

Using the Spectrum of Opportunities to Support Childhood Obesity Prevention In Early Care & Education Settings

Kentucky Case Study



Nemours is currently funded by the Centers for Disease Control and Prevention (CDC) under a five-year Cooperative Agreement to support childhood obesity prevention in early care and education settings. The views expressed in written materials or publications does not necessarily reflect the official policies of the Department of Health and Human Services nor does the mention of trade names, commercial practices or organizations employ endorsement by the U.S. Government.

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Thanks to the following who shared their feedback, provided comments, and offered feedback on the case studies:

Caliste Chong, Julie Odom & Gail Piggot, Alabama Partnership for Children
Bonnie Williams, Arizona Department of Health Services
Meredith Reynolds, CDC
Christi Smith and Leadell Ediger, Child Care Aware of Kansas
Beth Ann Lang & Jessica Rose-Malm, Child Care Aware of Missouri
Wil Ayala & Pam Hollingsworth, Early Learning Coalition of Miami, Dade and Monroe Counties
Marta Fetterman, Early Learning Indiana
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National Early Care and Education Learning Collaboratives (ECELC) Integration of Childhood Obesity Prevention into State/Local ECE Systems

Executive Summary and Overview as of July 2017

National ECELC

Launched fall 2012, the National Early Care and Education Learning Collaborative (ECELC) is a six-year, Centers for Disease Control and Prevention (CDC)-funded effort, implemented by Nemours and partners. ECELC was designed to prevent childhood obesity through the spread of impactful, sustainable policy and practice improvements in the early care and education (ECE) setting with respect to healthy eating, physical activity, breastfeeding and screen time (HEPA).

The ECELC project partners with organizations in states and communities to 1) provide an intensive ‘learning collaborative’ obesity prevention intervention to groups of center and home-based ECE providers (child care, Head Start, pre-kindergarten), and 2) better integrate national obesity prevention standards¹ and implementation support for these standards into components of state and local ECE systems.

As of July 2017, eight states (Alabama, Arizona, Indiana, Kansas, Kentucky, Missouri, Virginia, and New Jersey) and four communities (North/Central Florida, South Florida, Los Angeles County California, Contra Costa County California) have participated in the National ECELC. The intervention¹ typically consists of five in-person learning sessions spread over a 10-month period, ongoing technical assistance for participating ECE providers, and access to tools, materials and resources.

Childhood obesity is a national epidemic and obesity prevention is an increasing focus for states supporting the healthy development of young children. Studies have shown that in the United States, approximately 23% of children ages 2 to 5 years old are overweight or obese.

Source: Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of Childhood and Adult Obesity in the United States, 2011-2012. JAMA. 2014;311(8):806-814.

Integrating Obesity Prevention into ECE Systems Using CDC’s Framework

Through this project, partners worked intentionally to understand the extent to which support for standards has been integrated into components of their ECE system. Assisted by technical assistance from Nemours, partners used the CDC’s ‘Spectrum of Opportunities for Obesity Prevention in the ECE Setting’ as a framework to identify gaps and opportunities for further integration and, working with broad internal stakeholder groups, select and pursue integration action steps. Integration efforts spread awareness of standards and build upon the main objectives of ECELC—increase number of ECE programs meeting standards, and increase the proportion of young children in programs that meet these standards.

Many factors influence how and when integration of best practice support into ECE systems can be achieved. This case study series explores some of



Figure 1: CDC Spectrum of Opportunities.

the integration opportunities pursued by each state/community, the outcomes of these efforts, and factors that may have hindered or enhanced their success. The uniqueness of each state or local ECE system (e.g., licensing, Quality Rating and Improvement Systems (QRIS), stakeholder groups) is described as an important contextual factor for integration activities.

Development and Purpose of State Case Studies

In fall 2016, Nemours gathered information from its ECELC partners, reviewed monthly progress and integration plans, and compiled case studies describing each partner's integration efforts. Reports for several states/communities and reports by Spectrum area were completed in July 2017 and posted on www.healthykidshealthyfuture.org.² These case studies provide real-life examples of how partners have leveraged initiatives (i.e. ECELC), funding, stakeholder engagement, and other factors to integrate HEPA practices/activities into ECE systems. The reports discuss how federal funding streams/initiatives (e.g., CACFP, Child Care Development Fund, State Public Health Actions—1305) are leveraged in a variety of ways *alongside* state or local resources to achieve integration activities across the Spectrum. Case studies serve multiple purposes: reflection, information sharing, and planning.

Reflection. Development of case study reports provided an opportunity for National ECELC partners to reflect on their pathway, progress, key challenges and lessons learned. This also allowed reflection on what was accomplished, how it was achieved and who was involved. All partners continue their integration activities and case studies will be updated as needed.

Information sharing. Case study reports provide valuable information at multiple levels. In the participating state or community, the case study may be a communication tool for partners' information sharing with stakeholders. For other participating ECELC states or communities, they provide an opportunity to learn about the impact driven by participation in the National ECELC project. For stakeholders in non-ECELC states and communities, the case studies are an opportunity to learn how others have integrated HEPA into ECE systems.

Planning. For National ECELC partners, their case study reports may help to serve as a planning tool for continued improvement and momentum. By reflecting on challenges and lessons learned, partners can celebrate the successes while focusing on filling gaps and continuing to integrate ECE obesity prevention efforts. For states and communities that have not participated in ECELC but are working on childhood obesity prevention via state or local ECE systems, case study reports provide a roadmap for possible change. Case study reports from those that have traveled a similar journey will help others consider a systems perspective for integration from the beginning.

The ECELC case study series explores some of the integration opportunities pursued by each state and community, the outcomes of these efforts, and factors that may have hindered or enhanced their success. Integration activities are characterized by their primary focus within the Spectrum of Opportunities. This summary report describes information learned, reflections, and recommendations from across the case studies.

Summary of Obesity Prevention Integration Activities Across States and Communities

Over the course of their participation in the National ECELC project, partners pursued integration activities across the Spectrum of Opportunities. Certain areas have risen to the top among partners' work. In particular, pre-service and professional development, licensing and administrative regulations, and QRIS. Many partners' activities touched multiple areas of the Spectrum of Opportunities despite being characterized under one primary area. The most prominent areas for each state or community are highlighted in their report.

The following summarizes partner activities within each area of the Spectrum of Opportunities. Additional detail about each area is available in the *Spectrum of Opportunities State Integration Highlights* reports, available at www.healthykidshealthyfuture.org.

Pre-Service and Professional Development

Pre-service and Professional Development was the area of the Spectrum of Opportunities most frequently leveraged by partners participating in the National ECELC. Eight out of ten used Pre-service and Professional development to integrate HEPA activities. Partners in Arizona and Kentucky created *online modules aligned to HEPA standards*, and in Kentucky technical assistance packages accompany those modules and enhance trainers' ability to support ECE programs to make changes. Other partners created *new trainings* to meet needs identified by ECE providers or stakeholders. For example, an infant/toddler feeding training was developed in Indiana, and parent trainings in Los Angeles.

The *development of toolkits* was another commonly used strategy to help large numbers of ECE providers make and sustain HEPA changes. In Los Angeles partners developed a Breastfeeding Friendly Child Care Toolkit, and Indiana partners created a Family Engagement Toolkit which is now an online module for ECE providers. Similarly, the partner in New Jersey developed *Policy Packets and Kits* to help give ECE providers the tools and language needed to make HEPA changes in their programs. In Virginia, *'supply kits'* were provided to technical assistance providers to share with ECE providers to encourage them to focus on HEPA changes.

Many partners that focused on Pre-service and Professional Development as an integration strategy strived to *ensure that continuing education units (CEUs) and licensing clock hours/in-service hours were available for ECE providers* participating in the learning collaboratives and in new and existing HEPA trainings.

Licensing and Administrative Regulations

Five partners focused on Licensing and Administrative Regulations as a primary integration strategy. In Kentucky, Los Angeles, CA, Missouri, and New Jersey this centered on *promoting the inclusion of HEPA standards in licensing regulations*. In each of the states, the effort is ongoing; it is a lengthy administrative process to update licensing regulations. Arizona has a highly visible HEPA initiative (Empower) in place tied to state licensing regulations and the *National ECELC was co-branded* to align with the program as Empower PLUS+. The partner in Arizona leverages licensing and QRIS support and *aligns training and data collection* for a coordinated strategy to support the achievement of HEPA practices in ECE settings. In California, stakeholders *built upon legislation that requires new licensed providers participating in Preventive Health and Safety Practices (PHSP) Training to receive a 1-hour training on child nutrition*. Partners aligned curricula and existing training with the new child nutrition training to ensure providers are up-to-date with current information.

Quality Rating and Improvement Systems (QRIS)

Five partners in Indiana, Kansas, Los Angeles, CA, New Jersey and South Florida, focused on QRIS as a primary integration strategy. Partners in these states have *engaged with stakeholders—public and private—to leverage the reach and potential of QRIS to weave HEPA topics into broader quality improvement strategies*. Four of the five partners that focused on QRIS did so from the perspective of *integrating HEPA standards into QRIS, either through the launch of a new QRIS or revisions to an existing QRIS*. In New Jersey, the partner successfully *included a HEPA-focused self-assessment (Let's Move! Child Care) in the state's QRIS*. In three of these states, South Florida, Kansas, and New Jersey—as well as Virginia³—the partner made efforts to *train QRIS technical assistants* to enhance their ability to assist ECE programs in their efforts to achieve HEPA best practice standards.

Emerging Opportunities

Emerging opportunities do not fit neatly into any one area of the Spectrum and are often unique. Partners in Arizona, Indiana, North/Central Florida and South Florida are pursuing emerging opportunities for integration. In South Florida, stakeholders partnered with Help Me Grow⁴ and YMCA of South Florida to further *integrate obesity prevention into existing systems and to promote consistent obesity prevention messages* to ECE programs and families across South Florida. In North/Central Florida and Indiana, partners collaborated with Head Start grantees to successfully *modify the National ECELC approach to meet the specific needs of Head Start programs*. The approach in Arizona focused extensively on the partner leveraging multiple avenues to elevate obesity prevention across the state system—from the state level to ECE provider-level change.

Child and Adult Care Food Program (CACFP)

Partners in Missouri and Virginia are using CACFP as a primary integration strategy. In Missouri, the state's existing CACFP recognition program *Eat Smart* and *MOve Smart*, was aligned to the National ECELC around *messaging and supports*. *Eat Smart*, in particular, focuses on supporting ECE programs to meet nutrition standards, including CACFP for those meeting more advanced standards. The National ECELC project helped *to add bandwidth through learning collaboratives to provide technical assistance to help ECE programs implement best practice nutrition standards and receive recognition*.

The partner in Virginia is similarly focused on *expanding the bandwidth of technical assistance, and in particular state CACFP and Infant Toddler Specialists, to assist ECE providers in their efforts to meet or exceed HEPA standards*. Stakeholders in Virginia held a *CACFP Summit* that resulted in the formation of workgroups to address barriers to ECE provider enrollment in CACFP and how these barriers can be overcome so that more eligible providers will participate.

Technical Assistance

Two partners (in Kansas and Virginia) focused on Technical Assistance as a primary integration activity.⁵ The partner in Kansas *collaborated with stakeholders to enhance the collective capacity* to increase healthy lifestyles in ECE. They supported a stakeholder initiative by *providing technical assistance for ECE programs to complete HEPA assessments and plan for change*. In Virginia, HEPA is incorporated into a variety of technical assistance supports. Technical assistance strategies accompanied implementation of a CDC-funded Go NAP SACC pilot, a “Rev Your Bev” campaign to engage children 0-5 in healthy lifestyles, as well as implementation of a breastfeeding friendly child care environments initiative.

Family Engagement

The partner in Kentucky was the only one that had integration activities that fell primarily in the Family Engagement area of the Spectrum. In Kentucky, there is an active 5-2-1-0 campaign to educate families on healthy, active living for young children. With 1305 funds, the state partner *developed a train the trainer course for ECE credentialed trainers to support their ability to deliver a 2-hour 5-2-1-0 training to ECE providers and families*. A similar online training on how to use 5-2-1-0 with parents was also developed.

Although the partner in Kentucky was the only to focus on Family Engagement as a primary integration strategy, others implemented changes that included family engagement but might have had a more prominent focus in a different area of the Spectrum. For example, the state partner in Indiana developed a self-assessment tool for ECE programs, *Indiana Early Childhood Family Engagement Toolkit* to help programs understand their current level of engagement and how they can improve practices and policies to engage families. The tool was initially implemented as part of the National ECELC project and was integrated into each learning session to bridge HEPA topics with family engagement strategies.

Exploring Challenges and Lessons Learned

When looking across states it becomes apparent that the challenges and lessons partners experience while working toward integration activities are quite similar and fall into the following categories:

Pace

Partners find that changes to the ECE system—most notably QRIS and licensing regulations—take significant time. The pace of change is slow due to administrative processes, changing priorities, staff turnover or other factors that cause delays in finalizing and implementing revised systems.

Navigating funding streams

Funding can be a barrier to change, and partners experience this from multiple perspectives. There is no dedicated funding stream for HEPA program improvement in ECE. Often partners have to seek grant funding to support integration activities or fight for public funds for HEPA versus other program improvement areas. Other funding-related challenges include having to weave together multiple funding sources to support integration activities, balancing the uncertainty of state budgets and the longevity of funded projects. Partners also depend on funding to maintain momentum and struggle to enhance existing initiatives with static funding.

Creating change within voluntary systems

As it relates to QRIS or other voluntary statewide initiatives (e.g., Arizona’s Empower program) partners have had to consider the depth of impact within voluntary systems. In some states, the QRIS reaches only a small number of ECE providers. In other states, exemptions to licensing requirements mean many ECE providers operate outside the regulatory system. With a focus on encouraging implementation of best practice HEPA standards across all ECE settings, some partners have had to balance that expectation with what is feasible within the existing systems.

Coordination among multiple partners or stakeholders

In many states multiple projects, initiatives, stakeholder groups, or public and private entities touch the ECE system and childhood obesity prevention. Creating shared goals and a coordinated path forward is a challenge for some partners, and particularly those that did not have an active ECELC stakeholder group or other group of key individuals already with buy-in and focused on creating an aligned strategy.

Staff and leadership turnover

When staff who were deeply involved in a particular effort left their position there were periods of having to restart collaborations or reconfirm priorities and paths forward. This also proved true with turnover at the state leadership level. Changes in administration and the political climate within a state may translate into changes in statewide priorities or funding allocations.

Technical assistance resources

Many of the integration efforts focus on *Spectrum of Opportunities* areas where technical assistance resources are available. For example, partners may access information about state licensing regulations and language for HEPA standards. They are also able to get ideas of how to build and integrate HEPA areas into QRIS. At the same time, there are few resources available on building new technical assistance networks or strategies to train existing networks not already knowledgeable on HEPA.

Course correction

As partners work toward integration activities, it is not uncommon to change course. A variety of factors (e.g., stakeholder buy-in, leadership priorities, staffing, funding) impact the degree to which partners were able to maintain course on particular strategies. Maintaining flexibility and adaptability have proven important factors for successfully integrating HEPA into state systems. Similarly, many partners targeted ‘easy wins’ alongside bigger, more challenging changes. This allowed them to celebrate successes while simultaneously navigating the course to more significant (and often time-consuming and more resource driven) changes to the ECE system.

Reflections and Recommendations

When considering the factors that contributed to partners’ success integrating HEPA activities into ECE systems, a few themes emerged. The partners themselves agree that these are the roadblocks encountered and paths forward. The following recommendations lay out suggested steps for consideration on the journey to fully integrate HEPA best practices into ECE systems.

Recommendation 1: Establish a system to become aware of new or unexplored funding opportunities and have an ability to respond to opportunities when they arise.

Successful partners had an ability to respond to external opportunities when they presented themselves. This is particularly evident related to funding, whether to expand the reach of provider level initiatives (e.g., North/Central Florida leveraging 1305 fund collaboratives in an underserved region), launch new programs (e.g., South Florida’s Early Childhood Education Structured Physical Activity (ECESPA) project), campaigns (e.g. Kentucky’s 5-2-1-0) or training. Continuously re-scan the environment to determine if there are new or unexplored opportunities.

Recommendation 2: Maintain flexibility with integration pathways and understand priorities, timing, and potential roadblocks.

The timing of external opportunities played an important role in partners' ability to create change. In states or communities where certain systems-level changes were already in process, for instance revisions to QRIS or licensing regulations, partners took advantage of the opportunity to weave HEPA into existing change efforts. Given the complexity and time required to update QRIS standards and/or licensing regulations, leaders can only make significant headway when there is already momentum towards revision. This was also true when certain strategies (e.g. licensing) may have been politically sensitive and a non-starter in certain political climates.

Recommendation 3: Be strategic about convening and using a stakeholder group and maintaining relationships with key individuals and organizations.

Convening and using a stakeholder group—whether tapping into an existing group or forming a new one—can serve important purposes, including enhancing buy-in, understanding stakeholders' priorities, aligning efforts, highlighting potential roadblocks, and identifying cross-sector opportunities for integration. Convene a stakeholder group and maintain strong relationships outside of the stakeholder group. Given at times slow pace of change and turnover in staff positions, it is possible for integration planning to hit roadblocks. Focus on relationship building because work may not sustain if and when key individuals or change-leaders leave an organization.

Recommendation 4: Manage planning, expectations of stakeholders, and communication with providers with respect to the pace of change.

The at-times slow pace of change, particularly related to QRIS and licensing regulations, proved challenging for partners. To the extent possible, manage expectations with stakeholders and providers about the pace of change, and plan accordingly for delays in development or implementation of updated systems. Acknowledge with stakeholders that many integration activities are ongoing and take time. Stakeholders should remain advocates for change throughout the process, and in particular, when there are changes in leadership or staff that may require a 're-start' on aspects of integration pathways. In other cases, it might be necessary need to wait for the right timing, buy-in, or funding to address particular integration activities. Be aware of those factors from the beginning and plan accordingly.

Recommendation 5: Determine from the onset where change takes place and put the appropriate resources and people in place to support the effort.

When planning integration activities, determine which stakeholder(s) is in the best position to lead the work. The type of organization may help or hinder integration activities. For example, in some cases a state agency may be the best fit given administrative oversight of key systems, whereas in other instances a private stakeholder may be better suited to advocate for change needed within a state agency. This ties back to the importance of having a dedicated stakeholder group that can identify the best champion(s) for integration activities and having the right people/agencies at the table to support change. Regardless of where changes is taking place within the system, have a person focused on policy change and navigating the 'pre-work' to ensure proper procedures and timelines are followed.

Looking Ahead—A Continued Focus on Integration

By using the case studies to understand and learn from the unique journey of states and communities in the National ECELC project, others interested in implementing the National ECELC model or a similar initiative can establish an integration pathway from the onset. Case studies share real-life examples of integration activities. While state infrastructure, stakeholders, funding, priorities, and context differ from state to state, themes emerging from case studies help to paint a picture of how to successfully integrate HEPA into systems. Case studies showcase that variety and highlight the pathways partners traveled as they worked to integrate HEPA into their ECE systems.

Integration activities are evolving and ongoing, and thus, the National ECELC case study reports will be updated in the future to reflect new ideas, activities, and accomplishments. There is opportunity for continued learning and improvements in system building for National ECELC partners as they reflect on their own journey and the journeys of their peers.

National ECELC

Launched fall 2012, the National Early Care and Education Learning Collaborative (ECELC) is a six-year, Centers for Disease Control and Prevention (CDC)-funded effort, implemented by Nemours and partners. ECELC was designed to spread impactful, sustainable policy and practice improvements in the early care and education (ECE) setting with respect to nutrition, breastfeeding support, physical activity, and screen time in order to prevent childhood obesity.

The ECELC project partners with organizations in states and communities to 1) provide an intensive ‘learning collaboratives’ obesity prevention intervention to groups of center and home-based ECE providers (child care, Head Start, pre-kindergarten), and 2) better integrate national obesity prevention standards¹ and implementation support for these standards into components of state and local ECE systems.

As of July 2017, 8 states (Alabama, Arizona, Indiana, Kansas, Kentucky, Missouri, Virginia, and New Jersey) and 4 communities (North/Central Florida, South Florida, Los Angeles County California, Contra Costa County California) have participated in the National ECELC. The intervention⁶ typically consists of 5 in-person learning sessions spread over a 10-month period, ongoing technical assistance for participating ECE providers, and access to tools, materials and resources.

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Source: Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of Childhood and Adult Obesity in the United States, 2011-2012. JAMA. 2014;311(8):806-814.

Integrating Obesity Prevention into State ECE System Components Using CDC’s Framework

Through this project, partners worked intentionally to understand the extent to which support for standards has been integrated into components of their ECE system. Assisted by technical assistance from Nemours, partners used the CDC’s ‘Spectrum of Opportunities for Obesity Prevention in the ECE Setting’ as a framework to identify gaps and opportunities for further integration and, working with broad internal stakeholder groups, select and pursue integration action steps. Integration efforts spread awareness of standards and build upon the main objectives of ECELC—increase number of programs meeting these standards, and increase the proportion of young children in programs that meet these standards.

Many factors influence how and when integration of best practice support into ECE system can be achieved. Standards and implementation support for these standards can be successfully integrated into the various components of an ECE system. This case study series explores the integration opportunities pursued by each state, the outcomes of these efforts, and factors that may have hindered or enhanced their success. The uniqueness of each state or local ECE system (e.g., licensing, Quality Rating and Improvement Systems (QRIS), stakeholder groups) is described as an important factor for integration success.

CDC Spectrum of Opportunities

CDC’s *Spectrum of Opportunities* framework (Figure 1; the Spectrum) identifies several ways that states, and to some extent communities, can support ECE programs in their abilities to achieve recommended standards and best practices for obesity prevention.⁷ Many states implement a coordinated approach to integration, drawing from multiple opportunities to reach providers. The avenues chosen by states and communities for integration efforts may depend on resources, costs, partnerships, stakeholder support, as well as provider needs.

National Efforts and Factors for Integration

In addition to factors at the state level (e.g., licensing, QRIS, professional development systems), states' and communities' ability to achieve integration of childhood obesity prevention components within ECE systems is often influenced by national policy, funding, and initiatives. Examples of such factors are listed below. While there is some direct overlap with the *Spectrum of Opportunities* (e.g., CACFP), these factors are generally broader than the avenues illustrated in the Spectrum and may impact multiple feathers or different feathers for each state. The major federal funding streams/initiatives that follow are consistent across all states and serve as the backdrop for state ECE systems. State case study reports describe how these funding streams/initiatives are leveraged in a variety of ways (alongside state resources) to achieve integration activities across the Spectrum.

Child and Adult Care Food Program (CACFP)⁸—

CACFP is a federal program that provides funding reimbursement for meals and snacks served to low-income children in ECE settings. Participating ECE programs follow CACFP standards regarding meal patterns and portions. Many states provide training or technical assistance to ECE providers related to CACFP, and some use CACFP as a guide for licensing regulations, QRIS standards, or other state-based programs. In early 2016 CACFP standards were revised, providing an opportunity and increased need for training and supports from states to ECE providers on implementation of nutrition best practices.

Child Care and Development Fund (CCDF)⁹—CCDF funding to states supports subsidized child care services, and also includes a portion of funding which must be used to improve the quality of care in ECE settings. The minimum amount of funding which states must use to support quality activities was increased as part of the 2014 reauthorization of the Child Care and Development Block Grant (CCDBG). Quality funds may support professional development, training, grants, or programs to providers, along with systemic improvements to enhance the quality of care for young children. Children's health and wellness may be a central focus of CCDF-funded efforts in states.

State Public Health Actions—1305¹⁰: CDC supports efforts nationwide to reduce the risk factors associated with childhood and adult obesity, diabetes, heart disease, and stroke. Through a federal grant (1305), all 50 states and the District of Columbia receive funds to help prevent these chronic diseases. 1305 focuses on healthy environments in workplaces, schools, early childhood education facilities, and in the community. This program also focuses on working through health systems and communities to reduce complications from multiple chronic diseases such as diabetes, heart disease, and stroke. The goal is to make healthy living easier for all Americans. Recently, CDC added a new 1305 requirement for states around physical activity in ECE settings. Since all states receive 1305 funding (basic and/or enhanced) and are required to set goals and performance measures, the new requirement forced state health departments to develop strategies for ECE providers.



Figure 2: CDC Spectrum of Opportunities.

Kentucky

Implementation Partner: Kentucky Department for Public Health, Obesity Prevention Branch

Case Study

Participation in National ECELC: 2014-2016

ECE programs trained¹¹: 154

Children served by trained programs: 14,367

Spectrum of Opportunities areas of focus:

- **Licensing & Administrative Regulations** – Collaborated with stakeholders to develop best practice recommendations for updates to licensing regulations, and continue to provide support for enhancing licensing regulations to include a focus on HEPA topics.
- **Pre-Service & Professional Development** – Developed four online modules to increase ECE providers' access to professional development on HEPA topics, and planned for the creation of a technical assistance package to enhance trainers across the state in their ability to support providers to implement HEPA practices.
- **Family Engagement** – Developed a train the trainer course for ECE credentialed trainers to support their ability to deliver a 2-hour 5-2-1-0 training to ECE providers and families, and included the course in the state's *5-2-1-0 Toolkit: Resources to Support Healthy Behaviors*

Setting the Stage

Nemours identified Kentucky as a state implementation partner in 2014 as part of the second group of states in the National ECELC. Kentucky was one of three new states selected to join the ECELC project alongside the six already participating. The state was chosen through a competitive process based on high rates of childhood overweight and obesity in the state, capacity to support learning collaboratives, and potential for sustainability efforts in ECE and child health systems. Nemours saw an opportunity to leverage current work and partnerships in Kentucky to expand the National ECELC model to impact additional programs, providers, and children.

Did you know?

In Kentucky, among low-income children aged 2 to 5 years old, nearly 16% are overweight and 15.6% are obese

Source: CDC. Division of Nutrition, Physical Activity, and Obesity. 2010 Pediatric Nutrition Surveillance System, Table 6 (PedNSS).

State Efforts Addressing Childhood Obesity

In 2012, through a CDC Communities Putting Prevention to Work (CPPW) grant, Kentucky stakeholders came together to launch a 5-2-1-0 public information campaign. The campaign encourages parents to adopt obesity prevention strategies for children. The Kentucky Department for Public Health, Kentucky Chapter of the American Academy of Pediatrics, Foundation for a Healthy Kentucky, and State Legislative Task Force on Childhood Obesity helped to establish the campaign. The campaign is centered on four key principles; eat 5 or more servings of fruits and vegetables each day, limit screen time to no more than 2 hours a day, get 1 or more hours of physical activity a day, and drink 0 sugar-sweetened beverages. Community-based organizations (e.g., child care, libraries, clinics, schools) can access a “5-2-1-0 Toolkit” and download posters, brochures, and pamphlets to share with parents. This campaign is evidence-based, built on stakeholder feedback, modeled after other states' successful implementation and a key feature of KY's childhood obesity prevention efforts.

The Partnership for Fit Kentucky (PFK), a collaborative group of public and private stakeholders, has also played a central role in shaping the obesity prevention vision in Kentucky. PFK was historically focused on worksite wellness, schools, and access to healthy foods and physical activity. Then, in 2010, PFK recognized the importance of focusing on young children and expanded its scope to include early care and education. An Early Care and Education Workgroup was formed that quickly recognized a need for change and developed Kentucky's *Call to Action for Preventing Obesity in Early Care and Education*¹², to provide a roadmap for KY's work.

State Efforts to Improve Early Care and Education

In 2013, Kentucky revised its early learning standards, *Building a Strong Foundation for School Success, Kentucky's Early Childhood Standards*³³, and the updates included physical development through gross motor and fine motor skills. Children's health and wellbeing are an essential component to school readiness in Kentucky, and the state's early learning standards include a focus on nutrition and physical activity (e.g., "the ability to describe how diet, exercise, and rest affect the body"). Kentucky's ECE training system aligns provider training and technical assistance to the standards for a coordinated strategy to support providers' improvements.

Additionally, the call to action described above led PFK and the Kentucky Department for Health to develop a resource, *Kentucky's Vision for Early Care and Education*¹⁴, to ensure all children have access to healthy environments in ECE settings. The resource was in development as KY DPH began partnering with Nemours, and provided an opportunity for KY DPH to think about integration efforts – aligned with state priorities – while implementing learning collaboratives. Released in late 2014, the vision document aligns with and builds on the call to action and highlights three key strategies: extensive training and technical assistance, family engagement, and consistent state-level policies. This document drives sustainability efforts in the state, helping to ensure coordinated practices, policies, and messaging among stakeholders and providers.

Establishing a Path to Success— A Plan for Integration

The integration of healthy eating and physical activity (HEPA) best practices into statewide ECE systems was a focus of Kentucky's participation in the National ECELC project as soon as it joined the initiative. At the same time as running learning collaboratives both Nemours and KY DPH staff were focused on identifying areas of opportunity for integration. KY DPH looked to leverage the work currently taking place to integrate obesity prevention components and build supports for providers. While KY DPH has worked in multiple areas of the CDC Spectrum of Opportunity, the focus has been predominately in three areas.

1. Integrate HEPA into **licensing regulations**.
2. Utilize 1305 funding to finance the enhancement of **professional development** through the development of online modules.
3. Expand **family engagement** opportunities focused on 5-2-1-0 messages.

Timeline

2010

- PFK expands scope to include Early Care and Education Workgroup, and workgroup issues call to action with best practices and strategies to prevent childhood obesity

2012

- 5-2-1-0 campaign launched

2013

- Release of revised Kentucky Childhood Learning Standards, including focus on nutrition and physical activity

2014

- Kentucky selected to join National ECELC project and cohort 1 launched
- KY DPH and PFK release *Kentucky's Vision for Early Care and Education*
- Process began to revise licensing regulations

2015

- Release of *5-2-1-0 Toolkit: Resources to Support Healthy Behaviors*

2016

- 5-2-1-0 online training module released
- Stakeholders await revised licensing regulations
- Healthy eating online training module released



Figure 3: State Areas of Focus within the CDC Spectrum of Opportunities

These three areas align with the core strategies identified in *Kentucky's Vision for Early Care and Education* (extensive training and technical assistance, family engagement, and consistent policies). Kentucky stakeholders weighed in significantly through the PFK ECE Committee and in the development of the vision document, and KY DPH aligned with that momentum to help realize the state's goals.

Integration Activities

LICENSING

In 2014, when Kentucky was planning its integration activities, the opportunity arose to recommend changes to the state's child care licensing regulations and KY DPH knew this was a significant opportunity to embed stronger regulations related to healthy environments. Kentucky's licensing regulations already required ECE programs to follow Child and Adult Care Food Program (CACFP) meal patterns (regardless of participation in CACFP) and to limit screen time for children. Stakeholders largely viewed these regulations as insufficient, and KY DPH was active in promoting the inclusion of HEPA best practices into the revised regulations. Over the course of the last two years the Division of Child Care has been in the process of revising child care licensing regulations in Kentucky.

A state Child Care Regulations Committee (CCRC) was formed in 2014 to oversee revisions to the licensing regulations, and the committee sought input from stakeholders. In February 2015, the PFK ECE Committee convened to brainstorm recommendations related to physical activity, menus, and breastfeeding. Then, in June 2015, KY DPH convened stakeholders to brainstorm a "wish list" that was submitted to the CCRC and included suggested regulations related to infant feeding, screen time, and reducing and eliminating juice. Kentucky's state project coordinator for the National ECELC project also joined the CCRC at a monthly meeting to share information about input received from ECELC leadership team members regarding regulations and local implementation.

As of December 2016 the revised regulations are pending, and stakeholders await the opportunity to comment on the proposed regulations.

PRE-SERVICE & PROFESSIONAL DEVELOPMENT

In Kentucky, there is a significant lack of health training available to ECE providers through licensing, QRIS and the professional development system. Kentucky has 14 child care health consultants housed within local health departments that are available to ECE programs, though many staff are part time and may spend substantial hours working outside of ECE. When working with ECE providers, much time is spent addressing licensing violations. With health consultants focused mostly on consultation and less on training, the need for widely accessible training has become more evident. Additionally, a review of data from the state's Early Care and Education Training Records Information System showed little training offered in HEPA areas, and KY DPH heard feedback from ECELC participants, regional trainers and child care health consultants about the need for training on these topics. The high need for trainings and the geographic disparity of Kentucky led KY DPH to consider the development of online training modules. Preliminary brainstorming about the development of online modules began in fall 2015.

According to a recent report, *Achieving a State of Healthy Weight 2015 Supplement: State Profiles*, in 2013 Kentucky was implementing licensing regulations that fully aligned with only 3 of 47 healthy weight practices in child care centers and family child care home, as defined by *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd Ed. (CFOC3)*. The three practices include:

- Hold infants while bottle feeding; Position an infant for bottle feeding in the caregiver/teacher's arms or sitting up on the lap
- Use only 100% juice with no added sweeteners
- Serve small-sized, age-appropriate portions

Source: National Resource Center for Health and Safety in Child Care and Early Education. 2016. *Achieving a state of healthy weight 2015 Supplement: State Profiles*. Aurora, CO: University of Colorado Denver.

With 1305 funding, KY DPH is developing four, 2-hour, online modules for use with participants in the National ECELC project. The modules will also be available to all Kentucky ECE providers who are interested in accessing professional development on healthy eating and physical activity. Providers will be able to access the online trainings through the University of Kentucky Human Resources Development Institute platform. Each of the four modules will have a unique focus on creating healthy environments in ECE settings: healthy eating, physical activity, family engagement, and staff wellness.

The online modules—while largely reflective of the content in the National ECELC curriculum—are being customized to reflect Kentucky-specific information. For example, highlights about 5-2-1-0, and drawing connections to Kentucky’s licensing regulations and early learning standards. Video clips from Kentucky providers provide real-life examples of community providers working to implement best practices.

The online modules will be integrated into the third round of learning collaboratives implemented in Kentucky in 2016 – 2017 to create training efficiencies. Participants will complete a module prior to attending an in-person learning session. This strategy will ensure participants come to learning sessions with preliminary content knowledge. The in-person learning sessions will then be used as time to recap knowledge and go into greater depth on the content and learning activities, including action planning. Providers that are not ECELC participants may access the modules for a \$5 fee that supports verification of information and the awarding of professional development hours.

Additionally, a technical assistance (TA) package is in development for each module, and the TA package will be available to all licensing, QRIS, CACFP and professional development trainers in the state. KY DPH identified this as an important strategy, as some trainers may be highly knowledgeable in a particular content area but may not have significant experience working with ECE providers or in a variety of ECE settings. There are also currently 15 independent specialty trainers in Kentucky that are able to train on topics related to HEPA ranging from breastfeeding to music and movement, and this TA package will help those trainers and others deepen their content knowledge across multiple areas.

The first module (healthy eating) was finalized in October 2016, and it is expected that the remaining modules and TA package will be complete in late 2016 and early 2017 (by March 2017). In 2017, 1305 funding will also support the development of a standalone module on family style dining, and the state’s WIC team also plans to develop a breastfeeding module.

FAMILY ENGAGEMENT

The 5-2-1-0 campaign has been a cornerstone in the state and ECE providers’ efforts to engage families around early childhood health and wellness. In early 2015, the *5-2-1-0 Toolkit: Resources to Support Healthy Behaviors*¹⁵ was released to child serving agencies and programs (e.g. home visiting, early intervention, child care, public preschool, Head Start). The toolkit includes brochures, coloring pages and an activity ring, as well as a monthly calendar, and screen time and fruit/vegetable logs. Early childhood professionals can access the materials for use with families.

In summer 2015, with 1305 funds, KY DPH developed a train the trainer course for ECE credentialed trainers to support their ability to deliver a 2-hour 5-2-1-0 training to ECE providers and families. The train the trainer was developed, in part, to help trainers who may not have backgrounds in health to become comfortable delivering the content. Trainers were educated on the basic content and were provided with guidance about how to respond to questions from ECE providers. Trainers were also supported in their ability to guide ECE providers through completion of the *Let’s Move! Child Care* self-assessment and brief action planning. Handouts for a 2-hour presentation for delivery by credentialed trainers and materials for a 20-minute presentation geared for community leaders are both included in the 5-2-1-0 toolkit. Recognizing the significant

Factors for Success in Kentucky

- Strong stakeholder engagement and established relationships with public and private partners to advance obesity prevention efforts
- Statewide vision for early childhood obesity prevention
- Clear knowledge at the state level of the types of supports needed by ECE providers
- Availability of funding to put integration plans into action
- The timing of revisions to state standards and regulations

need for online trainings, KY DPH also developed a 5-2-1-0 online training module for providers on how to use 5-2-1-0 with parents. The module was released in June 2016 and is now part of the toolkit.

Finally, once Kentucky’s licensing regulations are revised, the state’s “Orientation to Child Care” (pre-service professional development) materials will be updated to include 5-2-1-0. All ECE professionals are required to obtain 6 hours of training within the first 60 days of employment. This strategy will help to embed principles of healthy environment trainings into the core of ECE providers’ training experiences.

Challenges to Integration

Initially, KY DPH hoped to integrate more HEPA content into their state-wide QRIS. In 2014, the Governor’s Office of Early Childhood oversaw the development of a new set of QRIS standards. Kentucky’s state project coordinator participated on the workgroup for the Governor’s Office development of the ALL STARS standards and helped to provide stakeholder input and a recommended list of HEPA best practices for inclusion. In fall 2014, those recommendations did not get included in the first set of standards. A pilot of ALL STARS was conducted in early 2015 and concluded in July 2015. Spring 2016 provided another opportunity for KY DPH and stakeholders to share recommendations with the Governor’s Office of Early Childhood, and the Department submitted a list of recommended assessments to support ECE providers’ efforts providing healthy environments for children. While the assessments were included in the next set of standards revisions, they were removed from the final version that was released to the field in July 2016. There are no health indicators included in Kentucky’s new ALL STARS standards.

During the course of the development of ALL STARS standards, state leadership in Kentucky experienced significant turnover of staff, including both the Director of the Division of Child Care and the Director of the Governor’s Office of Early Childhood. With the turnover of staff, changing priorities, and the need to build new relationships, there was a change in momentum. In addition, federal monitoring of Kentucky’s Race to the Top – Early Learning Challenge grant (which funds ALL STARS) showed a slower than predicted pace of implementation. These factors may have impacted the final outcome of KY DPH’s efforts to support the inclusion of HEPA best practices in the ALL STARS standards. KY DPH will continue to work with ECE stakeholders to leverage QRIS and develop strategies to promote best practices outside of the system.

Similarly, with new political appointees continuing to be placed in leadership positions and turnover in staff positions there were also challenges in getting some of KY DPH and stakeholders’ newer ideas for integration activities off the ground. KY DPH convened stakeholders to consider implementing a HEPA recognition program for ECE providers. While there was enthusiasm, the group was challenged by the need to identify where the program would sit within the state system and had difficulty envisioning who would oversee its development and implementation. The issue of ownership was coupled with dovetailing discussions related to staff wellness, and KY DPH and stakeholders decided to refocus efforts on the integration activities detailed above.

Kentucky undertook a strategy with its integration activities to target high need areas (online trainings), while leveraging the momentum from a statewide campaign (5-2-1-0 family engagement) and taking advantage of the timing of revisions to licensing regulations. Some of the more complex topics that continue to arise within stakeholder groups—in particular, staff wellness—remain at the forefront of ongoing discussions about how to support ECE programs’ ability to support the healthy development of young children within the context of an evolving state system.

Lessons Learned

It is important to have not only the right organizations, but also the right individuals from those organizations, at the table to plan sustainability and integration activities. Despite stakeholders’ recommendations for QRIS standards not being included in the revised system, the value of planning and partnership was not lost. To maintain momentum, communicative and collaborative stakeholders must continue to convene and explore strategies for integration.

It may not be possible to address all the Spectrum of Opportunities areas at once. By identifying and prioritizing opportunities for integration, some of the greatest needs will begin to be met. In Kentucky, the need for quality,

HEPA-related training, has been evident for years. It was a recurring need across stakeholder groups, and when KY DPH had the opportunity to leverage 1305 funding to develop online modules it was a natural fit for what was achievable for the state and best for ECE providers.

Keeping tabs on the needs that continue to resurface will help stakeholders build upon early successes to achieve greater integration over time. For example, Kentucky struggles with very high rates of adult obesity with the and ECE providers' staff wellness has come up multiple times as a factor – and in some cases, a barrier – to supporting the health and wellness of young children in ECE programs. All staff, and in particular staff who prepare food, may need training. Many ECE program kitchens are in poor shape; lacking storage, equipment and training for individuals preparing food. Currently, there are not nutrition hours available to staff serving in this role. The gap has been identified but the state hasn't yet figured out how to address the issue. Learning from the development of online modules may help the state determine a way to leverage this training strategy to further support staff wellness. This may also provide opportunity for revising a staff recognition program.

Glossary of Key Terms

1. ***5-2-1-0 campaign*** – Launched in 2012 through support from multiple state stakeholders, the campaign encourages parents to adopt obesity prevention strategies for children.
2. ***Building a Strong Foundation for School Success, Kentucky's Early Childhood Standards*** – Kentucky's early learning standards.
3. ***Child Care Regulations Committee*** – Formed in 2014, under the Division of Child Care, to oversee revisions to the licensing regulations.
4. ***Kentucky's Call to Action for Preventing Obesity in Early Care and Education*** – A call to action to ECE providers and stakeholders outlining guidance and strategies for childhood obesity prevention.
5. ***Kentucky Department for Health (KY DPH)*** – State implementation partner for National ECELC project, and key stakeholder in Kentucky's ECE childhood obesity prevention efforts.
6. ***Kentucky's Vision for Early Care and Education*** – Building upon the call to action, this document presents a comprehensive vision for ECE obesity prevention strategies, and provides data, best practice guidance to create healthy environments.
7. ***Partnership for Fit Kentucky (PFK)*** – Group of public and private stakeholders focused on obesity prevention vision in Kentucky, and contains an Early Care and Education Workgroup.

REFERENCES FOR: *National Early Care and Education Learning Collaboratives (ECELC) Integration of Childhood Obesity Prevention into State/Local ECE Systems*

1. Aligned with the Preventing Childhood Obesity (2nd ed.) standards (CFOC3/PCO), included in *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, (3rd ed.).
2. Case studies were written for Arizona, North/Central Florida, South Florida, Indiana, Kansas, Kentucky, Missouri, Virginia, and New Jersey. For the purpose of the summary, there are 10 states/regions highlighted which include Los Angeles, CA. Alabama is in the preliminary stages of integrating HEPA in to its state system and thus not included in this report. Contra Costa, CA did not include integration work in their ECELC activities.
3. In Virginia, the state partner's activities fall primarily into the Pre-Service and Professional Development area of the Spectrum.
4. Help Me Grow is a national initiative that helps to identify children at-risk for developmental or behavioral disabilities and connects children and families with community-based programs for health-related services. In South Florida, Help Me Grow is administered by Switchboard Miami.
5. Other states' strategies included a focus on technical assistance (TA) as part of other change strategies. For example, TA offered as part of a new initiative or to accompany trainings or use of toolkits.
6. Aligned with the Preventing Childhood Obesity (2nd ed.) standards (CFOC3/PCvO), included in *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, (3rd ed.).
7. The avenues for change illustrated in the Spectrum are described in detail in the Spectrum of Opportunities document, available on the CDC's website - https://www.cdc.gov/obesity/downloads/spectrum-of-opportunities-for-obesity-prevention-in-early-care-and-education-setting_tabriefing.pdf
8. <http://www.fns.usda.gov/cacfp/child-and-adult-care-food-program>
9. <http://www.acf.hhs.gov/occ/fact-sheet-occ>
10. <http://www.cdc.gov/chronicdisease/about/state-public-health-actions.htm>
11. This number includes only programs that fully completed the intervention and completed sufficient baseline and post assessment materials to be included in evaluation activities.
12. <http://fitky.wordpress.cdpehs.com/wp-content/uploads/sites/2/2014/09/ECE-Call-to-Action.pdf>
13. <http://kidsnow.ky.gov/School%20Readiness/Documents/Kentucky%20Early%20Childhood%20Standards.pdf>
14. <http://www.fitky.org/wp-content/uploads/sites/2/2015/05/ECE-Vision-Doc-Final-Approved.pdf>
15. <http://chfs.ky.gov/dph/mch/hp/5210/>

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