



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

Child and Adult Care Food Program

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

Thanks to the following authors for their contributions to the case studies:

Kevin Cataldo
Katey Halaz
Alex Hyman
Roshelle Payes
Kelly Schaffer
Julie Shuell

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

Caliste Chong, Julie Odom & Gail Piggot, Alabama Partnership for Children
Bonnie Williams, Arizona Department of Health Services
Meredith Reynolds, CDC
Christi Smith and Leadell Ediger, Child Care Aware of Kansas
Beth Ann Lang & Jessica Rose-Malm, Child Care Aware of Missouri
Wil Ayala & Pam Hollingsworth, Early Learning Coalition of Miami, Dade and Monroe Counties
Marta Fetterman, Early Learning Indiana
Rebekah Duchette, Kentucky Cabinet for Health & Family Services
Juliet Jones & Peri Nearon, New Jersey Department of Health
Emily Keenum & Kathy Glazer, Virginia Early Childhood Foundation

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

Overview as of September 2018

National ECELC

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

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

As of September 2018, eight states (Alabama, Arizona, Indiana, Kansas, Kentucky, Missouri, Virginia, and New Jersey) and four communities (North/Central Florida, South Florida, Los Angeles County California, Contra Costa County California) have participated in the National ECELC. The intervention¹ typically consists of five in-person learning sessions spread over a 10-month period, ongoing technical assistance for participating ECE providers, and access to tools, materials and resources.

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

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

Integrating Obesity Prevention into ECE Systems Using CDC’s Framework

Through this project, partners worked intentionally to understand the extent to which support for standards had been integrated into components of their ECE system. Assisted by technical assistance from Nemours, partners used the CDC’s ‘The *Spectrum of Opportunities* Framework for State-Level Obesity Prevention Efforts’ 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 built 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 influenced how and when integration of best practice support into ECE systems was 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.

Figure 1: CDC *Spectrum of Opportunities* (2.0)



Development and Purpose of State Case Studies

In fall 2016, Nemours gathered information from its ECELC partners, reviewed monthly progress and integration plans, and compiled case studies describing each partner's integration efforts. Reports for several states/communities and reports by Spectrum area were completed in July 2017 and posted on www.healthykidshealthyfuture.org.² In summer 2018, Nemours updated these case studies to reflect the continued successes of ECELC state partners. 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.

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 systems, 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 Systems. Pre-service and Professional Development Systems were the area of the *Spectrum of Opportunities* most frequently leveraged by partners participating in the National ECELC. Nine out of eleven used Pre-service and Professional development to integrate HEPA activities. Partners in Arizona and Kentucky created *online modules aligned with 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. Alabama trained professional development providers as well as licensing consultants on HEPA best practices.

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. Six partners focused on Licensing and Administrative Regulations as a primary integration strategy. In Alabama, 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). Six partners in Indiana, Kansas, Los Angeles, CA, New Jersey, South Florida, and Virginia 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*. Five of the six partners that focused on QRIS did so from the perspective of *integrating HEPA standards into QRIS, either through the launch of a new QRIS or revisions to an existing QRIS*. In New Jersey, the partner successfully included a *HEPA-focused self-assessment (Let's Move! Child Care) in the state's QRIS*. In three of these states, South Florida, Kansas, and New Jersey—as well as Virginia³—the partner made efforts to *train QRIS technical assistants* to enhance their ability to assist ECE programs in their efforts to achieve HEPA best practice standards. Additionally, Virginia co-created an on-line QRIS module that explicitly *linked HEPA best practices to Virginia's Early Learning Standards and QRIS system*.

ECE Funding Streams. Three states used ECE Funding Streams to further their integration work. 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*. Alabama secured *funding through the Child Care Development Fund* to expand ECELC to other counties in the state and Indiana *secured additional grant funding* to expand ECELC to reach new providers as well.

Child Care Food Program (CACFP). Partners in Missouri, Virginia, Indiana, and Alabama 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.

Work in Indiana and Alabama is focused on increasing awareness and provider participation. Indiana conducted CACFP mapping of participants, and created *marketing and outreach tools to increase enrollment of new providers*. Alabama also completed mapping of providers and is working to *develop outreach tools to increase participation*.

Statewide Recognition and Intervention Programs. Partners in three states focused on Statewide Recognition and Intervention Programs—South Florida, North/Central Florida, and Alabama. In 2018, Florida partners worked to *create and launch a Statewide Early Childhood Education Recognition Program*. The program celebrates ECE programs that prioritize healthy eating and physical activity best practices. Alabama is working to launch a *statewide breastfeeding friendly designation* program, providing a toolkit and training for interested providers.

Technical Assistance. Three partners (in Kansas, Kentucky, and Virginia) focused on Technical Assistance as a primary integration activity.⁴ 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. 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.

Statewide Access Initiatives. Partners in South Florida and Alabama focused on statewide access initiatives. South Florida worked to *integrate childhood obesity prevention/intervention into the referral service Help Me Grow*. This allows Help Me Grow to connect families with health care providers and community agencies to support children’s healthy weight. In Alabama, partners have been working on implementing a statewide initiative to *provide support to ECE programs regarding procuring fresh and locally grown produce* for use in the child care setting through Farm to ECE.

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 are taking place within the system, have a person focused on policy change and navigating the 'pre-work' to ensure proper procedures and timelines are followed.

Looking Ahead—A Continued Focus on Integration

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

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

National ECELC

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

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

As of July 2018, 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 intervention⁵ typically consists of 5 in-person learning sessions spread over a 10-month period, ongoing technical assistance for participating ECE providers, and access to tools, materials and resources.

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

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

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

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

CDC *Spectrum of Opportunities*

CDC’s *Spectrum of Opportunities* framework (Figure 1; the Spectrum) identifies several ways that states, and to some extent communities, can support ECE programs in their abilities to achieve recommended standards and best practices for obesity prevention.⁶ 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 spectrum areas different spectrum areas for each state. The major federal funding streams/initiatives that follow are consistent across all states and serve as the backdrop for state ECE systems. State case study reports describe how these funding streams/initiatives are leveraged in a variety of ways (alongside state resources) to achieve integration activities across the Spectrum.

Child and Adult Care Food Program (CACFP)⁷ – 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)⁸ – 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 – 1305⁹: CDC supports efforts nationwide to reduce the risk factors associated with childhood and adult obesity, diabetes, heart disease, and stroke. Through a federal grant (1305), all 50 states and the District of Columbia receive funds to help prevent these chronic diseases. 1305 focuses on healthy environments in workplaces, schools, early childhood education facilities, and in the community. This program also focuses on working through health systems and communities to reduce complications from multiple chronic diseases such as diabetes, heart disease, and stroke. The goal is to make healthy living easier for all Americans. Recently, CDC added a new 1305 requirement for states around physical activity in ECE settings. Since all states receive 1305 funding (basic and/or enhanced) and are required to set goals and performance measures, the new requirement forced state health departments to develop strategies for ECE providers.

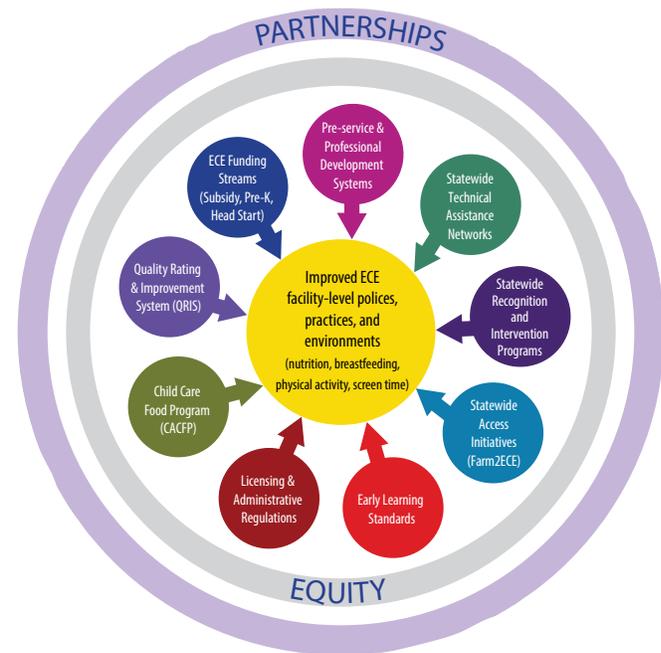


Figure 2: CDC *Spectrum of Opportunities* (2.0)

Integration Highlights: *Child and Adult Care Food Program*

The Child and Adult Care Food Program (CACFP) is a federal program that provides funding reimbursement for meals and snacks served to low-income children in early care and education (ECE) settings. Participating ECE programs follow CACFP standards regarding meal patterns in portions. Many states provide training or technical assistance to ECE providers related to CACFP, and some use CACFP as a guide for licensing regulations, quality rating and improvement system (QRIS) standards, or other state-based programs. In 2016, new CACFP standards were released. These new standards went into effect October 1, 2017 providing an opportunity and increased need for training and supports from states to ECE providers on implementation of nutrition best practices, in order for programs to meet the implementation deadline.

As defined in *The Spectrum of Opportunities Framework for State-Level Obesity Prevention Efforts Targeting the Early Care and Education Setting*, there are seven primary ways states can use CACFP to help promote healthy eating and decrease obesity in young children in ECE.¹⁰

1. **Increase participation and retention** of ECE providers in CACFP.
2. **Enhance state CACFP standards** to align with other national nutrition guidelines such as the U.S. Dietary Guidelines for Americans if they do not already.
3. **Promote a specific obesity prevention intervention** to all providers participating in CACFP.
4. **Include comprehensive obesity prevention content in CACFP sponsored trainings.**
5. **Provide technical assistance on non-nutrition related obesity prevention topics** (e.g. physical activity and screen time) in addition to the required nutrition training topics through CACFP.
6. Partner with CACFP sponsoring organizations to incorporate obesity prevention into their work.
7. Address barriers that prevent state utilization of federal CACFP funds

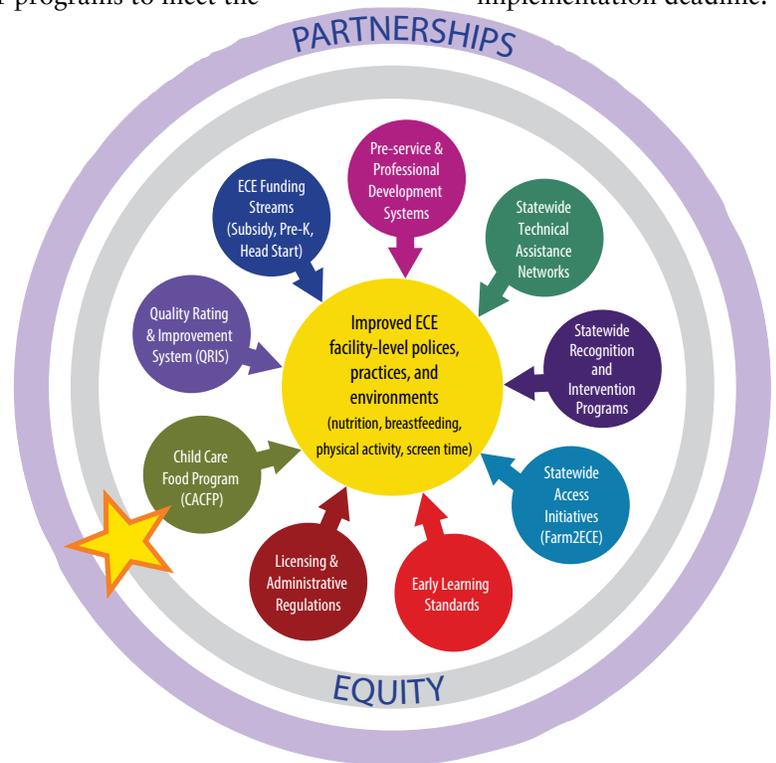


Figure 3: State Areas of Focus within the CDC Spectrum of Opportunities (2.0)

Among the 11 states/regions participating in the National Early Care and Education Learning Collaborative (ECELC) project from 2013-2018, four focused on CACFP as one of their primary strategies to integrate obesity prevention into state systems: **Alabama, Indiana, Missouri, and Virginia**. Highlights of these states' efforts are provided below, and additional detail is available in each state's *Case Study for Integrating Obesity Prevention into State ECE Systems*.

State efforts, though different, illustrate the importance of cross-agency and sector collaboration to support ECE programs in their implementation of best practice nutrition standards.

Alabama:

Included promotion of CACFP in Alabama Early Childhood Nutrition Summit and worked with the Food Research and Action Center (FRAC) to develop maps to begin identifying regions and providers to target outreach to promote CACFP.

The Alabama Partnership for Children (APC), the National ECELC state implementation partner, held the Alabama Early Childhood Nutrition Summit in August 2018. The success of the Summit was evidence of the work APC and the Stakeholder Group has focused on over the last two and a half years to build partnerships, coordinate collaborative projects, and develop programs to support child care providers. As part of this Summit, the Stakeholder Group launched and convened five Working Groups prior to the Summit around key areas of impact, including a workgroup on Food Insecurity and one on Access to Healthy Foods/Nutrition Education. While the work of the groups had different focuses, both wanted to work to increase participation in CACFP. Working with FRAC, APC completed GIS mapping using Alabama CACFP participation data, DHR child care licensing data, and DHR CCDF subsidy participation data. FRAC overlaid these maps with several other national data sources, including the United States Census Bureau's American Community Survey and United States Department of Agriculture's Rural-Urban Continuum Codes. The maps will be used to target providers for participation in CACFP.

Indiana:

Increased participation in the Child and Adult Care Food Program (CACFP) and improved retention among current enrollees.

In Indiana, Early Learning Indiana worked to facilitate compliance with updated meal patterns and increase childcare provider's participation in CACFP, particularly in underserved regions of Indiana. ELI utilized GIS mapping to determine areas of the state where they could provide direct outreach to providers to increase enrollment in the program. In summer 2018, recruitment and outreach materials were created and mailed to programs that were identified as eligible for the program, but not currently participating. ELI will continue to track increases in program participation in CACFP based on this targeted outreach.

Missouri:

Aligned ECELC Curriculum with State Initiatives to Support ECE Programs to Meet Healthy Eating and Physical Activity (HEPA) Best Practices.

Child Care Aware of Missouri (CCAMO), the National ECELC state implementation partner, aligned the ECELC learning curriculum with the Eat Smart/MOve Smart program and branding, which helped expand those programs' reach and certification throughout the state. Eat Smart was developed by the Missouri Department of Health and Senior Services (DHSS) to address the eating habits of young children in ECE settings, and includes nutrition guidelines at three levels: minimum, intermediate, and advanced. Providing support for programs participating in CACFP is an integral aspect of the initiative. Through the National ECELC project, CCAMO provided ECE staff with strategies, resources, and technical assistance that helped them to achieve improvements in their policies and practices. These improvements would also enable programs to meet Eat Smart/MOve Smart guidelines and achieve state certification. CCAMO helped DHSS promote their program and reach ECE sites across the state that may not have been able to participate in the effort due to the agency's limited bandwidth and resources to provide technical assistance. Staff from DHSS and Cooperative Extension have also presented at ECELC Learning Sessions to orient participating ECE staff on the nutrition, physical activity, and breastfeeding support programs and incentives for being certified. Connecting these initiatives was mutually beneficial to CCAMO and DHSS. ECE programs viewed ECELC learning collaboratives as part of a broader statewide effort, instead of duplicative.

In fall 2015, the ECELC Project Coordinator from the Virginia Early Learning Foundation (VELF), National ECELC state implementation partner, and Virginia Department of Health (VDH) Director of Community Nutrition met to discuss how Virginia's ECLEC project, CACFP and WIC intersect, and how strengthening these connections might be advantageous to childhood obesity prevention across the state. Virginia's CACFP state agency has limited bandwidth to provide additional nutrition support and training beyond programmatic compliance and monitoring. ECE programs participating in the ECELC program often requested help developing acceptable menus that exceed CACFP nutrition guidelines, and partners discussed potential strategies to collectively address this need. Subsequent to these conversations, 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 nutrition-focused training and technical assistance. While the application wasn't funded, it spurred conversations between cross sector partners on how state agencies invested in child health and in quality child care could work more closely supporting nutrition and HEPA standards for ECE programs.

State partners continue to work together to:

- Extend eligibility to non-licensed religious exempt centers and unregulated family child care providers who receive child care subsidy to enroll in CACFP and support them in the process;
- 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 systematically promote CACFP to ECE providers; for example, including information about the value of CACFP and local CACFP contact information within all the early care divisions of social services that come into contact with ECE providers, such as QRIS, licensing, etc
- Collaborate across state agencies in a campaign to expand ECE participation in CACFP.

Between June 2016 and September 2018, partners advanced recommendations from the state CACFP Summit, such as CACFP eligibility for religious-exempt providers in good standing as CCDF subsidy providers. Virginia has also made progress in promotion of CACFP to ECE providers within VDSS. VDSS Licensing Division is adding CACFP information about CACFP into training for newly licensed child care providers. Virginia's CACFP team plans to provide webinar training addressing CACFP FAQs and familiarize licensing staff with basic principles of CACFP for ECE providers. In addition, CCAVA added CACFP support as one of the TA priorities stipulated in the 2018-2019 Scope of Services agreements disseminated to their five regional offices.

Many of Virginia's Smart Beginnings community partnerships have engaged local ECE networks in elevating child nutrition best practices as a feature of quality ECE, promoting CACFP as a key resource for providers and children, and supporting recruitment of new ECE providers into Virginia's CACFP. These local, on-the-ground partnerships are building grass-roots support for broader state-wide efforts to ECE CACFP expansion and child nutrition. Smart Beginnings and other community partners are engaging local stakeholders to advance a 2018-2019 CACFP and child nutrition push.

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

1. Aligned with the Preventing Childhood Obesity (2nd ed.) standards (CFOC3/PCO), included in *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, (3rd ed.).
2. Case studies were written for Alabama, 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. 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. 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.
5. 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.).
6. 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/strategies/early-care-education/pdf/TheSpectrumofOpportunitiesFramework_May2018_508.pdf
7. <https://www.fns.usda.gov/cacfp/child-and-adult-care-food-program>
8. <https://www.acf.hhs.gov/occ/fact-sheet-occ>
9. <https://www.cdc.gov/nccdphp/dnpao/state-local-programs/span-1807/past-program.html>
10. *Spectrum of Opportunities for Obesity Prevention in the Early Care and Education Setting (ECE)*, CDC Technical Assistance Briefing Document: <https://www.cdc.gov/obesity/downloads/spectrum-of-opportunities-obesity-prevention.pdf>

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