Healthy Kids, Healthy Future: Opportunities for Action

Healthy Kids, Healthy Future 2016 Summit

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Full video content from the summit can be found at the Healthy Kids, Healthy Future YouTube Channel (https://www.youtube.com/channel/UC7Si8HMTkId2yAjgshHMV3w) and speaker presentations and additional resources can be accessed at:
https://www.dropbox.com/sh/3r57ozsx8fv7emx/AAD1lSmyx5Wu5y2TIyojcqzJa?dl=0

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EXECUTIVE SUMMARY

The prevalence of overweight and obesity among children and adolescents has more than tripled over the last 30 years. Childhood obesity has both immediate and long-term consequences for health and wellbeing, including supporting healthy cognitive development, and early childhood settings present a tremendous opportunity to prevent obesity through promotion of healthy eating and physical activity behaviors among children, their families, and early care and education (ECE) professionals.

On February 11 and 12, 2016, Nemours Children's Health System, with many supporting partners including W.K. Kellogg Foundation, USDA National Institute of Food and Agriculture, the David and Lucile Packard Foundation, the Robert Wood Johnson Foundation, the American Heart Association, Penn State Better Kid Care, Blue Cross and Blue Shield of North Carolina Foundation, Kaplan Early Learning Company, and the Centers for Disease Control and Prevention, convened the *Healthy Kids, Healthy Future 2016 Summit*. The focus of the summit was to identify opportunities to accelerate and leverage existing work and identify collective next steps to ensure that all children in ECE settings grow up healthy. To accomplish this goal, the summit focused on engaging key thought leaders and policy makers to (1) increase attendees' knowledge and raise awareness of innovative programs and initiatives, and (2) help foster and strengthen new and existing collaborations so that promising practices in health promotion and obesity prevention can be spread, scaled, and sustained through collective action.

Seven areas were identified representing the highest priorities for strategic action. While not comprehensive, the list provides a starting point for identifying specific actions and steps that individuals and/or their organizations can take to help support the health of children, families, and ECE professionals. Details of this Action Plan are outlined in the following pages. Briefly, the top seven strategic areas for action are:

1. **SUPPORT ECE PROFESSIONALS** through professional development, technical assistance, and promotion of staff wellness.
2. Encourage and support **FAMILY ENGAGEMENT**.
3. Develop and disseminate strong, positive, and consistent **MESSAGES**.
4. Strengthen and promote state and local **LICENSING and QUALITY RATING IMPROVEMENT SYSTEMS** adoption and expansion.
5. **PARTNER** between and across providers, organizations, and agencies.
6. Develop and implement, in collaboration with others, **INNOVATIVE SOLUTIONS** to tough problems.
7. Examine, evaluate, and discuss individual and organizational **BIASES and INEQUITIES**.

GLOSSARY & DEFINITIONS

Adverse Childhood Experiences	Traumatic experience(s) in a person's life occurring before the age of 18 that is remembered as an adult.[a]
Child Care	Refers to the care or supervision of a child that is not performed by the child's parent or permanent guardian. While there are available rules and regulations in every state, child care can take place in virtually any setting.
Child Care/ECE Professional	Any individual working in Early Learning and Care Programs (Early Care and Education settings), including but not limited to center-based and family child care providers, infant and toddler specialists, early intervention specialists and early childhood special educators, home visitors, related service providers, administrators, Head Start teachers, Early Head Start teachers, preschool and other teachers, teacher assistants, family service staff, and health coordinators.
Early Care and Education	This is the most general and all-encompassing term referring to any form of formal or informal education aimed at children between birth and 5 years of age.
Head Start	Head Start is a program of the United States Department of Health and Human Services that provides comprehensive education, health, nutrition, and parent involvement services to low-income children and their families.
Office of Child Care Licensing	A common name for the state offices that provide regulation and support services for any entity wishing to become a licensed child care facility. Each state has their own office and set of criteria and requirements for licensing.
Overweight & Obesity	Defined as having excessive weight for height (and age); Overweight is having defined as having a body mass index [BMI; weight (kg)/ height (m2)] $\geq 85^{th}$ percentile and $< 95^{th}$ percentile and obesity is defined as having a BMI $\geq$ 95th percentile for children and teens at the same age and sex.[b]
Physical Activity	Can include recess, physical education classes, organized sports, or any other moderately rigorous activity in which children participate. The U.S. Surgeon General suggests that children get at least one hour of moderately rigorous physical activity each day.
Policy	A principle or course of action chosen to guide decision-making.
Practice	A habit, custom, or method of doing something.
Social Determinants/Upstream Determinants of Health	Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[c] These circumstances are shaped by the distribution of money, power, and resources.

a. Centers for Disease Control and Prevention. About Adverse Childhood Experiences. Website accessed on May 23, 2016 at http://www.cdc gov/violenceprevention/acestudy/about_ace.html

b. Centers for Disease Control and Prevention. Defining Childhood Obesity. Website accessed on May 23, 2016 at http://www.cdc.gov/obesity/childhood/defining.html

c. Healthy People 2020, accessed online on May 16, 2016 at https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

ABBREVIATIONS

ACE	Adverse Childhood Experience
BMI	Body Mass Index
CACFP	Child and Adult Care Food Program
CCDBG	Child Care Development Block Grant
CDC	Centers for Disease Control and Prevention
CCHC	Child Care Health Consultant
EBT	Electronic Benefits Transfer
ECE	Early Care and Education
ESSA	Every Student Succeeds Act
GRAS	Generally Recognized as Safe
HEPA	Healthy Eating and Physical Activity
HKHF	Healthy Kids, Healthy Future
LMCC	*Let's Move!* Child Care
NCCP	National Center for Children in Poverty
QRIS	Quality Rating and Improvement Systems
SNAP	Supplemental Nutrition Assistance Program
USDA	United States Department of Agriculture

INTRODUCTION

Childhood Obesity Remains a Critical Issue

The prevalence of overweight and obesity among children and adolescents has more than tripled over the last 30 years.[1] This is especially true among certain racial/ethnic and socioeconomic groups who tend to suffer from higher rates of obesity and other weight-associated adverse health outcomes.[2] Among families living well below the poverty line, 14.2% of preschool aged children were obese. By comparison, in families at higher income levels, 11.8% of preschool aged children live with obesity. Ethnic minorities, including Hispanics and non-Hispanic Blacks, also suffer from higher rates of obesity (22.4% and 20.2% respectively) compared to non-Hispanic Whites (14.1%).[2] Similar patterns among preschoolers are observed for rates of overweight/obesity as well, with Non-Hispanic Whites (males: 26.0%; females: 21.3%) having a lower prevalence than their Hispanic (males: 34.1%; females: 32.1%) and Non-Hispanic Black (males: 30.5%; females: 27.0%) peers.[3]

Childhood obesity has both immediate and long-term consequences for health and wellbeing. Youth who are obese are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure,[4] exhibit symptoms of pre-diabetes,[5,6] and are at greater risk for bone and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self-esteem.[7-9] And these health consequences continue well into adulthood. Beginning as early as 2 years of age, children and adolescents who are obese are likely to remain obese as adults[10-13] and are therefore at continued risk for heart disease, diabetes, cancer, and osteoarthritis.

Furthermore, early childhood is a critical period of cognitive development, and proper nutrition (and access to regular physical activity) helps lay the foundation for a child's physical and intellectual development. Mounting evidence continues to demonstrate the association between physical activity and healthy diets and better cognitive outcomes.[14] Thus, improving nutrition is a critical strategy for ensuring children are entering kindergarten ready to learn, while setting them on a path for lifelong health.

Why Focus on Early Care and Education Settings

Early childhood settings present a tremendous opportunity to prevent obesity through promotion of healthy eating and physical activity (HEPA) behaviors among preschool children, their families, and caregivers.[15] More than one-third of young children (≤ 4 years old) overall, and an even higher percentage of children with mothers who work full-time, spend time each week in center-based or home-based care.[16-19] In addition, children spend a considerable amount of time in care, averaging 36 hours/week for children whose mothers worked full-time and 21 hours/week for children whose mothers did not.[17] As such, parents and child care providers share the responsibility for promoting diet and physical activity patterns in those critical early years.

Numerous state and federal policies and programs have been instituted to support obesity prevention efforts in early care and education (ECE) settings including increasing time for active play, decreasing sedentary inactivity (such as limiting screen time), and improving the nutritional quality of foods served. Adoption of obesity prevention best-practices into state licensing standards and the Quality Rating and Improvement Systems (QRIS) help incorporate healthy policies and practices on a statewide scale.

At the federal level, numerous examples also exist. A recent update to nutrition standards for the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP)[20] will soon provide more than 1.9 billion healthier meals and snacks to approximately 3.3 million children each day in ECE settings. Programs such as the *I Am Moving, I Am Learning* curriculum provide a proactive approach to increasing physical activity throughout Federal Head Start preschools, and the well-established Virtual Lab School and newly developed THRIVE initiative, created in collaboration with the Department of Defense, empower families and support ECE providers in their efforts to promote healthy behaviors.

Expansion and use of these opportunities is critical. Investments in early childhood have been shown to prolong life and improve health and wellness in later childhood and adulthood.[21] Evidence exists that several programs most effective at promoting adult health and wellbeing are actually those that focus efforts on improving the health of—and reducing poverty for—young children, including the Special Supplemental Program for Women, Infants, and Children (WIC), home visiting with nurse practitioners, and high-quality, center-based early childhood care and education.[22,23]

GOALS OF THE SUMMIT

In 2009, Nemours Children's Health System (Nemours) and the Centers for Disease Control and Prevention (CDC) identified an opportunity to address obesity in ECE settings around the country. At the same time, a growing body of research regarding the importance of promoting HEPA among young children was gaining attention. Nemours and CDC, recognizing an opportunity to leverage their combined experience and expertise, launched *Healthy Kids, Healthy Future* (HKHF), a national movement to promote health and prevent obesity in kids from birth to age 5.

In 2009, HKHF held its first conference, designed to provide a multi-disciplinary approach to child health and obesity prevention. This conference marked one of the first times that leading experts in the fields of child health, obesity prevention, and ECE were convened at a national level. That meeting generated momentum toward identifying innovative strategies to improve wellness policies and practices in ECE at local, state, and federal levels and provided a solid foundation for those interested in working together in this space. These efforts were further bolstered through the creation of an HKHF Steering Committee. This group facilitated the ongoing discussion, interaction, and energy necessary to push the collective work forward.

HKHF has continued building this momentum by advancing policy, practice, and research, providing regular opportunities for important discussions about health promotion and obesity prevention in ECE, and engaging thought leaders and policy makers to implement changes that can accelerate, impact, and sustain current efforts and support continued progress. But there is still more to do, and promoting the health of our youngest citizens has increasingly become a priority among policy makers, and non-profit and for-profit institutions.

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that all children in ECE settings grow up healthy. To accomplish this goal, the summit focused on engaging key thought leaders, researchers, practitioners, and policy makers to (1) increase attendees' knowledge and raise awareness of innovative programs and initiatives, and (2) help foster and strengthen new and existing collaborations so that promising practices in health promotion and obesity prevention can be spread, scaled, and sustained through collective action.

This Action Plan is a result of the myriad conversations and ideas that were shared during the two-day event. It is meant to serve as a summary of the event itself, as well as a resource for identifying specific action steps that can be taken by individuals and organizations. The Action Plan highlights:

- The remarkable strides that have already been made in child health promotion and obesity prevention
- Additional opportunities for improvement
- Five cross-cutting considerations that can significantly impact inequality and improve child health
- Innovative strategies for incorporating these promising approaches
- Specific ideas for taking action in practice, research, and policy settings

OUR EFFORTS ARE PAYING OFF

Remarkable advancements have been made at the local, state, and federal level—in both policy and practice—in the area of health promotion and obesity prevention broadly, and among ECE policies, practices, and practitioners specifically. "When we started this work [obesity prevention in the ECE sector]," said Debbie Chang, Senior Vice President of Policy and Prevention at Nemours in her opening remarks, "very few states were working intensely in healthy eating and physical activity. Now, virtually all states are working in this space and states are finding creative and effective ways to incorporate obesity prevention into all kinds of areas that impact children." Roughly 70% of those who recently responded to a survey on the *Let's Move!* Child Care (LMCC) website identified that they were meeting half of the 'best practices' identified for supporting obesity prevention in ECE. Chang went on to describe other successful efforts and the positive cumulative impact on young children.

Major federal milestones have also contributed to the advancement of obesity prevention among young children. Deb Eschmeyer, Executive Director of *Let's Move!* and Senior Policy Advisor to the President, described some of the unprecedented progress that has been made over the last six years toward increasing access to healthy foods for all children. "In fiscal years 2013-2015, the USDA made 900 investments in infrastructure that connects local growers to consumers and since 2009 the number of food hubs has increased by 100%" bringing more local food to more people. This food has also become more affordable to an increasing number of people: "Electronic Benefits Transfer (EBT) is now more widely available at farmers' markets and Supplemental Nutrition Assistance Program (SNAP) redemption has increased from $4 million in 2009 to $18 million in 2014."

Ms. Eschmeyer described a number of other successes as well, including creation and adaptation of "My Plate, removing the generally recognized as safe (GRAS) status for trans-fats, finalizing the Nutrition Facts Label changes, and the collaboration with Partnership for a Healthier America (PHA) and the 200 private sector commitments made to make the healthy choice the default." And while the more than 70

recommendations from the Presidential memorandum creating the White House Task Force on Obesity Prevention have served as the backbone of the *Let's Move!* initiative, the key to its success, "the foundation of this approach, has been that everyone has a role to play in reducing childhood obesity."

MORE OPPORTUNITIES EXIST

Even with this significant progress, there is still more that we all can do. Over the course of the summit, a number of specific action items were identified that, if pursued, will further develop, spread, and scale innovative and proven strategies for obesity prevention in the ECE setting. Some are context specific, best suited to those working in the broad areas of research, policy, or practice. But others are more inclusive, encouraging a more systematic approach to evaluating our current policies, beliefs, and practices, and possibly requiring a fundamental shift in how we think about health and the provision of child care services. We begin by discussing the five broad, cross-cutting considerations before describing the specific opportunities for action.

CROSS-CUTTING CONSIDERATIONS

No single individual, organization, or focus on a particular setting can halt the rise of the growing obesity epidemic, especially when it comes to our youngest citizens because their safety and care are often shared by numerous professionals and occur in a variety of environments/settings. Successfully challenging childhood obesity requires a collective refocus and continued commitment to spreading and scaling best practices.

But it is not enough to simply focus on the proximal causes of ill health like a lack of physical activity or poor diet. What is needed is a fundamental shift in how we identify, understand, and address the upstream contributors to childhood obesity and how we strategically place our own and our collective work within these broader frameworks. To this end, it is critical that we examine the potential impact of our programs, policies, and research questions on ECE professionals, and that we consider the health of the communities in which our children live; not just the health of the facilities in which they are cared for. Further, stemming this epidemic will require expanding our networks and partnerships to provide more fully integrated and supported services for families as well as systems for information sharing between practice, policy, and research organizations. Lastly, our internal and external organizational discussions increasingly need to consider equity as an essential element of health and to openly acknowledge how we—as individuals and organizations—support, and potentially unintentionally undermine, the provision of equitable access to resources, and to identify areas where we can improve.

These five broad themes—Supporting ECE Professionals, Community Health, Partnership, Strengthening Cross-Sector Initiatives, and Equity—recurred throughout the two-day conference and served as the common thread connecting each of the panel and breakout sessions. Below, we discuss each of these topics in further detail and provide specific examples of individuals and organizations (and the resources they use) working to address these topics in their own communities and circles of influence. It is critical that these five considerations underlie all of the specific actions individuals and organizations take because doing so will greatly expand the reach and scale of our collective efforts.

SUPPORT THE ECE PROFESSIONALS WHO SUPPORT OUR KIDS.

If we are serious about providing upward mobility and building a skilled workforce, pre-school is the place to begin. – Madeliene M. Kunin

The characteristics of high-quality learning—ongoing, coherent, collaborative, tied to practice, responsive—are well known and well documented, as are the critical foundational knowledge and competencies needed by adults who care for and educate young children.[24] A theme that repeatedly emerged over the two-day summit was the critical need to better support those ECE professionals in their personal and professional lives, so that

they can be healthy role models for the children they serve. In particular, ideas emerged around two central needs, which are described below: (1) better training and professional development opportunities, and (2) empowering the caregiver.

Training and Professional Development

"There are some unique challenges that face the ECE workforce when they try to access training and development," said Dr. Claudia Mincemoyer, Director of the Penn State Better Kid Care Program, "and we must keep all these in mind as we think about supporting our ECE professionals and providing them the tools they need to provide the highest quality care they can. [Professional development] has to be accessible, affordable, relevant to the specific practice environment (home vs. center-based care), and specific to the role and age groups of the children." Additionally, ECE professionals have a "diversity in learning styles, educational levels, and, often, a lack of support following these trainings."

To try to address these diverse needs, groups like Penn State Better Kid Care and the Virtual Lab School (Department of Defense) use online training platforms and modules to provide evidence-informed professional development to ECE and youth development professionals. What's most promising about these particular models of training is that they are accessible to a wide variety of ECE professionals. ECE professionals differ greatly in the length of time they have been providing care, in the families they serve, in the type of care settings that they work, the amount of time they have to access training and professional development, and in the amount of education they have. Therefore, online training flexible enough to impact this diverse group of professionals is critical.

Empower the Caregiver

It is also critical for us to recognize the important role that stress plays in ECE professionals' lives. "This [stress reduction and stress management] should be a priority as we think about professional development … we need to help those professionals think about ways they can be healthy emotionally, physically, and to be there for the kids because that is the way to have a positive classroom experience," said Dr. Mincemoyer. To address this, a module has been developed, *Resilient Caregivers: Bouncing Back from Stress*, which is freely available (**www.extension.psu.edu/youth/betterkidcare**) and is a valuable resource for all ECE professionals.

ECE professionals often serve families within their own communities. Therefore, they often face the same economic, environmental, and social-emotional challenges that affect the children they serve. They also share common health inequities, especially in relation to HEPA habits, adverse childhood experiences (ACEs), and rates of obesity; gaps in knowledge about HEPA behaviors, such as understanding the role of nutrition in brain development, serving sizes, food groups, and the appropriate number of servings for children; and skills needed to implement obesity prevention policies. "If we're going to come to grips with these issues in the broader ECE environment," said Dr. William Dietz, Director of the Sumner Redstone Global Center for Prevention and Wellness at the Milken Institute School of Public Health at George Washington University, "we must discuss how to come to grips with this in the providers themselves."

These sentiments were echoed by Florence Rivera, Initiatives Manager at the American Academy of Pediatrics (AAP). "Providers are often from the communities they serve, so they share the same inequities as their populations." Yet we less frequently consider their needs or the impact of the requests we are making on the providers when we introduce new regulations. "We [AAP] see a gap between policy and action, for example having preschools that are serving family-style meals but still requiring children to clean their plates, or seeing a failure to teach providers about reading hunger signals."

Empowering ECE professionals—through ongoing training and technical assistance—so they can create a positive environment and serve as positive role models for children is "an incredibly healing experience for the providers themselves who have often lived those same adverse experiences," noted Capt. Meredith Reynolds, Director of the Early Care and Education Team in the Obesity Prevention and Control Branch of the CDC. Institutionalizing training and technical assistance to support ECE professionals, and developing interventions that target both children/child care facilities and the ECE professionals themselves, is likely to have a positive impact on providers, our children, their classrooms, and the broader community.

COMMUNITY HEALTH IS CRITICAL.

No epidemic has ever been resolved by paying attention to the treatment of the affected individual.
– Dr. George Albee

Although much attention is paid to individual or family-level characteristics that contribute to obesity, the important role that environmental influences play in the development of long-term adverse behaviors and health outcomes cannot be understated. This is especially true of those environmental factors that create adverse child or family experiences. Increasingly, evidence suggests that cumulative ACEs are linked with a broad range of adverse health outcomes and chronic diseases including obesity, mood disorders, heart disease, and cancer.[25-30] Children who live in stressful home environments or who are exposed to community trauma, resulting from continued violence, oppression, or social injustice, are more likely to develop obesity in childhood.[31-33] Several speakers addressed the critical role that community health and resilience plays in creating safe and healthy spaces for engagement and for empowering ECE professionals and families to champion and advocate for their children's health.

Putting Community Health in Context

"Health inequities are easy to describe," stated Dr. Dietz. "But it's pretty hard to figure out how we approach them." The challenge of figuring out how to address ACEs is made even more difficult—yet remains crucial—because these traumatic adverse experiences in childhood are expressed in adulthood as behaviors that are also linked to obesity, and are further reinforced by adverse community experiences. "There's this alignment between an individual's experiences, the trans-generational exposure to those experiences, and the community experiences" in which children live, he continued.

One of the key elements, Dr. Dietz argued, for how to address health inequities in the context of ACEs and adverse community experiences is to integrate the individual (i.e., clinical) approaches that we already have with community-level approaches. "This turns on our ability to engage individuals and families—to empower them—and that's what it's going to take to foster childhood resilience."

Strategies for building community resilience are many, but focus on three main areas: fostering political and social engagement to enhance social networks and social capital (investing in people); improving the quality and safety of the built environment including housing, parks, and transportation (investing in place); and improving job availability and workforce development to reduce—or eliminate—intergenerational poverty and encourage economic empowerment (investing in equitable experiences especially in the workplace). Dr. Dietz identified a number of potential institutions that can foster this community resilience including churches, community-based organizations, and community projects (e.g., community gardens) and reminded

us that these institutions and the projects they pursue do not necessarily need to directly target obesity prevention or health promotion efforts in order to bolster community health and social connectedness.

One of the more promising types of organizations to engage in building community health and connectedness, in Dr. Dietz's opinion, are hospitals. Describing them as anchor institutions "[hospitals] bring a variety of resources and make huge investments in a community … they do purchasing, which can be local, they are major employers, and hospitals can train people—all of which foster jobs and further opportunities." He cited the Cleveland Clinic as an example, which has built low-income housing in a deserted area near the clinic as a way of improving access and building community infrastructure. "The Affordable Care Act, which increasingly reimburses based on outcomes, not volume, offers a potential mechanism for hospitals to pay for engagement in these types of initiatives" and may help close the trans-generational gap.

Example Resources for Supporting Communities

Finding ways to successfully engage families is also critical for building community health. "What Head Start believes," said Amanda Bryans from the Office of Head Start, Administration for Children and Families in the Department of Health and Human Services, "is that parents are partners and lifelong teachers. They have a unique and really important role to play." At Head Start centers, parents participate as decision makers, and when they get to participate in this way there must be an exchange of information between ECE professionals and parents. Not only is this exchange empowering to parents, but it also helps guard against the assumption that the professionals know more about kids than the parents do. It creates a formal system of dialogue that allows parents to help shape their children's learning environments and allows parents and ECE professionals to reinforce each other's goals. In this way, the Head Start model—or least aspects of it—can serve as a resource for other child care providers and professionals for how to engage families.

Dr. Carol Byrd-Bredbenner, Professor of Nutrition/Extension Specialist at Rutgers University, echoed this idea. She found that regular and ongoing conversations with parents lead to parents feeling supported as they work to shape their home environment to be conducive to optimal growth and health. "We don't talk to parents about obesity; this really turns them off." Instead, Homestyles (healthyhomestyles.com), a program designed to help parents combat childhood obesity through lifestyle and environmental changes, provides quick, easy, low-cost, and daily solutions parents can implement to promote and encourage family bonding in ways that support child (and parent) health. "In doing so, we are also building community ambassadors who can champion these changes in their community as well as their own family."

Myth 1: Families are busy enough and don't want to take extra time out of their schedules to participate in classes, meetings, or social gatherings hosted by their child's child care provider.

Myth 1 Busted: Many families are eager to learn about parenting, coping, time management skills, and nutrition and physical activity (among other topics) and welcome an opportunity for social engagement with other families. But they do have competing needs and conflicting schedules, so finding ways to support their participation is key to successful engagement. This includes providing child care—or opportunities for children to be involved—and potentially pairing classes or meetings with dinner! Evaluating the needs of your own parent/teacher community will help you identify other potential barriers and brainstorm ways to overcome them.

PARTNER FOR MORE ACCELERATED REACH.

Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has. – Margaret Meade

When it comes to early childhood and early child care "there is no 'single system'," said Jeff Capizzano, President and Founder of The Policy Equity Group, LLC, "which makes advocacy a significant challenge." Instead, there are dozens of possible levers that could be pulled to impact child health. And while pulling one might have an impact, a single lever cannot have the kind of deep and significant impact that pulling many of them together would have. And given the spread of these levers across local, state, and federal levels, there is no single group or organization that has the reach and power necessary to pull all of these levers on its own. To expand our collective reach and strengthen existing efforts in the ECE and child obesity prevention space, we are going to have to start pulling these multiple levers together.

State Level Change is Critical

Carrie Dooyema, Behavioral Scientist in the Division of Nutrition, Physical Activity and Obesity, in the Obesity Prevention and Control Branch of the CDC cited the important role that the CDC's Spectrum of Opportunities (Figure 1) can play in helping states build partnerships and plan for sustainability. By embedding obesity prevention efforts into existing ECE systems using the Spectrum of Opportunities as a framework, states and communities are able to energize and engage diverse departments and organizations to work toward a more unified goal. A recent survey of state obesity prevention practices in ECE revealed that "39 states have some type of group or taskforce that is addressing obesity prevention in ECE… [This means that] states are pulling together diverse stakeholders to advance the work." Through these partnerships, CDC continues to encourage action by requiring states to work with ECE centers to move obesity prevention forward and supports their efforts through initiatives including the National Early Care and Education Learning Collaborative initiative with Nemours (https://healthykidshealthyfuture.org/about-ecelc).

Figure 1: The CDC's Spectrum of Opportunities. Accessed on June 14, 2016, from: https://healthykidshealthyfuture.org/state-local-leaders/spectrum-of-opportunities

Adopting, expanding, and strengthening state and local licensing and QRIS requirements for ECE centers and licensed family homes is another opportunity to significantly and positively impact HEPA behaviors and activities in ECE. The Public Health Law Center has an extensive database documenting how child care regulations differ by state and care setting, and how these regulations apply to key standards including nutrition, active play, screen time, and playground safety (to name a few). Policy makers and advocates can use this database to identify areas of opportunity for expansion and strengthening of licensing requirements across all child care settings.

Myth 2: Physical activity behavior and nutrition requirements must remain separate from each other and from any other required practices and guidelines that child care facilities need to follow in order to ensure that recommendations are being met.

Myth 2 Busted: Everyone will experience greater success when opportunities to promote health—including healthy eating and physical activity—are more fully integrated into existing frameworks of operation (i.e., existing programs, curricula, etc.) Working across disciplines, departments, organizations, licensing requirements/standards will help create a fully integrated practice where providing healthy development opportunities underlie every aspect of what is done and what is taught.

Increasing access to high-quality preschools represents another opportunity to expand the scope and reach of early childhood obesity prevention and health promotion. The Preschool Development Grants program, which funds states to (1) build or enhance a preschool program infrastructure that would enable the delivery of high-quality preschool services to children, and (2) expand high-quality preschool programs in targeted

communities, was recently expanded to provide services for children birth to age 5. "The program is designed to give states flexibility in how they use the funds so that their needs can be met best," said Steven Hicks, Special Assistant on Early Learning in the Office of Early Learning in the US Department of Education.

Myth 3: Spreading and scaling effective healthy eating and physical activity behavior policies and interventions can only be accomplished by exact replication of an original concept.

Myth 3 Busted: What is important in scaling policies, programs, and/or interventions that have been successful in one community is the identification of those core elements that have been critical for success and the flexibility for communities to adopt and implement those elements in a manner that is best suited to their particular communities' or organizations' needs.

The Department of Education also supports states in building their systems of early learning and provides guidance on the 12 different elements that a quality preschool must include. One of those is "comprehensive services," which would include screenings, supporting family engagement, and providing proper nutrition. The Department is also working to improve instruction, practices, services, and policies through the development of the Statewide Longitudinal Data System program and other technical assistance resources to states. Resources can be found on their homepage at **http://www2.ed.gov/about/inits/ed/earlylearning/index.html**.

Dr. Sherri Killins, Director of the State Systems Alignment and Integration for the BUILD Initiative, described how BUILD is working with state leaders to integrate state policy and messages to ensure that partnership opportunities are identified and promising approaches spread. "BUILD has been interviewing state leaders and what we continue to hear is the importance of early identification and the ability to connect families to services." The Ohio Child Care Resource & Referral Association (**https://www.occrra.org/ohp.php?pid=2**) serves as an excellent model for how to create more formal partnerships between federal and state government and community leaders to accelerate and scale obesity prevention and health promotion efforts that have been proven effective. The integration of Ohio Early Learning and Development Standards into each component of an innovative new program (discussed below) and the program's tie-in to the state's QRIS make it a model for further dissemination.

Child and Adult Care Food Program is an Opportunity for Partnership

Efforts to expand access to CACFP could have a significant impact on child health, especially in light of the recent changes to the meal patterns and best practices covered under the final rule. USDA has a number of resources available to assist with the implementation of these new rule changes, including trainings (webinars and online and in-person modules), which will be offered in partnership with the state agencies that operate the program, and additional planning (recipes, meal plans) and educational resources (posters, tip sheets). "We very much like to work with our partners when getting information out," said Cindy Long, Deputy Administrator, Child Nutrition Programs in USDA's Food and Nutrition Services. "So in terms of webinars we would be happy to work with any of our national or state level partners" to ensure that the information is available and accessible.

Geri Henchy, Director of Nutrition Policy at the Food Research and Action Center, identified opportunities around CACFP by building connections between state and/or local obesity initiatives, working groups, and/or coalitions and ECE facilities. "Create and share nutrition materials, connect CACFP program operations to nutrition experts, or identify and address the gaps that are created by state agency capacity," she encouraged. In partnership with the Department of Health, the Arizona Department of Education provides a unique example for encouraging and supporting CACFP participation. On an ongoing cycle of review, the Department of Education cross-references all ECE facilities in Arizona against a list of CACFP participants to identify all

Myth 4: The organizational and administrative requirements for child care administrators are not overly burdensome for participation in programs like CACFP and do not present a significant barrier to facilities taking advantage of this and similar federal programs.

Myth 4 Busted: Many providers already feel overburdened and underfunded, so participation in programs like CACFP present a challenge due to the added burden of time, paperwork, and monitoring. Further, there is often little offered in the way of assistance. The Colorado-based Merage Foundation's Early Learning Ventures, however, is one example of an organization working to address this challenge by offering a shared network service that provides cloud-based CACFP management, automates paperwork, and saves administrators significant time each week.

those that are eligible but not yet participating. Similar collaborations and data sharing agreements could be possible in other states or between other state agencies whose missions align around child health and wellbeing.

Sue Renner, Executive Director of the Merage Foundation, described their *Early Learning Ventures*, a shared services network of more than 600 ECE providers. *Early Learning Ventures* seeks to automate, through a cloud-based CACFP management system, much of the CACFP-required paperwork. The result is an estimated 20 hours per week saved for administrators. Tools and support like those provided by the Arizona Department of Education and the Merage Foundation serve to collectively raise the level of quality care available to children and communities while supporting ECE professionals in their jobs and increasing access to resources and services through partnership.

Opportunities for partnership—across federal and state-level agencies, between state organizations, and across sectors—are numerous and these partnerships typically serve to benefit everyone involved. Additionally, collecting multiple perspectives and utilizing a variety of expertise encourages solutions that benefit the intended group. It's easy to "sit around the table and come up with an idea or present solutions without taking them back to the group that we are trying to impact," said Dr. Killins. "We talk about access, but are we defining and examining access from all possible angles and doing all we can to ensure that the people who need the assistance are getting it?" Engaging in previously untapped partnerships could be the difference in providing for unmet needs and missing the opportunity to do so.

STRENGTHENING CROSS-SECTOR INITIATIVES.

If you want to go fast, go alone. If you want to go far, go together. – African proverb

Options also exist for strengthening and building upon critical cross-sector initiatives. One such option is Child Care Health Consultant (CCHC) initiatives where child health professionals—a majority of whom are registered nurses—who have some experience in the child care setting and have knowledge of resources and regulations impacting these facilities, can create links between child care facilities, providers, and families to health resources in the community. In states where CCHCs are active and receive widespread support, they play a number of vital roles including: supporting the child care facilities by evaluating and assessing health and safety policies and practices, supporting child care staff through technical support, and offering health and physical activity trainings and classes to children and families. "We've already heard [at the summit] about the importance of following up on some of the web-based trainings that are available these days with onsite coaching. It is child care health consultants who do that every day," said Dr. Jonathan Kotch, research professor and former Carol Remmer Angle Distinguished Professor of Children's Environmental Health at The University of North Carolina—Chapel Hill.

And after years of tracking outcomes, we are beginning to see that CCHC efforts have considerable impact on the children and facilities that they serve. Researchers in North Carolina followed 14 CCHCs over two years working in 77 child care facilities spread across the state and have documented a number of improvements, including: "An increase in written health and safety policies, improvement in health and safety practices over time, an increase in completed performance of health screening taking place right in the child care facilities, and, at the child-level, improvements in access to medical care, enrollment in health insurance, and documented immunization status," said Dr. Koch.

Myth 5: Facilities do not need direction or assistance knowing where to begin evaluating their current facility practices and already know where they can find tools to help them make changes in the areas that they would like to improve.

Myth 5 Busted: Many facilities and providers would like to make positive changes, but don't know where to begin. But numerous tools are out there. Here are just a few examples:

- **NAP SACC**: A self-assessment tool that helps ECE programs set goals and make improvements to their nutrition and physical activity practices.
- ***Let's Move!* Child Care**: A website that provides resources for evaluating current facility practices and tools for creating a plan of action. www.healthykidshealthyfuture.org
- **Penn State Better Kid Care**: An extensive online training resource for ECE professionals.

Efforts specifically targeting nutrition and physical activity in these facilities have also demonstrated remarkable improvements. Seventeen child care facilities in three states were followed for seven months in a randomized controlled trial using CCHCs. During this period, CCHC intervention facilities demonstrated change in provider knowledge about childhood obesity, nutrition and physical activity, improvements in providers' personal health, and in confidence working with families. Compared to control centers, those participating in the intervention saw small increases in the proportion of children who were normal weight, but a significant decrease in children with obesity. The opposite was observed in the control centers. "This type of individual level impact is impressive," Dr. Koch concluded.

Ohio Healthy Programs (OHP, https://www.occrra.org/ohio-healthy-programs) is another example of a model of integration for many of the cross-sector initiatives. With funding from the Ohio Department of Health and in cooperation with the CDC, the program offers ECE facilities the opportunity to earn recognition as an Ohio Healthy Program. Steps toward this designation include: attending approved professional development which uses the Healthy Children, Healthy Weights curriculum, implementing a wellness policy, improving menus, and engaging families. OHP was developed in response to growing concerns around childhood obesity at both state and national levels and has been used as a way to elevate the standard of care across different types of care settings (family homes, centers) across the state. Key to OHP's success is the integration of the Ohio Early Learning and Development Standards into each component of the program and its tie-in to the state's QRIS. A Collaborative Improvement & Innovation Network (CoIIN) is another example of a program that could be replicated in other states to bring together diverse stakeholders and ECE professionals to identify and implement opportunities and strategies for improvement, especially related to HEPA standards in state child care licensing.

IT'S TIME TO TALK ABOUT EQUITY.

A child is a child of everyone. – Sudanese proverb

In America today, 15% of the nation's total population, but 22% of children, live in poverty.[34] This means that poverty overly burdens our youngest citizens. The harsh reality for families living in poverty is that, in addition to more obvious experiences like food insecurity and lack of opportunity, they suffer from additional stressors such as lack of stable and appropriate housing and maternal depression that are also linked to adverse outcomes. With respect to early learning opportunities, evidence continues to build that demonstrates the early years are a critical period in children's learning and development because they provide the necessary foundation for more advanced skills. A robust body of research shows that children who participate in high-quality preschool programs have better health, social-emotional, and cognitive outcomes than those who do not participate, and these effects are particularly powerful for children from low-income families.[35,36]

But the current practice of providing the same level of support—providing equal access to resources and opportunities—regardless of income, has just perpetuated the existing inequalities in child outcomes and school readiness. "One of the things that we know to be true," said Dr. Renee Wilson-Simmons, Director of the National Center for Children in Poverty (NCCP), "is that children do better when families do better. So when we talk about preventing childhood obesity among low-income families, it's important to consider the difficult choices they face," and to consider the potential unintended consequences that our programs and policies have. "Many programs," she described, "aim to improve the situation among one group while simultaneously impoverishing or unintentionally harming another."

So-called two-generation programs provide opportunities to support the wellbeing of children and parents. Model programs in Minneapolis, Minnesota and Tulsa, Oklahoma are testing the efficacy of programs that enroll young children in high-quality preschool programs while their parents receive education and training in high-demand jobs. The goal is to provide greater economic advancement and security to parents while providing high-quality educational opportunities for their children. NCCP suggests that states develop the capacity of existing policy councils and initiatives, such as Early Learning Advisory Councils and child poverty commissions, to promote strong two-generation supports for families with young children.

It is also critical that we consider how our policies and/or recommendations may be received by, or impact, the communities we intend for them to reach. "You talk about play and going outside and part of our prescription is getting more physical activity," said Dr. Killins, "but 230 African American and 228 Hispanic parents of 1,000 surveyed said they felt they lived in unsafe environments compared to 68 in the White community." Despite all of our efforts, and all of our initiatives, communities are not being impacted at the same rate. "It is a really uncomfortable idea for many," Dr. Killins continued, "but we really need to invest more in some children (some communities) in order to get them to the same level or result. Providing data/information that this additional effort pays off is critical because if we keep spreading the same services and the same resources in the same way, then you still end up with a lot of children who are being left behind."

Organizations, even those whose mission is to improve conditions, such as hunger, that often face low-income and minority communities, need to carefully examine and consider how their policies and practices adversely impact the very populations they seek to serve. "Racial and ethnic biases or unexamined beliefs are not just a problem of individuals," said Shannon Maynard, Executive Director of the National Hunger Center (NHC). "Each year NHC identified young people to participate in their leadership development process to provide leadership training and community-building capacity, but we recently realized how much institutional racism was present in our own process of selecting and working with these young leaders."

In an open letter to the AAP in March of 2016, Bernard Dreyer, MD, FAAP, President of AAP and Professor of Pediatrics at New York University, described poverty as "a disease we can't ignore. Not only is poverty poisoning our children, it is costing our country $500 billion per year in lost productivity and poor health … Research now shows us that giving children a healthy start pays off in health and wellbeing. This is not just important for children and their families, but for society as a whole." Examining how institutional racism is embedded in the policies that govern child care regulation and licensing, in particular, is critical, argued Natasha Frost, attorney at the Public Health Law Center "because facilities are going underground because of this." Ensuring that licensing laws reach those who are most in need means carefully considering "how those policies are impacting the people we need them to."

WAYS YOU CAN TAKE ACTION.

Collaboration without action is not meaningful. – Debbie Chang

Over the course of the two-day summit, speakers, moderators, and attendees were asked to identify specific policy, practice, and research actions they and their organizations could take to further spread and scale ideas that work and to leverage the learnings from the conference—and those gained over the previous years—to benefit children nationwide. Breakout session moderators were specifically tasked with identifying concrete action items pertaining to their discussion topic, and individual attendees were regularly provided opportunities to brainstorm their own ideas.

The conclusion of the two-day summit was an interactive session where attendees shared what they believed were the most important ideas for moving the field of obesity prevention and health promotion in the ECE setting forward. In addition to sharing the collective ideas from the breakout sessions, attendees shared their individual ideas with each other. These ideas were scored and ranked by the group, in an effort to identify and build consensus around the group's priorities for moving forward in action.

These priorities were then grouped according to seven overarching strategic action goals, and select specific action items oriented toward policy, practice, and research were drawn from the full list provided by conference attendees. This list is not intended to be comprehensive, but is intended to provide a starting point for identifying specific actions and steps that individuals and/or their organizations can take to help create the place that we all want: a place for healthy children, healthy families, and healthy ECE professionals.

1. **SUPPORT EARLY CARE AND EDUCATION (ECE) PROFESSIONALS through professional development, technical assistance, and promotion of staff wellness** to elevate the child care profession and ensure that all child care workers have the training, tools, and support they need to be the best role models and advocates they can.

*If you work in **Policy** you can …*

- Get approval through the appropriate agency in your state so that providers get documented credit for having taken training courses. It is important that providers are able to show they meet Child Development Associate competencies, new Child Care Development Block Grant requirements, and have Continuing Education Units.
- Incorporate professional development and staff wellness components into Quality Rating and Improvement System and/or licensing regulations.
- Partner with other organizations to ensure low-cost trainings that have technical support are geared toward the appropriate education level of the providers.

*If you work in **Practice** you can …*

- Find ways to provide ongoing training and technical assistance, and for ECE professionals to receive educational/training credit for participation. Incentivizing their participation will increase buy-in and engagement.

- Incorporate provider wellness into existing and new trainings to empower the providers to successfully implement the new requirements.
- Participate in state learning collaboratives.
- Explore how to use the Child Care Development Block Grant to include support for technical assistance for nutrition and physical activity initiatives and programs.

*If you work in **Research** you can …*

- Evaluate optional and required health and safety trainings for specific and measureable outcomes at the facility, caregiver, and child level.
- Evaluate and disseminate findings of effective staff-wellness models.

2. Encourage and support FAMILY ENGAGEMENT in understanding, promoting, and developing healthy eating and physical activity behaviors both in the ECE setting and at home to strengthen child outcomes and provide consistency in knowledge, tools, habits, and expectations between ECE and home.

*If you work in **Policy** you can …*

- Embed family engagement into state Quality Rating and Improvement Systems. The Administration for Children and Families has a wealth of resources for use in planning and implementation.
- Develop breastfeeding-friendly policies in all ECE facilities.
- Create a policy that allows for reimbursement of ECE facilities for providing refrigerators to store breast milk to encourage breastfeeding, especially for mothers who are unable to breastfeed on site.

*If you work in **Practice** you can …*

- Invite parents to trainings that ECE providers attend, such as I Am Moving, I Am Learning, so that parents and ECE professionals have the same information/skills and are working toward the same goals. Empower parents to be ambassadors for health in the community.
- Emphasize parents as participants in the health promotion efforts of their children. Use motivational interviewing practices when talking with them to better understand their needs and how to partner with them to work toward shared goals.
- Bring parents to the table with ECE professionals and technical assistance staff to have discussions around opportunities for pursuing shared goals and to provide resources (to parents and staff) to pursue those goals.
- Help families fully address their other health needs before focusing on healthy eating and physical activity so that they have a solid foundation from which to begin.
- Work in collaboration with health organizations to provide or expand services that support at-risk children, including wrap-around services, through Medicaid-funded case management.

*If you work in **Research** you can …*

- Determine where parents have needs with respect to healthy eating and physical activity. Also, expand beyond healthy eating and physical activity to determine what other emotional, economic, or physical needs parents and families have that would prevent them from providing the most supportive environment they can.
- Expand on the understanding of what types of support parents need and what methods for disseminating this information and support will be successful at reaching them.

3. **Develop and disseminate strong, positive, and consistent MESSAGES** on healthy eating and physical activity and the value of those behaviors on ECE settings that can be used for multiple audiences including child care leaders, decision makers, and on-the-ground child care facilities.

*If you work in **Policy** you can …*

- Create and implement clear and consistent nutrition policy messages across all ECE facilities that sugar-sweetened beverages will not be served and that there will be increased and consistent access to water.
- Create the business case for early childhood interventions, pull together consistent messages to support this, and tailor the communication strategy for multiple audiences to garner support across all sectors that policies that promote high-quality early care and that support the early caregivers make financial sense.

*If you work in **Practice** you can …*

- Reframe messages as opportunities rather than as deficits, focusing on positive development rather than prevention of negative health outcomes.
- Work across sectors (health care, child care, etc.) to create and disseminate consistent messages.
- Spread and scale success stories so that policy makers, practitioners, and researchers can learn from what is working.
- Tell your story again, and again, and again. Several experts stressed the importance of continued messaging in this 24-hour news-cycle world.

*If you work in **Research** you can …*

- Conduct extensive participatory-based interviews to understand what messages resonate with ECE professionals and families from underserved, low-income, diverse communities to ensure that messages are culturally sensitive and appropriate.
- Develop effective messaging on water and healthy beverage choices for children, families, and ECE professionals in the ECE setting.

4. **Strengthen and promote state and local LICENSING and QUALITY RATING IMPROVEMENT SYSTEMS adoption and expansion** so that minimum requirements for ECE facilities and (licensed) family homes include standards for incorporating healthy eating and physical activity behaviors and activities.

*If you work in **Policy** you can …*

- Push forward the best practices and standards that can be easily adapted into licensing or incorporated into states' Quality Rating and Improvement Systems.
- The Federal Government recently released 72 basic foundations related to healthy ECE settings. Examine how these can be adapted to licensing standards.
- Create a consensus document regarding shared practices/recommendations to reduce the number of source documents providers have to manage.

*If you work in **Practice** you can …*

- Create and implement wellness policies in your facility that address healthy eating and physical activity or work with facilities to create and implement wellness policies.

- Examine what activities are already required in your state to meet Quality Rating and Improvement Systems benchmarks and use those as opportunities to integrate health messaging and behaviors. Engage parents as partners in this work.
- Participate in state learning collaboratives to learn how to successfully leverage Quality Rating and Improvement Systems as a mechanism to change healthy eating and physical activity practices.
- Have child and food nutrition program staff (for example, Caring for Our Children and Bright Futures) join licensing monitors.
- Exclude sugar-sweetened beverages from all ECE facilities.

If you work in ***Research*** *you can …*

- Continuously monitor and evaluate the impact of changes to licensing standards or Quality Rating and Improvement Systems adoption of healthy eating and physical activity outcomes on specific and measurable outcomes among children, facilities, and staff members.
- Evaluate the impact of sugar-sweetened beverage exclusion and increased water availability in the ECE setting on child and caregiver health.

5. **PARTNER between and across providers, organizations, and agencies** at local, state, and federal levels to further bolster current and ongoing efforts, expand reach, and capitalize on the knowledge, experiences, and expertise of others working in the field of early childhood obesity prevention.

If you work in ***Policy*** *you can …*

- Foster communication and sharing of data and ideas between similar organizations and platforms (e.g., federal agency with federal agency, state agency with state agency) to avoid redundancies and/or inconsistencies.
- Explore opportunities for federal resources, like block grants, to be used by smaller, unlicensed programs to help these care providers raise the quality of care they provide.
- Partner with other organizations with similar missions working in different areas to draft statements in support of federal policy.
- If appropriate and allowable, call, write, text, email, or tweet your law-makers and make your voice heard.

If you work in ***Practice*** *you can …*

- Connect ECE facilities, directors, and other ECE professionals with health providers and resources in their area.
- Identify and use available grant opportunities from partner agencies. For example, Supplemental Nutrition Assistance Program Education funds obesity prevention and education. Determine how these funds can be used in your facility or organization or how you could encourage others to leverage them.
- Learn about accessing ECE and Development Block Grant money for professional development on healthy eating and physical activity and other topics aimed at improving the supply and quality of infant and toddler care.
- The community health needs assessments that nonprofit hospitals are required to undertake include consultations with community members and public health experts, which can help launch productive partnerships between hospitals and ECE facilities. ECE facilities can also partner with many other community-based organizations and institutions to enrich the health services available to children.

*If you work in **Research** you can …*

- Explore opportunities for data sharing—at the local, state, and/or federal level—between organizations that work with children. At the local level, for example, you could explore opportunities for data sharing between the Special Supplemental Nutrition Program for Women, Infants and Children; Head Start; and hospital systems.

6. **Develop and implement, in collaboration with others, INNOVATIVE SOLUTIONS to tough problems.** Across policy, research, and practice, this means:

- Allow for additional reimbursement for safe drinking water in Child and Adult Care Food Program participating facilities that are located in districts with unsafe drinking water.
- Use technical solutions, such as cloud-based management systems, as a model for creating administrative resource sharing policies between facilities.
- Explore ways that state and federal money can be used to support Child Care Health Consultants or other home visiting program efforts to connect families with resources and provide ongoing support during the critical early years.
- Create and support policies that will professionalize the ECE career, starting with increased pay for ECE professionals.
- Create the business case for early childhood intervention by pulling together the best of the existing evidence and creating a tailored communication strategy for multiple audiences including political leaders, fiscal conservatives, and the private sector (for partnership opportunities).
- Advocate for funding to disseminate studies of programs that work. There are excellent resources/programs that need to be tried in a variety of settings by a wide array of practitioners.
- Explore opportunities for promoting and facilitating data sharing at the local level.

7. **Examine, evaluate, and discuss individual and organizational BIASES and INEQUITIES** to develop solutions that will improve cultural and geographic accessibility of programs, practices, policies, and research hypotheses and interventions.

*If you work in **Policy** you can …*

- Work with policy makers to ensure that licensing policies do not adversely impact the ability of ECE professionals and facilities to provide quality care, especially in at-risk communities and among vulnerable populations.
- Work to ensure that federal programs—like the Child and Adult Care Food Program—are flexible enough in their guidelines to allow for culturally appropriate foods (that still meet basic minimums).
- Explore ways that central kitchens could be used to reduce the burden on facilities or homes in lower-income, lower-resource communities while raising the level of nutrition quality available to children attending these facilities.

*If you work in **Practice** you can …*

- Ensure that your community's social, racial, and cultural beliefs and practices are understood and represented in the policies, practices, and messages that are disseminated through your ECE facility.
- Raise the frequency and level of equity conversations so that you, your staff, and your organization become more comfortable in addressing problems of equity, and become better at designing solutions and ways to reduce institutional and structural inequities.
- Ensure that policies, recommendations, training materials, and other resources are available and distributed in multiple languages.
- Use district health offices to saturate underserved communities with resources and provide strategic partnerships for ongoing technical assistance and support, as demonstrated in New York City.
- Seek out and provide racial equity training and resources to implement in your work place; plan for this annually.

*If you work in **Research** you can …*

- Evaluate what the youngest children in low-income families and families of color are actually eating, what feeding practices are being used, and how those decisions are being made.
- Identify the most pressing needs and barriers to meeting healthy eating and physical activity guidelines in underserved, minority, rural, or economically suppressed communities.
- Identify the strengths that underserved communities have in helping their citizens meet healthy eating and physical activity guidelines.
- Expand the health field's understanding and knowledge base around alternative models of ECE (home visiting and parent participation preschools) and their power to create equity and opportunities in poverty zip codes.

CONCLUSION

The goals of the summit—to identify opportunities to accelerate and leverage existing work and identify collective next steps to ensure that all children in ECE settings grow up healthy—were explicitly and successfully met. These goals were accomplished by strategically focusing on engaging key thought leaders, researchers, practitioners, and policy makers to increase knowledge and raise awareness of innovative programs and initiatives, and by helping to foster and strengthen new and existing collaborations so that promising practices in health promotion and obesity prevention can be spread, scaled, and sustained through collective action.

Bringing together leaders and experts in the ECE, nutrition, physical activity, and child health fields, who in the past have generally worked in silos, has continued to propel the field forward. Supporting collaboration of these cross-sector efforts will allow for larger scale more effective outcomes. These combined efforts, to improve nutrition and physical activity environments in ECE settings will help to create a lifetime of healthy habits for children in the United States.

PLANNING COMMITTEE MEMBERS

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