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

Licensing and Administrative Regulations

Nemours. Children's Health System

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

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

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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).

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

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

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

As of 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.

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 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.

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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.

Integration Highlights: *Licensing and Administrative Regulations*

EECE program licensing regulations establish a minimum set of health, safety, and program standards that must be followed to legally operate a child care program. Licensing regulations are defined by a state, and in some cases, counties, cities, or municipalities[10].

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 Licensing and Administrative Regulations to help promote healthy eating and decrease obesity in young children in ECE[11]:

1. **Improve licensing standards** for obesity prevention
2. **Include** obesity prevention content in **licensing approved trainings**
3. **Provide incentives** for providers to exceeding licensing standards
4. **Enhance content** in licensing commentary/ support materials
5. Use **licensing monitors as a technical assistant touch-point**
6. **Collect and use data** from licensing monitors
7. **Support enhanced local standards** (if not pre-empted by the state)

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, six have focused on Licensing and Administrative Regulations as one of their primary strategies to integrate obesity prevention into state systems: **Alabama, Arizona, Kentucky, Los Angeles, CA, Missouri, and New Jersey**. Highlights of these efforts are provided below, and additional detail is available in each location's *Case Study for Integrating Obesity Prevention into State ECE Systems*.

Five of these locations—Alabama, Kentucky, Los Angeles, Missouri, and New Jersey – focused on promoting the inclusion of healthy eating and physical activity (HEPA) standards in licensing regulations as their primary strategy. The efforts are ongoing and stakeholders continue to advocate for HEPA to remain at the forefront of planning. Arizona's strategy focused on aligning the ECELC program with a HEPA initiative tied to state licensing regulations. In California, stakeholders also supported approved legislation that now requires that providers participating in Preventive Health and Safety Practices (PHSP) Training receive a 1-hour training on child nutrition.

Alabama:

Focused on improving licensing standards for obesity prevention related to nutrition, physical activity and screen time.

The Alabama Partnership (APC) for Children is working with VOICES, and the Southern Institute for Public Life to build a partnership with DHR to embed practice and training requirements related to obesity prevention topics in the Minimum Standards for child care and in requirements for providers receiving CCDF payments. VOICES received a Voices for Healthy Kids grant to advocate for the Alabama Minimum Standards to be updated to include enhanced nutrition, physical activity, and screen time standards and has engaged with APC because of their efforts to implement the ECELC and due to the relationships APC has built with essential partners through the Stakeholder Group.

Arizona:

Leveraged Arizona's Empower program to align HEPA messages, and built supports for ECE providers to achieve HEPA standards.

At the start of the National ECELC project, Arizona Department of Health Services (ADHS), Nemours' state implementation partner, and their partners identified an existing ECE health and wellness initiative, Empower, which could be built upon. 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 through a set of enhanced standards. The National ECELC project materials were customized and branded to align with Empower, and to ensure further alignment the learning collaboratives were named Empower PLUS+. Co-branding 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.

The ADHS Bureau of Nutrition and Physical Activity (BNPA) partnered with ADHS Child Care Licensing in 2013 to monitor ECE programs' compliance with Empower standards and to collect data that would inform future training and technical assistance on HEPA topics. Using the Centers for Disease Control and Prevention (CDC) 1305 funding and with technical assistance from CDC, the project coordinator began collecting data about Arizona's 1305 basic and enhanced activities in ECE programs. Data was also gathered from Head Start/Early Head Start programs, ECE programs participating in ECELC (Empower PLUS+), and Quality First (Arizona's quality rating and improvement system) to help identify gaps in types of providers served, technical assistance provided, and HEPA content delivered. As a result of this data collection and analysis, training materials, including the Empower Guidebook, 3rd edition, were revised in 2016 with a lens on family engagement, children with special health care needs and disabilities, language and cultural accommodations, multi-age groups and home settings.

Kentucky:

Promoted the inclusion of HEPA best practices into revised licensing regulations

In 2014, when the Kentucky Department of Public Health (KY-DPH) was planning its HEPA integration activities, the opportunity arose to recommend changes to the state's child care licensing regulations. KY-DPH leveraged this as an opportunity to embed stronger regulations related to healthy environments. KY DPH has been active in promoting the inclusion of HEPA best practices into the revised regulations, collaborating with the Division of Child Care which oversees licensing regulations.

A state Child Care Regulations Committee (CCRC) was formed to oversee revisions to the licensing regulations, and the committee sought input from stakeholders. In February 2015, the PFK ECE Committee convened to brainstorm recommendations related to physical activity, menus, and breastfeeding. Then, in June 2015, KY DPH convened stakeholders to brainstorm a "wish list" of HEPA standards that was submitted to the CCRC and included suggested regulations related to infant feeding, screen time, and reducing and eliminating juice. When the revised regulations were released for public comment, the revisions relating to HEPA areas were not included. Stakeholders from the PFK submitted responses to the cabinet; however, the regulations remain unchanged. Although the licensing regulations were not revised to include the HEPA recommendations, the current regulations provide minimum standards.

Los Angeles:

Advocated for improve licensing regulations that include HEPA best practices

Child Care Aware of Los Angeles (CCALA), Nemours' local implementation partner, worked closely with the Resource and Referral Network in California to advocate in Sacramento for the adoption of improved licensing standards. As new legislation is drafted and put forward to appropriations, CCALA continues its advocacy work. CCALA has prepared recommendations that include best practices in healthy eating and physical activity and will submit those recommendations when the state is accepting public comments on new recommendations.

Additionally, in 2013, California governor Jerry Brown signed AB 290 into law which increased the required hours of the Preventive Health and Safety Practices (PHSP) Training for providers to include one hour on childhood nutrition. AB 290 established that for child care licensures issued on or after January 1, 2016, providers receiving PHSP training will receive at least one hour of childhood nutrition training. CCALA supported the passing of AB 290 through letters of support with the California Department of Education, and is working to align existing professional development for ECE providers in Los Angeles County with AB290 training.

Missouri:

Collaborated with stakeholders and provided recommendations for the inclusion of HEPA topics in revised licensing regulations

In 2014, Child Care Aware of Missouri (CCAMO), Nemours' state implementation partner, and stakeholders began exploring changes to the child care licensing rules that could positively impact the health and development of Missouri's children. A statewide subcommittee on childhood obesity was formed for this purpose.

Missouri stakeholders developed a three-stage approach to improve licensing. Prior to launching the first stage, CCAMO and the Public Health Law Center conducted a landscape analysis of all policies impacting the standards, including gaps, barriers and synergies in MO's current child care policies. By 2016, CCAMO had secured funding for Stage 1 to develop a stakeholder prioritization survey in partnership with the University of Missouri – Kansas City. The survey aimed to narrow the focus of the licensing review by identifying the key gaps in current licensing rules most critical to 1) normal growth and development, 2) promoting and developing healthy behaviors, and 3) prevention of childhood obesity. By December 2016, the survey had been issued and completed, and detailed findings will be available in early 2017 and directly inform the next stage.

The subsequent stages were to focus on a survey of child care professionals, including program directors, administrators and educators in child care facilities (stage two) and focus groups/community meetings statewide to gather input from other constituent groups (stage three). Based on the findings from these efforts, CCAMO and MOCAN planned to develop an action plan to outline strategic steps to advance implementation of the standards including communication, legislative changes (if needed), rules changes, and a means to assure implementation of these standards by child care providers. While stakeholders made progress in advancing their multi-staged approach, there were challenges in fundraising. Given the statewide effort, each stage represents significant costs and funders have been reluctant to fund the entire effort. Therefore CCAMO has explored "budget braiding" where different but complementary funding sources are employed to complete the activities. CCAMO continues to review the three stages with the hopes of applying for funding to VOICES for Healthy Kids for a future statewide campaign.

In 2016, newly elected Governor Greitens issued an executive order freezing all new and proposed business regulations and ordering a review of all existing regulations, including child care licensing rules. By 2018, the governor resigned placing the rule review in limbo. CCAMO has worked with MOCAN and DHSS to identify next steps to maintain momentum. This includes working with DHSS on a revision of the MOve Smart guidelines that will launch statewide in late 2018.

New Jersey:

Continued focus on including best practice HEPA standards in licensing regulations and aligning training to those standards

In 2012, New Jersey enacted revised licensing regulations that put a greater emphasis on health, nutrition, and active play. Therefore, when New Jersey Department of Health (NJDOH) was funded as the state implementation partner for the Nemours in 2013, licensing regulations were already an area of the Spectrum of Opportunities to pursue for integration activities. NJDOH aligned training, including the ECELC, with the new regulations, to reach hundreds of providers statewide.

Then, in 2016, NJDOH had the opportunity to weigh in on licensing regulations for Family Child Care homes. NJDOH convened members of the *ShapingNJ*[12] early care and education setting workgroup to conduct a focus group survey with providers to understand what standards would be simple to meet and which they would find more difficult. Advocates submitted findings, recommended standards, rationale and research references to the state agency overseeing licensing regulations. Unfortunately, in an anti-regulatory environment, these recommendations were not implemented. However, other states may find New Jersey's group process useful for advocacy as well.

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. ***http://childcareaware.org/providers/opening-a-new-child-care-program/getting-your-business-licensed/***
11. Spectrum of Opportunities for Obesity Prevention in the Early Care and Education Setting (ECE), CDC Technical Assistance Briefing Document: ***https://www.cdc.gov/obesity/strategies/early-care-education/pdf/TheSpectrumofOpportunitiesFramework_May2018_508.pdf***
12. *ShapingNJ* is a diverse, multi-sectorial partnership to address nutrition, physical activity and obesity prevention in New Jersey. The goal of this partnership was and is to prevent obesity and improve the health of populations at risk for poor health outcomes in New Jersey by making "the healthy choice, the easy choice."

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