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

New Jersey Case Study

Nemours. Children's Health System

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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).

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.

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 standards[1] 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 intervention[1] 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.

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

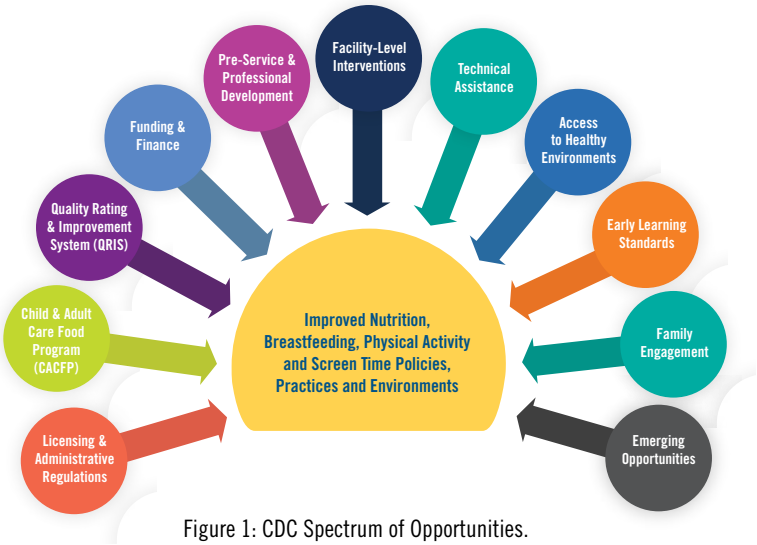

Figure 1: CDC Spectrum of Opportunities.

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 complied case studies describing each partner's integration efforts. Reports for several states/communities and reports by Spectrum area where 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 Virginia[3]—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 Grow[4] 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.

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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.

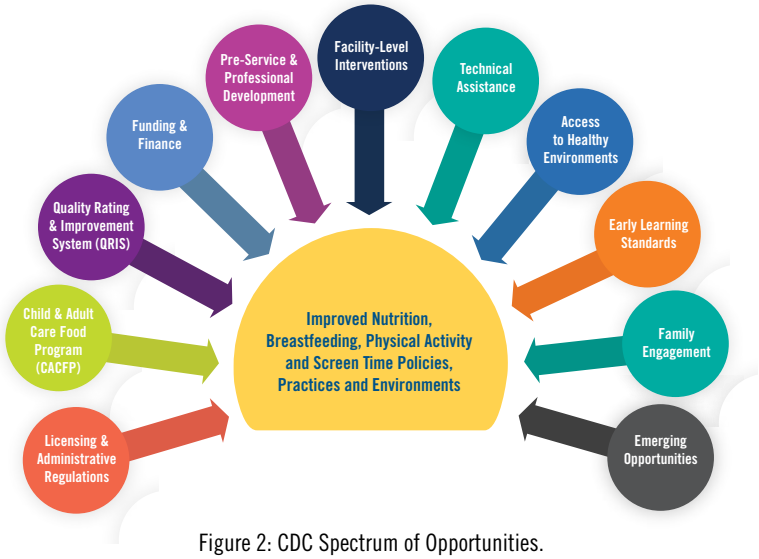

Figure 2: CDC Spectrum of Opportunities.

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—1305[10]: 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.

New Jersey
Implementing Partner: New Jersey Department of Health
Case Study

Participation in National ECELC: 2013-2017

ECE programs trained[11]: 153

Children served by trained programs: 16,100

Spectrum of Opportunities areas of focus:

- ***Licensing & Administrative Regulations*** – Gathered input from ECE providers about possible changes to licensing regulations and convened stakeholders to review findings and develop recommended improvements.
- ***Quality Rating and Improvement System (QRIS)*** – Developed the Grow NJ Kids Self-Assessment Tool, which included a focus on HEPA topics (via the LMCC quiz) and developed training for Quality Improvement Specialists to enhance their ability to support ECE providers with achievement of HEPA practices.
- ***Pre-Service & Professional Development*** – Developed six Policy Packets and corresponding Policy Kits (quality improvement materials and supplies) to support ECE centers in setting and implementing policies that support healthy eating and physical activity, and provided training to Quality Improvement Specialists use of the LMCC Assessment Tool.

Setting the Stage

Nemours identified New Jersey as a state implementation partner in 2013 during the development of the National ECELC proposal to the Centers for Disease Control and Prevention (CDC). New Jersey had high preschool overweight and obesity rates, large numbers of early care and education (ECE) programs, and existing efforts to prevent childhood obesity via ECE settings. Starting in 2013 and continuing into the present, New Jersey has had a variety of contextual factors which have impacted integration of healthy eating and physical activity (HEPA) best practices into ECE settings. Many of these are described below.

Did you know?

16.2 % of low-income children in New Jersey ages 2-4 years old are obese (2011). This is a decline from the 2008 rate of 17.9%.

Source: Trust for America's Health and Robert Wood Johnson Foundation. The State of Obesity 2015. Washington, D.C.: 2015

State Efforts Addressing Childhood Obesity

The NJ Department of Health (NJDOH) leads *ShapingNJ*, a diverse, multi-sectorial partnership to address nutrition, physical activity and obesity prevention in New Jersey. The goal of this partnership was, and is, to prevent obesity and improve the health of populations at risk for poor health outcomes in New Jersey by making "the healthy choice, the easy choice." *ShapingNJ* consists of high-level partnerships across the state, and is structured as workgroups in six settings including health care, schools, community, worksites, faith based, and early care and education. The ECE setting work group consisted of 25-50 partners and had subcommittees in healthy eating, physical activity, and nutrition. In 2013, CDC funding (via a five year Nutrition, Physical Activity, Obesity grant - NPAO) for *ShapingNJ* ended. In 2012, the ECE setting workgroup recommended to the New Jersey Department of Children and Families (DCF) Office of Licensing (OL) that revisions be made in child care licensing regulations. The recommendations put new emphasis on health, nutrition and active play for kids in care. These regulations were enacted in 2012 and implemented in 2013. As part of this work, ***ShapingNJ*** also created a Child Care Best Practices Toolkit and implemented a Nutrition and Physical Activity Self Assessment in Child Care (NAP SACC) initiative to support providers in meeting the new standards. ***ShapingNJ*** also sponsored a *Let's Move! Child Care (LMCC)* training for providers.

A more recent CDC grant, State Public Health Actions – 1305, along with the Preventive Health and Health Services Block Grant, funds obesity prevention strategy implementation in all 6 settings and sustains the *ShapingNJ* partnership, now consisting of 230 organizations.

Additionally, after CDC added new 1305 requirements for states related to physical activity in ECE settings, New Jersey found that this new requirement for spending CDC's 1305 funding closely corresponded to the NJDOH's receipt of the National ELELC grant. This provided opportunities for leveraging and coordination.

Finally, New Jersey Partnership for Healthy Kids (NJPHK), funded by the Robert Wood Johnson Foundation (RWJF) focuses intense efforts in 5 New Jersey cities (Newark, New Brunswick, Trenton, Camden, Vineland), convening, connecting and empowering community partnerships across the state to implement environment and policy changing strategies that prevent childhood obesity.

State Efforts to Improve Early Care and Education

New Jersey was awarded funding in Phase 3 of the Race to the Top—Early Learning Challenge, a federal Department of Education initiative to improve state early learning systems. The focus of New Jersey's plan was the expansion of Grow NJ Kids, a voluntary Quality Rating and Improvement System (QRIS). New Jersey developed standards, piloted an operational framework, and set ambitious goals for recruiting centers and family child care homes. As a result, many of the state's ECE systems (provider training, technical assistance and formal education) were aligned around the QRIS requirements. Regional Child Care Resource and Referral Agencies (CCR&Rs) had been providing much of the training for ECE providers in New Jersey via contract with NJ DCF. However, as QRIS was rolled out, the CCR&Rs role changed and public universities became more involved in supporting ECE program improvement aligned to the QRIS standards.

Timeline

2012

- Revised licensing regulations enacted, and include a focus on health, nutrition and active play

2013

- New Jersey selected to join National ECELC project and cohort 1 launched

2014

- Policy Packets and Policy Kits created to support ECE centers in setting and implementing policies that support healthy eating and physical activity

2015

- *Let's Move! Child Care* checklist added to the enrollment packet required for ECE programs to participate in Grow NJ Kids

2016

- *ShapingNJ* and stakeholders recommended licensing regulations for family child care homes

Public preschool for four-year-old children has been a priority in New Jersey since the landmark Abbott court decisions in the early 2000. The state serves a large portion of low income and disadvantaged children in school-based and community-based preschool classrooms under the direction of the New Jersey Department of Education. In 2014 and 2015 New Jersey applied for and received federal funding to expand their preschool programming through a federal Department of Education Preschool Development Grant.

Establishing a Path to Success—A Plan for Integration

New Jersey was funded in the first year of the National ECELC project, and integration of HEPA best practices into statewide ECE systems was not a focus until the second year. In the first year, the mechanics of developing and running learning collaboratives was all encompassing, curriculum was being developed and tested, administrative systems were created and piloted, and the evaluation framework was designed. After running learning collaboratives for a year, both Nemours and NJDOH staff were better equipped to identify areas of opportunity for integration. The contextual factors above impacted the areas of opportunity, as did feedback from stakeholder engagement. While NJDOH has worked in all areas of the CDC Spectrum of Opportunity, their focus has been predominately in three areas.

1. Improve **licensing** regulations to align with HEPA best practices.
2. Integrate HEPA into statewide **QRIS**.
3. Utilize 1305 funding to finance facility level supports, training and technical assistance and **professional development**.

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

NJDOH did not use a formal set of planning tools to arrive at these priorities. The project coordinator hired by NJDOH to oversee the National ECELC project has background and experience with the ECE sector, as did another member of the NJDOH obesity prevention team. Both women had existing connections and relationships in the health and ECE sectors and broadened them during their support of the National ECELC project. Through serving on committees, meeting with stakeholders, and exploring opportunities, they were able to identify places where NJDOH could positively contribute to the obesity prevention work in ECE settings.

Integration Activities

LICENSING AND ADMINISTRATIVE REGULATIONS

Given the *ShapingNJ* child care setting workgroup's success in 2012, NJDOH continued to view licensing as an area of the Spectrum of Opportunities worth pursuing. In 2013, NJDOH's work initially focused on helping providers meet the regulations enacted in 2012, and the department offered learning collaboratives to hundreds of providers, alongside existing technical assistance taking place in the state. NJDOH also offered to train NJ DCF OL staff on how to determine if ECE programs were meeting the new regulations; however, this offer was not accepted.

In 2016, NJDOH again had the opportunity to weigh in on licensing regulations for Family Child Care homes. NJDOH reconvened members of the *ShapingNJ* early care and education setting workgroup to conduct a focus group survey with providers to understand what standards would be simple to meet and which were more difficult. Partners in this work included the NJPHK and New Jersey Alliance of YMCAs. Advocates submitted findings, recommended standards, rationale and research references to NJ DCF OL. While the recommendations have not been adopted at this time, the template can and should be adopted by other states, as it is a compelling format combined with feedback from providers.

QUALITY RATING & IMPROVEMENT SYSTEM (QRIS)

After two years of running learning collaboratives for providers, NJDOH identified an opportunity through the state's Grow NJ Kids initiative to weave HEPA into the QRIS. The system was in development, growing, and receiving more funding, so it was difficult to get ECE providers to focus on other quality improvement initiatives. Also, as the plan was laid out, there was a vision of statewide implementation where large numbers

of (i.e. the majority) of ECE centers and homes would be participating. NJDOH saw this as an opportunity to work on program improvements in HEPA at the same time as working on program improvements in other areas. The NJ Department of Human Services, Division of Family Development (DFD) is the lead for Grow NJ Kids, and DFD led a stakeholder group for the development of the Grow NJ Kids Self-Assessment Tool. The group was comprised of a number of NJDOH key stakeholders, including the NJDOH Project Coordinator. Through this stakeholder group, NJDOH staff were able to directly communicate their support of HEPA best practices and the inclusion in the standards.

Factors for Success in New Jersey

- NJDOH willingness to work outside of state government on ECE obesity prevention.
- The NJDOH Project Coordinator was familiar with the ECE landscape and could help identify points of connection and build relationships.
- NJDOH opportunistically looked at what was going on in the state already and tried to coordinate.
- Dedicated point of contact for the state around ECE and childhood obesity.

NJDOH was successful in adding the LMCC Checklist to the enrollment packet required for ECE programs to participate in Grow NJ Kids. This packet includes an application and other self-assessment tools for providers to use to establish their baseline areas for improvement. After an ECE center director/owner completes the LMCC Self-Assessment, they work with their assigned Child Care Resource and Referral (CCR&R) Quality Improvement Specialist (QIS) to decide on best practice goals they wish to work on. All programs submit their LMCC quiz to the evaluators at the time of their formal assessment and NJDOH is collecting them. The gathering and assessment of the LMCC quiz will also allow the NJDOH Project Coordinator to summarize trends (areas where programs self-report being unable to meet) and plan relevant training.

As part of this approach, the NJDOH Project Coordinator developed training for the QRIS Technical Assistance Specialists. The NJDOH Project Coordinator also supported Rutgers Center for Effective School Practice (ECE Training Academy developed with Race to the Top – Early Learning Challenge funding) to develop and implement obesity prevention trainings for QIS and ECE center staff and family child care providers.

PRE-SERVICE AND PROFESSIONAL DEVELOPMENT

A key element in New Jersey's integration plan has been strategic programming of 1305 funds. While National ECELC funding and 1305 funding go to different departments within NJDOH, staff made a concerted effort to ensure that funding and programming is aligned. In Year 1 and 2 of 1305 funding—beginning June 2014—NJDOH created a series of six Policy Packets and corresponding Policy Kits (quality improvement materials and supplies) to support ECE centers in setting and implementing policies that support healthy eating and physical activity. Much of the work in the National ECELC project was focused on practice change and NJDOH recognized that developing written policies that could be shared with parents and staff for years to come would help sustain the changes. Policy Packets were designed to help any provider find and use appropriate language, and the packets continue to be used by ECE programs (not only those that participated in ECELC).

Policy Packets include three nutrition-focused packets including Breastfeeding and Infant feeding, Child Nutrition and Family Style Dining. Three additional Policy Packets include Indoor/Outdoor Play, Family Engagement, and Worksite Wellness. Six corresponding Policy Kits are made available to programs when they *create, adopt and share it* with ECE contracted trainers or TA providers. Policy Kits include items such as posters, videos, parent handouts (Breastfeeding Kit), clear pitcher with lid and portion control serving spoons (Family Style Dining Kit), and activity calendars in English and Spanish and foam playground ball set (Indoor/Outdoor Play Kit). The cost of each Policy Kit was approximately $150 and each ECE program participating in the National ECELC project was offered up to four of the six kits with submission of a policy. Approximately 150 Kits were distributed.

Also in Year 2, NJDOH collaborated with New Jersey Association of Child Care Resource and Referral Agencies (NJACCRRA) to provide technical assistance and support to ECE centers participating in Grow NJ Kids. NJACCRRA provided a one-day training conducted by a NJDOH-approved trainer for QIS from the CCR&Rs, Head Start staff, state funded preschools, CCR&R staff, and other agency staff (i.e. Department of Education, Office of Licensing). The purpose of the training was to provide consistent information on the use of the LMCC Assessment Tool to all QIS staff statewide so that they may support ECE programs participating in Grow NJ Kids. As noted above, the LMCC quiz is being collected from programs participating in Grow NJ Kids to meet the performance measure. NJDOH also created 2-hour workshops on nutrition and physical activity to train center-level staff on HEPA best practices.

Challenges to Integration

The first challenge for New Jersey was organizational. When it was funded as a state implementation partner for the National ECELC project, the initiative was housed in the NJDOH Office of Nutrition & Fitness (ONF), Division of Family Health Services. In October 2013 ONF was restructured, leaving less bandwidth to support *ShapingNJ* and integration activities. NJDOH staff were reassigned leaving the National ECELC funded NJDOH Project Coordinator as the only staff dedicated to both running learning collaboratives and integration activities. There also remains significant state departmental isolation within New Jersey that requires intensive efforts to overcome. For example, efforts to partner with the Office of Licensing to support changes in the regulations have been slow.

The second challenge for New Jersey has been the slow pace of implementation of Grow NJ Kids. Despite best-laid plans for integrating LMCC into QRIS, NJDOH was dependent upon QRIS start-up and operational effectiveness that has been slow. Fewer than projected providers have enrolled, so the process of completing LMCC quiz and programs receiving corresponding TA has been delayed.

Finally, New Jersey, like many other states, has a lot going on with ECE and childhood obesity prevention but it has been a challenge to coordinate activities and measure progress. For example, it is difficult to get an accurate count of how many ECE programs statewide have received support related to HEPA (learning collaboratives, NAP SACC, Policy Kits, LMCC training) and whether they have made and sustained significant improvements as a result.

Lessons Learned

Licensing changes alone are not sufficient to promote provider level changes in the achievement of HEPA best practices. It is unclear whether changes in the licensing regulations from 2012 have resulted in any significant improvements at the program level. New Jersey has not automated its licensing forms so there has been no summary of how and how often licensing staff are looking at HEPA standards and whether providers are having trouble meeting them. It is unclear whether licensing staff have been trained on the HEPA regulations and/or whether they are able to provide adequate technical assistance. While New Jersey did develop a template for licensing regulations supportive of HEPA best practices that other could use, the resulting regulations may or may not be impacting providers.

Second, New Jersey's experience illustrates the importance of State Health Departments knowing and understanding ECE in order for HEPA integration to happen, and happen in such a way that ECE providers achieve and sustain best practices and their progress is measurable.

Finally, particularly with the intersection of ECE and childhood obesity prevention, there is a strong need for coordinating agencies to be strategic about the convening and use of a stakeholder group. The stakeholder group will need concrete areas of focus for which they can provide insight and recommendations, and will also need to be kept aware of all state level activities to ensure a coordinated approach for planning and integration.

Glossary of Key Terms

1. ***Grow NJ Kids*** – New Jersey's quality rating and improvement (QRIS) system.
2. ***New Jersey Department of Children and Families (DCF) Office of Licensing (OL)*** – State agency overseeing child care licensing regulations.
3. ***New Jersey Department of Health (NJDOH)*** – State implementation partner for National ECELC project, and leads ShapingNJ.
4. ***New Jersey Department of Human Services, Division of Family Development (DFD)*** – State agency overseeing Grow NJ Kids.
5. ***ShapingNJ*** – A multi-sectorial partnership to address nutrition, physical activity and obesity prevention in New Jersey.
6. ***New Jersey Association of Child Care Resource and Referral Agencies (NJACCRRA)*** – Child care resource and referral agency that supports access to and provision of high quality early care and education, and provides technical assistance to ECE programs.

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.

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