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

## Virginia 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.

Figure 1: CDC Spectrum of Opportunities.

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

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.healthykidshealthyfutures.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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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 intervention[6] 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.

## 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.

# Virginia
# Implementing Partner: Virginia Early Childhood Foundation
# Case Study

**Participation in National ECELC:** 2014-2017

**ECE programs trained[11]:** 212

**Children served by trained programs:** 15,024

**Spectrum of Opportunities areas of focus:**

- ***Technical Assistance*** – Leveraged partnerships and funding to implement multiple technical assistance strategies to support ECE providers with tools, materials, and resources to integrate HEPA into their program.
- ***Child and Adult Care Food Program (CACFP)*** – Held a CACFP Summit and convened partners for ongoing work to improve the quality of nutrition for more communities with low-income children and families.
- ***Pre-Service and Professional Development*** – Provided training and materials on HEPA topics to professional development providers working with ECE providers. Working with the state community college system to include obesity prevention priorities in Early Childhood Education and Development Associate Degree coursework.

## Setting the Stage

In 2013 Nemours Children's Health System and CDC identified Virginia as a state lacking substantive work on childhood obesity prevention in early care and education settings. Nemours issued a Request for Proposals to Virginia organizations interested in ECELC and in 2014 selected a joint application from the Virginia Department of Social Services (VDSS), Virginia Department of Health (VDH), Child Care Aware of Virginia (CCAVA), the Virginia Foundation for Healthy Youth and the Virginia Early Childhood Foundation (VECF). VECF was proposed as the programmatic and fiscal lead. The addition of Virginia to the ECELC coincided with the addition of Kentucky and California as states receiving funding and intensive support to implement the ECELC model and integrate childhood obesity prevention into state ECE and child health systems.

**Did you know?**

***20% of 2-4 year old WIC participants in Virginia are obese. This is more than any other state.***

*Source:* Trust for America's Health and Robert Wood Johnson Foundation. The State of Obesity 2016. Washington, D.C.: 2016

VECF was in a unique position to lead the implementation of ECELC with its partners. VECF, a non-profit public-private partnership founded in 2006, is the statewide entity entrusted with accountability, outcomes and leadership in holistic early childhood systems building. Through its "Smart Beginnings" initiatives, VECF builds the capacity of local communities to integrate programs and policies that address the comprehensive needs and opportunities across family support, health, and early learning for young children in Virginia. Since 2006, the Foundation has fostered nearly 30 locally-driven initiatives across the state, providing substantive leadership and facilitating innovative initiatives to ensure its mission that Virginia's children enter kindergarten healthy and ready to learn.

In preparation for implementing ECELC, VECF convened an Advisory Board with members of the key state agencies that provide professional development to ECE providers in Virginia – VDSS, VDH, CCA-VA, Virginia Quality (Virginia's Quality Rating and Improvement System), and Infant and Toddler Specialist Network (ITSN). All these entities and initiatives are interested in integrating obesity prevention best practices in ECE environments and committed to cross-training professional development providers in the *Let's Move! Child Care* best practices. This group informs Virginia's implementation of the ECELC.

At the time ECELC was launched in Virginia, statewide support for childhood obesity prevention in ECE was limited. However, described below are the initiatives that were in place around childhood obesity prevention and ECE program improvement.

## State Efforts Addressing Childhood Obesity

At the time Nemours funded VECF, Virginia Foundation for Healthy Youth (VFHY) and their Healthy Communities Action Teams (HCAT) did much of the state's childhood obesity work, although these efforts focused on school age and community approaches. Rev Your Bev, an annual "Day of Action" is promoted across the state to encourage water consumption in place of sugar-sweetened beverages. HCAT grants allow community organizations to implement promising practices in childhood obesity prevention suggested by the National Institute of Medicine (IOM) and the CDC. VFHY awarded more than $1.2 million in HCAT grants during FY 2013 and 2014 to establish and/or support 18 community coalitions across Virginia to fight childhood obesity on the local level.

HCATs serve as coordinators and conveners for local activities and build momentum around increasing access to healthy foods, promoting physical activity, and preventing childhood obesity. VFHY's HCAT grantees implement a variety of strategies for childhood obesity prevention, such as working with or establishing farmers' markets to increase community access to fresh produce; increasing physical activity in children enrolled in after-school programs; creating and maintaining community gardens; increasing breastfeeding; and increasing awareness of good nutrition habits. Most of these efforts were not targeted at ECE environments however they did impact many communities and school systems.

### Timeline

**1999**

- Virginia Foundation for a Healthy Youth established by the Virginia General Assembly to empower Virginia's Youth to make healthy choices by promoting active, nutrition and tobacco-free living.

**2013**

- Virginia Association of YMCAs awarded a Pioneering Healthy Communities grant from the YMCA of the USA.

**2014**

- Nemours funds a partnership led by Virginia Early Childhood Foundation to support ECE practice level and systems changes to prevent childhood obesity.
- ECELC Stakeholder meeting held to discuss integration opportunities.
- Cohort 1 launched.

**2015**

- VECF received a grant from Bon Secours Health Systems to pilot an adapted ECELC project with family child care providers in Richmond's East End.

In 2013 the Virginia Alliance of YMCAs was awarded a Pioneering Healthier Communities grant from the Robert Wood Johnson Foundation and the YMCA of the USA. The grant brought together public health, education, business, and policy leaders to focus on policy, systems, and environmental change to reduce the rate of childhood obesity in Virginia. The grant, now concluded, supported HEPA work in the ECE facilities operated by eight YMCAs across the state with training and information on HEPA standards. The grant also supported work around:

1. Increasing physical activity and nutrition components in early childhood and out-of-school time settings.
2. Increasing the number of youth participating in 150 minutes of physical activity per week.
3. Advocating for shared-use agreements with schools and community facilities to increase the number of spaces community members can access for physical activity.
4. Supporting the implementation of competitive food guidelines and policies to improve the nutritional intake of all youth.
5. Creating greater partnerships to address childhood obesity in Virginia.

The ITSN had also done some work related to obesity prevention. Through eight regional offices and 15 infant and toddler specialists located throughout the state, services are offered to ECE providers caring for children birth-36 months.

Finally, Virginia Quality provides only basic, licensing required HEPA support in ECE. Mentors receive a copy of the American Academy of Pediatrics *Caring Our Children National Health & Safety Performance Standards* for ECE programs, and many have participated in Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) or I Am Moving I Am Learning curriculum training. Virginia Quality specialists are working on-site with ECE programs that choose to participate in the QRIS, and they are available to support programs with HEPA topics.

## State Efforts to Improve Early Care and Education

Across Virginia, close to 70% of children from birth to age five have "all available parents working" and therefore are likely enrolled in ECE programs (child care – centers and homes, Head Start, Early Head Start, preschool). As such, Virginia has directed funding at a variety of ECE program improvement efforts.

Virginia Quality, co-administered by VECF and VDSS, is a voluntary system designed with two primary purposes:

- Helping families identify high quality child care options for their young children; and
- Assisting child care and preschool programs, regardless of their setting, with their efforts to provide high quality early care and education

More than 850 child care and preschool programs participate, receiving support (on-site coaching and training) and incentives (learning materials and scholarships for continuing education) to continually improve the quality of the early learning opportunities they provide to over 34,000 children in Virginia. Local early childhood coalitions or organizations work with the state administrative hub to recruit programs and coordinate activities locally.

Virginia also has an intentional, organized system of local initiatives that connect children and families to quality early experiences for optimal development. These collaborations are known as Smart Beginnings. Smart Beginnings connect and maximize the efforts of varied early childhood stakeholders within localities. The goal is to galvanize communities to positively impact the development of children.

Finally, through VDSS, the Child Care & Development Block grant funds many ECE program improvement efforts including professional development via regional training, a statewide Infant and Toddler Specialist Network, and support for social emotional development in ECE settings.

# Establishing a Path to Success—A Plan for Integration

VECF was funded to implement ECELC in the second round of states and was therefore focused on integration from the beginning. VECF included integration opportunities in their application for funding and the Advisory Board was engaged in discussions of opportunities from their first meeting. Nemours staff visited the Advisory Board in fall 2014 and provided an overview of the Spectrum of Opportunities and helped to identify areas where members could provide support and leadership.

VECF's well-established relationships with the ECE system facilitated a high profile for ECELC which has spurred interest in obesity prevention despite limited funds and competing priorities. These relationships also paved the way for the ECELC Project Coordinator into relevant committees.[12] VECF's Smart Beginnings Initiatives have provided community support to the ECELC local projects, convening stakeholders and supporting broad outreach to recruit ECE participants.

While VECF and the Advisory Group identified opportunities across all areas of the CDC Spectrum of Opportunities, their focus has been mainly on three areas:

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

1. Incorporating HEPA into a variety **technical assistance** support provided to ECE providers;
2. Broadening the reach of **CACFP** to providers serving low income children at risk for obesity; and
3. Promoting HEPA topics in **professional development** offerings for ECE providers, and integrating best practice nutrition and physical activity standards for community colleges statewide to use in both a one-year certificate and a two-year Associate Degree program.

## Integration Activities

### TECHNICAL ASSISTANCE

In 2015, the Virginia Department of Health (VDH) applied to CDC as a pilot state for an **online *Go NAP SACC* self assessment**, action planning and technical assistance tool. VDH proposed to work with Advisory Council partner CCA-VA to facilitate broad statewide ECE provider involvement. CCA-VA staff facilitated training of 17 CCA-VA consultants from five regions in online *Go NAP SACC*. These consultants subsequently recruited more than 100 ECE programs to self assess, plan for HEPA improvements, track program-level progress, and access resources. A four-hour HEPA group training ("Think Outside the Juice Box") was co-created by CCAVA and the ECELC PC, adapted from ECELC training outlines and delivered by CCA-VA local staff. In addition to access and support from the online tool, and this group training, programs received email, phone and in-person technical assistance, and classroom equipment kits to support nutrition and physical activity improvements, using VDH's 1305 funds. This activity extended the reach of HEPA support to ECE providers not participating in the ECELC. The Go NAP SACC partnership has expanded subsequently to pilot integration of Go NAP SACC platform and 1305-funded classroom equipment kits into the service delivery of other ECE systems' consultants (such as Infant and Toddler Specialists, CACFP Child Care Specialists, etc.) Both the pilot partnership with ECE systems and the CCA-VA statewide training and support with *Go NAPSACC* will be expanding in 2017 to reach another 200 ECE programs in Virginia.

Eastern Virginia Medical Services (EVMS), in Norfolk, Virginia, launched a grant-funded (through HCAT) initiative in Hampton, Newport News, Chesapeake, Suffolk, Norfolk, Virginia Beach, and Portsmouth to develop **breastfeeding friendly child care (BFFCC) environments**, using guidelines and materials from the Carolina Global Breastfeeding Institute. ECELC programs in those communities are invited to participate in the EVMS training/ grant opportunity as an optional part of their 6-month follow up period, guided by ECELC trainers and EVMS Outreach Coordinator cooperatively. This initiative makes available more detailed and specific training and parent outreach resources regarding breastfeeding support as well as up to $300 in materials to create/enhance a breastfeeding room. EVMS has also agreed that those ECELC programs which implemented breastfeeding friendly policies and practices that meet Carolina Global Breastfeeding Institute benchmarks through their learning collaborative work will be eligible to receive a "BFFCC Designation" and be listed on a registry of Breastfeeding Friendly Child Care programs.

In 2014, VFHY created materials and messages for their **"Rev Your Bev" campaign** to engage children 0-5, and launched these through ECELC. This was the first time children 0-5 were included in the campaign. Through VFHY's partnership 70 events were held in ECE settings in central and southeast Virginia. VFHY provided resources for ECE programs to promote healthy beverages with children and families. Based on this success, VFHY has continued to engage ECE in the annual campaign which has provided needed resources and technical assistance for ECE providers around water.

Finally, in January 2015 VECF received a grant from Bon Secours Health Systems **to adapt ECELC for family child care (FCC)** providers in Richmond's East End. While this initiative only reached 5 providers, it allowed the model to be tested with FCC providers in a low resourced community.

### CACFP

In fall 2015 the ECELC Project Coordinator and VDH Director of Community Nutrition met to discuss how Virginia's ECELC, CACFP and WIC intersect, and how strengthening these connections might be advantageous to childhood obesity prevention across the state. CACFP federal funding limits state agency ability to provide nutrition support and training beyond essential compliance and monitoring.. ECE programs participating in the ECELC program often request help developing acceptable menus that exceed CACFP nutrition guidelines, and it was discussed how partners could work together to help address this need.

Subsequent to this conversation, VDH and a number of Advisory Council partners developed a USDA Team Nutrition grant proposal to expand the bandwidth of the state CACFP staff to provide training and technical assistance. VDH proposed to provide intensive nutrition and physical activity training and support to CACFP providers including support with new meal patterns, and to develop HEPA standards that would be recommended for amendment of Virginia's child care licensing regulations. Even though the application wasn't funded, it spurred additional conversations between cross sector partners on the need for state agencies invested in child health and in quality child care to work more closely supporting nutrition and HEPA standards for ECE programs.

In June 2016, VECF and several state agency partners convened a State CACFP Summit to build momentum and cultivate cross-sector collaboration to more robustly support ECE enrollment in CACFP. The summit resulted in the formation of workgroups which produced recommendations to address barriers to ECE provider enrollment in CACFP as a strategy to improve the quality of nutrition for children in communities with low income families and children.

State partners are now working together to:

- Extend eligibility to non-licensed religious exempt child care providers to enroll in CACFP and have support doing so;
- Compile a data portrait of CACFP regional and local utilization rates by ECE to identify areas of CACFP "unmet need," and to inform outreach and targeted CACFP enrollment activities;
- Execute cross-agency agreements to promote CACFP more intentionally to ECE providers; for example, including information about the value of CACFP and local CACFP contact information in all VDSS New Provider Orientation Trainings statewide, so that all providers seeking licensure learn about this nutrition resource.
- Promote CACFP enrollment of early care providers in Southwest and rural Virginia and enrollment of more family child care providers statewide; and
- Partner with No Kid Hungry Virginia team to engage local support for and expansion of CACFP (and possibly WIC) at the community level.

## PRE-SERVICE AND PROFESSIONAL DEVELOPMENT

A variety of individuals provide professional development to Virginia's ECE providers (Infant and Toddler Specialist Network, Child Care Aware of Virginia, Virginia's QRIS mentors/raters, Child Care Health Consultants, Head Start Health Coordinators). Not only do these professionals benefit receiving training regarding childhood obesity, but they need motivation to prioritize health topics in their work with providers. HEPA changes are often easy and quick to make which provides instant success for programs and technical assistance providers can see change.

ECELC's Advisory Council partnerships facilitated cross program collaboration and leveraging of resources to support Obesity Prevention activities within Virginia's pre-service and professional development systems. IN 2014, HEPA-specific supply kits (were funded with CDC 1305 grant) were used to engage TA providers to focus on HEPA because they had something to give programs and a way to start the conversation. VECF has conducted webinars, given presentations and trained CCA-VA mentors, Virginia Quality coordinators and mentors, Smart Beginnings coordinators, VDH child care health consultants, and Infant and Toddler specialists using the ECELC information. VECF worked with ITSN specialists to explore existing alignments in ITNS goals (breastfeeding, infant and toddler movement and activity, responsive feeding) and obesity prevention priorities. These specialists were also trained on the overall ECELC project and specifically on action planning so they could provide another level of TA support to programs participating in learning collaboratives.

In 2015, the statewide ITSN network leveraged their partnership in ECELC to create the *Celebrating Healthy Babies and Tots* all-day institute delivered in four regions of the state which focused on child health and physical activity with a frame of early obesity prevention. The Institute featured recommendations from Nemours' *Child Care Provider's Guide* and the *Best Practices for Physical Activity: A Guide to Help Children Grow Up Healthy*. Conference workshops were built around best practices in infant/toddler physical activity, and the National ECELC project coordinator served as keynote speaker. Statewide audio conferences and webinars for ECE providers also provided information on health and nutrition.

Utilizing the services of Dr. Dianne Craft, VECF, VDH and CCA-VA partnered to host a stakeholders meeting addressing the importance of promoting physical activity in early care, and plan a train-the-trainer session for Virginia's ECE technical assistance providers. In summer 2015, VDH and CCA-VA hosted forty-five trainers and mentors from Virginia's ECE technical assistance systems (see list above) for a 4-hour session, which included science-based rationales for a wide range of physical activities, and presentation of strategies to help ECE educators integrate age-appropriate and varied physical activity into early learning environments. Evaluations of this session were very positive. VDH plans to offer additional train-the-trainer sessions with Dr. Craft via webinar to reach professional development providers who were unable to travel to Richmond for this in-person training.

The Early Childhood Education Faculty Peer Group within Virginia's Community College System has agreed to incorporate key obesity prevention concepts and material from the ECELC into two classes taught in 18 colleges across the state, highlighting childhood obesity prevention as a critical issue for early care professionals, and ensuring that expert consensus recommendations regarding nutrition and physical activity are addressed. One targeted class is required for early childhood education Associate Degree seekers (EDU 235 Health, Safety, and Nutrition Education), and the other class is a frequently selected elective for other students (HLT 135 Health, Safety and Nutrition).

The ECELC coordinator is working with college faculty to ensure that these lesson plans align with existing course objectives, and can ultimately be delivered both face-to-face and online, reaching approximately 1000-1200 students annually. When launched, these lesson plans will make it easy for instructors to incorporate consistent, best practice-specific information into classes that build the knowledge of students who will likely become ECE educators.

## Challenges to Integration

Virginia has experienced challenges in coordinating and aligning the work related to ECE and childhood obesity prevention; programs have grown exponentially since the launch of the ECELC. Even bolstered by strong partnerships, Virginia's ECE service systems contend with competing priorities and program boundaries. The Nemours funded Project Coordinator has worked to cultivate partnerships across agencies and serve on various committees to better align the work and ensure that HEPA integration continues to be part of conversations around training and professional development for ECE providers.

The lack of a fully implemented state-wide QRIS has proven challenging. While designed to coordinate all ECE program improvement efforts, Virginia's QRIS has been undergoing redesign during the implementation of the ECELC. As such, it has been unclear when/if a stronger focus on HEPA could be included. More recently, Virginia Quality partners have expressed interest in integrating stronger HEPA priorities, and plans to develop a training module on best practices as well as a crosswalk of health practices with Virginia Quality levels are being explored.

## Lessons Learned

Involvement of stakeholders via the Advisory Group has proven invaluable as they have been essential partners in planning integration work. VECF worked hard to not only work in partnership with Advisory Group agencies but to facilitate partner ownership of the integration plans.

VECF and their partners have also learned that timing of integration opportunities is not always right (see QRIS example above) but that being ready to take advantage of opportunities is important. For example, the HEPA standards work done as a result of preparing a Team Nutrition grant has better prepared the partners for HEPA standards implementation.

**Glossary of Key Terms**

1. ***Virginia Department of Health (VDH)*** **–** State department involved in Virginia child obesity prevention efforts, overseeing CACFP, WIC, child care health consultants and other statewide initiatives. Participates on National ECELC project Advisory Group.
2. ***Virginia Department of Social Services (VDSS)*** **–** Oversees ECE program licensing, and administers Child Care & Development Block grant funding to provide professional development via regional training, a statewide Infant and Toddler Specialist Network.
3. ***Virginia Early Childhood Foundation (VECF)*** - A non-profit public-private partnership founded in 2006. It is a statewide overseeing early childhood systems building in Virginia, the "Smart Beginnings", and capacity-building of local communities to implement initiatives, and is the state implementation partner for the National ECELC project.
4. ***Virginia Quality*** **–** Virginia's quality rating and improvement system, co-administered by VECF and VDSS.

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 in cohorts 1-4 that fully completed the intervention and completed sufficient baseline and post assessment materials to be included in evaluation activities.
12. Lt. Governor's Commonwealth Council on Childhood Success, Health and Well Being Workgroup; VDH Interagency Task Force on Obesity; and the Virginia Cross-Sector Professional Development Consortium.

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