A Comparision of the National Association for the Education of Young Children's Accrediation Standards and Caring for Our Children: National Health and Safety Performance Standards 3rd Edition

Introduction

High-quality early care and education (ECE) programs improve young children's health and promote development and learning. Early education includes all of a child's experiences at home, in child care and other preschool settings[1]. Key indicators of quality, as identified by Child Care Aware of America, consist of adult-to-child ratio, group size, caregiver qualifications, turnover and accreditation. Accrediation is a key indicator of quality because accredited providers meet standards that are above their state licensing regulations. Emerging research identifies new issues impacting the early childhood field. Childhood obesity is a widespread epidemic impacting over 12 million children who spend time in early care and education settings[2]. Evidence-based research supports the need to provide healthy nutrition and physical activity environments for children at young ages[3]. Accreditiation standards have undergone revisions to address these issues to increase quality and ensure children reach their optimal development.

NAEYC and CFOC

The National Association for the Education of Young Children is one of the largest and leading organzations to accredit ECE programs. NAEYC developed accreditation standards to support and promote quality in early care and education programs for children age birth to eight. These standards serve as the mark programs use to raise the level of quality they provide. The NAEYC accreditation standards support children and their families in understanding the importance of a quality program and strengthening children's learning and development. The NAEYC accreditation standards are divided into four categories, focusing on children, teachers, family and community partners, and program administration. These categories form the structure that leads to program quality and are are supported by best practices in the early childhood field.

Caring for Our Children: National Health and Safety Performance Standards, 3rd Edition were developed in collaboration with the American Academy of Pediatrics, American Public Health Association and National Resource Center for Health and Safety in Child Care and Early Education. From these CFOC standards, Preventing Childhood Obesity in Early Care and Education Programs, 2nd Edition, was developed. These standards increase quality through the development of healthy habits focusing on nutrition, physical activity, and screen time in ECE settings. They represent the best evidence, expertise, and experience in the country on quality health and safety practices and policies that should be followed in today's early care and

[1] American Academy of Pediatrics(2015) Policy Statement. Quality Early Education and Child Care From Birth to Kindergarten. retrieved May 17, 2016 from http://pediatrics.aappublications.org/content/pediatrics/115/1/187.full.pdf

[2] National Association of Child Care Resource and Referral Agencies. Retrieved March 8, 2010 from http://highqualitychildcare.org/Naccrra_main/alert-description.html?alert_id=15204232.

[3] Committee on Obesity Prevention Policies for Young Children, Institute of Medicine. "Front Matter." Early Childhood Obesity Prevention Policies. Washington, DC: The National Academies Press, 2011.

education settings[4]. By identifying the need to help children grow and learn in a healthy and safe environment, following these best practices are important to providing a quality ECE program.

A Brief Look Inside NAEYC Accreditation Standards and CFOC Standards that Support Childhood Obesity Prevention

NAEYC accreditation focuses on program quality through ten standards. Each standard illustrates best practices that impact children and lead to program quality advancement. The ten standards include: relationships, curriculum, teaching, assessment of child progress, health, teachers, families, community relationships, physical environment and leadership and management.

Supporting childhood obesity prevention, NAEYC standards ensure children's nutritional well-being is met. These standards support the Child and Adult Care Food Program (CACFP) guidelines as well as the Caring for Our Children standards. Nutritional standards include; serving meals and snacks that meet CACFP guidelines, individualized and special health care needs, providing healthy beverages, infant feeding and breastfeeding support. Although not assessed, programs are encouraged to comply with the CACFP meal guidelines when serving meals and snacks to children as well as meals brought from home. Individualized and special feeding needs are identified in NAEYC standards specifically towards children with disabilities. While the CFOC addresses maintaining written documentation on any special nutrition or feeding needs, best practices to specifically support children with disabiities are not addressed. Both sets of standards address healthy beverages, requiring clean drinking water be made available to children throughout the day. CFOC and NAEYC infant feeding standards address bottle feeding, storage and preparation of breastmilk, introduction to solid foods, fruit juice, hunger cues, serving of cow's milk, and feeding schedules. Additionally, NAEYC standards address breastfeeding support,requiring programs to have a place for breastfeeding mothers to breastfeed their children in acomfortable and private area.

Physical activity best practices for children and staff are highlighted and encouraged in both the NAEYC and CFOC standards. Physical activity is defined as a form of play, which should be planned for each day. NAEYC defines play as opportunities for children to be actively engaged, including outdoor and gross motor play. Throughout the day,teaching staff are expected to encourage and facilitate active play involving physical movement. Children of all ages should have daily opportunities for outdoor play, weather permitting, and when outdoor opportunities for large gross motor activities are not possibe the program should provide similar activities inside.

NAEYC also provides standards addressing technology and screen time to ensure they are developmentally appropriate and accessable. CFOC standards for screen time include a recommended amount as well as limiting their use to educational and physical activity.

Conclusion

Incorporating both standards into ECE settings promote practices that support childhood obesity prevention. This increases the opportunities to develop healthy habits among children focusing on nutrition, physical activity, breastfeeding support and screen time. While the NAEYC and CFOC standards address many of the same content areas, those standards addressing nutrition see the most overlap.As childhood obesity rates rise, the need for linking prevention habits with quality care increases. ECE programs serve as buildng blocks that allow children to develop healthy habits sustained over time.

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[4] American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education. 2012. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs,* 3rd Edition.

National Association for the Education of Young Children (NAEYC) and Caring for Our Children: National Health and Safety Performance Standards 3rd Edition
Physical Activity and Nutrition Standards Crosswalk

NAEYC Physical Activity Standards	Caring for Our Children Standards
2.A.09.c Materials and equipment used to implement the curriculum for infants and toddler/twos encourage their practice of developing their physical skills through self-initiated movement.	Infant equipment such as swings, stationary activity centers, infant seats, molded seats etc. if used, should only be used for short periods of time. A least restrictive environment should be encouraged at all times.
2.C.04 Children have varied opportunities and are provided equipment to engage in large motor experiences that: stimulate a variety of skills, enhance sensory-motor integration, develop controlled movement, enable children with varying abilities to have large motor experiences similar to those of their peers, range from familiar to new and challenging, and help them learn physical games with rules and structure.	**There are no standards that specifically address equipment to promote physical activity.**
3.A.03 Teaching staff support children's needs for physical movement, sensory stimulation, fresh air, rest and nourishment,	Caregivers/teachers should promote children's active play, and participate in children's active games at times when they can safely do so.
3.F.02.a Play is planned for each day. (Play is not just limited to outdoor or gross motor play. Play is characterized by children's active engagement and enjoyment and their ability to determine how the activity is carried out. Teaching staff are expected to encourage and facilitate active play involving physical movement, as well as pretend or dramatic play.)	The facility should promote children's active play every day. Children should have ample opportunities to do moderate to vigorous physical activities such as running, climbing, dancing, skipping, and jumping. All children birth to six, should participate in: • Two to three occasions of active play outdoors, weather permitting; • Two or more structured or caregiver/teacher/adult –led activities or games that promote movement over the course of the day-indoor and outdoor; and • Continuous opportunities to develop and practice age-appropriate gross motor and movement skills. Caregivers/teachers should promote children's active play, and participate in children's active games at times when they can safely do so.
5.A.06.a Children of all ages have daily opportunities for outdoor play.(When weather,	Children should play outdoors daily when weather and environmental conditions do not pose a significant health or safety risk. Outdoor play for

air quality, and environmental safety conditions do not pose a health risk.)	infants may include riding in a carriage or stroller; however, infants should be offered opportunities for gross motor play outdoors as well. Infants (birth-12months) should be taken outside two to three times per day, as tolerated. Toddlers and preschoolers should be allowed 60-90 minutes of outdoor play.
5.A.06.b When outdoor opportunities for large gross activities are not possible because of conditions, the program provides inside similar activities.	The time allotted for outdoor play and moderate to vigorous indoor or outdoor physical activity can be adjusted for the age group and weather conditions. Toddlers and preschoolers should be allowed 60-90minutes of outdoor play. These outdoor times can be curtailed somewhat during adverse weather conditions in which children may still play safely outdoors for shorter periods, but should increase the time of indoor activity, so the total amount of exercise time should remain the same.
9.B.01.d The program makes adaptations so children with disabilities can fully participate in the outdoor curriculum and activities.	**There are no standards that specifically address physical activity for children with special needs.**

NAEYC Nutritional Standards 5.B. Ensuring Children's Nutritional Well-being	Caring for Our Children Standards
5.B.01 Not Currently Assessed: Best Practice If the program provides food for meals and snacks (whether catered or prepared on-site), the food is prepared, served, and stored in accordance with the U.S. Department of Agriculture(USDA), Child and Adult Care Food Program (CACFP) guidelines.	All meals and snacks and their preparation, service, and storage should meet the requirements for meals of the child care component of the U.S. Department of Agriculture (USDA), Child and Adult Care Food Program.
5.B.02 Not Currently Assessed: Best Practice Staff take the steps to ensure the safety of food brought from home: • They work with families to ensure that foods brought from home meet the USDA's CACFP food guidelines. • All foods and beverages brought from home are labeled with the child's name and date. • Staff makes sure that food requiring refrigeration stays cold until served. • Food is provided to supplement food brought from home, if necessary. • Food that comes from home for sharing among the children must be either whole fruits or commercially prepared packaged foods in factory sealed containers.	The facility should provide parents/guardians with written guidelines that the facility has established a comprehensive plan to meet the nutritional requirements of the children in the facility's care and suggested ways parents/guardians can assist the facility in meeting these guidelines. The facility should develop policies for foods brought from home, with parent consultation, so that expectations are the same for all families. The facility should have food available to supplement a child's food brought from home if the food brought from home is deficient in meeting the child's nutrient requirements. If the food the parent/guardian provides consistently does not meet the nutritional or food safety requirements, the facility should provide the food and refer the parent/guardian to a Nutritionist/Registered Dietitian, the child's primary health care provider, or community resources.
5.B.04 For all infants and children with disabilities who have special feeding needs, program staff keeps a daily record documenting the type and quantity of food a child consumes and provides families with that information.	**There are no standards specifically addressing special feeding needs for children with disabilities.**
5.B.05 For each child with special health care needs or food allergies or special nutrition needs, the child's health provider gives the program an individualized care plan that is prepared in consultation with family members and specialists involved in the child's care. The program protects children with food allergies from contact with the problem food. The program asks families of a child with food allergies to give consent for posting information about that child's food allergy, and if consent is given, then posts that information in the food preparation area and in the areas of the facility the child uses so it is a visual reminder to all those who interact with the child during the program	Before a child enters an early care and education facility, the facility should obtain a written history that contains any special nutrition or feeding needs for the child. The staff should review the history with the child's parents/guardians, clarifying and discussing how parental home feeding routines may differ from the facilities planned routine. The child's primary care provider should provide written information about any dietary modifications or special feeding techniques that are required at the ECE program and these plans should be shared with the child's parents/guardians upon request.

day.	When children with allergies attend the early care and education facility, the following should occur: • Each child with a food allergy should have a care plan prepared for the facility by the child's primary care provider. • Based on the child's care plan, the child's caregivers/teachers should receive training, demonstrate competence in, and implement measures for: preventing exposure to specific foods, recognizing the symptoms of allergic reactions, and treating allergic reactions. • Parents/Guardians and staff should arrange for the facility to have necessary medications, and the equipment and training to manage the child's allergy. • Individual child's food allergies should be posted prominently in the classroom where staff can view and/or wherever food is served.
5.B.06 Clean and sanitary drinking water is made available to children throughout the day. (Infants who are fed only human milk do not need to be offered water.)	Clean, sanitary drinking water should be readily available, in indoor and outdoor areas, throughout the day. On hot days, infants receiving human milk in a bottle can be given additional human milk in a bottle but should not be given water.
5.B.08 If a program provides food to infants, then the program staff work with families (who are informed by their child's health care provider) to ensure that the food is based on the infants' individual nutritional needs and developmental stage.	At a minimum, meals and snacks the facility provides for infants should contain the food and meal snack patterns of CACFP. Foods should be appropriate for the infant's individual nutrition requirements and developmental stages as determined by written instructions obtained from the child's parent or primary care provider.
5.B.09 The program supports breastfeeding by: • Accepting, storing, and serving expressed human milk for feedings; • Accepting human milk in ready-to-feed sanitary containers labeled with the infant's name and date and storing it in a refrigerator for no longer than five days or at 39 degrees F, or in a freezer at five degrees Fahrenheit or below for up to two weeks, up to three to six months in a freezer compartment with separate doors at zero degrees, or up to six to twelve months in a chest or upright deep freezer at -4 degrees F; • Ensuring that staff gently mix ,not shake, the milk before feeding to preserve special infection-fighting and nutritional components in human milk; and • Providing a comfortable place for breastfeeding and coordinating feedings with the infant's mother.	The facility should encourage, provide arrangements for, and support breastfeeding. Facilities should have a designated place set aside for breastfeeding mothers who want to come during work to breastfeed as well as a private are with an outlet (not a bathroom) for mothers to pump their breast milk. Expressed human milk should be placed in a clean and sanitary bottle with a nipple that fits tightly or into an equivalent clean and sanitary sealed container to prevent spilling during transport to home or to the facility. The bottle or container should be properly labeled with the infant's full name and the date and time the milk was expressed. The bottle or container should immediately be stored in the refrigerator upon arrival. After warming, bottles should be mixed together gently (not shaken) and the temperature of the milk tested before feeding.

	Human milk should be stored in the refrigerator no longer than 5 days and in the freezer no longer than three to six months.
5.B.10.a Emerging Practice Indicator If formula is served, staff serve only formula that comes to the facility in factory-sealed containers (e.g., ready-to –feed powder or concentrate formulas and baby food jars)prepared according to the manufacturer's instructions. If solid food is served, families may bring solid food prepared at home for use by their child, or the program may prepare solid infant food in the facility when the kitchen is governed by the regulations established by the local health department.	Formula provided by parent/guardians or by the facility should come in a factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength or liquid concentrate to be diluted using water from a source approved by the health department. Powdered infant formula, though it is the least expensive, requires special handling in mixing because it cannot be sterilized. The primary source for proper and safe handling and mixing is the manufacturer's instructions that appear on the can of powdered formula.
5.B.10.b Bottle feedings do not contain solid foods unless the child's health care provider supplies written instructions and a medical reason for this practice.	Formula mixed with cereal, fruit juice, or any other foods should not be served unless the child's primary care provider provides written documentation that the child has a medical reason for this type of feeding.
5.B.10.c-e c. Staff discard after one hour any formula or human milk that is served but not completely consumed or is not refrigerated. d. If staff warms formula or human milk, the milk is warmed in water at no more than 120 degrees Fahrenheit for no more than five minutes. e. No milk, including human milk and no other infant foods are warmed in a microwave oven.	Bottles and infant foods can be served cold from the refrigerator and does not have to be warmed. If a caregiver/teacher chooses to warm them, bottles should be warmed under running, warm tap water or by placing them in a container of water that Is no warmer than 120 degrees Fahrenheit. Bottles should not be left in a pot of water to warm for more than five minutes. Bottles and infant foods should never be warmed in the microwave. Prepared formula must be discarded within one hour after serving to an infant. Prepared formula that has not been given to an infant may be stored in the refrigerator for twenty –four hours to prevent bacterial contamination.
5.B.11 Teaching staff do not offer solid foods and fruit juices to infants younger than six months of age, unless that practice is recommended by the child's health care providers and approved by families. Sweetened beverages are avoided. If juice (only 100% fruit juice is recommended) is served, the amount is limited to no more than four ounces per child daily.	A plan to introduce age-appropriate solid foods (complementary foods) to infants should be made in consultation with the child's parent/guardian and primary care provider. Age-appropriate solid foods may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child's nutritional and developmental needs. For breastfed infants, gradual introduction of iron fortified foods may occur no sooner than around four months but preferably six months and to complement the human milk. The first and solid foods should be single ingredient foods and should be introduced one at a time at two-to seven-day- intervals. The facility should serve only full-strength fruit juice diluted with water from a

	cup to children twelve months of age or older. Juice should have no added sweeteners. The facility should offer juice at specific meals and snacks instead of continuously throughout the day. Juice consumption should be no more than a total of four to six ounces a day for children one to six years. This amount includes juice served at home. Whole fruit, mashed or pureed, is recommended for infants seven months up to one year of age.
5.B.12 Teaching staff who are familiar with the infant feed him or her whenever the infant seems hungry. Feeding is not used in lieu of other forms of comfort.	Caregivers/teacher should feed infants on the infants cue unless the parent/guardian and the child's primary care provider give written instructions otherwise. Whenever possible, the same caregiver/teacher should feed a specific infant for most of that infants feedings. Caregivers/teachers should not feed infants beyond satiety, just as hunger cues are important in initiating feedings, observing satiety cues can limit overfeeding.
5.B.13 The program does not feed cow's milk to infants younger than 12 months. The program only serves whole milk to children of ages 12 months to 24 months.	The facility should not serve cow's milk to infants from birth to twelve months of age, unless provided with a written exception and direction from the child's primary care provider and parent/guardians. Children between twelve and twenty-four months of age, who are not on human milk or prescribed formula, can be served whole pasteurized milk, or reduced fat (2%) pasteurized milk for those children who are risk for obesity.
5.B.16 The program serves meals and snacks at regularly established times. Meals and snacks are at two hours apart but not than three hours apart.	The facility should ensure that the following meal and snack pattern occurs: • Children in care for eight hours or fewer hours in one day should be offered at least one meal and two snacks or two meals and one snacks; • Children in care for more than eight hours in one day should be offered at least two meals and two snacks or three snacks and one meal; • A nutritious snack should be offered to all children in midmorning(if they are not offered a breakfast onsite that is provided within three hours of lunch) and in the middle of the afternoon; and • Children should be offered food at intervals at least two hours apart and not more than three hours apart unless the child is asleep.
9.A.15 Nursing mothers have a place to breastfeed their children that meet their needs for comfort and privacy**.**	Facilities should have a designated place set aside for breastfeeding mothers who want to come during work to breastfeed as well as a private area with an outlet (not a bathroom) for mothers to pump their breast milk. A place that mothers feel they are welcome to breastfeed, pump, or bottle feed can create an environment when offered in a supportive way.

NAEYC Technology Standards	Caring for Our Children Standards
2.H.01 The use of passive media such as television, film, videotapes, and audiotapes, is limited to developmentally appropriate programming.	**There are no standards that specifically address media use for developmentally appropriate programming.**
2.H.02 All children have access to technology that they can use by themselves, collaboratively with their peers, and with teaching staff or a parent.	**There are no standards that specifically address children's accessibility to technology.**
2.H.03 Technology is used to extend learning within the classroom and integrate and enrich the curriculum.	For children two years and older in early care and education settings, total media time should be limited to not more than thirty minutes once a week, and for educational or physical activity use only.