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

Arizona 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

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 standards[1] and implementation support for these standards into components of state and local ECE systems.

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.

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 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 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.

Figure 1: CDC Spectrum of Opportunities (2.0)

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.

Development and Purpose of State Case Studies

In fall 2016, Nemours gathered information from its ECELC partners, reviewed monthly progress and integration plans, and complied case studies describing each partner's integration efforts. Reports for several states/communities and reports by Spectrum area where completed in July 2017 and posted on *www.healthykidshealthyfuture.org*.[2] 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 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. 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 Summi***t 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.

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 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 standards[1] 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 intervention[5] 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.[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.

Figure 2: CDC Spectrum of Opportunities (2.0)

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 – 1305[9]: 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.

Arizona
Implementation Partner: Arizona Department of Health and Human Services
CDC Spectrum of Opportunity Case Study

Participation in National ECELC: 2013-2016

ECE programs trained[10]: 163

Children served by trained programs: 16,841

Spectrum of Opportunities areas of focus:

- ***Licensing & Administrative Regulations***—Leveraged Arizona's Empower program to align messages and build supports, through Empower PLUS, to support ECE providers' achievement of HEPA standards.
- ***Pre-Service & Professional Development***—Developed seven online training modules to train ECE programs on the Empower standards; provided licensing clock hours as an incentive.
- ***Emerging Opportunities****—Extended the reach of the National ECELC project and collaborated with stakeholders to understand the needs and provide support to ECE programs as they work toward achievement of HEPA best practices.

Setting the Stage

Arizona was among the first states Nemours identified for the National Early Care and Education Learning Collaboratives (ECELC) project due to its commitment to child health and wellness in early care and education (ECE) settings, and high rates of preschool overweight and obesity. The Arizona Department of Health Services (ADHS), Bureau of Nutrition and Physical Activity (BNPA) was the lead in implementing the National ECELC project in Arizona. From 2013-2015, ADHS implemented learning collaboratives in the cities of Tucson and Phoenix, and addressed system integration from 2013-2016. As a lead state agency in health, ADHS was, and continues to be, well positioned to expand on their current work and explore additional childhood obesity prevention strategies within Arizona. Since the inception of the project, internal and external stakeholders were involved in the planning and implementation of the National ECELC project and continue to be engaged in supporting childhood obesity prevention efforts.

Did you know?

14.5% of low-income children in Arizona ages 2-4 are obese. The adult obesity rate in Arizona is nearly 30%. Early childhood obesity prevention efforts are essential.

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

ADHS' relationships with stakeholders were an asset when awarded funds to implement the National ECELC project. Child Care Licensing, Arizona Head Start Association, the United Way of Tucson and Southern Arizona, and the Pima and Maricopa County Departments of Public Health all played important roles in helping to get the project off the ground—aiding with planning, recruitment, curriculum refinement, and implementation. While support was central to implementation of the National ECELC project, stakeholders' involvement was an important way to leverage cross-agency support for childhood obesity prevention efforts in Arizona and to help build awareness and buy-in for strategies that may be implemented as part of broader state systems integration.

While ADHS did not form a formal stakeholder group to inform its integration work, the department is connected to colleagues through formal (e.g., Early Childhood Health and Development Board, Arizona's State Early Childhood Advisory Council) and informal avenues, allowing them to be in contact with organizations and individuals to support integration activities. ADHS gathered input but could have benefitted from a dedicated stakeholder group to help set the direction of integration activities, enhance buy-in and provide opportunity for cross-sector collaboration.

* Since original publication of this report in 2016, CDC has updated the Spectrum of Opportunities. The updated Spectrum can be found by visiting: *https://www.cdc.gov/obesity/strategies/early-care-education/pdf/TheSpectrumofOpportunitiesFramework_May2018_508.pdf"*

State Efforts Addressing Childhood Obesity Prevention

Through the convening of stakeholders at the beginning of the project, ADHS and their partners quickly identified an existing ECE health and wellness initiative, Arizona's Empower program, which could be built upon through the National ECELC project. Empower is a voluntary initiative led by ADHS Child Care Licensing that focuses on integrating best practices for healthy eating, physical activity, oral health, sun safety, and smoking cessation into licensed ECE programs. The National ECELC project materials were customized and branded to align with Empower, and to ensure further alignment with a recognized statewide initiative for ECE, the learning collaboratives were named Empower PLUS+. Co-branding with Empower was essential to align efforts. ADHS was able to leverage momentum that had already begun around childhood obesity prevention in ECE settings through Empower, and co-brand to implement a new program tied to a *known* initiative in the state. This aided with communication efforts with stakeholders, recruitment of ECE providers, and ensured alignment with existing and planned efforts by Child Care Licensing to promote HEPA.

State Efforts to Improve Early Care and Education

Quality First, Arizona's statewide quality rating and improvement system (QRIS) overseen by First Things First (FTF), drives state efforts to improve early care and education settings. ECE programs participating in Quality First are required to enroll in Empower (a requirement in place prior to Arizona's participation in the ECELC project), and this connection helps to ensure that child health and wellness is integrated into ECE program quality improvement efforts. Additionally, First Things First oversees a network of Child Care Health Consultants (CCHC) who help to bridge ECE program quality improvement and childhood obesity prevention efforts linked to Empower. While CCHCs are not trained specifically on the Empower standards, CCHCs receive initial training and ongoing professional development from trainers who have completed National Training Institute for Child Care Health Consultants. Topics include nutrition and physical activity best practices. However, data is not collected on the effectiveness of CCHCs in helping programs in Quality First to achieve Empower standards.

Establishing a Path to Success—A Plan for Integration

Opportunities for integration were chosen by ADHS based on alignment with the current work of the Department (e.g., Child Care Licensing, WIC, BNPA, Empower, Arizona Nutrition Network) and funding streams. By leveraging existing work, ADHS was able to use outcomes from the National ECELC project to help inform and meet the needs of BNPA and the ECE field. The three primary areas of ADHS' integration efforts include:

1. Strengthen Empower, a voluntary program associated with child care **licensing;**
2. Enhance the availability of **professional development** for ECE providers that includes HEPA and is approved for state licensing required annual training hours; and
3. Leverage **emerging opportunities*** for extended reach, stakeholder engagement, and data collection.

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

* Since original publication of this report in 2016, CDC has updated the Spectrum of Opportunities. The updated Spectrum can be found by visiting: *https://www.cdc.gov/obesity/strategies/early-care-education/pdf/TheSpectrumofOpportunitiesFramework_May2018_508.pdf"*

Integration Activities

LICENSING & ADMINISTRATIVE REGULATIONS

In 2010, and prior to the National ECELC project, Arizona's child care licensing fees were raised dramatically due to state budget cuts. In response, ADHS used funding from multiple sources (Title V Maternal and Child Health Services Block Grant, tobacco tax, and lottery dollars to WIC) and developed Empower[16] as a mechanism to offset child care licensing fees by 50% for child care centers and group homes. To receive a reduction in licensing fees, ECE providers voluntarily agree to implement the Empower standards and have a written policy on each standard. Providers receive a resource kit when they sign up which contains the Empower Guidebook containing information on Empower standards, the rationale for the standards as well as policy samples. Additionally, ADHS provides collateral pieces for education and awareness such as window clings, stickers, magnets, resource brochures, posters and handouts. Empower is supported jointly by Child Care Licensing and the BNPA staff and other ADHS subject matter experts. Training and technical assistance has been provided to ECE programs through conferences, regional trainings, community-based training by partners, webinars, newsletters, and online web-based modules in order to meet the standards.

Factors for Success in Arizona

- Existing childhood obesity prevention program, Empower, and its alignment with the National ECELC project goals
- Strong inter-agency coordination within ADHS
- Ability to leverage 1305 funding and data from CDC
- Availability of funding from the Avandia Settlement Grant

In 2013, at the time of the implementation of the National ECELC project, one of Arizona's biggest challenges was the long-term viability of Empower. Reaching nearly 99% of licensed ECE providers, the voluntary Empower initiatives is one of the largest statewide efforts for childhood obesity prevention. With a desire to maintain its momentum and to continue to offer a reduction in licensing fees through the program, ADHS looked to bring more visibility to Empower through the National ECELC project.

Since five of the ten Empower standards aligned directly with *Let's Move! Child Care* goals highlighted in the National ECELC project, Empower was a natural fit for alignment. To increase the visibility of Empower, the National ECELC project curriculum was customized to align with the branding of Empower and was renamed Empower PLUS+. With licensed providers seeking opportunities to meet the training requirement of 18 clock hours per year, the built-in incentive of reduced licensing fees through the Empower, and the new opportunity to meet those training requirements through participating in Empower PLUS+, ECE providers eagerly joined learning collaboratives in the first and second year of the National ECELC project.

Since both Empower and Empower PLUS+ are voluntary, BNPA partnered with ADHS Child Care Licensing in 2013 to monitor program compliance with Empower standards and collect and analyze data to inform future training and technical assistance. Coordinating efforts was relatively easy since both Child Care Licensing and BNPA are housed within ADHS. Licensing oversees the initial enrollment and renewal status of ECE programs' licensing, and also enrolls the programs in Empower. Licensing staff then monitors programs on compliance with licensing regulations and assesses the Empower standards. However, since Empower is voluntary, licensing monitors cannot cite a program for non-compliance related to Empower. Each Empower standard has 6-8 indicators associated with it where programs self-report if they're "fully," "partially," or have "not met" that indicator. These indicators address both program policies and practices that should be in place to meet the standard. Since July 2013, all Empower reports have been collected by licensing surveyors and submitted to BNPA for analysis. Gaps in meeting specific indicators and standards are identified to inform future technical assistance. Prior to July 2013 portions of data was collected by Child Care Licensing and submitted to BNPA's evaluation department; however, data was often incomplete and technical assistance varied and dependent on subject matter experts (e.g., oral health, nutrition, breastfeeding) to support ECE programs.

While the internal partnership within ADHS bureaus dated back to the inception of the Empower in 2010, there was little coordination for data collection from other projects and initiatives targeting ECE providers in the state. In order to assess the effectiveness of the technical assistance and trainings provided, the ECLEC project coordinator identified other sources of ECE data that could be gathered and analyzed. Using the Centers for Disease Control and Prevention (CDC) 1305 funding and with technical assistance from CDC, the project coordinator began collecting data from their 1305 basic and enhanced activities, Head Start/Early Head Start, National ECELC project (Empower PLUS+), and Quality First to help identify gaps in types of providers served, technical

assistance provided, and any gaps in the content delivered. As a result of this data collection, in 2016 training materials, including the Empower Guidebook, 3rd edition, were revised with a lens on family engagement, children with special health care needs and disabilities, language and cultural accommodations, multi-age groups and home settings.

Further, in summer 2016, ADHS played an important role collaborating with Quality First, Arizona's QRIS, to add an Empower implementation statement into the Quality First Implementation Guide. The implementation statement specifies that as part of participation in Quality First programs are *"required to participate in the Empower program and receive technical assistance as needed… As part of your Empower agreement and licensing fee reduction, your program is required to have a written policy for each standard and to implement each standard."*

PRE-SERVICE & PROFESSIONAL DEVELOPMENT

A online professional development system for ECE providers was being developed by ADHS when they were funded for ECELC. Specific trainings had not been developed, approved, and made available for ECE providers participating in Empower. Creation of these modules was an opportunity to align professional development with Empower, while offering licensing hours to ECE providers who completed training. In 2015, the ECELC project coordinator supported development of seven online training modules that align with each of the ten Empower standards. These trainings are self-guided PowerPoint presentations with a narrative that providers can complete at their own pace to receive a training certificate. The trainings were reviewed by content experts at ADHS and Child Care Licensing and will be uploaded to the Empower page of the ADHS website. Licensing has approved these trainings as an option for the required three hours of annual Empower topics. Currently, three of the 7 trainings are offered through the Arizona Nutrition Network (AzNN) website (Family Style Meals, Fruit Juice, and Sedentary Activity/Screen Time). The remaining four training modules will be available alongside the completed modules on a redesigned Empower website by July 2017.

To continue to engage National ECELC project participants after the learning collaboratives ended, ADHS developed a monthly newsletter to highlight materials and events that would be of interest to ECE providers and stakeholders. The distribution of these monthly newsletters kicked off in 2015 and in June 2017 reaches over 4,000 subscribers. The newsletters are sent out through an email listserv and are available on the Empower website. If opportunities or activities arise between the releases of the monthly newsletters, ADHS sends an email blast to all National ECELC project participants, other interested ECE providers, and internal and external partners. This effort was supported by CDC 1305 activities described above that allowed BNPA to identify gaps in providers served, training opportunities and content as well as support the overall goal of raising awareness for the Empower Program.

Timeline

2010

- Empower launched and linked to licensing fee reductions

2013

- Arizona selected to join National ECELC project and launches first cohort of Empower PLUS+
- BNPA begins ongoing review of Empower reports

2014

- First cohort of Empower PLUS+ concludes, and second cohort begins implementation

2015

- Second cohort of Empower PLUS+ concludes implementation
- Seven electronic training modules developed to align with Empower standards
- ADHS begins monthly newsletter to highlight Empower and Empower PLUS+ materials and resources
- Arizona State Health Improvement Plan developed, including childhood obesity prevention initiatives and strategies
- ADHS received $400,000 from Avandia settlement to train 300 child care group homes and provide activity kits
- National ECELC trainer implemented learning collaboratives with the San Carlos tribe in rural Arizona

2016

- Empower statement added to Quality First Implementation Guide

EMERGING OPPORTUNITIES*

State Health Improvement

By 2015, the Arizona State Health Improvement Plan—including childhood obesity prevention initiatives and strategies—was developed and workgroups were defined to begin the implementation phase. BNPA was asked to participate in the workgroup to help align childhood obesity prevention efforts. Around the same time, the Supplemental Nutrition Assistance Program-Education (SNAP-Ed), also known as the AzNN, released a request for proposals (RFP). The RFP solicited stakeholders interested in applying for a three year grant focused on 16 obesity prevention strategies. Three of those strategies focus specifically on early childhood development.[17] Nineteen grantees were chosen, a majority of which (e.g., county health departments, cooperative extension) are focusing on at least one ECE strategy. AzNN developed protocols to ensure provide guidance to SNAP-Ed partners choosing to work on an ECE strategy. An ECE subcommittee consisting of state agencies and grantees helped inform this effort.

Avandia Settlement Grant

Between 2012-2016, ADHS had unique opportunities to fund HEPA work with ECE. In 2012, the State of Arizona received over 3 million dollars from a diabetes drug manufacturer due to unlawful promotion of their product. The state used part of this funding to issue grants from the Arizona Attorney General's Office (AGO). BNPA applied for funds in 2015 to focus on training Child Care Group Homes[18] (CCGH) on tenets of the National ECELC project. There are about 300 CCGHs in the state which are often underrepresented and isolated when compared to the 2,100+ centers. In 2015, ADHS received $400,000 from the Avandia settlement, and began planning how to target the 300 CCGHs over the course of two years. ADHS contracted with the Maricopa County Department of Public Health for trainers who would prepare and implement four regional trainings each year using a train-the-trainer model. The trainers are using the technical assistance strategies and Empower resources provided to assist the CCGHs in meeting best practices related to healthy eating, physical activity and family-style dining.

The first project year ended in April 2016. Over the course of that first year, ADHS reached about 80% of the targeted CCGHs across four counties. Of the 175 child care group homes on the licensing list in Phoenix, 118 programs and 157 individual providers (CCGH owners and their staff) were reached. The evaluation to assess the effectiveness of the first year will be a retrospective survey completed by the providers approximately 2-3 months after the last training or technical assistance visit occurred. In year two, additional trainings will be held in Tucson and in rural parts of the state. Every child care group home will receive either group training or 1:1 technical assistance in their home. In addition, each provider facility received a curriculum kit of family style meal service pieces, nutrition education and physical activity equipment, including a copy of *Active Play!* by Dr. Diane Craft.

Data collected during the Avandia contract is also being analyzed among data collected from 1305 basic and enhanced activities, Head Start/Early Head Start, National ECELC project (Empower PLUS+), and Quality First to compare across projects and determine their effectiveness. Due to ADHS' efforts to raise awareness for Empower and analyze data across all projects targeting ECE providers, the Department of Economic Security (DES) collaborated with BNPA in 2016 to require enrollment in the Empower program for all Family Child Care (FCC) providers in the state. The addition of these 600 providers brings the total of Empower facilities to almost 3,000 throughout the state.

San Carlos Tribe

In 2015, a National ECELC (Empower PLUS+) trainer who worked for the United Way in Tucson and Southern Arizona received $150,000 from First Things First for a 3-year project focused on healthy eating and physical activity. Using the learning collaborative model and Empower PLUS+ materials, the trainer ran collaboratives with the San Carlos tribe in rural Arizona, which included parents and families, Head Start participants, and other tribal members. Eight ECE programs participated in the first year of training. All participating sites made improvements, for example, providing parents with written policies and guidelines on food brought from home, reducing non-educational media time for children, and increasing the frequency of whole grain foods and vegetables served to children. As of August 2016 United Way is planning its second year of Empower PLUS+ training with ECE providers on the San Carlos Apache Reservation.

***** Since original publication of this report in 2016, CDC has updated the Spectrum of Opportunities. The updated Spectrum can be found by visiting: *https://www.cdc.gov/obesity/strategies/early-care-education/pdf/TheSpectrumofOpportunitiesFramework_May2018_508.pdf*"

Challenges to Integration

ADHS has ongoing concerns about the lack of stable of funding for Empower. The Empower program allow programs to gain additional knowledge and resources to improve their program policies and practices related to healthy eating and physical activity, but it is still a voluntary program for ADHS programs. While linked to licensing, Empower standards are not required and monitored in the same way as licensing regulations. It is widely known that child care licensing regulations are difficult to change, but it may improve ECE program compliance with best practices if Arizona licensing regulations are updated and appropriately monitored to include the Empower standards. In this case, ADHS would need to consider if and how programs would still receive a reduction in licensing fees, which is currently tied to participation in Empower. Technical assistance for ECE programs needing to comply with the new regulations would have to be a top priority for Child Care Licensing if this update is made.

Additionally, during integration planning in 2014 another issue ADHS uncovered was low levels of participation in the federal Child and Adult Care Food Program (CACFP). A high percentage of children attending ECE programs bring their own lunches and therefore many programs are not eligible or do not have a desire or capacity (e.g., resources, availability of approved kitchen) to participate in CACFP. However, the funds ECE programs receive for CACFP participation can cover the cost of healthy meals and snacks provided to children. Encouraging more providers to participate in CACFP, and providing them the training and technical assistance to do so, would increase the quality of meals served to children versus those brought from home. ADHS did not choose to focus on this area, although since 2015, have been meeting with CACFP staff on a monthly basis and participating at their annual summit.

Finally, ADHS' biggest challenge may have been the tendency to rely only on systems integration opportunities within their department. For example, BNPA and Child Care Licensing were housed within ADHS and were successful in coordinating efforts on the Empower due to proximity and ease of ongoing communication within. However, at the beginning of their integration work it seemed difficult for ADHS to identify opportunities within other state-level systems that did not reside within their department. This was evident in their hesitation to choose CACFP as a viable opportunity as well as the difficulty to reach family child care providers. This could be in part due to the fact that CACFP is overseen by the Arizona Department of Education and family child care providers are overseen by the DES. Recognizing the importance of needing to include these key stakeholders in their work, ADHS regularly contacted the two departments for involvement in advisory committee meetings in order to advance healthy eating and physical activity messaging in ECE settings. They now enjoy ongoing collaborative meetings, creating common messages and themes. Having a dedicated stakeholder group at the onset for integration activities may have helped with coordination of systems-level integration activities.

Increasing participation of tribal communities in Empower was also a challenge. Tribal programs are legally exempt from child care licensing regulations, do not have licensing fees, and as such, have not systematically participated in Empower. During recruitment of child care centers for the National ECELC project, the project coordinator invited tribal programs to enroll but there was little interest. What did gain their interest, however, was the annual Empower conference, which many tribal members regularly attend. The need to reach additional tribal communities was recognized by ADHS, and in 2015 one of the National ECELC project (Empower PLUS+) trainers working at the United Way of Tucson brought a modified version of the project to the San Carlos Apache tribe. If funding arises in the future to support additional learning collaboratives, results from this work could be leveraged to demonstrate successful recruitment and project implementation with child care programs in other tribal communities.

Finally, in 2014, the reauthorization of the Child Care and Development Block Grant (CCDBG) brought a promising opportunity to include HEPA activities within the Arizona Child Care and Development Fund (CCDF) plan. With a strong interest in quality improvement, the National ECELC project coordinator had discussions with members of the advisory council for development of the CCDF plan. However, with DES as the lead in developing the CCDF plan and high staff turnover within the department, DES was focused on complying with the new group size requirement since Arizona does not have any. During this time the state plan was being developed and subsequent meetings with DES, the project coordinator shared the importance of HEPA-related messaging in ECE programs. As a result, DES now requires their family child care providers, who are overseen by DES, to enroll in the Empower Program.

Lessons Learned

Aligning existing childhood obesity prevention efforts (i.e. Empower) with new projects or initiatives is key to providing consistent messaging to raise awareness for HEPA best practices. However, the HEPA best practices must be included in state systems such as licensing and QRIS with proper monitoring and technical assistance provided to support those changes.

An individual or department in a leadership role with experience working with ECE programs is needed to identify and convene stakeholders to move the work forward. Or, at the very least, that individual or department must be a vocal member of existing advisory committees or stakeholder groups.

When planning for implementation of a childhood obesity prevention project or intervention, it is essential to involve and obtain buy-in and leadership from both internal and external partners. Keeping partners informed during the initial stages of planning and throughout the implementation process is essential to their ongoing support and collaboration. This is also important given that there can be multiple childhood obesity prevention projects or initiatives occurring simultaneously at the local or state level. Coordinating efforts to collect data across all project and leverage existing funding (i.e. CDC 1305) can help identify providers served and gaps in technical assistance to help inform future work.

Glossary of Key Terms

1. ***Arizona Department of Economic Security (DES)*** – Oversees family child care home providers in the state, and is leading development of Arizona's Child Care and Development Fund plan.
2. ***Arizona Department of Health Services (ADHS), Bureau of Nutrition and Physical Activity (BNPA)*** – State agency leading implementation of the National ECELC project in Arizona.
3. ***Arizona Nutrition Network (AzNN)*** – Arizona's Supplemental Nutrition Assistance Program-Education (SNAP-Ed).
4. ***Avandia Settlement Grant Project*** – Grant funding resulting from a settlement in which Arizona received over 3 million dollars from a diabetes drug manufacturer due to unlawful promotion of their product.
5. ***Empower*** – Voluntary childhood obesity prevention program led by ADHS Child Care Licensing.
6. ***Empower PLUS+*** – National ECELC project in Arizona; materials co-branded to align with Empower.
7. ***First Things First*** – Organization overseeing implementation of Quality First, and provides training and professional development to ECE program staff.
8. ***Quality First*** – Arizona's quality rating and improvement system (QRIS).

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. http://www.fns.usda.gov/cacfp/child-and-adult-care-food-program
8. http://www.acf.hhs.gov/occ/fact-sheet-occ
9. http://www.cdc.gov/chronicdisease/about/state-public-health-actions.htm
10. This number includes only programs that fully completed the intervention and completed sufficient baseline and post assessment materials to be included in evaluation activities.
11. **Standard 1:** Provide at least 60 minutes of daily physical activity, including adult -led and free play. Limit screen time to three hours of less per week and no more than 60 minutes of sedentary activity at a time.

    Standard 2: Practice "sun safety."

    Standard 3: Provide a breastfeeding-friendly environment.

    Standard 4: Determine whether the facility is eligible for the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP), and participate if eligible.

    Standard 5: Limit serving fruit juice to no more than two times per week.

    Standard 6: Serve meals family-style and do not use food as a reward.

    Standard 7: Provide monthly oral health education or implement a toothbrushing program.

    Standard 8: Ensure that staff members and child care providers receive three hours of training annually on Empower topics.

    Standard 9: Make Arizona Smokers' Helpline (ASHLine) education materials available at all times.

    Standard 10: Maintain a smoke-free environment.
12. 1. Support development, implementation and evaluation of food, beverage and physical activity policies and environments consistent with Empower standards. 2. Improve the capacity of child care providers and food service personnel in nutrition education, healthy meal planning and food preparation. 3. Improve the capacity of child care providers to give children daily opportunities for physical activity including outside play when possible. http://www.eatwellbewell.org/collaborators/resources/early-childhood-development#strategies
13. In Arizona, child care group homes (CCGH) serve between 5-10 children.

Nemours.org