

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

Missouri 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
Rebekah Duchette, Kentucky Cabinet for Health & Family Services
Juliet Jones & Peri Nearon, New Jersey Department of Health
Emily Keenum & Kathy Glazer, Virginia Early Childhood Foundation

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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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.

Missouri

Implementation Partner: Child Care Aware of Missouri

Case Study

Participation in National ECELC: 2013-2017

ECE programs trained¹¹: 216

Children served by trained programs: 18,613

Spectrum of Opportunities areas of focus:

- **Child and Adult Care Food Program (CACFP)** – Aligned the ECELC curriculum with the *Eat Smart/MOve Smart* program and branding, which helped expand those programs' reach and certification throughout the state.
- **Licensing and Administrative Regulations** – Partnered with state stakeholders to plan to align licensing regulations with best practice standards for nutrition, physical activity and screen limitation.
- **Pre-service and Professional Development** – Offered ECELC participants opportunities to continue to access professional development and technical assistance to continue program improvements after the conclusion of the ECELC project, and leveraged funding to offer I Am Moving, I Am Learning training to additional providers throughout the state.

Setting the Stage

Nemours identified Child Care Aware of Missouri (CCAMO) as a state implementation partner in 2013 during the development of the National ECELC proposal to the Centers for Disease Control and Prevention (CDC). Missouri had high preschool overweight and obesity rates, large numbers of early care and education (ECE) programs, urban and rural regions, and a statewide program aimed at improving nutrition and physical activity in ECE settings. Missouri has had a variety of contextual factors which have impacted integration of healthy eating and physical activity (HEPA) best practices into ECE settings.

Did you know?

In Missouri, among low-income children aged 2 years to 5 years old, 16.2% are overweight and 13.6% are obese.

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

State Efforts Addressing Childhood Obesity

Introduced in 2010, Missouri *Eat Smart* was developed to address the eating habits of young children in child care settings. Led by the Department of Health and Senior Services (DHSS) and initially funded by a USDA Team Nutrition grant, Missouri developed nutrition guidelines. The guidelines are divided into three levels: minimum, intermediate, and advanced. The minimum level is the same as the Missouri State Licensing requirements. The guidelines are meant to be simple and realistic for both centers and family child care homes to implement. DHSS staff have provided outreach and support to help programs achieve recognition at the higher levels but have primarily focused on centers participating in CACFP.

All licensed child care facilities must at least meet the minimum level while programs that reach intermediate and advanced levels are eligible for recognition as an *Eat Smart* program. The guidelines are disseminated to ECE programs through training and technical assistance which has been provided by nurse consultants with the local county health departments and through the University of Missouri Cooperative Extension. To be certified as *Eat Smart*, programs submit an application with copies of their menus, nutrition policies, recipes and food labels. The application is followed up with an in-person visit by DHSS staff to verify the nutrition and food programming reported. Once verified, the program receives their *Eat Smart* recognition which includes a certificate, window clings, and a listing on the DHSS website. The recognition is valid for one year with the possibility of renewal.

In 2013, this effort was expanded with the introduction of *MOve Smart*, which provides physical activities guidelines and tools to address physical activity habits of children in child care. *MOve Smart* includes two levels: Intermediate and Advanced and the guidelines align with Missouri Licensing Rules for Child Care. Similar to *Eat Smart*, *MOveSmart* requires programs to submit their policies, weekly schedules, equipment checklist, photos, and list of physical activity trainings completed by staff. *Eat Smart* is the only certification that requires an on-site visit. *MOve Smart* and Breastfeeding Friendly Child Care (described below) only require written applications, documentation and/or photos to request certification. There are more than 2,500 centers and family child care homes participating in CACFP in the state, but only about 4-5% have been recognized as an *Eat Smart* or *MOve Smart* program. DHSS suspects the low uptake may be challenged by a few reasons, including: the certifications not being advertised widely, *Eat Smart* / *MOve Smart* leadership has changed and lost some momentum, and there is limited TA available for programs. The biggest factor, though, is the lack of incentives for ECE programs to pursue the certification. Besides helping children's health and development, the main incentive is to use certification as a marketing tool.

DHSS also added a Breastfeeding Friendly Child Care Facility certification in 2014 to improve support for breastfeeding women as they return to work. To receive the certification, child care programs complete an application and provide supporting documentation, including facility policies and photos. Programs aim to meet five criteria including having a written policy supporting breastfeeding families, provide a welcoming environment for breastfeeding mothers, offer resources to parents, feed infants on demand and communicate with moms about feeding preferences; and, train staff to support parents. Similar to *Eat Smart* / *MOve Smart* recognition, successful programs receive a certificate, window cling and recognition on the DHSS website. However, unlike *Eat Smart* there is no in-person visit to verify the application. To date, about 60 ECE programs serving approximately 3,500 children have been certified as Breastfeeding Friendly facilities.

In addition to the DHSS-led efforts, Missouri has an active stakeholders group known as The Missouri Council for Activity and Nutrition (MOCAN). This is a coalition of representatives from statewide and local agencies, institutions, organizations, and individuals who work together to advance the goals and objectives of the statewide plan, *Preventing Obesity and Other Chronic Diseases: Missouri's Nutrition and Physical Activity Plan*. The MOCAN Early Childhood Working Group focuses on advancing healthy eating and active living policies and environmental change in early care and education. Jessica Rose, Director of Wellness Initiatives with Child Care Aware of Missouri, sits on the MOCAN Child Care Working Group.

Another important partner has been the Missouri's Children's Services Commission (MCSC) Subcommittee on Childhood Obesity which was established in February 2014. The subcommittee was tasked with reviewing the issue of childhood obesity in Missouri and the evidence for effective prevention and treatment approaches; compiling recommendations for a comprehensive state approach and ultimately presenting recommendations to the Governor and General Assembly. In December 2014 the subcommittee put forward recommendations that included updating child care center and home licensing rules to align with the latest evidence on standards for feeding practices, nutrition, physical activity, and screen time limitations to prevent obesity and support long-term health. The recommendations emphasized the necessity of an engaged network of collaborating partners to provide training and support services to child care professionals to achieve full compliance with any newly adopted standards. Since the release of the Subcommittee report in 2014, Child Care Aware® of Missouri has been taking steps toward moving the recommendations forward with the support and guidance of other key partners including Children's Mercy Hospitals and Clinics in Kansas City, the University of Missouri (MU) Extension, Missouri YMCA Alliance, and the MOCAN Child Care Working Group.

Timeline

2010

- DHSS introduced *Eat Smart*

2013

- DHSS introduced *MOve Smart*
- National ECELC project began and cohort 1 launched

2014

- MCSC Subcommittee on Childhood Obesity established
- CCAMO began delivering IMIL training across the state (continuing through 2017)
- DHSS launched Breastfeeding Friendly Child Care Facility certification

2015

- CCAMO and partners launched Wellness Roundtables for Child Care

2016

- CCAMO secured funding for *stage 1* of the plan to improve licensing regulations

Lastly, in 2015 Missouri was selected by Child Care Aware of America to participate in the *Healthy Child Care, Healthy Communities* initiative through August 2017. Through this initiative, CCAMO receives support to implement systems-level change strategies that will have an impact on child health. As part of participation, Missouri stakeholders reviewed existing policies and practices related to obesity prevention in ECE settings and will work together to develop a plan to enhance healthy practices in child care settings. Child Care Aware also provided assistance to Missouri to integrate health-focused strategies within the state's 2016-2018 CCDF state plan.

State Efforts to Improve Early Care and Education

In 2013 when the ECELC was launched, Missouri was the only state in the U.S. with a statutory prohibition on quality rating systems (QRS) for child care. These systems aim to improve the quality of ECE settings through self-assessment, program improvement, financial incentives and ratings. Other states have adopted rating systems through administrative action, without passing new laws but this has not been successful in Missouri. The development of a QRS system has been politically contentious in the state for many years with anti-regulatory sentiments from both the child care community and elected officials. There was a perception such a system would impact a center's bottom line. Additionally, previous iterations of a QRS were developed without provider input and administrated in a top-down manner, leaving providers with a negative view of such programs.

However, thanks to committed advocacy efforts in Missouri, the ban on QRS systems was overturned in June 2016. Governor Nixon signed a new law which allows for the creation of a time limited, voluntary pilot program for center based, home based and exempt religious providers. During the next three years, the Missouri Head Start Collaboration Office and Missouri Department of Elementary and Secondary Education will work together to establish an early learning quality assurance report. Partners will be working on developing the ratings system and release a plan for the pilot by 2019.

Missouri has made investments in multiple early childhood initiatives, including Parents as Teachers (PAT), the Missouri Preschool Project, and, *Teacher Education And Compensation Helps* (T.E.A.C.H). PAT is an evidence based and nationally renowned home visiting program that helps parents develop skills to be their child's first teacher in the critical early years of life in order to enhance school readiness. The program also serves as a first point of detection of potential developments delays or other health programs. PAT was first developed in Missouri and is now available in all 50 states and other countries. However, state funding for PAT has been substantially reduced from \$34m in 2009 to \$17.5m most recently in FY16.¹²

Launched in 1998, the Missouri Preschool Program (MPP) is a competitive grant opportunity led by the Department of Elementary and Secondary education. Revenue for the Early Childhood Development, Education, and Care (ECDEC) Fund is generated by gaming and it supports MPP in addition to other early childhood services (PAT, First Steps, Head Start, child care assistance). MPP aims to create or expand high quality early care and education programs for children who are one or two years from kindergarten eligibility. The program provides up to \$50,000 in startup funds in the first year, along with \$4,000 - \$4,500 per student. Grantees are eligible for renewal funding after the second year.¹³ The program is unique in that it requires grantees to set aside 10 percent of their grant funding to support the professional development of those licensed child care programs within the school district that did not receive MPP funding. Public school districts, government agencies, private preschool, Head Start, YMCA, United Way, other licensed child care programs, family child care group homes and religious entities are not eligible. Fluctuation in ECDEC revenue continues to create funding uncertainties for programs as Missouri operates under legislation requiring a balanced budget. The goal of MPP is to eventually provide preschool access to all families throughout the state regardless of income; however, MPP currently serves only 4% of 4-year-olds and 1% of 3-year-olds.¹⁴

To develop a quality early childhood workforce, the state also launched T.E.A.C.H. Missouri in 2000. T.E.A.C.H. is a scholarship and compensation opportunity designed specifically for early childhood professionals working at least 30 hours or more a week in a licensed program with children under five years old. The program allows child care professionals to earn up to 15 college credit hours a year towards a degree in early childhood education. The scholarship links education, compensation and commitment to improving the quality of early childhood care and education programs for young children.¹⁵ To date, T.E.A.C.H. provided more than 3,500 scholarships to ECE professionals in the state.

Establishing a Path to Success—A Plan for Integration

CCAMO has a long history of providing child care training across the state, but managing healthy eating and physical activity learning collaboratives was their first entry into childhood obesity prevention. As a new player in the child wellness space, CCAMO had to develop partnerships and build trust with state agencies and organizations to run successful collaboratives but also to work on integrating obesity prevention into early childhood systems statewide. Given limited funding for this type of work, some partners were initially concerned CCAMO would be competing for funding. However, due to the success of the collaboratives over the last four years and increasing provider demand for this type of training, CCAMO has been able to build a robust child wellness portfolio. They have also increased their leadership in childhood obesity prevention initiatives in the state.

The growth of CCAMO’s child wellness portfolio coincided with the spread and scale of the ECELC project in the state. As CCAMO became more proficient in implementing learning collaboratives, they were increasingly seen as a trusted resource on healthy eating and physical activity. They also took on leadership roles in statewide coalitions, such as the Child Care Working Group for the MOCAN and the MCSC subcommittee on childhood obesity. CCAMO built upon their expertise in training and technical assistance (TA), established relationships with ECE providers, and successful collaborations with state agencies and stakeholders, to integrate and expand HEPA best practices in three areas.

1. Supporting CACFP programs through alignment with Eat Smart/MOve Smart.
2. Updating child care center and home **licensing regulations** to align with latest evidence on standards for feeding practices, nutrition, physical activity and screen limitation.
3. Expanding **professional development**, training and networking opportunities for ECE providers around healthy eating, physical activity, breastfeeding, and screen time.

These goals enable CCAMO to continue strengthening their stakeholder relationships and leadership around HEPA in the state.



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

Integration Activities

CACFP

After the first project year, CCAMO aligned the ECELC learning curriculum, “*Taking Steps to Healthy Success*” (TSHS) with the *Eat Smart/MOve Smart* program and branding, which helped expand those programs’ reach and certification throughout the state. Through TSHS CCAMO provided ECE staff with strategies, resources, and TA that helped them to achieve improvements in their policies and practices. These improvements would also enable programs to meet *Eat Smart/MOve Smart* guidelines and achieve certification. CCAMO also helped DHSS promote their program and reach ECE sites across the state that may not have been able to participate in the effort due to the agency’s limited bandwidth and resources to provide TA. Staff from DHSS and Cooperative Extension have also presented at Learning Sessions to orient participating ECE staff on the nutrition, physical activity, and breastfeeding support programs and incentives for being certified. Connecting these initiatives was mutually beneficial to CCAMO and DHSS. ECE programs viewed TSHS learning collaboratives as part of a broader statewide effort, instead of duplicative.

By linking TSHS with *Eat Smart/MOve Smart*, CCAMO has been able to support ECE programs to achieve this recognition. Overall, two programs received *Eat Smart* recognition, 16 received *MOve Smart* and 10 received the breastfeeding friendly designation. Through this collaboration CCAMO also enhanced their relationship with DHSS. In 2014, CCAMO and DHSS won the *Governor’s Award for Efficiency*

and Innovation for their collaborative work. In October 2016, CCAMO launched their fourth round of collaboratives and will also explore opportunities to support DHSS in rolling out the new CACFP meal patterns and supporting ECE programs in meeting them.

LICENSING AND ADMINISTRATIVE REGULATIONS

Missouri child care licensing standards around health and wellness have not been updated in nearly 25 years. The CDC's 2013 report comparing the *Caring for our Children (CFOC)* recommended standards against Missouri's licensing rules and found that the state's licensing standards only fully satisfied five CFOC recommendations and partially met 13 of 44 standards. Beginning in 2014, CCAMO and stakeholders began exploring feasible changes to the child care licensing rules that could positively impact the health and development of thousands of Missouri's children in licensed child care. While stakeholders recognized that updating the licensing standards would be a long-term endeavor, all agreed that an inclusive, phased approach could increase the possibility of updated standards ultimately being adopted by Missouri legislators and accepted by providers.

In 2014, the MCSC launched a subcommittee on childhood obesity, which consisted of elected officials, academics, state department personnel and representatives of children services organizations. CCAMO is represented on the subcommittee by their Chief Executive Officer. MCSC is statutorily required to advise state laws and policies around issues that impact Missouri's children. The subcommittee was tasked with providing legislative and administrative recommendations to the MCSC by fall of 2014 with the intent of queuing up legislation for the 2015 legislative session. The subcommittee determined that the recommendations would include both treatment and prevention-focused solutions for childhood obesity, as well as focus on streamlining statewide prevention efforts.

Factors for Success in Missouri

- CCAMO's ability to build relationships with stakeholders to advance HEPA activities statewide
- Statewide coalitions committed to child obesity prevention efforts
- Established programs and branding (e.g., *Eat Smart* and *MOve Smart*) and opportunity for TSHS to align

In support of MCSC's recommendations, CCAMO and MOCAN developed a three stage approach to begin tackling the licensing process. Prior to launching the first stage, CCAMO partnered with the Public Health Law Center to conduct a landscape analysis of all policies impacting the standards, including gaps, barriers and synergies in Missouri's current child care policies. From 2015-2016, CCAMO and partners sought funding to advance each stage of their overall approach. By 2016, CCAMO had secured funding for Stage 1 to develop a stakeholder prioritization survey in partnership with the University of Missouri – Kansas City. The survey aimed to narrow the focus of the licensing review project by identifying the key gaps in current licensing rules most critical to 1) normal growth and development, 2) promoting and developing healthy behaviors, and 3) prevention of childhood obesity. The 39 standards unsatisfied by current licensing rules were also divided into nine categories: infant feeding methods, infant food plans, child food nutrition, beverage nutrition, nutrition environment, staff training, policies and environment for physical activity, screen time, and daily physical activity requirements. Stakeholders were asked to rank the standards within each category as well as rank the categories themselves in order of importance based on the above criteria. By December 2016, the survey had been issued and completed with a 45% response rate. Detailed findings will be available in early 2017 and directly inform the next stages of the approach.

The subsequent stages will focus on a survey of child care professionals, including program directors, administrators, and teachers in child care facilities (stage two) and focus groups/community meetings statewide to gather input from other constituent groups (stage three). Based on the findings from these efforts, CCAMO and MOCAN plan to develop an action plan to outline strategic steps to advance implementation of the standards including communication, legislative changes (if needed), rules changes, and a means to assure implementation of these standards by child care providers. While stakeholders have made progress in advancing their multi-staged approach, there have been challenges in fundraising. Given the statewide effort, each stage represents significant costs and funders have been reluctant to fund the entire effort. Therefore CCAMO has explored "budget braiding" where different but complementary funding sources are employed to complete the activities. CCAMO aims to complete these three stages which would then enable them to apply for funding to *VOICES for Healthy Kids* for a statewide campaign.

Most recently, newly elected Governor Greitens issued an executive order freezing all new and proposed business regulations and ordering a review of all existing regulations, including child care licensing rules. CCAMO and partners intend to proceed on licensing rule change as soon as an opportunity presents itself. Given that the Section for Child Care Regulation has until June 2018 to complete its review of existing rules, CCAMO will work with MOCAN and DHSS to identify next steps to maintain momentum. This may include identifying new ways to support *Eat Smart/MOve Smart* and Breastfeeding Friendly activities.

PRE-SERVICE AND PROFESSIONAL DEVELOPMENT

CCAMO has a long history in providing quality training and professional development opportunities for ECE staff. The organization's expansion into health and wellness was a natural fit since CCAMO had access to experienced trainers and is a trusted resource among ECE providers for training opportunities. CCAMO offers a wide range of clock-hour workshops and manages the overall training calendar for the state. This calendar includes all the required and non-required trainings approved for clock-hours by DHSS Section for Child Care Regulation. Before launching the first round of learning collaboratives, CCAMO ensured that the TSHS learning sessions and action period tasks were approved for clock hours and included on the statewide workshop calendar. CCAMO did have to modify the action period tasks by having trainers directly lead the tasks on-site at each participating ECE program versus other states where Center Directors can train their own staff. This was an important modification since clock-hours are an important incentive for ECE providers and helps keep them engaged throughout the 10 month collaborative.

In an effort to provide ECE programs with on-going support and resources after the collaboratives ended, CCAMO partnered with the DHSS, the YMCA Alliance, and the Missouri Foundation for Health to launch *Wellness Roundtables for Child Care* in 2015. The wellness roundtables provided information on improving nutrition and physical activity practices in ECE settings along with networking time for staff. The roundtables were open to past ECELC participants as well as any other interested ECE programs. Topics also included parent engagement and staff wellness practices in the child care setting. The events created opportunities for child care staff to support each other in implementing early childhood health and wellness best practices and disseminate new strategies and information.

In 2014, using USDA Team Nutrition funding DHSS contracted with CCAMO to deliver *I am Moving, I am Learning (IMIL)* trainings across the state for two years. This contract has enabled CCAMO Trainers to further advance the practices and policies around physical activity and healthy child care environments. These trainers were also active or past TSHS trainers which helped streamline messaging and strengthen connections with programs. The contract was renewed in 2016 with 1305 funding and CCAMO has provided eight seven-hour IMIL trainings and nine two-hour Moving and Learning trainings. CCAMO continues to explore further collaboration with DHSS including the possibility of expanding the learning collaboratives model to other regions of the state and/or with family child care providers.

Challenges to Integration

While CCAMO and partners have advanced their work around updating licensing regulations, long-term funding and political will for such changes continue to be a challenge. CCAMO reported that even when they have been able advance efforts, they then experience a setback, such as state agency staff turnover, disinterest, or insufficient funding. Most recently the transition to a new Governor's administration presents new uncertainties regarding social services, state agency leadership/appointees, and funding availability. Once new staff is appointed in partner agencies, CCAMO will have to start building their relationships again with key staff and garner support for HEPA in ECE settings. Nonetheless, CCAMO and partners are optimistic that the stakeholder and provider survey findings will help garner additional support for updated regulations.

Another barrier to integrating HEPA in broader ECE systems is a lack of dedicated funding. CCAMO and partners have submitted several proposals for funding the various stages of their licensing effort but there are limited funders interested in this work. The most significant private foundation is the Missouri Foundation for Health but they have been reluctant to fund the entire stakeholder and provider survey and engagement work for the licensing project. CCAMO was successful in securing funding from a regional foundation for the stakeholder survey and is exploring other funding options to complete the remaining stages. Ultimately they are aiming to work with VOICES for Healthy Kids on a statewide advocacy campaign.

As demonstrated by the licensing efforts, pursuing statewide systems change is a substantial undertaking. While CCAMO is committed to advancing statewide systems change, they are also pursuing regional opportunities which often present fewer political and regulatory barriers. CCAMO has collaborated with partners in St. Louis through the St. Louis City Department of Health’s *Healthy Eating Active Living Partnership*. Since 40% of all child care programs are located in St. Louis, it is critical for CCAMO to coordinate with local agencies and partners in this region.

Most recently, CCAMO is partnering with American Heart Association and Nemours on a newly funded initiative to engage 120 ECE providers in the St. Louis region to improve nutrition and physical activity in ECE programs. This \$3.9m, five-year effort will focus primarily on high need, underserved areas and support Child Care Specialists to intensively work with Center directors and staff to develop wellness policies and implement improved policies and practices around HEPA in their programs.

Lessons Learned

Implementing the ECELC has enabled CCAMO to directly contribute to improving healthy eating and physical activity in ECE programs across the state. At the same time, this provider level work has also increased their visibility, influence and leadership around child wellness in the state. *State committees are important for buy-in, attention to an issue (childhood obesity prevention) and relationships. However, their ability to influence change, raise/dedicate funds, or influence systems may be limited.* While the systems change activities require a substantial amount of time before successes are achieved, CCAMO has recognized the value of building these partnerships, contributing to strategic planning efforts, and continuously pursuing additional funding opportunities.

Similar to other states with an anti-regulatory climate, updating regulations can be a daunting task requiring creative solutions. Through their stakeholder groups, surveys, and focus groups, CCAMO and partners are investing in valuable activities that will prepare them with important information and voices from the field. CCAMO’s experience also emphasizes the importance of pursuing multiple strategies at once, including regional approaches and “budget braiding”. Given the declining investment in statewide early childhood programming in Missouri¹⁶, CCAMO will need to continue seeking funds from private foundations and companies to advance this work in the long-term.

Glossary of Key Terms

1. ***Child Care Aware of Missouri (CCAMO)*** – State implementation partner for the National ECELC project in Missouri.
2. ***Department of Health and Senior Services (DHSS)*** – State agency overseeing *Eat Smart* and *MOve Smart*, as well as key divisions such as CACFP and Child Care Licensing.
3. ***Missouri’s Children’s Services Commission (MCSC)*** – Stakeholder group consisting of elected officials, academics, state department personnel and representatives of children services organizations. MCSC is statutorily required to advise state laws and policies around issues that impact Missouri’s children.
4. ***Missouri Council for Activity and Nutrition (MOCAN)*** – Coalition of representatives from statewide and local agencies, institutions, organizations, and individuals who work together to advance the goals and objectives of the statewide plan, *Preventing Obesity and Other Chronic Diseases: Missouri’s Nutrition and Physical Activity Plan*. MOCAN includes an Early Childhood Working Group focused on advancing healthy eating and active living policies and environmental change in early care and education.

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://www.mobudget.org/wp-content/uploads/2015/10/Early-Education-Invest-in-MO-October-20151.pdf>
13. <https://dese.mo.gov/sites/default/files/eel-el-2016-FY16-17-MPP-Administrative-Manual.pdf>
14. <http://www.mobudget.org/wp-content/uploads/2015/10/Early-Education-Invest-in-MO-October-20151.pdf>
15. <http://teach-missouri.org/>
16. <http://www.mobudget.org/wp-content/uploads/2015/10/Early-Education-Invest-in-MO-October-20151.pdf>

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