section 3: Assessment / Program Improvement

Please note, at the end of this section you will have the opportunity clarify or provide additional information about your responses to the questions in this section. An optional open-ended comment box will be provided.

11. Does your state encourage (either required or voluntary) providers to use a self-assessment tool that includes a focus on healthy eating, breastfeeding, physical activity, and/or screen time (e.g. *Let's Move!* Child Care quiz; Nutrition and Physical Activity Self Assessment for Child Care (NAP SACC)) as part of participating in the QRIS?
    a. (Check one) [Y/N]
        i. If no, SKIP to question 14

12. Is use of a self-assessment tool(s) required or voluntary?
    a. (Check one) [Required, voluntary, both (e.g. some tools required, others voluntary)]

13. Who reviews the results of the self-assessment?
    a. (Check all that apply) [Licensing specialists/monitors, QRIS technical assistants/coaches, QRIS monitors/raters, Other technical assistance provider, No outside review; Other [Open-ended]]

14. Which self-assessment tools may be used?
    a. (Check all that apply) [Let's Move! Child Care, NAP SACC, Other [Open-ended]]

15. How are self-assessment tools used? (Check all that apply)
    a. As part of the application for QRIS participation and/or as part of the rating process for QRIS
    b. To develop an action or program improvement plan
    c. To allow providers to determine if they want to work on healthy eating, breastfeeding, physical activity, and/or screen time as part of their QRIS continuous improvement strategy
    d. Other [Open-ended]

16. Are observational tools used in your state QRIS to provide insight into whether a provider is implementing healthy eating, breastfeeding, physical activity, and/or screen time practices?
    a. (Check one) [Y/N]
        i. If no, SKIP to question 20

17. Is use of an observational tool(s) required or voluntary?
    a. (Check one) [Required, voluntary, both (e.g. some tools required, others voluntary)]

18. What observational tools are used?
    a. [Open-ended]

19. Please identify which specific areas are addressed by the observational tool(s).
    a. (Check all that apply) [healthy eating; physical activity; breastfeeding; screen time]

20. Who completes the observation?
    a. (Check all that apply) [Licensing specialists/monitors, QRIS technical assistants/coaches, QRIS monitors/raters, Other technical assistance provider, Other [Open-ended]]

21. How is information from the observational assessment used? (Check all that apply)
    a. As part of the application for QRIS participation and/or as part of the rating process
    b. To develop an action or program improvement plan
    c. To allow providers to determine if they want to work on healthy eating, breastfeeding, physical activity, and/or screen time practices as part of their QRIS continuous improvement strategy
    d. Other [Open-ended]

22. Is there information available on the state level to know how many providers are meeting best practices in healthy eating, breastfeeding, physical activity, and/or screen time?
    a. [Y/N/I don't know]

23. If yes, please provide additional information.
    a. [Open-ended]

24. Has any organization in your state done a survey with ECE providers to understand their needs for support and/or strategies for successfully meeting healthy eating, breastfeeding, physical activity, and/or screen time best practices?
    a. (Check one) [Y/N/I don't know]

25. If yes, please provide additional information, including agency that completed the survey.

26. **OPTIONAL:** Please use the box below to clarify or provide additional information about your responses to the questions in this section.
    a. [Open-ended]

Section 4: Technical Assistance tied to QRIS

Please note, at the end of this section you will have the opportunity clarify or provide additional information about your responses to the questions in this section. An optional open-ended comment box will be provided.

27. Does your state provide technical assistance tied to QRIS that supports providers meeting healthy eating, breastfeeding, physical activity, and/or screen time practices?
    a. (Check one) [Y/N]
        i. If no, SKIP to Section 5

28. Who provides technical assistance related to healthy eating, breastfeeding, physical activity, and/or screen time practices in your state? (Check all that apply)
    a. QRIS technical assistants/coaches
    b. QRIS monitors
    c. Child care health consultants
    d. Early childhood mental health consultants
    e. Infant/toddler specialists
    f. Licensing specialists/monitors
    g. Other [Open-ended]

29. Do individuals providing technical assistance linked to QRIS receive training on healthy eating, breastfeeding, physical activity, and/or screen time?
    a. (Check one) [Y/N]

30. What technical assistance strategies are implemented to support providers achieving healthy eating, breastfeeding, physical activity, and/or screen time practices? (Check all that apply)
    a. Coaching and mentoring
    b. On-site observations
    c. Peer networking
    d. Policy review
    e. Other [Open-ended]

31. Is there information available at the state level to know how many ECE providers have received training or technical assistance or participated in a special project to help implement healthy eating, breastfeeding, physical activity, and/or screen time practices?
    a. (Check one) [Y/N/I don't know]

32. **OPTIONAL:** Please use the box below to clarify or provide additional information about your responses to the questions in this section.
    a. [Open-ended]

Section 5: Incentives

Please note, at the end of this section you will have the opportunity clarify or provide additional information about your responses to the questions in this section. An optional open-ended comment box will be provided.

33. Does your state offer incentives (financial and/or non-financial, e.g. free training) and/or points toward their QRIS rating to providers for any of the following? (Check all that apply)
    a. Participation in healthy eating, breastfeeding, physical activity, and/or screen time focused initiatives (e.g. *Let's Move!* Child Care, or a state-specific childhood obesity program initiative)
    b. Use of an assessment tool focused on healthy eating, breastfeeding, physical activity, and/or screen time (e.g. *Let's Move!* Child Care quiz; Nutrition and Physical Activity Self Assessment for Child Care (NAP SACC)
    c. Working toward achievement of healthy eating, breastfeeding, physical activity, and/or screen time best practices identified by the state
    d. Full achievement of healthy eating, breastfeeding, physical activity, and/or screen time best practices identified by the state
    e. Achievement of a designation identified by the state
    f. Other incentives [Open-ended]

34. If yes to any of the above, what types of incentives are offered?
    a. [Open-ended]

35. **OPTIONAL:** Please use the box below to clarify or provide additional information about your responses to the questions in this section.
    a. [Open-ended]

Section 6: Other / Wrap up

Please note, at the end of this section you will have the opportunity clarify or provide additional information about your responses to the questions in this section. An optional open-ended comment box will be provided.

36. Are there other strategies your state is using to support providers participating in the QRIS to meet healthy eating, breastfeeding, physical activity, and/or screen time practices that have not been addressed in this survey? If so, please describe the strategies below.
    a. [Open-ended]

37. After reflecting on the strategies your state utilizes, please check the box below which best describes your state's interest/commitment to implementing strategies to help providers participating in QRIS to implement healthy eating, breastfeeding, physical activity, and/or screen time practices.
    a. (Check one) [No commitment; Minimal commitment; Moderate commitment; Significant commitment]

38. What other efforts (beyond QRIS initiatives) are taking place in your state (local, regional, and/or statewide) that help to promote healthy eating, breastfeeding, physical activity, and/or limited screen time for young children in ECE settings? Please provide any additional information you think would be helpful to share about your state.
    a. [Open-ended]

39. Would your agency/organization be willing to explore participation in a case study analysis by Nemours to learn more about your state's strategies? Checking Yes below does not require participation.
    a. (Check one) [Y/N]
        i. If no, SKIP to end of survey

40. If yes, what do you believe is the most compelling reason a case study on your state would be useful to the field?
    a. [Open-ended]

41. **OPTIONAL:** Please use the box below to clarify or provide additional information about your responses to the questions in this section.
    a. [Open-ended]

Appendix C: Professional Development Strategies tied to HEPA

State Utilization of Voluntary Course Offerings to Support Providers in HEPA Areas

	Number of States	Percent of States
Voluntary course offerings tied to all focus areas	12	63%
Voluntary course offerings tied to healthy eating, breastfeeding, and physical activity	2	11%
Voluntary course offerings tied to healthy eating, physical activity, and screen time	2	11%
Voluntary course offerings tied to healthy eating and physical activity	2	11%
Voluntary course offerings tied to only healthy eating	1	5%
Total (out of 19 states with voluntary course offerings linked to QRIS)	**19**	**100%**

State Utilization of Mandatory Course Requirements to Support Providers in HEPA Areas

	Number of States	Percent of States
Mandatory course requirements tied to healthy eating and physical activity	3	18%
Mandatory course requirements tied to healthy eating, breastfeeding, and physical activity	2	12%
Mandatory course requirements tied to breastfeeding and physical activity	1	6%
Total (out of 17 states with mandatory course requirements linked to QRIS)	**6**	**35%**

State Utilization of Core Competencies to Support Providers in HEPA Areas

	Number of States	Percent of States
Core competencies offerings tied to all focus areas	4	25%
Core competencies tied to healthy eating, breastfeeding, and physical activity	3	19%
Core competencies tied to healthy eating, physical activity, and screen time	2	13%
Core competencies tied to only healthy eating	4	6%
Core competencies tied to only physical activity	1	6%
Total (out of 16 states with core competencies linked to QRIS)	**11**	**69%**

Appendix D: Case Study Interviewees and Organizations

Arizona

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Indiana

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Rhonda Clark, Deputy Director
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Note: *Melanie Brizzi, former Director, was interviewed for Indiana's case study with Rhonda Clark, Deputy Director.*

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