

August 4, 2025

Chairperson and Members Nevada State Board of Health Division of Public and Behavioral Health 4150 Technology Way Carson City, NV 89706

RE: Request for Agenda Placement – Proposed Amendments to NAC Codes for Early Childhood Health

Dear Chairperson and Members of the Nevada State Board of Health:

On behalf of the Nevada Early Childhood Obesity Prevention workgroup, I am writing to respectfully request placement on the agenda for the upcoming meeting of the Nevada State Board of Health on September 5, 2025. Our workgroup would like the opportunity to present proposed amendments to several Nevada Administrative Codes (NAC) related to healthy behaviors in early childcare settings.

Over the past two years, our workgroup has conducted an extensive review of NAC codes in relation to national recommendations for 47 specific indicators in nutrition, physical activity, and screen time in early childhood care. For the indicators where Nevada did not fully meet the national standards, we developed potential amendments to strengthen the state's alignment with best practices. Following the development of these proposed amendments, we sought input from stakeholders to ensure broad support. We first surveyed all 600 licensed childcare facilities in Nevada and received approximately 200 responses. Based on this feedback, modifications were made, and a second survey was then sent out to families of children attending licensed facilities across the state. After reviewing this additional input, we conducted a final round of revisions with input from Nevada Childcare Licensing to the proposed amendments.

We would now like to present these recommendations to the Board for review and consideration. Attached, you will find a summary of national standards and best practices, the proposed amendments, as well as supporting data. Our team would be available at the next scheduled meeting to present these recommended amendments to the Nevada Administrative code and answer any questions.

Thank you for your consideration of this request and for your continued commitment to improving the health of Nevada's youngest residents. Please do not hesitate to contact me at (702) 895-1040 or amanda.haboush@unlv.edu should you require any additional information in advance.

Sincerely,

Amanda Haboush-Deloye, PhD
Executive Director, Nevada Institute for Children's Research and Policy
Nevada Early Childhood Obesity Prevention Workgroup
4505 S. Maryland Parkway Box 453030
Las Vegas, NV 89154-3030
(702) 895-1040
amanda.haboush@unlv.edu



Attachments:

- 1. Achieving a State of Healthy Weight (ASHW) 2023 Annual Report
- 2. Origin of Achieving a State of Healthy Weight High-Impact Obesity Prevention Standards
- 3. ASHW: Nevada Survey Results of Licensed Childcare Providers and Families
- 4. Overview of Priority Amendments to Nevada Administrative Codes and Regulations



2023 ANNUAL REPORT

Achieving a State of Healthy Weight



2023 Annual Report **Achieving a State of Healthy Weight**

University of Colorado Anschutz Medical Campus College of Nursing

Program Director

Alison M. Pilsner, MPH, BSN, RN, CPH, IBCLC

Assessment Team

Nicole R. Patterson, MSACN, NDTR Scott B. Harpin, PhD, MPH, RN, FSAHM, FNAP

Advisor

Margaret West, MPA Division of Nutrition, Physical Activity and Obesity Centers for Disease Control and Prevention



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Executive Summary

What is the Achieving a State of Healthy Weight (ASHW) Report?

Annually, the University of Colorado collaborates with CDC's <u>Division of Nutrition</u>, <u>Physical Activity</u>, <u>and Obesity</u>, to assess child care licensing regulations in all 50 states and the District of Columbia. The 2023 *Achieving a State of Healthy Weight* (ASHW) report and three state supplements¹⁻³ are the 13th update to the baseline assessment that began in 2010. The report describes how well licensing regulations for early care and education (ECE) programs align with the High-Impact Obesity Prevention Standards (HIOPS).⁴ These 47 standards are a subset of Caring for Our Children's special collection, <u>Preventing Childhood Obesity</u>.⁵

What Do We Know?

Overweight and obesity often begin in early childhood and can have lifelong negative effects on health. ECE programs serve millions of very young children each week and may promote development of healthy lifestyles to prevent obesity. State child care licensing regulations can encourage ECE programs to adopt science-based standards and practices that promote recommended infant feeding practices, healthy nutrition standards and mealtime practices, opportunities for active play, and less screen time.

What's New?

Since 2010, annual updates have documented changes and improvements of the HIOPS within state child care licensing. However, more work remains to embed healthy eating, physical activity, and obesity prevention strategies in state ECE regulations to benefit our nation's youngest children. The 2023 ASHW publications present the level of support, nationally, for 47 HIOPS in child care licensing regulations. The updated <u>Supplements</u> present state-by-state data for each licensed child care type in 2023. Notably, 2023 saw the highest number of revisions impacting the HIOPS since 2012, with the most improvements observed in infant feeding practices.

How Can this Report be Used?

- Determine how state regulations support obesity prevention in licensed ECE programs
- 2. Highlight state successes
- 3. **Identify** opportunities for ECE regulations to improve support of obesity prevention in young children







Early Care and Education Matters

Evidence-based statewide interventions can help ECE programs improve their policies, practices, and nutrition and physical activity offerings.

Introduction

Pediatric overweight and obesity continues to be a public health crisis in the United States, with 1 in 5 children and adolescents considered overweight. 6 Rates are higher among children from low-income families and those from Black, Native American, and Hispanic populations. From 2017 to 2020, approximately 13% of children aged two to five were reported to have obesity. Obesity often persists through adolescence 8,9 and into adulthood, 10 and is associated with increased morbidity and mortality. 11,12 The early childhood period can be crucial for creating behaviors that support healthy weight practices and built a foundation for healthy living. 13-17



Why ECE?: About 12.5 million children participate in early care and education (ECE) programs outside their homes at least once a week, 18 representing nearly 60% of children aged zero to five nationwide. This includes vulnerable and at-risk children who may benefit from federally subsidized child care. 19 Licensed child care settings provide opportunities for active play, learning healthy mealtime practices, and sharing meals and snacks. 13,20-27



Why ECE Licensing?: Licensing regulations are established by states to ensure that ECE programs meet specific standards for quality and safety. To obtain and maintain their licensure, ECE programs must adhere to these state-specific regulations. Compliance to these regulations is crucial for providing a safe and developmentally appropriate environment for young children. Child care licensing serves as a crucial gateway to enhancing the ECE environment and offers states the potential to impact a large number of children.



High-Impact Obesity Prevention Standards (HIOPS):

In 2010, a National Advisory Committee reviewed the scientific evidence and identified 47 standards that have high impact for obesity prevention called HIOPS.²⁸ HIOPS cover four domains: infant feeding, nutrition, physical activity, and screen time. Public health practitioners, licensing officials and child care providers can integrate these science based obesity prevention standards into their ECE system. Adopting HIOPS can promote the adoption of healthy behaviors for children in care. To learn more about the national advisory committee and the <u>development of the HIOPS</u> you can consult the Caring for Our Children (CFOC) Special collection called Preventing Childhood Obesity.²⁹



History of ASHW: The 2023 Achieving a State of Healthy Weight (ASHW) Annual Report is the 13th update³⁰ of the assessment that began with *Achieving a Healthy Weight: A National Assessment of Obesity Prevention Terminology in Child Care Regulations 2010.*³¹ The annual publications provide state by-sate assessments over time on obesity prevention practice across several licensed care types, including child care centers, large family child care homes, and small family child care homes.





ASSESSMENT YEARS

State Assessments: 2010 to 2023

This table shows years in which states were assessed based on child care licensing regulation changes. The assessment period for the 2023 report is from January 1, 2023 to December 31, 2023. For a list of state documents rated in 2023, please see Appendix B.

Years Rated														
State	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Alabama	X		Χ						Х	Х		Х		Х
Alaska	Χ		Х					Х						
Arizona	Χ	Х								Х	Х			
Arkansas	Χ	Х				Х		Х			Х			
California	Χ		Χ					Х						Х
Colorado	Χ		Χ			Х	Χ	X				Χ		
Connecticut	Χ		Χ					X				Χ		Χ
Delaware	Χ		Χ			Χ		Х		Х	Х	Χ		
D.C.	Χ						Х	Х						
Florida	Χ		Χ	Х				Х		Х				
Georgia	Χ		Χ		Х			Χ			Х		Х	Х
Hawaii	Χ		Х					Х						Х
Idaho	Χ												Х	Х
Illinois	Χ				Х									Х
Indiana	Χ												Χ	
lowa	Χ		Х					Χ						
Kansas	Χ		Х	Х										
Kentucky	Χ			Х					Х			Χ		
Louisiana	Χ		Χ			Χ		X				Χ		Х
Maine	Χ		Х					Х				Χ		
Maryland	Χ		Х			Χ		Х						Х
Massachusetts	Х													
Michigan	Х		Χ		Х			Х		Х				
Minnesota	Х		Χ					Х						
Mississippi	Х		Χ	Х							Х			
Missouri	Χ						Х							Х

State assessed at baseline (2010) for all regulated child care types

State assessed due to new or revised licensing regulations

State assessed due to national **CACFP** updates

ASSESSMENT YEARS

State Assessments: 2010 to 2023 (continued)

Years Rated														
State	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Montana	Х		Х					Х				Х		
Nebraska	X		Χ	Х				Χ						
Nevada	X		Х						Х					
New Hampshire	X							Χ					Χ	
New Jersey	X			Χ				Χ						
New Mexico	X		Х		Х			Х						
New York	X			Х	Х	Χ		Х						
North Carolina	X		Х	Х				Х	Х					Х
North Dakota	X	Х									Х			Х
Ohio	X		Χ				Х					Χ		
Oklahoma	X						Х	Х					Χ	
Oregon	X		Χ					Х				Χ		
Pennsylvania	X										Χ			Х
Rhode Island	X		Χ	Х				Χ				Х		Х
South Carolina	X		Χ					Х						
South Dakota	X													Х
Tennessee	X								Χ				Χ	
Texas	X		Χ		Χ							Χ		Х
Utah	X		Χ					Χ						
Vermont	X						Х	Х						
Virginia	Х		Х					Х						
Washington	Х		Х					Х		Х				
West Virginia	Х		Х		Х									Х
Wisconsin	Х		X							Х				
Wyoming	Х		Х	Х									Х	

State assessed at baseline (2010) for all regulated child care types

State assessed due to new or revised licensing regulations

State assessed due to national **CACFP** updates

Status of High-Impact Obesity Prevention Standards (HIOPS): 2023

This report describes the extent to which the 50 states and the District of Columbia have incorporated the 47 evidence-based HIOPS into licensing regulations for child care centers and family child care homes.

In 2023, the ASHW assessment team screened over 61 regulatory documents. Seventeen states implemented changes that impacted the HIOPS in one or more licensed child care types (see Table 1). This report outlines these changes and their impact on state rankings of the HIOPS nationally.



Nationally, HIOPS are supported in:

- 64% of Child Care Centers
- 58% of Large Family Child Care Homes
- 55% of Small Family Child Care Homes



Most supported HIOPS in 2023:

- Provide children with space for play (PA1)
- Make water available inside and outside (ND1)
- Serve small-sized, age-appropriate portions (NF1)



Least supported HIOPS in 2023 continue to be:

- Limit oils and avoid fried foods (NA1)
- Limit salt by avoiding salty foods (NG1)
- Provide staff orientation training opportunities for physical activity (PA2)

State Highlights

In 2023, states had the greatest number of revisions impacting the 47 High-Impact Obesity Prevention Standards (HIOPS) since 2012. Some key highlights include:



Breastfeeding Support

Revisions to strengthen breastfeeding support and promotion were implemented in 5 states: Georgia, Louisiana, South Dakota, Illinois, and West Virginia.



Infant Feeding

Revisions in California, Maryland, Missouri, Rhode Island, and South Dakota included feeding infants on cue (SD & MO) and prohibiting the alteration of infant formula (CA, MD, & RI).



Nutrition

Revisions included Texas banning all sugar-sweetened beverages, Illinois child care centers improving overall support of the HIOPS, and Missouri centers requiring water to be freely available.



Healthy Mealtime Practices

Revisions included improved meal portion sizing in Georgia, prohibiting using food as a punishment in Idaho and Pennsylvania, and prohibiting forced feeding of children in Pennsylvania.



Physical Activity

Revisions included stronger outdoor play rules for children under age two in Louisiana, prohibiting withholding outdoor play in South Dakota, and enhancing moderate to vigorous play rules in Pennsylvania.



Screen Time Limits

Revisions included stronger regulations in North Carolina and West Virginia, which limited screen time and digital media usage to educational or physical activity purposes.



What Else is New in 2023?

Tennessee leads the nation in support of the HIOPS, followed by Texas and Washington.

REGULATORY PROGRESS: Changes Over Time



Most improved states since 2010 are: District of Columbia, Nevada, Tennessee, Florida, Texas, and Vermont



States with the most opportunity for improvement are: Alabama, Idaho, Massachusetts, South Dakota, Missouri, and Wyoming



Most positive changes in 2023 were seen in HIOPS related to breastfeeding promotion, feeding infants on cue, not altering infant formula, prohibiting sugar-sweetened beverages, and limiting screen time for educational or physical activity purposes

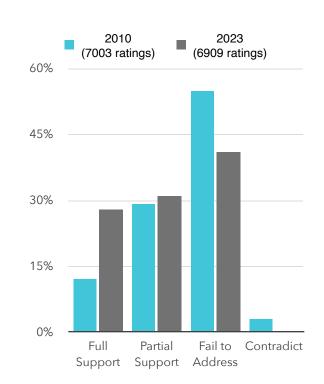
Support for the following HIOPS improved the most across all care types:

- Serve no juice to children younger than 12 months of age (ID3)
- Serve skim or 1% milk to children two years of age and older (NA5)
- Offer juice (100%) only during meal times (NC2)
- Serve fruits, mashed or pureed, for infants 6 months up to 1 year of age (ID2)

State Support: 2010 vs. 2023 (Figure 1)

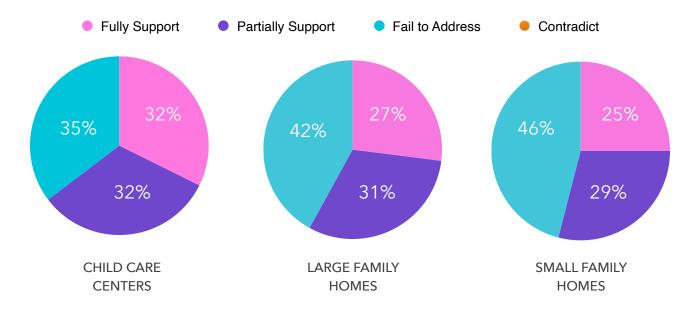
This figure shows change over time, comparing child care licensing support of the HIOPS in 2010 versus 2023. More states now fully support the HIOPS and fewer states fail to address or contradict the HIOPS than in 2010.

*In 2023, less than 0.5% of the HIOPS contradicted current best practices nationally.



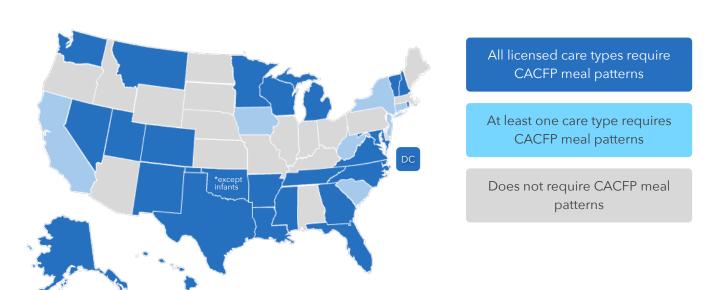
Differences in Support of the HIOPS by Licensed Child Care Type (Figure 2)

This figure shows the extent to which licensing regulations differ by child care type in their support of High-Impact Obesity Prevention Standards (HIOPS) nationally.



States Requiring CACFP Meal Patterns (Figure 3)

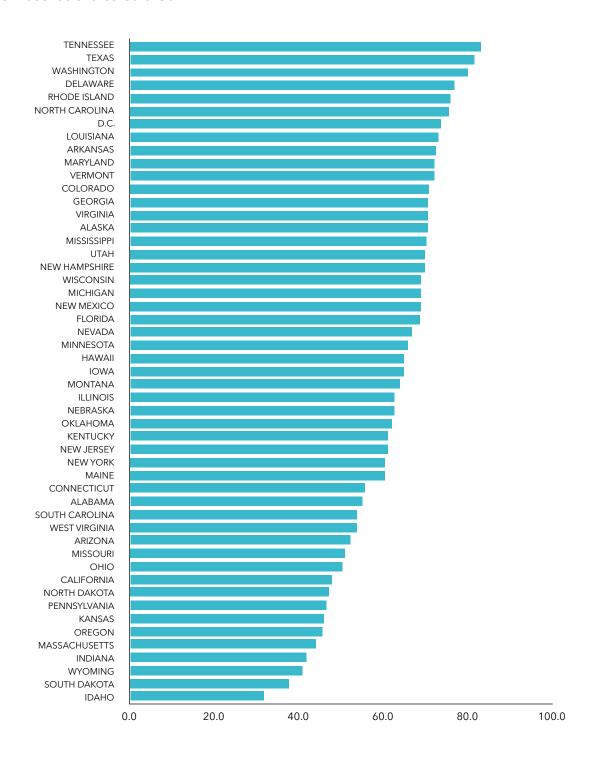
This figure shows the states that explicitly cite the USDA Child and Adult Care Food Program (CACFP) meal patterns (CFR 226.20) in their child care licensing regulations, regardless of whether the program formally participates in CACFP.



STATE RANKINGS IN 2023: ALL CHILD CARE TYPES

2023 State Ranking by Obesity Prevention Summary Score: ALL CHILD CARE TYPES (Figure 4)

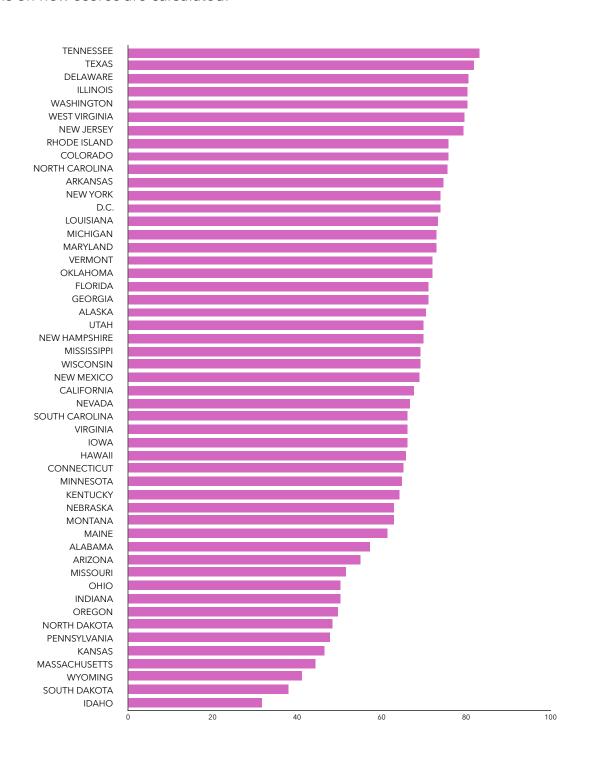
This figure illustrates the 2023 national rankings of state Obesity Prevention Summary Scores (OPSS) across all child care types (i.e., child care centers, large family child care homes, and small family child care homes). *Note: Refer to <u>ASHW Methodology</u>*³² for details on how scores are calculated.



STATE RANKINGS IN 2023: CHILD CARE CENTERS

2023 State Ranking by Obesity Prevention Summary Score: CHILD CARE CENTERS (Figure 5)

This figure illustrates the 2023 national rankings of state Obesity Prevention Summary Scores (OPSS) specifically for child care centers. *Note: Refer to <u>ASHW Methodology</u>*³² for details on how scores are calculated.

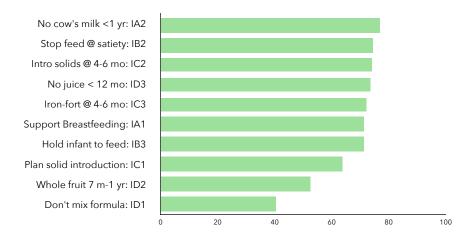


HIOPS SUPPORT ACROSS DOMAINS

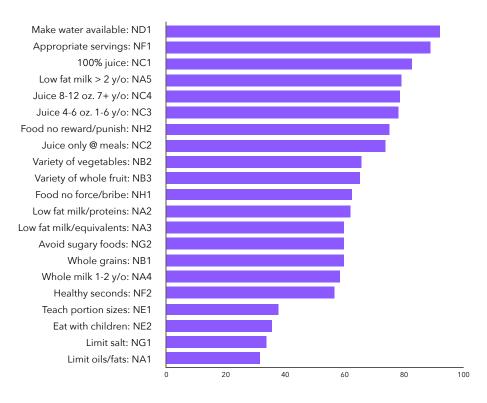
Support of Individual High-Impact Obesity Prevention Standards (HIOPS) in 2023 (Figures 6-9)

The figures below provide a rank order of HIOPS from those standards supported the most to those standards supported the least across all child care types for each of the four domains *Note: Refer to <u>ASHW Methodology</u>³² for details on how scores are calculated.*

Breastfeeding & Infant Feeding Practices (11 HIOPS):



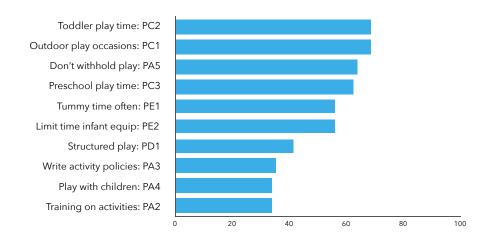
Nutrition & Healthy Mealtime Practices (21 HIOPS):



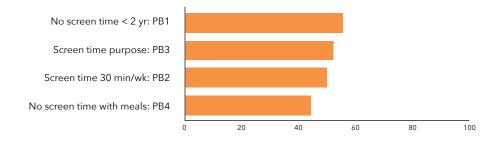
SUPPORT FOR STANDARDS 2023

Support of Individual High-Impact Obesity Prevention Standards in 2023 (continued)

Physical Activity (11 HIOPS):

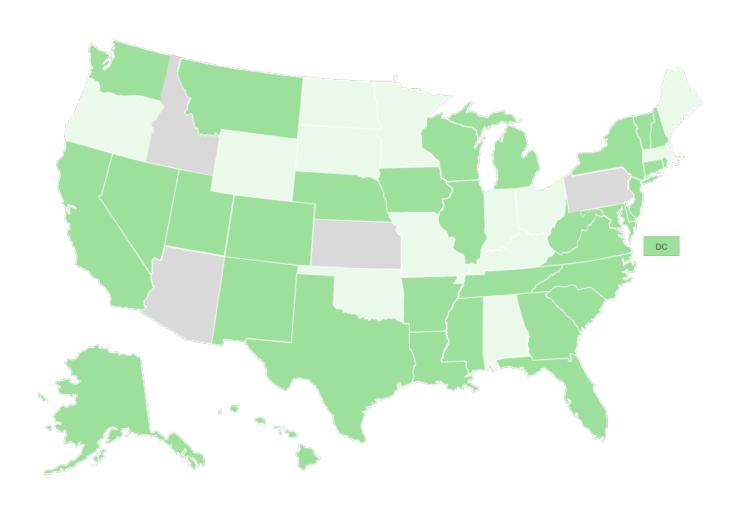


Screen Time Limits (4 HIOPS):



2023 State Progress on Fully Meeting Infant Feeding **High-Impact Obesity Prevention Standards (HIOPS)**

The map illustrates how well each state meets the 11 infant feeding (IF) HIOPS for child care centers in 2023. For a detailed assessment of each state's ratings, refer to the 2023 State Profiles: Child Care Centers.1

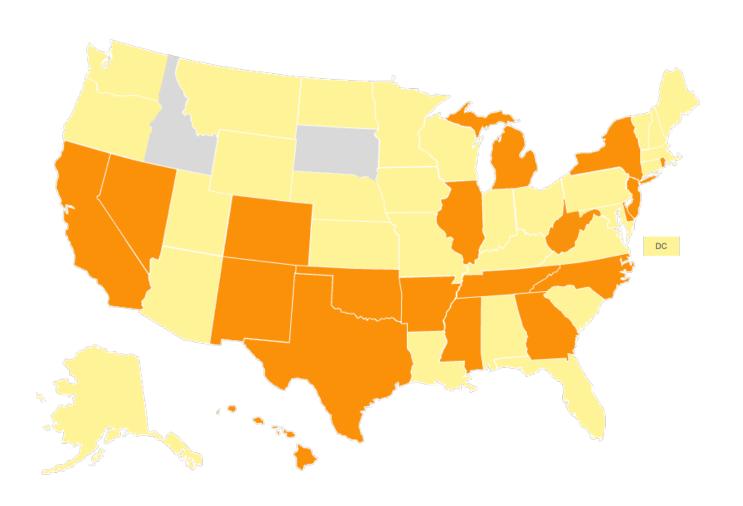


Note: Currently, no state meets the highest category of 9 to 11 IF HIOPS. Fully meeting is defined as a rating of a 4.



2023 State Progress on Fully Meeting Nutrition High-Impact Obesity Prevention Standards (HIOPS)

The map illustrates how well each state meets the 21 nutrition (NU) HIOPS for child care centers in 2023.

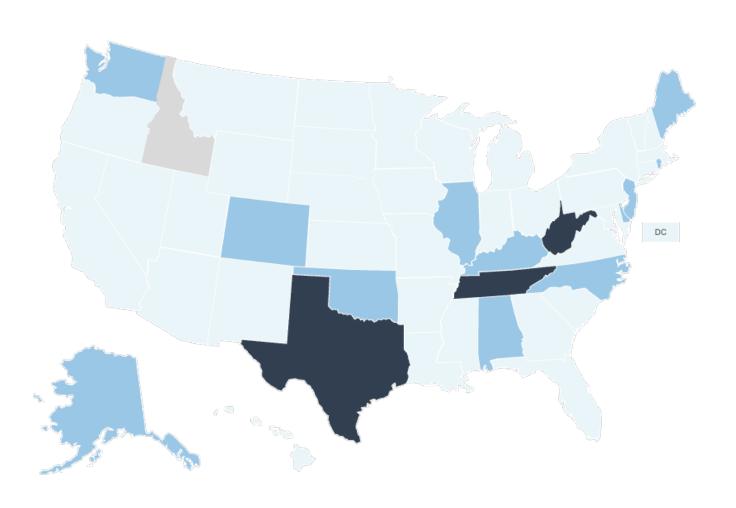


Note: The states highlighted in orange, fully meeting 8 to 15 NU HIOPS, have included adherence to CACFP meal patterns in their licensing regulations, except for Illinois.

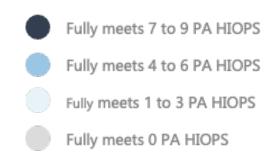


2023 State Progress on Fully Meeting Physical Activity **High-Impact Obesity Prevention Standards (HIOPS)**

The map illustrates how well each state meets the 11 physical activity (PA) HIOPS for child care centers in 2023.

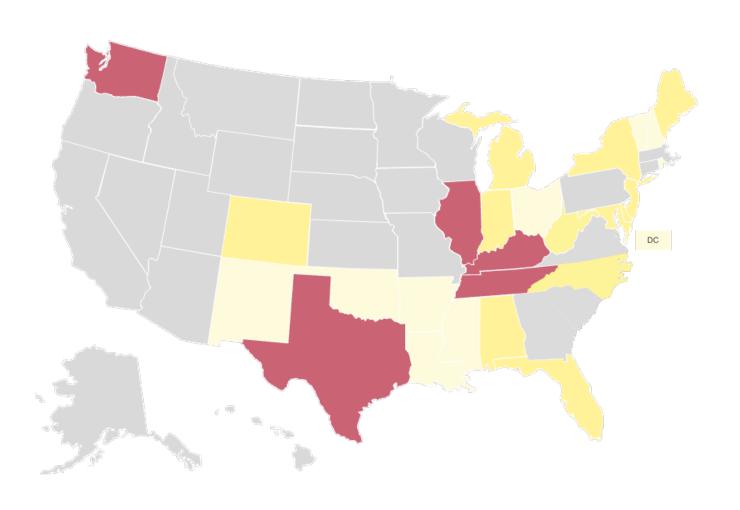


Note: Currently, no state meets all 11 PA HIOPS. Opportunities exist for all states' ECE licensing regulations to improve physical activity.



2023 State Progress on Fully Meeting Screen Time **High-Impact Obesity Prevention Standards (HIOPS)**

The map illustrates how well each state meets the 4 screen time (ST) HIOPS for child care centers in 2023.



Note: Currently, no state meets all 4 ST HIOPS. Opportunities exist for all states' ECE licensing regulations to improve screen time limits.





- 65% of states align their infant feeding and nutrition standards with USDA CACFP meal patterns.
- In 2023, states' infant feeding practices were most positively impacted in licensing regulations.

Discussion

In 2023, seventeen states (Alabama, California, Connecticut, Georgia, Hawaii, Idaho, Illinois, Louisiana, Maryland, Missouri, North Carolina, North Dakota, Pennsylvania, Rhode Island, South Dakota, Texas, and West Virginia) implemented regulatory changes affecting High-Impact Obesity Prevention Standards (HIOPS) in child care licensing. While most of these changes positively impacted the HIOPS, disparities persist among care types. Typically, regulations for child care centers better align with evidence-based practices compared to regulations for family child care homes. Greater alignment across care types is needed to address these disparities and ensure consistent implementation of effective obesity prevention strategies. Additionally, eight states (Arizona, Illinois, Indiana, Kansas, Kentucky, Mississippi, Oregon, and West Virginia) still have regulations that contradict best practices.

2023 States Changes:

- **Tennessee** continues to lead the nation in supporting HIOPS.
- Texas now prohibits all sugar-sweetened beverages, joining five other states (California, Illinois, Rhode Island, Tennessee, and West Virginia).
- Georgia and Louisiana updated regulations in three key areas: infant feeding, breastfeeding support, nutrition, and outdoor play.
- Maryland and Rhode Island received rating increases for requiring infant formula to be mixed and served according to manufacturer's instructions.
- North Carolina added language across all licensed care types prohibiting screen time for children under age three, allowing it only for educational or physical activities.
- Idaho implemented a single change across all licensed child care types prohibiting the use of food as punishment.

- Hawaii and South Dakota were rated for the first time since 2010 to ensure to assure rating alignment with current methodology. Hawaii had two rating adjustments to match current scales, while **South Dakota** showed improvements in infant feeding practices and in prohibiting the withholding of physical activity.
- Illinois revealed numerous positive changes, including improvements in breastfeeding accommodations, infant feeding practices, and nutrition standards. Although child care center rules do not require adherence to current USDA CACFP meal patterns, they include language that aligns with and exceeds these standards. These improvements did not extend to large and small family regulations, where contradictory language still exists for serving of milk, juice, and solid foods to infants. Illinois was last fully rated in 2010.
- West Virginia introduced major changes in their child care center licensing regulations, including the requirement to adhere to USDA CACFP meal patterns and strengthened rules for physical activity and screen time. However, these updates were not incorporated into family child care regulations. Regulations for large and small family child care homes still lack requirements for USDA CACFP meal pattens, but do include provisions for feeding infants on cue and limiting foods high in sugar and salt content.
- Missouri made positive changes by requiring infants to be fed on cue and allowing them to regulate their feeding pace. The state also enhanced requirements for fruit and vegetable consumption, implemented restrictions on juice intake for older children, and ensured water is freely available indoors and outdoors for child care centers.
- North Dakota introduced a unified change across all child care types, ensuring infants are fed developmentally appropriate foods and requiring parental and/or healthcare provider input before introducing solids foods before 6 months of age.
- Connecticut underwent a full rating assessment for the first time since 2010, showing an improvement in outdoor play rules for small family child care homes.
- Pennsylvania enhanced healthy mealtime practices by prohibiting force-feeding and using food as a form of discipline. Regulations now include new language promoting moderate to vigorous physical activity in child care centers and large family homes.
- California revised its regulations, resulting in updated rating adjustments and several higher ratings for child care centers in infant feeding and healthy beverage standards.
- Alabama saw a downgrade in infant feeding and nutrition ratings due to lack of explicit mention of USDA CACFP meal patterns.

Lessons Learned

Over the last 13 years, the team overseeing the ASHW assessments has observed several state actions that consistently strengthen the HIOPS in early care and education (ECE) regulations. For states seeking to make improvements to their child care regulations, consider the following:



Ensure consistency in regulatory changes across all licensed child care types. In 2023, disparities persist in the strength of obesity prevention rules, particularly when comparing child care centers and family child care homes.



Align infant feeding and nutrition requirements with the current USDA Child and Adult Family Food Program (CACFP) meal patterns, regardless of formal participation in the CACFP program by licensed providers.



Sustain HIOPS language in licensing standards during rule revisions to provide young children with a strong foundation for lifelong healthy behaviors. Ensure that physical activity and screen time HIOPS align with the national standards outlined in Caring for Our Children (CFOC).



Strive to achieve an Obesity Prevention Summary Score (OPSS) of 100, as no state has reached this milestone to date. However, continuous progress has been observed nationally over the past 13 years.

Roadmap to Success: Ensuring Safe, **Healthy Environments Where All** Children Thrive



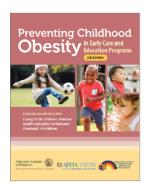
The ASHW reports continue to highlight opportunities for states to support obesity prevention in early care and education (ECE) programs. Here are several resources states can use to help advance obesity prevention regulations in ECE programs.



ASHW 2023 State Supplements. The ASHW Supplements¹⁻³ for child care centers, large family child care homes, and small family child care homes provide a comprehensive view of each state's strengths and areas for improvement across the 47 HIOPS.4 The state profile pages show ratings in 2010, compared to 2023.



CDC's State Licensing Scorecards on Obesity Prevention in Child Care Centers: CDC's State Licensing CDC's State Licensing Scorecards³³ assess how well each state's ECE licensing regulations support the 47 HIOPS. State scores are determined using a pointbased algorithm and include four obesity prevention domains: healthy infant feeding, nutrition, physical activity, and limits on screen time.



Caring for Our Children (CFOC) updated special collection, Preventing Childhood Obesity in Early Care and Education Programs (PCO). PCO⁵ presents expert and evidence-based best practices that were used to create the HIOPS. Assisting licensing professionals in revising regulations to promote obesity prevention. Current CFOC health and safety standards³⁴ can be found at: https://nrckids.org/cfoc



The 2023 Early Care and Education State Indicator Report.

This report,³⁵ published by CDC's Division of Nutrition, Physical Activity, and Obesity, provides data on what states are doing to promote healthy growth and obesity prevention in ECE settings. This report can guide future ECE nutrition, physical activity, healthy growth, and obesity prevention efforts.



CDC's Spectrum of Opportunities Framework. This framework³⁶ can guide states in their ECE efforts to integrate healthy growth and obesity prevention policies and activities into ECE systems. It describes nine areas for states at consider as they work to improve ECE policies and practices. Communities can also consider the nine focus areas when planning their own work.



USDA CACFP Meal and Snack Patterns. CACFP meal and snack patterns³⁷ are based on the Dietary Guidelines for Americans and reflect science-based recommendations from the National Academy of Medicine. States can strengthen support of infant feeding and nutrition standards in state child care licensing regulations by incorporating current CACFP meal patterns.



Note to States: Starting with ASHW 2022, states must explicitly reference USDA CACFP in their child care regulations to quality for CACFP ratings for the HIOPS. Regulations that only cited "USDA Guidelines," outdated meal pattern charts, or reproduced similar charts did not receive CACFP credit for 2023.

References

- 1. University of Colorado College of Nursing. 2023 Supplement: Achieving a State of Healthy Weight. State Profile Pages: Child Care Centers. University of Colorado Anschutz Medical Campus; 2024. https://nursing.cuanschutz.edu/ docs/librariesprovider2/research/ashw/ ashw-2023-supp-centers.pdf
- 2. University of Colorado College of Nursing. 2023 Supplement: Achieving a State of Healthy Weight. State Profile Pages: Large Family Child Care Homes. University of Colorado Anschutz Medical Campus; 2024. https:// nursing.cuanschutz.edu/docs/ librariesprovider2/research/ashw/ ashw-2023-supp-large.pdf
- 3. University of Colorado College of Nursing. 2023 Supplement: Achieving a State of Healthy Weight. State Profile Pages: Small Family Child Care Homes. University of Colorado Anschutz Medical Campus; 2024 https:// nursing.cuanschutz.edu/docs/ librariesprovider2/research/ashw/ ashw-2023-supp-small.pdf
- 4. National Resource Center for Health and Safety in Child Care and Early Education. Origin of Achieving a State of Healthy Weight High-Impact Obesity Prevention Standards. University of Colorado Anschutz Medical Campus; 2020. https://nursing.cuanschutz.edu/ docs/librariesprovider2/research/ashw/ hiopsorigin.pdf?sfvrsn=d6b975bb_0

- 5. American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education. Preventing Childhood Obesity in Early Care and Education Programs: Selected Standards from Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd ed. American Academy of Pediatrics; 2011. https://nrckids.org/CFOC/ Childhood_Obesity
- 6. Centers for Disease Control and Prevention. Childhood Obesity Facts. CDC.gov Web site. Last reviewed April 2, 2024. https://www.cdc.gov/obesity/ php/data-research/childhood-obesityfacts.html
- 7. Stierman B, Afful J, Carroll MD, et al. National Health and Nutrition Examination Survey 2017-March 2020 Prepandemic Data Files - Development of Files and Prevalence Estimates for Selected Health Outcomes, National health statistics reports; no 158. Hyattsville, MD: National Center for Health Statistics. 2021. https:// stacks.cdc.gov/view/cdc/106273

- 8. Weihrauch-Blüher S, Schwarz P, Klusmann JH. Childhood obesity: increased risk for cardiometabolic disease and cancer in adulthood. Metabolis. 2019;92:147-152. doi:10.1016/j.metabol.2018.12.001
- 9. Geserick M, Vogel M, Gausche R, et al. Acceleration of BMI in early childhood and risk of sustained obesity. N Engl J Med. 2018;379(14):1303-1312. doi:10.1056/NEJMoa1803527
- 10. Ward ZJ, Long MW, Resch S C, Giles CM, Cradock AL, Gortmaker SL. Simulation of growth trajectories of childhood obesity into adulthood. N Engl J Med. 2017;377(22):2145-2153
- 11. Bradwisch SA, Smith EM, Mooney C, Scaccia D. Obesity in children and adolescents: An overview. Nursing. 2020;50(11):60-66. doi:10.1097/01.NURSF .0000718908.20119.01
- 12. Caprio S, Santoro N, Weiss R. Childhood obesity and the associated rise in cardiometabolic complications. Nat Metab. 2020;2(3):223-232. doi:10.1038/s42255-020-0183-z
- 13. Gato-Moreno M, Martos-Lirio MF, Leiva-Geal, et al. Early nutritional education in the prevention of childhood obesity. Int J Environ Res Public Health. 2021;18(12):6569. doi:10.3390/ ijerph18126569

- 14. Ward D, Story M. Role of policies and practices within early care and education programs to support healthy food and physical activity practices. Child Obes. 2018;14(6):340. doi:10.1089/chi.2018.29004.ms
- 15. Ward DS, Welker E, Choate A, et al. Strength of obesity prevention interventions in early care and education settings: a systematic review. Prev Med. 2017;95 Suppl:S37-S52. doi:10.1016/j.ypmed.2016.09.033
- 16. Taveras E1. Reynolds MA, Jackson Cotwright C, Polhamus B, Gertel-Rosenberg A, Chang D. Obesity prevention in the early care and education setting: successful initiatives across a spectrum of opportunities. J Law Med Ethics. 2013 Winter; 41 Suppl 2:8-18. doi:10.1111/jlme.12104
- 17. Zaltz DA, Hecht AA, Neff RA, et al. Healthy eating policy improves children's diet quality in early care and education in South Carolina. Nutrients 2020;12(6):1753
- 18. Cui J, Natzke L. Early Childhood Program Participation: 2019. National Center for Education Statistics, Institute of Education Sciences, US Department of Education; 2021. Publication NCES 2020-075REV

- 19.U.S. Department of Education National Center for Education Statistics. Early Childhood Program Participation: 2019. NCES 2021; NCES 2020-2075REV: Table 1
- 20. USDA Food and Nutrition Service. Nutrition standards for CACFP meals and snacks. Updated May 9, 2023. https://www.fns.usda.gov/cacfp
- 21. Ward S, Blanger M, Donovan D, et al. Association between childcare educators' practices and preschoolers' physical activity and dietary intake: a cross-sectional analysis. BMJ Open. 2017;7(5):e013657. doi:10.1136/ bmjopen-2016- 013657
- 22. Anundson K, Sisson SB, Anderson M, Horm D. Soto J. Hoffman L. Staff foodrelated behaviors and children's tastes. of food groups during lunch at child care in Oklahoma. J Acad Nutr Diet. 2018;118(8):1399-1407 doi:10.1016/ j.jand.2017.07.023
- 23. Hughes SO, Power TG, Beck A, et al. Short-term effects of an obesity prevention program among lowincome Hispanic families with preschoolers. J Nutr Educ Behav. 2020;52(3):224-239. doi:10.1016/ j.jneb.2019.12.001

- 24. Lessard L, Breck A. Childhood obesity prevention in childcare settings: the potential of policy and environmental change interventions. Curr Obes Rep. 2015;4(2):191-197. doi:10.1007/ s13679-015-0154-y
- 25. Tandon P, HaD. Obesity prevention in the early care and education setting: successful initiatives across a spectrum of opportunities. J Law Med Ethics. 2013 Winter; 41 Suppl 2:8-18. doi:10.1111/jlme.12104
- 26. Wardnock AL, Dooyema C, Blanck HM, et al. Healthy start: National rrends in child care regulations and iptake of obesity prevention standards (2010-2018). Child Obes. 2021;17(3):176-184. doi:10.1089/ chi.2020.0298
- 27. Kenney EL, Mozaffarian RS, Frost N, Looby AA, Cradock, AL. Opportunities to promote healthy weight through child care licensing regulations: Trends in the United States, 2016-2020. J Acad Nuts Diet. 2021;121(9):1763-1774. doi: 10.1016/j.jand.2021.02.023

- 28. National Resource Center for Health and Safety in Child Care and Early Education. Origin of Achieving a State of Healthy Weight High-Impact Obesity Prevention Standards. University of Colorado Anschutz Medical Campus College of Nursing; 2020. https:// nursing.cuanschutz.edu/docs/ librariesprovider2/research/ashw/ hiopsorigin.pdf?sfvrsn=d6b975bb 0
- 29. American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education. 2012. Preventing Childhood Obesity in Early Care and Education Programs: Selected Standards from Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd ed. American Academy of Pediatrics; 2011. https://nrckids.org/CFOC/ Childhood_Obesity
- 30. University of Colorado College of Nursing. Archived ASHW Reports. University of Colorado Anschutz Medical Campus; Updated September 19, 2024. https:// nursing.cuanschutz.edu/research/ healthy-weight/healthy-weight-archives

- 31. National Resource Center for Health and Safety in Child Care and Early Education. Achieving a State of Healthy Weight: A National Assessment of Obesity Prevention Terminology in Child Care Regulations 2010. University of Colorado Anschutz Medical Campus College of Nursing; 2011. https:// nursing.cuanschutz.edu/docs/ librariesprovider2/research/ashw/ regulations_report_2010.pdf
- 32. University of Colorado College of Nursing. ASHW Methodology University of Colorado Anschutz Medical Campus; Updated September 19, 2024. https:// nursing.cuanschutz.edu/research/ healthy-weight/healthy-weight-archives
- 33. Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity and Obesity. State Licensing Score Cards. 2023. https:// www.cdc.gov/obesity/strategies/earlycare-education/state-scorecards.html
- 34. Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity and Obesity. State and local programs. Last reviewed February 20, 2024. https://www.cdc.gov/earlycare-education/php/state-childcarelicensing/state-licensingscorecards.html

- 35. Centers for Disease Control and Prevention. Early care and education state indicator report 2023. U.S. Department of Health and Human Services; 2023. https://www.cdc.gov/ early-care-education/media/pdfs/earlycare-education-report-2023-508.pdf
- 36. Centers for Disease Control and Prevention. Spectrum of opportunities framework. CDC.gov. Updated December 21, 2023. https:// www.cdc.gov/early-care-education/ php/getting-started/spectrum-ofopportunities.html
- 37. USDA Food and Nutrition Service. Nutrition standards for CACFP meals and snacks. FNS.USDA.gov. Updated July 12, 2024. https:// www.fns.usda.gov/cacfp/nutritionstandards
- 38. University of Colorado College of Nursing. State documents rated for ASHW: 2010 to 2023. University of Colorado Anschutz Medical Campus; 2024. https://nursing.cuanschutz.edu/ docs/librariesprovider2/research/ashw/ ashw-2023-statedocumentsrated.pdf

Source of ASHW High-Impact Obesity Prevention Standards (HIOPS) in PCO/CFOC Online Standards

The tables below present the ASHW High-Impact Obesity Prevention Standards (HIOPS) as outlined in the PCO/CFOC standards. To view the full details of each standard, including its rationale, references, and related standards, use the links to the searchable CFOC Online Standards Database at https://nrckids.org/CFOC.

Multiple-sourced HIOPS. The concepts captured in some ASHW HIOPS appear in different contexts in more than one PCO/CFOC standard. For example, the Infant Feeding HIOPS IB2: do not feed beyond satiety, is a core concept that is addressed slightly differently in two standards: 4.3.1.2 - Feeding Infants on Cue by a Consistent Caregiver/Teacher ("observing satiety cues can limit overfeeding") and 4.3.1.8 - Techniques for Bottle Feeding ("allow infant to stop the feeding"). Therefore, some ASHW HIOPS have more than one linked standard in the tables below.

	INFANT FEEDING							
HIOPS	ASHW HIOPS Text	Source of HIOPS in PCO/CFOC Standards						
IA1	Encourage and support breastfeeding and feeding of breast milk by making arrangements for mothers to feed their children comfortably on-site.	4.3.1.1 - General Plan for Feeding Infants						
IA2	Serve human milk or infant formula to at least age 12 months, not cow's milk, unless written exception is provided by primary care provider and parent/guardian.	4.3.1.7 - Feeding Cow's Milk & 4.2.0.4 - Categories of Foods						
IB1	Feed infants on cue.	4.3.1.2 - Feeding Infants on Cue by a Consistent Caregiver/Teacher & 4.3.1.8 - Techniques for Bottle Feeding						
IB2	Do not feed infants beyond satiety; Allow infant to stop the feeding.	4.3.1.2 - Feeding Infants on Cue by a Consistent Caregiver/Teacher & 4.3.1.8 - Techniques for Bottle Feeding						
IB3	Hold infants while bottle feeding; Position an infant for bottle feeding in the caregiver/teacher's arms or sitting up on the caregiver/teacher's lap.	4.3.1.8 - Techniques for Bottle Feeding						
IC1	Develop a plan for introducing age-appropriate solid foods (complementary foods) in consultation with the child's parent/guardian and primary care provider.	4.3.1.11 - Introduction of Age-Appropriate Solid Foods to Infants						
IC2	Introduce age-appropriate solid foods no sooner than 4 months of age, and preferably around 6 months of age.	4.3.1.11 - Introduction of Age-Appropriate Solid Foods to Infants						
IC3	Introduce breastfed infants gradually to iron-fortified foods no sooner than four months of age, but preferably around six months to complement the human milk.	4.3.1.11 - Introduction of Age-Appropriate Solid Foods to Infants						
ID1	Do not feed an infant formula mixed with cereal, fruit juice or other foods unless the primary care provider provides written instruction.	4.3.1.5 - Preparing, Feeding, and Storing Infant Formula						
ID2	Serve whole fruits, mashed or pureed, for infants 6 months up to one year of age.	4.2.0.4 - Categories of Foods 4.3.1.11 - Introduction of Age-Appropriate Solid Foods to Infants						
ID3	Serve no fruit juice to children younger than 12 months Aର୍ଦ୍ରୀଷ୍ଟ୍ରକ୍ରnual Report	<u>4.2.0.4 - Categories of Foods</u> & <u>4.2.0.7 - 100% Fruit Juice</u>						

	NUTRITION	
HIOPS	ASHW HIOPS Text	Source of HIOPS in PCO/CFOC Standards
NA1	Limit oils by choosing monounsaturated and polyunsaturated fats (such as olive oil or safflower oil) and avoiding trans fats, saturated fats and fried foods.	4.2.0.4 - Categories of Foods
NA2	Serve meats and/or beans - chicken, fish, lean meat, and/or legumes (such as dried peas, beans), avoiding fried meats.	4.2.0.4 - Categories of Foods
NA3	Serve other milk equivalent products such as yogurt and cottage cheese, using low-fat varieties for children 2 years of age and older.	4.2.0.4 - Categories of Foods
NA4	Serve whole pasteurized milk to twelve to twenty-four month old children who are not on human milk or prescribed formula, or serve reduced fat (2%) pasteurized milk to those who are at risk for hypercholesterolemia or obesity	4.3.2.3 - Encouraging Self-Feeding by Older Infants and Toddlers
NA5	Serve skim or 1% pasteurized milk to children two years of age and older.	4.3.2.3 - Encouraging Self-Feeding by Older Infants and Toddlers
NB1	Serve whole grain breads, cereals, and pastas.	4.2.0.4 - Categories of Foods
NB2	Serve vegetables, specifically, dark green, orange, deep yellow vegetables; and root vegetables, such as potatoes and viandas.	4.2.0.4 - Categories of Foods
NB3	Serve fruits of several varieties, especially whole fruits.	4.2.0.4 - Categories of Foods
NC1	Use only 100% juice with no added sweeteners.	4.2.0.7 - 100% Fruit Juice
NC2	Offer juice only during meal times.	4.2.0.7 - 100% Fruit Juice
NC3	Serve no more than 4 to 6 oz juice/day for children 1-6 years of age.	4.2.0.4 - Categories of Foods & 4.2.0.7 - 100% Fruit Juice
NC4	Serve no more than 8 to 12 oz juice/day for children 7-12 years of age.	4.2.0.4 - Categories of Foods & 4.2.0.7 - 100% Fruit Juice
ND1	Make water available both inside and outside.	4.2.0.6 - Availability of Drinking Water
NE1	Teach children appropriate portion size by using plates, bowls and cups that are developmentally appropriate to their nutritional needs.	4.3.2.2 - Serving Size for Toddlers and Preschoolers & 4.7.0.1 - Nutrition Learning Experiences for Children
NE2	Require adults eating meals with children to eat items that meet nutrition standards.	4.5.0.4 - Socialization During Meals
NF1	Serve small-sized, age-appropriate portions.	4.3.2.2 - Serving Size for Toddlers and Preschoolers
NF2	Permit children to have one or more additional servings of the nutritious foods that are low in fat, sugar, and sodium as needed to meet the caloric needs of the individual child; Teach children who require limited portions about portion size and monitor their portions.	4.3.2.2 - Serving Size for Toddlers and Preschoolers & 4.5.0.4 - Socialization During Meals
NG1	Limit salt by avoiding salty foods such as chips and pretzels.	4.2.0.4 - Categories of Foods
NG2	Avoid sugar, including concentrated sweets such as candy, sodas, sweetened drinks, fruit nectars, and flavored milk.	4.2.0.4 - Categories of Foods
NH1	Do not force or bribe children to eat.	4.5.0.11 - Prohibited Uses of Food
NH2	Do not use food as a reward or punishment.	4.5.0.11 - Prohibited Uses of Food

PHYSICAL ACTIVITY/SCREEN TIME								
HIOPS	ASHW HIOPS Text	Source of HIOPS in PCO/CFOC Standards						
PA1	Provide children with adequate space for both inside	3.1.3.1 - Active Opportunities for Physical						
ГАТ	and outside play.	<u>Activity</u>						
	Provide orientation and annual training opportunities							
PA2	for caregivers/teachers to learn about age-appropriate	3.1.3.4 - Caregivers'/Teachers'						
	gross motor activities and games that promote	Encouragement of Physical Activity						
	children's physical activity. Develop written policies on the promotion of physical							
PA3	activity and the removal of potential barriers to physical	9.2.3.1 - Policies and Practices that						
	activity participation.	Promote Physical Activity						
	Require caregivers/teachers to promote children's	2.1.2.1. Companies and /Topoch and						
PA4	active play, and participate in children's active games at	3.1.3.4 - Caregivers'/Teachers' Encouragement of Physical Activity						
	times when they can safely do so.	<u>Efficient of Physical Activity</u>						
	Do not withhold active play from children who							
DAE	misbehave, although out-of-control behavior may	3.1.3.1 - Active Opportunities for Physical						
PA5	require five minutes or less calming periods to help the child settle down before resuming cooperative play or	Activity						
	activities.							
	Do not utilize media (television [TV], video, and DVD)							
PB1	viewing and computers with children younger than two	2.2.0.3 - Screen Time/Digital Media Use						
	years.							
	Limit total media time for children two years and older	2.2.0.3 - Screen Time/Digital Media Use &						
PB2	to not more than 30 minutes once a week. Limit screen	3.1.3.4 - Caregivers'/Teachers'						
	time (TV, DVD, computer time).	Encouragement of Physical Activity						
PB3	Use screen media with children age two years and older only for educational purposes or physical activity.	2.2.0.3 - Screen Time/Digital Media Use						
	Do not utilize TV, video, or DVD viewing during meal or							
PB4	snack time.	2.2.0.3 - Screen Time/Digital Media Use						
	Provide daily for all children, birth to six years, two to	3.1.3.1 - Active Opportunities for Physical						
PC1	three occasions of active play outdoors, weather	Activity						
	permitting.							
PC2	Allow toddlers sixty to ninety minutes per eight-hour	3.1.3.1 - Active Opportunities for Physical						
	day for vigorous physical activity. Allow preschoolers ninety to one-hundred and twenty	Activity						
PC3	minutes per eight-hour day for vigorous physical	3.1.3.1 - Active Opportunities for Physical						
	activity.	Activity						
	Provide daily for all children, birth to six years, two or	3.1.3.1 - Active Opportunities for Physical						
PD1	more structured or caregiver/ teacher/ adult-led	Activity &						
101	activities or games that promote movement over the	3.1.3.4 - Caregivers'/Teachers'						
	course of the day-indoor or outdoor.	Encouragement of Physical Activity						
PE1	Ensure that infants have supervised tummy time every	3.1.3.1 - Active Opportunities for Physical						
	day when they are awake. Use infant equipment such as swings, stationary activity	Activity						
PE2	centers (ex. exersaucers), infant seats (ex. bouncers),	3.1.3.1 - Active Opportunities for Physical						
	molded seats, etc. only for short periods of time if at all.	Activity						

State Documents Rated in 2023 for Achieving a State of Healthy Weight (ASHW)

Documents rated in 2023 are presented below, with a comprehensive list of all documents rated since 2010 available here.³⁸ The ASHW assessment team works diligently to identify new and revised documents through website searches, emails, and calls to state licensing agencies. However, some regulations may go undiscovered in their effective year. In such cases, the study team will screen and rate these documents for inclusion in the ASHW report for the year they are discovered. If state licensing personnel are aware of any missed documents, please inform the assessment team at healthyweight@cuanschutz.edu.

CTR=Child Care Centers, LRG=Large Family Child Care Homes, SML=Small Family Child Care Homes

C	Regulation Document Title	Document	ASHW	Child Care Types		
State	For links to states' documents, click <u>here</u>	Date	Year	C T R	L R G	S M L
AL	Alabama					
	Child Care Licensing and Performance Standards for Day Care Centers and Nighttime Centers Regulations and Procedures	9/13/2021	2023	Χ		
	Child Care Licensing and Performance Standards for Family Day Care Homes/Family Nighttime Homes and Group Day Care Homes/Group Nighttime Homes Regulations and Procedures	9/13/2021	2023		Χ	Χ
CA	California					
	Chapter 3.4 California Child Day Care Act	7/10/2023	2023	Χ	Χ	Χ
	Title 22, Division 12, Chapter 1, Articles 1-2 - Child Care Centers	11/3/2023	2023	Χ		
	Title 22, Division 12, Chapter 1, Article 3 - Child Care Centers	11/3/2023	2023	Χ		
	Title 22, Division 12, Chapter 1, Articles 4-5 - Child Care Centers	9/27/06	2023	Χ		
	Title 22, Division 12, Chapter 1, Article 6 - Child Care Centers	11/3/2023	2023	Χ		
	Title 22, Division 12, Chapter 1, Article 7 - Child Care Centers	9/18/2020	2023	Χ		
	Title 22, Division 12, Chapter 1 Subchapter 2 - Child Care Centers - Infant Centers	11/3/2023	2023	Χ		
	Title 22, Division 12, Chapter 3 - Family Child Care Homes	4/1/2022	2023		Χ	Χ
СТ	Connecticut					
	Statutes and Regulations for Licensing Centers & Group Day Care	5/2023	2023	Χ	Χ	
	Statutes and Regulations for Family Child Care Homes	5/2023	2023			Χ
GA	Georgia					
	Rules and Regulations Learning Centers: Chapter 591-1-1	10/1/2023	2023	Χ		
	Rules and Regulations Family Learning Homes: Chapter 290-2-3	10/1/2023	2023			Χ
HI	Hawaii					
	Title 17, Chapter 896 Licensing of Before and After School	12/19/2002	2023	Χ		
	HAR_17-895 Infant and Toddler Child Care Center Rules	11/3/2023	2023	Χ		
	Title 17, Chapter 891.1 Registration of Family Child Care Homes	9/22/2023	2023		Χ	Χ
ID	Idaho					
	16.06.02 Rules Governing Standards for Child Care Licensing	3/28/2023	2023	Χ	Χ	Χ

State Documents Rated in 2023 (continued)

	Regulation Document Title	Document	ASHW		ild Ca Types	
State	For links to states' documents, click <u>here</u>	Date	Year	C T R	L R G	S M L
IL	Illinois					
	Part 407: Licensing Standards for Day Care Centers	10/30/2023	2023	Χ		
	Part 408: Licensing Standards for Group Day Care Homes	10/18/2023	2023		Χ	
	Part 406: Licensing Standards for Day Care Homes	10/25/2020	2023			Χ
LA	Louisiana					
	Bulletin 137 - Early Learning Site Licensing Regulations	10/2023	2023	Χ		
MD	Maryland					
	Title 13A State Board of Education Subtitle 16 Child Care Centers	11/2023	2023	Χ		
	Title 13A State Board of Education Subtitle 18 Large Family Homes	11/2023	2023		Χ	
MO	Missouri					
	Chapter 500 Licensing Rules for Group Homes and Child Care	10/21/2022	2023	Х		
	Centers	12/31/2023	2023	^		
	Chapter 400 Licensing Rules for Family Child Care Homes		2023		Χ	Χ
NC	North Carolina					
	Chapter 9- Child Care Rules	7/1/2023	2023	Χ	Χ	Χ
ND	North Dakota					
	Chapter 75-03-10 Child Care Center Early Childhood Services	1/1/2023	2023	Χ		
	Chapter 75-03-09 Group Child Care Early Childhood Services	1/1/2023	2023		Χ	
	Chapter 75-03-08 Family Child Care Early Childhood Services	1/1/2023	2023			Χ
PA	Pennsylvania					
	Chapter 3270 - Child Day Care Centers	3/2023	2023	Χ		
	Chapter 3280 - Group Child Day Care Homes	3/2023	2023		Χ	
	Chapter 3290 - Family Child Day Care Homes	3/2023	2023			Χ
RI	Rhode Island					
	218-RICR-70-00-1 Child Care Center and School Age Regulations	11/29/2023	2023	Χ		
	218-RICR-70-00-7 Group Family Child Care Home Regulations	1/1/2023	2023		Χ	
	218-RICR-70-00-2 Family Child Care Home Regulations	1/1/2023	2023			Χ
SD	South Dakota					
	Chapter 67:42:17 Child Care Licensing	7/3/2023	2023	Χ	Χ	Χ
TX	Texas					
	Chapter 746: Minimum Standards for Child-Care Centers	5/3/2023	2023	Χ		
	Chapter 747: Minimum Standards for Licensed and Registered				V	.,
	Child-Care Homes	5/3/2023	2023		Χ	Х
WV	West Virginia					
	Title 78, Legislative Rules, DHHR, Series 1 Child Care Center	4/1/2000	2022	V		
	Licensing Regulations	4/1/2023	2023	Χ		
	Title 78, Legislative Rules, DHHR, Series 18, Family Child Care	4/1/2022	2022		V	
	Facility Licensing Requirements	4/1/2023	2023		Χ	
	Title 78, Legislative Rules, DHHR, Series 19, Family Child Care	4/1/2022	2022			V
	Home Registration Requirements	4/1/2023	2023			Χ

Rating of the Child and Adult Care Food Program (CACFP)

U.S. Department of Agriculture (USDA) Food and Nutrition Service (FNS) Child and Adult Care Food Program (CACFP, also referred to as CFR 226.20) offers reimbursement to eligible programs to provide nutritious meals and snacks for children from low income families in child care programs (as well elderly adults in day care programs). Participating programs must follow age-specific CACFP Meal and Snack Patterns that define types of food and appropriate serving sizes. As CACFP offers guidance specific to early care and education (ECE), many states' child care licensing regulations require some or all categories of ECE programs to adhere to USDA CACFP guidelines, whether or not the individual programs formally participate in CACFP.

Caring for Our Children Standard 4.2.0.3 - Use of US Department of Agriculture Child and Adult Care Food Program Guidelines encourages adoption of the CACFP food guidance by all child care programs. 1 In 2010, the ASHW assessment team's 2010 external expert workgroup rated Standard 4.2.0.3 as high in impact upon obesity prevention, as part of the process to inform selection of ASHW variables (now HIOPS, or High Impact Obesity Prevention Standards).² Since CACFP Infant and Child Meal and Snack Patterns often constitute or enhance states' nutrition regulations, the ASHW assessment team rated CACFP on all ASHW Nutrition and Infant Feeding variables. When states reproduce CACFP requirements as part of licensing regulations for a given care type, or specify/confirm with the ASHW assessment team a licensing requirement for adherence to CFR 226.20/CACFP guidelines, the ASHW assessment team regards these states as ASHW "CACFP states." CACFP ratings are taken into account in rating the associated regulations. If there is no additional state text, the state receives the ASHW CACFP ratings for select HIOPS. If regulations include supplementary relevant text, that text is reviewed to determine whether it raises or lowers the CACFP rating.

Two CACFP updates occurred since 2010 that required revision of ASHW CACFP ratings. In 2012, the ASHW assessment team applied the improved ratings for two HIOPS to all CACFP states. In 2017, newly updated Meal and Snack Patterns were made mandatory for CACFP participants, improving ASHW ratings for four Infant Feeding and five Nutrition HIOPS. To identify states that should be assigned the improvements, the ASHW assessment team reviewed the 2010 categorization of CACFP states. The deciding factor for improved ratings was the clarity of the need to follow current CACFP guidelines. (See the ASHW 2017 Report, Appendix C. Methodology.²) State regulations vary in the ways they present the requirement to align nutrition practices with CACFP. Some cite CFR 226.20 or explicitly name CACFP. Others refer the reader to the USDA FNS CACFP website or instate CACFP contacts. Some reproduce the patterns with or without identification as CACFP materials. Some states use some combinations of the preceding.

¹ See Standard 4.2.0.3 @ https://nrckids.org/CFOC/Database/4.2.0.3

² National Resource Center for Health and Safety in Child Care and Early Education. Origin of Achieving a State of Healthy Weight high-impact obesity prevention standards. University of Colorado Anschutz Medical Campus College of Nursing; 2020. https://nursing.cuanschutz.edu/docs/ librariesprovider2/research/ashw/hiopsorigin.pdf

³ ASHW 2017 Report, Appendix C: ASHW 2017 Method Notes (p.33-34) @ https://nursing.cuanschutz.edu/docs/librariesprovider2/research/ashw/ ashw-2017-report.pdf

The ASHW assessment team's general rule is that reference to the federal code, to the CACFP program name or website, and/or reproductions of current Meal Patterns are sufficient to award improved CACFP ratings. When there are ambiguities (e.g., "USDA Guidelines" only), the ASHW assessment team typically reaches out to the state licensing agency for clarification. If no response is obtained, the ASHW assessment team uses best judgement. When a state newly requires adherence to CACFP guidelines, the state's ratings are adjusted accordingly. Tables 1 and Table 2, list the Infant Feeding and Nutrition HIOPS, respectively, and present the rating CACFP receives for each. CACFP Best Practices,4 introduced in the second CACFP update, provide stronger support for a few HIOPS than the basic Meal and Snack Patterns. They also are identified in Tables 1 and 2. However, through 2023, no state's regulations required adherence to the CACFP Best Practices.

ASHW RATING SCALE

- 1 = Content contradicts the HIOPS
- 2 = Content does not address the HIOPS
- 3 = Content partially supports the HIOPS
- 4 = Content fully supports the HIOPS

Table 1. Infant Feeding

Table 1 summarizes Infant Feeding ratings assigned to states' regulations that require licensed programs to follow CACFP. The ratings for 2010 versus 2017 updates are displayed (e.g., 3/4). 2017 CACFP Best Practice ratings are noted in the last column where applicable.

	HIGH-IMPACT OBESITY PREVENTION STANDARDS (HIOPS)	ASHW CACFP Rating 2010/2017	ASHW CACFP Best Practice Rating
IA1.	Encourage and support breastfeeding and feeding of breast milk by making arrangements for mothers to feed their children comfortably on-site.	3/3	4
IA2.	Serve human milk or infant formula to at least age 12 months, not cow's milk, unless written exception is provided by primary care provider and parent/guardian.	4/4	-
IB1.	Feed infants on cue.	4/4	-
IB2.	Do not feed infants beyond satiety; Allow infant to stop the feeding.	4/4	-
IB3.	Hold infants while bottle feeding; Position an infant for bottle feeding in the caregiver/teacher's arms or sitting up on the caregiver/teacher's lap.	2/2	-
IC1.	Develop a plan for introducing age-appropriate solid foods (complementary foods) in consultation with the child's parent/guardian and primary care provider.	3/3	-
IC2.	Introduce age-appropriate solid foods no sooner than 4 months of age, and preferably around 6 months of age.	3/4	-
IC3.	Introduce breastfed infants gradually to iron-fortified foods no sooner than four months of age, but preferably around six months to complement the human milk.	3/4	-
ID1.	Do not feed an infant formula mixed with cereal, fruit juice or other foods unless the primary care provider provides written instruction.	2/2	-
ID2.	Serve whole fruits, mashed or pureed, for infants 6 months up to one year of age.	1/3	-
ID3.	Serve no fruit juice to children younger than 12 months of age.	1/4	-

Table 2. Nutrition

Table 2 summarizes Nutrition ratings assigned to states' regulations that require licensed programs to follow CACFP. The ratings for 2010 versus 2017 updates are displayed (e.g., 3/4). 2017 CACFP Best Practice ratings are noted in the last column where applicable.

	HIGH-IMPACT OBESITY PREVENTION STANDARDS (HIOPS)	ASHW CACFP Rating 2010/2017	ASHW CACFP Best Practice Rating
NA1.	Limit oils by choosing monounsaturated and polyunsaturated fats (such as olive oil or safflower oil) and avoiding trans fats, saturated fats and fried foods.	2/2	3
NA2.	Serve meats and/or beans - chicken, fish, lean meat, and/or legumes (such as dried peas, beans), avoiding fried meats.	3/3	-
NA3.	Serve other milk equivalent products such as yogurt and cottage cheese, using low-fat varieties for children 2 years of age and older.	3/3	-
NA4.	Serve whole pasteurized milk to 12-24 month old children who are not on human milk or prescribed formula, or serve reduced fat (2%) pasteurized milk to those who are at risk for hypercholesterolemia or obesity.	2/3	-
NA5.	Serve skim or 1% pasteurized milk to children two years of age and older.	4*/4	-
NB1.	Serve whole grain breads, cereals, and pastas.	3/3	4
NB2.	Serve vegetables, specifically, dark green, orange, deep yellow vegetables; and root vegetables, such as potatoes and viandas.	3/3	4
NB3.	Serve fruits of several varieties, especially whole fruits.	3/3	4
	Use only 100% juice with no added sweeteners.	4/4	-
	Offer juice only during meal times.	2/4	-
	Serve no more than 4 to 6 oz juice/day for children 1-6 years of age.	3/4	-
	Serve no more than 8 to 12 oz juice/day for children 7-12 years of age.	3/4	-
	Make water available both inside and outside.	4*/4	-
NE1.	Teach children appropriate portion size by using plates, bowls and cups that are developmentally appropriate to their nutritional needs	2/2	-
NE2.	Require adults eating meals with children to eat items that meet nutrition standards.	2/2	-
NF1.	Serve small-sized, age-appropriate portions.	4/4	-
NF2.	Permit children to have one or more additional servings of the nutritious foods that are low in fat, sugar, and sodium as needed to meet the caloric needs of the individual child; Teach children who require limited portions about portion size and monitor their portions.	3/3	-
	Limit salt by avoiding salty foods such as chips and pretzels. (Selected to complete the food groups)	2/2	-
NG2.	Avoid sugar, including concentrated sweets such as candy, sodas, sweetened drinks, fruit nectars, and flavored milk.	1/3	-
NH1.	Do not force or bribe children to eat.	2/2	-
NH2.	Do not use food as a reward or punishment.	2/2	-

^{*} NA5 and ND1 2010 values = 2. Starred rating values were effective in ASHW 2012 due to CACFP improvement.

2023 State Support Across the HIOPS: Child Care Centers

This table shows the percentage of ratings per state, across child care centers, that a) contradict, b) fail to address, c) partially support, and d) fully support the 47 High-Impact Obesity Prevention Standards (HIOPS).

State	Contradicts	Fail To Address	Partially Supports	Fully Supports
ALABAMA	0%	51%	23%	26%
ALASKA	0%	26%	38%	26%
ARIZONA	0%	45%	38%	26%
ARKANSAS	0%	17%	45%	26%
CALIFORNIA	0%	36%	23%	26%
COLORADO	0%	19%	36%	26%
CONNECTICUT	0%	36%	32%	26%
DELAWARE	0%	9%	45%	26%
DISTRICT OF COLUMBIA	0%	19%	43%	26%
FLORIDA	0%	26%	36%	26%
GEORGIA	0%	28%	32%	26%
HAWAII	0%	36%	30%	26%
IDAHO	0%	96%	4%	26%
ILLINOIS	0%	15%	23%	26%
INDIANA	0%	60%	13%	26%
IOWA	0%	34%	34%	26%
KANSAS	0%	60%	32%	26%
KENTUCKY	0%	36%	28%	26%
LOUISIANA	0%	19%	45%	26%
MAINE	0%	40%	34%	26%
MARYLAND	0%	21%	40%	26%
MASSACHUSETTS	0%	72%	17%	26%
MICHIGAN	0%	21%	40%	26%
MINNESOTA	0%	32%	43%	26%
MISSISSIPPI	0%	21%	38%	26%
	0%	57%	28%	26%
MISSOURI		40%		
MONTANA	0%		30%	26%
NEBRASKA	0%	40%	30%	26%
NEVADA	0%	32%	36%	26%
NEW HAMPSHIRE	0%	26%	40%	26%
NEW JERSEY	0%	15%	34%	26%
NEW MEXICO	0%	30%	34%	26%
NEW YORK	0%	19%	43%	26%
NORTH CAROLINA	0%	21%	32%	26%
NORTH DAKOTA	0%	62%	28%	26%
OHIO	0%	62%	21%	26%
OKLAHOMA	0%	23%	38%	26%
OREGON	0%	51%	34%	26%
PENNSYLVANIA	0%	64%	26%	26%
RHODE ISLAND	0%	19%	36%	26%
SOUTH CAROLINA	0%	32%	38%	26%
SOUTH DAKOTA	0%	85%	9%	26%
TENNESSEE	0%	9%	36%	26%
TEXAS	0%	15%	26%	26%
UTAH	0%	26%	40%	26%
VERMONT	0%	23%	38%	26%
VIRGINIA	0%	34%	34%	26%
WASHINGTON	0%	13%	36%	26%
WEST VIRGINIA	0%	17%	28%	26%
WISCONSIN	0%	28%	38%	26%
WYOMING	0%	79%	13%	26%

2023 State Support Across the HIOPS: Large Family Homes

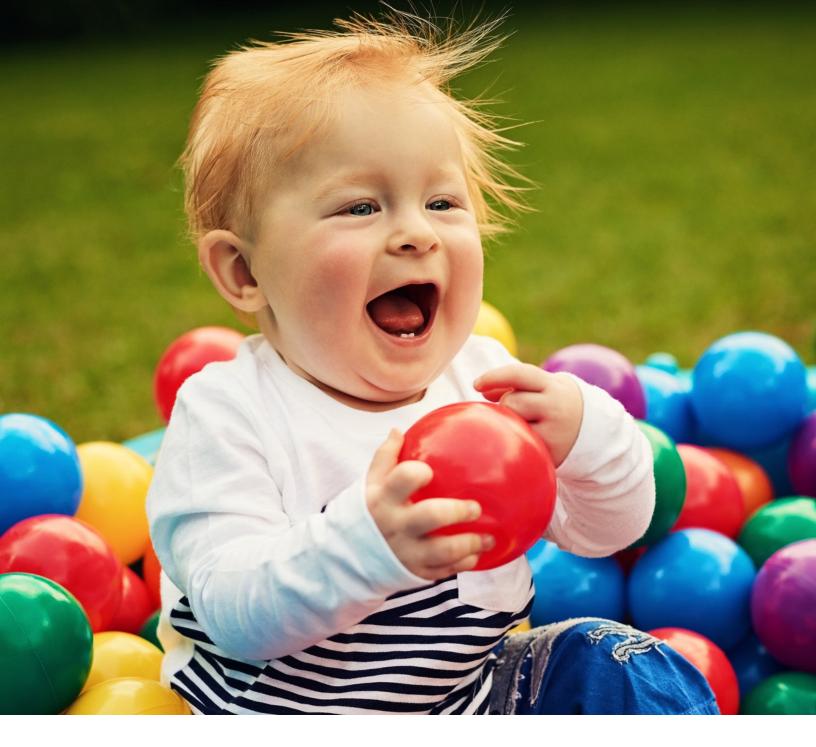
This table shows the percentage of ratings per state, across small family child care homes, that a) contradict, b) fail to address, c) partially support, and d) fully support High-Impact Obesity Prevention Standards (HIOPS).

State	Contradicts	Fail To Address	Partially Supports	Fully Supports
ALABAMA	0%	55%	23%	21%
ALASKA	0%	26%	38%	36%
ARIZONA	2%	57%	28%	13%
ARKANSAS	0%	23%	40%	36%
CALIFORNIA	0%	85%	9%	6%
COLORADO	0%	30%	36%	34%
CONNECTICUT	0%	36%	32%	32%
DELAWARE	0%	19%	38%	43%
DISTRICT OF COLUMBIA	0%	19%	43%	38%
FLORIDA	0%	23%	43%	34%
GEORGIA	0%	0%	0%	0%
HAWAII	0%	38%	30%	32%
IDAHO	0%	96%	4%	0%
ILLINOIS	6%	45%	28%	21%
INDIANA	0%	85%	9%	6%
IOWA	0%	38%	30%	32%
KANSAS	2%	62%	30%	6%
KENTUCKY	2%	36%	28%	34%
LOUISIANA	0%	0%	0%	0%
MAINE	0%	45%	30%	26%
MARYLAND	0%	21%	38%	40%
MASSACHUSETTS	0%	72%	17%	11%
		30%		
MICHIGAN	0%	30%	40% 38%	30%
MINNESOTA	0% 4%	19%	38%	30%
MISSISSIPPI				
MISSOURI	0%	57%	30%	13%
MONTANA	0%	36%	34%	30%
NEBRASKA	0%	40%	30%	30%
NEVADA	0%	32%	36%	32%
NEW HAMPSHIRE	0%	26%	40%	34%
NEW JERSEY	0%	0%	0%	0%
NEW MEXICO	0%	30%	34%	36%
NEW YORK	0%	53%	30%	17%
NORTH CAROLINA	0%	21%	32%	47%
NORTH DAKOTA	0%	66%	23%	11%
OHIO	0%	62%	21%	17%
OKLAHOMA	0%	45%	38%	17%
OREGON	4%	49%	38%	9%
PENNSYLVANIA	0%	64%	26%	11%
RHODE ISLAND	0%	17%	40%	43%
SOUTH CAROLINA	0%	32%	40%	28%
SOUTH DAKOTA	0%	85%	9%	6%
TENNESSEE	0%	9%	36%	55%
TEXAS	0%	15%	28%	57%
UTAH	0%	26%	40%	34%
VERMONT	0%	23%	38%	38%
VIRGINIA	0%	21%	40%	38%
WASHINGTON	0%	13%	36%	51%
WEST VIRGINIA	2%	70%	23%	4%
WISCONSIN	0%	0%	0%	0%
WYOMING	0%	79%	13%	9%

2023 State Support Across the HIOPS: Small Family Homes

This table shows the percentage of ratings per state, across small family child care homes, that a) contradict, b) fail to address, c) partially support, and d) fully support High-Impact Obesity Prevention Standards (HIOPS).

State	Contradicts	Fail To Address	Partially Supports	Fully Supports
ALABAMA	0%	55%	23%	21%
ALASKA	0%	26%	38%	36%
ARIZONA	0%	0%	0%	0%
ARKANSAS	0%	23%	43%	34%
CALIFORNIA	0%	85%	9%	6%
COLORADO	0%	30%	36%	34%
CONNECTICUT	0%	87%	6%	6%
DELAWARE	0%	19%	38%	43%
DISTRICT OF COLUMBIA	0%	19%	43%	38%
FLORIDA	0%	36%	34%	30%
GEORGIA	0%	28%	34%	38%
HAWAII	0%	36%	32%	32%
IDAHO	0%	96%	4%	0%
ILLINOIS	6%	45%	28%	21%
INDIANA	0%	85%	9%	6%
IOWA	0%	38%	30%	32%
KANSAS	2%	62%	30%	6%
KENTUCKY	2%	49%	28%	21%
LOUISIANA	0%	0%	0%	0%
MAINE	0%	45%	30%	26%
MARYLAND	0%	26%	40%	34%
MASSACHUSETTS	0%	72%	17%	11%
MICHIGAN	0%	30%	40%	30%
MINNESOTA	0%	32%	38%	30%
MISSISSIPPI	4%	19%	38%	38%
MISSOURI	0%	57%	30%	13%
MONTANA	0%	36%	34%	30%
NEBRASKA	0%	40%	30%	30%
NEVADA	0%	32%	36%	32%
NEW HAMPSHIRE	0%	26%	40%	34%
	0%	72%	21%	6%
NEW JERSEY				
NEW MEXICO	0%	30%	34%	36%
NEW YORK	0%	53%	30%	17%
NORTH CAROLINA	0%	21%	32%	47%
NORTH DAKOTA	0%	66%	23%	11%
OHIO	0%	62%	21%	17%
OKLAHOMA	0%	45%	38%	17%
OREGON	0%	85%	11%	4%
PENNSYLVANIA	0%	70%	21%	9%
RHODE ISLAND	0%	17%	40%	43%
SOUTH CAROLINA	0%	100%	0%	0%
SOUTH DAKOTA	0%	85%	9%	6%
TENNESSEE	0%	9%	36%	55%
TEXAS	0%	15%	28%	57%
UTAH	0%	26%	40%	34%
VERMONT	0%	23%	38%	38%
VIRGINIA	0%	21%	40%	38%
WASHINGTON	0%	13%	36%	51%
WEST VIRGINIA	0%	79%	17%	4%
WISCONSIN	0%	28%	38%	34%
WYOMING	0%	79%	13%	9%



For more information please contact

College of Nursing, ASHW Assessment Team
University of Colorado Anschutz Medical Campus
<a href="https://nursing.cuanschutz.edu/research/healthy-weight@cuanschutz.edu/healthy-weight@cuan



Origin of Achieving a State of Healthy Weight High-Impact Obesity Prevention Standards

Background. In 2010, the National Resource Center for Health and Safety in Child Care and Early Education (NRC) at the University of Colorado College of Nursing sought to identify a set of high impact best practices for obesity prevention in early child care and education (ECE) programs, based upon Caring for Our Children (CFOC) standards.^a The subset of evidence-based practices then could be used by ECE professionals, policy makers, regulators and to inform child care licensing regulations and strategies to prevent childhood obesity and promote healthy habits.1 The task was jointly funded under the Health and Human Services (HHS) Healthy Weight Initiative by the Health Resources and Services Administration Maternal and Child Health Bureau (HRSA MCHB) and by the Administration for Children and Families Child Care Bureau (ACF CCB, now, the ACF Office of Child Care). The source document for the set of practices was a subset of CFOC standards developed with the input of more than 50 content experts nationally. It was published as Preventing Childhood Obesity in Early Care and Education Programs: Selected Standards from Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd Edition (PCO).¹

Healthy Weight Advisory Meeting Goal. The first step was the assembly of a national advisory group to guide the process. NRC convened the Healthy Weight Advisory Meeting in Aurora, Colorado (July 2010) with MCHB and CCB support. The meeting goal was to identify those components of the PCO standards with the highest probable impact upon pediatric obesity when implemented consistently in ECE programs.

Participants. Invitees were selected by NRC leadership in consultation with MCHB and CCB officers. Representation of diverse perspectives on children's health, nutrition, and physical activity from multiple disciplines, practitioners in pediatric health and child care sectors, and child care licensing regulation was imperative. The list of experts drew heavily upon the nearly 300 CFOC Technical Panel contributors and external reviewers who were concurrently engaged in NRC's comprehensive revision of CFOC standards, and

especially those who also assisted development of PCO. Participants represented: key federal agencies (Centers for Disease Control and Prevention Division of Nutrition, Physical Activity and Obesity (DNPAO), Head Start, U.S. Department of Agriculture Food and Nutrition Service, MCHB and CCB); leading organizations in child health and development and child care delivery and licensing (Food Research and Action Center, National Association for Regulatory Administration, National Association for Family Child Care, National Training Institute for Child Care Health Consultants, Nemours Foundation); as well as researchers from leading universities (Columbia University, Duke University, University of North Carolina at Chapel Hill, Yale University), and others (see Appendix. Healthy Weight Advisors).

Meeting Implementation. NRC contracted with experts in participatory evaluation at The Evaluation Center of the School of Education and Human Development at University of Colorado Denver to jointly facilitate the three-day meeting and for data analysis. Advisor invitation packages included copies of PCO, suggested readings, and instructions to prepare for the meeting. To enable advisors to focus on individual practices included PCO/CFOC standards, NRC staff extracted 275 components from the complete PCO standards. After deleting safety-oriented components (e.g., responses to choking or allergic reactions), a 217 item pool remained, consisting of practices with the potential to impact pediatric obesity. On Day 1, facilitators introduced background information and described meeting goals and procedures. Day 2 was dedicated to assigning impact ratings. In a Gallery Walk process, a poster for each component was mounted on meeting room walls. Participants were assigned to two matched groups (by discipline and sector). Each group rated half of the components. In successive sessions, the two groups rated their assigned components for ease of implementation in ECE programs, then switched rooms to view the work product of the other group and post notes on their opinions. In a second round, the groups rated the set of components they had not previously rated—this time for the *impact of* implementation upon the prevention of childhood obesity. After rating, they again switched rooms to

review and post comments upon the work of the other group. Ratings of impact used four-point scale: 4 = Definitely will make a big difference; 3 = Definitely will make some difference; 2 = Could make some difference; and, 1 = Could make a small difference. Facilitators recorded the posted comments and the assigned ratings, and calculated descriptive statistics for each component. The average ratings across the 217 components for both ease and impact of implementation showed normal distributions. On Day 3, facilitators shared the rating results and comments, highlighting the top quartiles of ease of implementation and impact. In the next step, advisors were asked to argue for inclusion of components they considered essential to preventing childhood obesity that received somewhat lower ratings. If at least five participants deemed a component "essential," it was noted as a possible candidate for the final set. All comments were recorded, as well as facilitators' field notes taken during group discussions. Participants also offered important feedback on methods of measuring the components in real-life settings, practical ideas for implementation, and potential barriers to adoption in ECE settings. A follow-up evaluation with the participants found that all respondents agreed that the meeting process assured the inclusion of a wide range of interdisciplinary perspectives and that their opinions were valued.

Defining Measurable High-Impact Obesity Prevention Components. After the Healthy Weight Advisory Meeting, MCHB funded NRC to finalize the set of high impact practices for use in a study of child care licensing regulations nationally (Achieving a State of Healthy Weight, ASHW). NRC focused initially upon Criterion 1: Statistical, selecting components that fell one standard deviation above the mean for impact ratings. The resulting components for impact were grouped into one of three content domains: Infant Feeding, Nutrition, or Physical Activity/Screen Time. Based upon expert advisory group discussions of "essential" components and written comments, two new review criteria were added: Criterion 2. Comprehensive Representation of Age Ranges (infants, toddlers, preschoolers/older children); and, Criterion 3. Construct Comprehensiveness, as illustrated in the following examples. Criterion 2: Components specifying appropriate milk fat percentages were included statistically for two of the

three age groups, so the third (rated slightly lower) was added for comprehensive age coverage. Criterion 3: In the beverage group, availability of water fell just short of the statistical cut-of, but was added to complete beverage coverage. As NRC developed rating scales for the first ASHW study,² some component language proved redundant or too vague to operationalize, so that Criterion 4. Feasibility of Reliable Measurement emerged as an additional basis for inclusion/exclusion or merging of components. For example, *promotion* of physical activity could not be reliably differentiated in states' rules from daily occasions for active play, which could be reliably identified and expressed the intention of promoting play. So, the concepts were merged into one variable. Application of the four preceding criteria resulted in the final 47 high impact obesity prevention components in 2010 (shown in Exhibit 1).

Naming conventions for the 47 high-impact obesity prevention components. In ensuing ASHW studies, the 47 components were referred to as ASHW variables or indicators, and later, as ASHW Healthy Weight Practices. Beginning in 2019, High-Impact Obesity Prevention Standards (HIOPS) was adopted, in collaboration with the CDC Division of Nutrition, Physical Activity and Obesity (funder of ASHW studies since ASHW 2015).

References

¹ American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education. *Preventing Childhood Obesity in Early Care and Education Programs: Selected Standards from Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd edition. Elk Grove Village, IL: American Academy of Pediatrics; 2010.*

² National Resource Center for Health and Safety in Child Care and Early Education. Achieving a state of healthy weight: a national assessment of obesity prevention terminology in child care regulations 2010. Updated September 2020. https://nrckids.org/HealthyWeight/Archives

Endnote

^a Caring for Our Children (CFOC) standards are nationally recognized as the best evidence- and expertise-based guidance in the nation for quality health and safety policies and practices in early care and education settings. The most up to date versions of the standards may be accessed in the free CFOC Online Database @ https://nrckids.org/CFOC.

Exhibit 1: Achieving a State of Health Weight 47 High-Impact Obesity Prevention Standards

144	
	Encourage and support breastfeeding and feeding of breast milk by making arrangements for mothers to feed their children on-site
	Serve human milk or infant formula to at least age 12 months, not cow's milk, unless written exception is provided
	Feed infants on cue
	Do not feed infants beyond satiety; Allow infant to stop the feeding
IB3	Hold infants while bottle feeding; Position an infant for bottle feeding in the caregiver/teacher's arms or sitting up on the lap
IC1	Develop plan for introducing age-appropriate solid foods in consultation with child's parent/guardian and primary care provider
IC2	Introduce age-appropriate solid foods no sooner than 4 months of age, and preferably around 6 months of age
IC3	Introduce breastfed infants gradually to iron-fortified foods no sooner than four months of age, but preferably around six months
ID1	Do not feed an infant formula mixed with cereal, fruit juice or other foods without primary care provider's written instruction
ID2	Serve whole fruits, mashed or pureed, for infants 7 months up to 1 year of age
ID3	Serve no fruit juice to children younger than 12 months of age
NA1	Limit oils by choosing monounsaturated and polyunsaturated fats and avoiding trans fats, saturated fats and fried foods
NA2	Serve meats and/or beans - chicken, fish, lean meat, and/or legumes (such as dried peas, beans), avoiding fried meats
NA3	Serve other milk equivalent products (yogurt, cottage cheese) using low-fat varieties for 2 years of age and older
NA4	Serve whole pasteurized milk to twelve to twenty-four month old children who are not on human milk or prescribed formula, or serve reduced
	fat (2%) pasteurized milk to those who are at risk for hypercholesterolemia or obesity
	Serve skim or 1% pasteurized milk to children two years of age and older
	Serve whole grain breads, cereals, and pastas
NB2	Serve vegetables, specifically, dark green, orange, deep yellow vegetables; and root vegetables, such as potatoes and viandas
NB3	Serve fruits of several varieties, especially whole fruits
NC1	Use only 100% juice with no added sweeteners
NC2	Offer juice (100%) only during meal times
NC3	Serve no more than 4 to 6 oz juice/day for children 1-6 years of age
	Serve no more than 8 to 12 oz juice/day for children 7-12 years of age
ND1	Make water available both inside and outside
NE1	Teach children appropriate portion sizes by using plates, bowls & cups that are developmentally suited to their nutritional needs
NE2	Require adults eating meals with children to eat items that meet nutrition standards
NF1	Serve small-sized, age-appropriate portions
	Permit children to have one or more additional servings of the nutritious foods that are low in fat, sugar, and sodium as needed to meet the caloric needs of the individual child; Teach children who require limited portions about portion size and monitor their portions
NG1	Limit salt by avoiding salty foods such as chips and pretzels
NG2	Avoid sugar, including concentrated sweets such as candy, sodas, sweetened drinks, fruit nectars, and flavored milk
NH1	Do not force or bribe children to eat
NH2	Do not use food as a reward or punishment
PA1	Provide children with adequate space for both inside and outside play
DA2	Provide orientation and annual training opportunities for caregivers/teachers to learn age-appropriate gross motor activities and games that promote physical activity
PA3	Develop written policies on the promotion of physical activity and the removal of potential barriers to physical activity participation
PA4	Require caregivers/teachers to promote children's active play, and participate in active games at times when they can safely do so
PA5	Do not withhold active play from children who misbehave
PB1	Do not utilize media (television [TV], video, and DVD) viewing and computers with children younger than 2 years
PB2	Limit total media time for children 2 years and older to not more than 30 min. weekly
PB3	Use screen media with children age two years and older only for educational purposes or physical activity
PB4	Do not utilize TV, video, or DVD viewing during meal or snack time
PC1	Provide daily for all children, birth to 6 years, two to three occasions of active play outdoors, weather permitting
PC2	Allow toddlers 60-90 minutes per 8-hour day for moderate to vigorous physical activity
	Allow preschoolers 90-120 minutes per 8-hour day for moderate to vigorous physical activity
PD1	Provide daily for all children, birth to six years, two or more structured or caregiver/ teacher/ adult-led activities or games that promote movement over the course of the day—indoor or outdoor
	Ensure that infants have supervised tummy time every day when they are awake
	Use infant equipment such as swings, stationary activity centers, infant seats, molded seats, etc. only for short periods if at all
	· · · · · · · · · · · · · · · · · · ·

Appendix: Healthy Weight Advisors

Donna Blum-Kemelor, MS, RD, LD, US Department of Agriculture, Center for Nutrition Policy and Promotion (CFOC3 Nutrition Technical Panel Member)

Charles T. Cappetta, MD, FAAP, American Academy of Pediatrics Council on Sports Medicine and Fitness, Dartmouth-Hitchcock, Nashua (CFOC3 AAP Reviewer)

Judy Collins, Senior Content Specialist, Tribal Child Care Technical Assistance Center; Past President, National Association for Regulatory Administration (CFOC3 Organization & Administration Technical Panel Member)

Melisssa Courts, Healthy Child Care Ohio Coordinator, Ohio Department of Health, Bureau of Early Intervention Services & former licensing regulator (CFOC3 Stakeholder Reviewer)

Catherine Cowell, PhD, Clinical Professor, Mailman School of Public Health, Columbia University (CFOC3 Nutrition Technical Panel Chair)

Angela Crowley PhD, APRN, PNP-BC, FAAN, Associate Professor, Yale University School of Nursing (CFOC3 Child Development Technical Panel Chair)

Allison S. Gertel-Rosenberg, MS, Senior Policy and Program Analyst/Special Assistant, Nemours Foundation, Office of the Vice President of Policy and Prevention

Danette Glassy, MD, FAAP, Clinical Professor, Department of Pediatrics, University of WA; Mercer Island Pediatric Associates; (CFOC3 Steering Committee Co-Chair for AAP)

Geraldine (Geri) Henchy, MPH, RD, Director, Nutrition Policy and Early Childhood Nutrition, Food Research and Action Center (CFOC3 APHA Reviewer)

Moniquin Huggins, Director, Program Operations
Division, Child Care Bureau, Administration for Children
and Families, Department of Health and Human
Services; (CFOC3 Reviewer)

Jonathan B. Kotch, MD, MPH, FAAP, Director, National Training Institute for Child Care Health Consultants, Carol Remmer Angle Distinguished Professor of Children's Environmental Health, University of North Carolina at Chapel Hill (CFOC3 Steering Committee Co-Chair for APHA)

Dottie Martinez, Director and Owner, Child Care Center and Preschool

Sara Benjamin Neelon, PhD, MPH, RD, Assistant Professor, Department of Community and Family Medicine, Duke University Medical Center; (CFOC3. Nutrition Technical Panel Member, phone-in participant 7/24/10)

Barbara Polhamus, PhD, MPH, RD, Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity and Obesity; (CFOC3 Nutrition Technical Panel Member)

Amy Revell Requa, MSN, CRNP, CPNP; Head Start Training/Technical Assistance I AM MOVING, I AM LEARNING; Early Childhood Health Consultant (phonein participant 7/24)

Barbara Sawyer, National Association of Family Child Care Special Projects; former Family Child Care Provider; (CFOC3 Staff Health Technical Panel Member)

Susan Schlosser, MS, RD, Nutrition Consultant; (CFOC3 Nutrition Technical Panel Member)

Phyllis E. Stubbs-Wynn, MD, MPH, FAAP, Maternal and Child Health Bureau, Department of Health and Human Services; (CFOC3 Steering Committee Member)

Nina Tristani, Director of Publications, American Public Health Association; (CFOC3 APHA Reviewer)

Jeanne (Anderson) VanOrsdal, MEd, Manager, Early Education and Child Care Initiatives, Division of Developmental Pediatrics and Preventive Services, American Academy of Pediatrics; (CFOC3 AAP Reviewer)

Dianne Stanton Ward, EdD, Professor of Nutrition, Associate Director, Clinical Nutrition Research, University of North Carolina at Chapel Hill

NRC Faculty and Staff (2010)

Marilyn J. Krajicek, EdD, RN, FAAN, Professor, CU Anschutz College of Nursing, NRC Director Jean Cimino, MPH, Professional Research Assistant, NRC Barbara Hamilton, MA, NRC Assistant Director Geraldine Steinke, PhD, Research Associate, NRC Grant Writer and Evaluator Virginia Torrey, Program Specialist, NRC



Achieving a State of Healthy Weight (ASHW)

Nevada Survey Results of

Licensed Childcare Providers and Families

January 2024



Survey Results of Licensed Childcare Providers and Families

Nevada Institute for Children's Research and Policy

The Nevada Institute for Children's Research and Policy (NICRP) is a not-for-profit, non-partisan organization dedicated to advancing children's issues in Nevada.

As a research center within the UNLV School of Public Health, NICRP is dedicated to improving the lives of children through research, advocacy, and other specialized services.

NICRP's History:

NICRP started in 1998 based on a vision of First Lady Sandy Miller. She wanted an organization that could bring credible research and rigorous policy analysis to problems that confront Nevada's children, but she did not want to stop there; Miller wanted to transform our research into meaningful legislation that would make a real difference in the lives of Nevada children.

NICRP's Mission:

Our mission is to conduct community-based research that will guide the development of programs and services for Nevada's children. For more information regarding NICRP research and services, please visit our website at https://nic.unlv.edu

NICRP Staff Contributors:

Brooke Conway Kleven, PT, DPT, PhD Research Analyst

Amanda Haboush-Deloye, PhD Executive Director

> Joycelene Bumagat Research Assistant

Nevada Institute for Children's Research and Policy
School of Public Health, University of Nevada, Las Vegas
4700 S. Maryland Parkway, Suite 335
Las Vegas, NV 89119
(702) 895-1040

https://nic.unlv.edu



Survey Results of Licensed Childcare Providers and Families

Overview of Childhood Obesity

Childhood obesity is of global concern due to its drastic impact on health, cognitive development, and psychosocial function. Obesity rates positively correlate with advancing age throughout the lifetime (Majcher et al., 2021), as approximately 26% of 2 to 5-year-olds, 41.5% of 16 to 19-year-olds, and 73.6% of adults over the age of 19 are living with overweight and obesity in the United States (Fryar et al., 2020; Skinner et al., 2018). However, there have been recent spikes in the prevalence of obesity specifically among the age range of 2 to 5-year-olds (Skinner et al., 2018), indicating obesity may now be impacting children at earlier ages.

Nevada. As of 2019, 11.7% of 2 to 4-year-olds, 13.7% of 10 to 17-year-olds, and 12.3% of high school students in Nevada met criteria for obesity, yet nearly 80% of youth and adolescents fail to be physically active at least 60 minutes per day (Trust for America's Health, 2020). Likewise, 32.4% of Nevada kindergartners in the 2019-2020 school year had overweight or obesity, a 2.53% increase from the year prior (Nevada Institute for Children's Research and Policy, 2021). As the age of onset for obesity becomes younger, children are at a higher risk of long-term physical, cognitive, and socioeconomic difficulties. Furthermore, obesity in early childhood is highly predictive of long-term obesity status, further warranting the need to increase efforts toward prevention and early intervention (Cunningham et al., 2017).

Achieving a State of Healthy Weight. Among children in Nevada who entered kindergarten during the 2019-2020 school year, nearly 73% attended preschool the year prior (Nevada Institute for Children's Research and Policy, 2021). With a vast majority of children attending early care and education (ECE) programs, these settings are especially important to assist in healthy development and obesity prevention efforts. Achieving a State of Healthy Weight (ASHW) is a national report inclusive of 47 high-impact obesity prevention standards (HIOPS, or 'standards') in child care licensing regulations that promote infant feeding practices; healthy nutrition and mealtime practices; opportunities for active play; and less screentime. The Centers for Disease Control and Prevention (CDC) identified these obesity prevention standards as a primary resource to guide states' child care licensing regulations (National Resource Center for Health and Safety in Child Care and Early Education, 2022). Currently, Nevada is ranked 24th in the nation and is fully meeting criteria for 15 of the 47 standards, partially meeting 17, and does not meet 15 of the standards within its state licensing codes and regulations. As these HIOPS have the potential to help promote health and well-being in young children, the Nevada Early Childhood Obesity Prevention (NECOP) statewide workgroup ('the workgroup') wanted to determine how Nevada could work toward changing regulations to better meet these standards.

Before attempting to revise all 32 partially/unmet standards, the workgroup reviewed each standard individually to determine its potential impacts on both providers and families, and to ensure changes would not increase disparities and create further inequities in the system. This could not be done without input from ECE providers and families. Therefore, the purpose of the current report is to provide an overview of the initial steps taken by the workgroup toward addressing the standards, specifically gathering feedback from ECE providers and families of children attending ECE facilities in Nevada.





Survey Results of Licensed Childcare Providers and Families

Methods

The Nevada Early Childhood Obesity Prevention statewide workgroup ('the workgroup') reviewed the 32 HIOPS that Nevada was partially meeting or failing to meet based on the 2021 ASHW Report. The workgroup reviewed each of these 32 partially/unmet standards over a series of three (3) committee meetings, two (2) technical assistance calls with the CDC, and two (2) calls with the Nevada state board of licensing. The intent of these meetings was to determine which of the 32 standards were appropriate for amendment in Nevada. A total of 8 of the 32 standards were removed from consideration, as 3 were noted by the CDC to be improved ratings for Nevada on the 2022 report (PA2, PA3, and PA5), and the remaining 5 standards were removed because the workgroup felt that they were not appropriate to modify following discussion with state licensing (NA1, NA2, NA3, PC1 and PD1). For a full description of the 8 standards removed from amendment, see Table A1 in the Appendix. This left a total of 24 standards remaining which the workgroup wanted to gather feedback from the community about the impact on the early care and education setting.

Survey Development. The workgroup then developed a community-based survey which overviewed the 24 standards and their proposed regulatory changes to suffice criteria for "fully met". The purpose of this survey was to gain the perspectives of ECE providers and families on foreseen limitations and barriers associated with the enactment of the proposed amendments. Table 1 below provides a brief overview of the ASHW health and wellness categories and the corresponding NAC codes which were amended for proposed revisions. A detailed description of all standards and proposed revisions is included in Table A2 of the Appendix.

Table 1. Categorization of Proposed Regulatory Changes by Health and Wellness Topics

Health and Wellness Topic	HIOP(s)	NAC		
	IA1	432A.425.14		
Breastfeeding Support	IB3	432A.385.2		
breastreeding Support	IC1, ID1	432A.385.1(o)		
	ID2	432A.380.2		
	NA4	432A.380.2		
Nutrition Standards	NB1, NB2, NB3	432A.380.2		
	NG1, NG2	432A.380.5		
	NE1	432A.385.1(d)		
Haalthy Maaltima Practices	NE2	(No current NAC addresses this standard)		
Healthy Mealtime Practices	NF2	432A.380.1		
	NH1	432A.380.11		
	PA4	432A.390.3		
Physical Activity	PC2, PC3	432A.430.4(f)		
-	PE1, PE2	432A.425.4(d)		
Screentime	PB1, PB2, PB3, PB4	(No current NAC addresses these standards)		

The workgroup performed a final review of the proposed amendments during the September 2022 quarterly meeting. Once final edits were complete, an electronic survey was developed in Qualtrics. Each of the questions provided the following information:



Survey Results of Licensed Childcare Providers and Families

- 1. Current state regulation text (NAC)
- 2. Description/justification for proposed revisions
- 3. Text of how the new standard would read
- 4. Response matrix including the following answer options:

"Based on the proposed revisions, please provide your feedback on any potential barriers:"

- a. Lack of funding
- b. Lack of assistance/support/knowledge
- c. Revisions are too cumbersome to implement
- d. Revisions would add too much stress on providers/families
- e. Other barriers/concerns (with open text option)
- f. No concerns with proposed revisions

Survey Collection. Once the final online survey was prepared, two main entities were asked to distribute the survey to ensure that it was received by as many providers as possible. The Nevada Child Care Licensing as well as the Nevada Department of Education Office of Early Learning and Development shared the information about this voluntary online survey on their listservs, which encompasses all licensed ECE facilities in the state of Nevada. To be eligible to complete the survey, respondents had to be a director and/or administrator of a licensed ECE facility in Nevada, and only one respondent was allowed to reply per licensed facility. The survey was available for completion between October and December 2022. A wellness gift valued at \$30 was offered as incentive for the first 30 administrators to complete the survey.

Following a review of the Provider survey, a second survey was disseminated to ECE families from August through September 2023. This was distributed to families by the partner organizations of the Nevada Early Childhood Obesity Prevention workgroup and licensed childcare facilities in Nevada. Family members were offered a \$50 Amazon e-gift card for the first 50 individuals to complete the survey. Only one adult per household was allowed to respond to the survey, and they must have a child between the ages of 0 to 5 in preschool or early care and education settings in Nevada. Due to limitations of the NRS codes not being currently available in Spanish, all flyers offered Spanish speaking families to call in and take the survey over the phone.

Results

The ASHW Survey was distributed to approximately 600 directors and administrators of licensed early childcare facilities in Nevada, with a total of 188 (31.3%) completed responses. Likewise, a total of 132 parents/caregivers across Nevada completed the survey. In total, 20 of the 24 proposed amendments (83.3%) received approval by the majority of childcare facility directors. Despite majority approval, all proposed amendments received valuable written feedback that potentially warrants minor revisions. For the family surveys, a large percentage of parents reported concerns with lack of knowledge of the proposed revisions, with concerns of lack of funding being the second greatest concern. Each of the wellness categories are described in further detail below.



Survey Results of Licensed Childcare Providers and Families

Breastfeeding Support

Proposed amendments to the breastfeeding HIOPS were among the least supported of all revisions by both families and administrators of ECE facilities in Nevada (Figures 1-5). Specifically, Revision 1 of IC1/ID1 (Figure 3 below) was the lowest approval of all standards at 41% for childcare providers and 34% for families due to concerns that it should be the parents' choice. Additionally, there was confusion among childcare providers related to the term "primary care provider", as many respondents assumed "primary care provider" referred to the ECE provider rather than healthcare provider. Among all breastfeeding HIOPS, the majority of barriers included a lack of space to provide a private room for breastfeeding, lack of staffing, amendments not accounting for baby-led weaning (BLW), a lack of modifications for infants/children with developmental delay, and concern for potential cultural barriers regarding breastfeeding. The amendment related to mashed or pureed food was the highest approval among breastfeeding standards, with nearly 73% of facilities stating they do not have concerns with the proposed changes. A full description of childcare provider and family response rates is provided below in Table 2.

Table 2. Overview of ECE Provider Feedback of Proposed Breastfeeding Standards

		IA1 (%)	IB3 (%)	IC1 (%)	ID1 (%)	ID2 (%)
No concerns with proposed	Provider	64	57	41	56	73
revisions	Family	43	-	34	37	49
Lack of funding	Provider	15	6	8	6	4
Lack of fulfulling	Family	16	-	37	21	9
Lack of assistance/ support/	Provider	9	6	8	7	8
knowledge	Family	20	-	26	24	12
Revisions are too	Provider	6	13	17	11	6
cumbersome to implement	Family	3	-	25	20	3
Revisions would add too much	Provider	10	24	17	14	11
stress on providers/families	Family	7	-	25	24	7
Other harriers / concerns:	Provider	15	21	8	6	17
Other barriers/ concerns:	Family	7	-	10	7	7



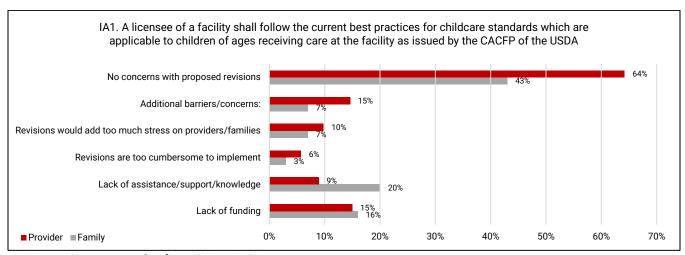


Figure 1. Survey results for ASHW HIOP IA1

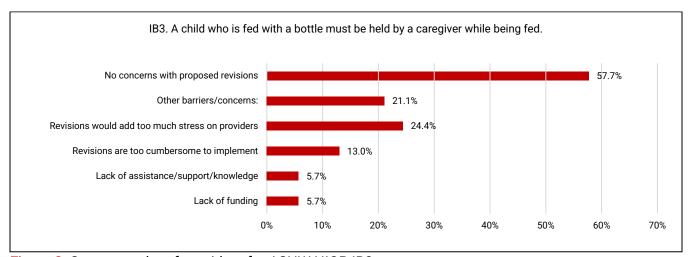


Figure 2. Survey results of providers for ASHW HIOP IB3

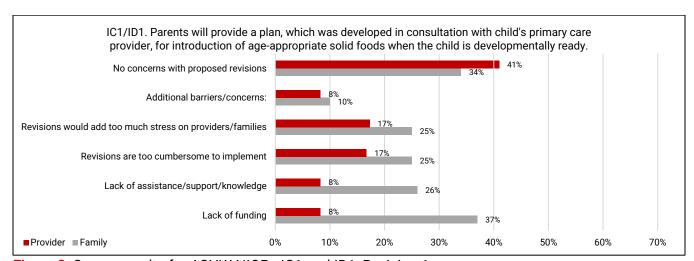


Figure 3. Survey results for ASHW HIOPs IC1 and ID1, Revision 1



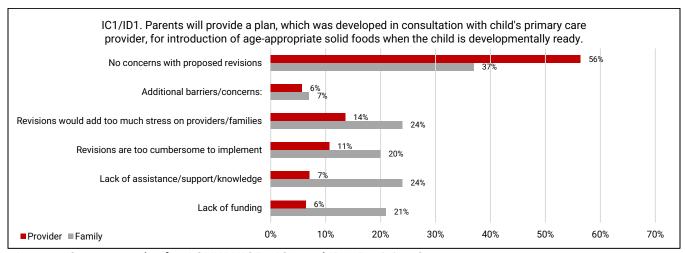


Figure 4. Survey results for ASHW HIOPs IC1 and ID1, Revision 2

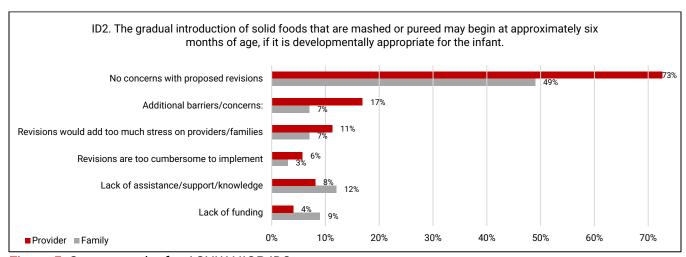


Figure 5. Survey results for ASHW HIOP ID2

Survey Results of Licensed Childcare Providers and Families

Nutrition Standards

The nutrition standards encompassed mixed opinions among the childcare facilities and families. Table 3 below provides a brief overview of feedback on each standard. For example, there were a wide range of opinions comparing 2% and skim milk for NA4. Several parents additionally noted that there should be non-dairy options to accommodate medical/cultural needs. NA4 specifically caused confusion related to age ranges, as it is not specified in the text if it is referring to children under 2 years of age, or all children, who are at risk of hypercholesteremia (Figure 6). Likewise, and similar to the breastfeeding standards, amendments must specify "primary healthcare provider" rather than PCP, as several childcare facilities noted they assumed "primary care provider" refers to the ECE provider. Other concerns of the facilities included financial costs associated with requiring fruits and vegetables to be served with all meals and snacks (Figures 8-9), while both families and providers commented on the vagueness of the proposed phrase "limit foods" (Figures 10-11).

Table 3. ECE Provider Feedback of Proposed Nutrition Standards

		NA4 (%)	NB1 (%)	NB2 (%)	NB3 (%)	NG1 (%)	NG2 (%)
No concerns with proposed	Provider	75	49	50	50	66	65
revisions	Family	53	40	48	45	46	45
Lack of funding	Provider	9	15	15	16	8	9
Lack of fullding	Family	9	25	31	28	23	32
Lack of assistance/ support/	Provider	7	7	4	4	5	7
knowledge	Family	11	19	18	16	16	21
Revisions are too	Provider	6	9	9	9	8	7
cumbersome to implement	Family	6	15	14	11	12	17
Revisions would add too	Provider	12	11	12	12	7	6
much stress on providers/families	Family	2	18	16	13	14	18
Other barriers/ concerns:	Provider	13	9	10	10	7	6
Other barriers/ concerns.	Family	8	8	8	8	3	7

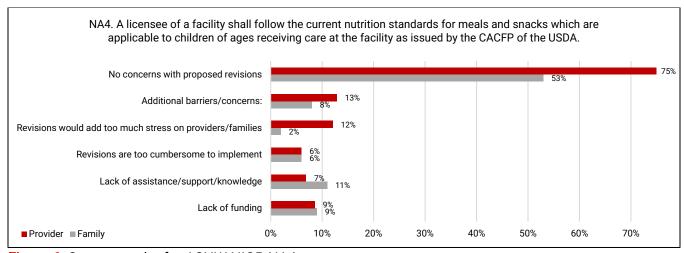


Figure 6. Survey results for ASHW HIOP NA4

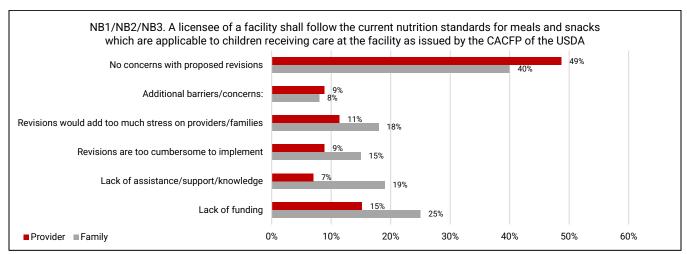


Figure 7. Survey results for ASHW HIOPs NB1, NB2, and NB3, Revision 1

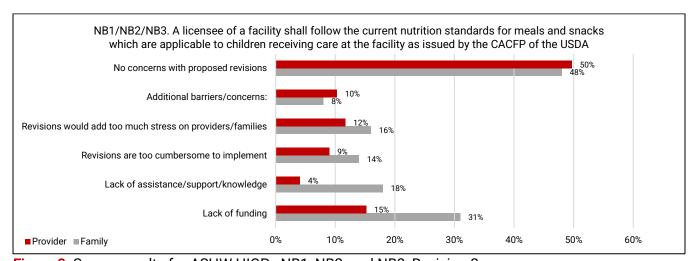


Figure 8. Survey results for ASHW HIOPs NB1, NB2, and NB3, Revision 2

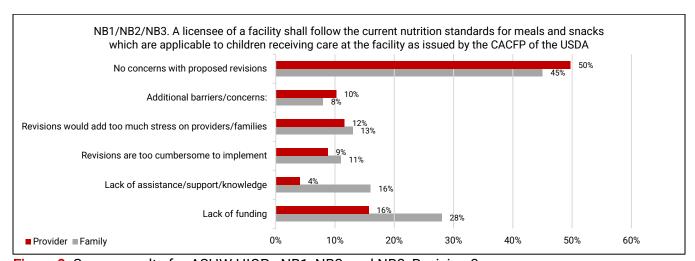


Figure 9. Survey results for ASHW HIOPs NB1, NB2, and NB3, Revision 3



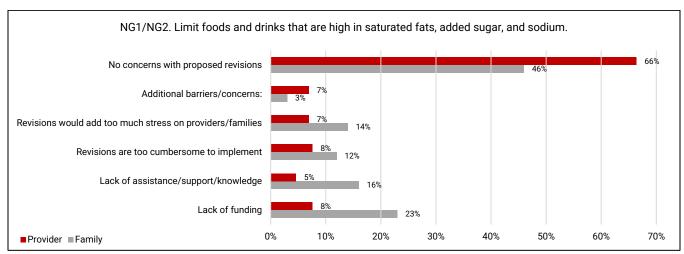


Figure 10. Survey results for ASHW HIOPs NG1 and NG2, Revision 1

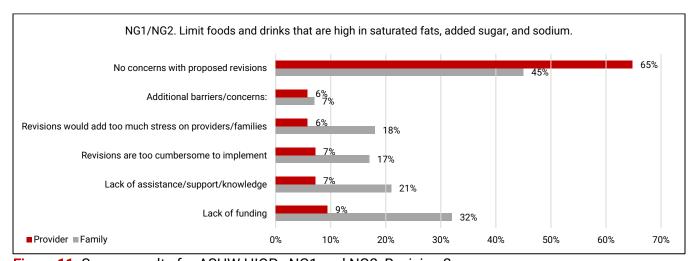


Figure 11. Survey results for ASHW HIOPs NG1 and NG2, Revision 2

Survey Results of Licensed Childcare Providers and Families

Healthy Mealtime Practices

The four proposed NAC amendments for healthy mealtime practices were generally well-received by both facilities and families (Table 4 and Figures 12-15 below). The most frequent concerns noted among feeding practices were increased risk of spreading COVID-19/Respiratory Syncytial Virus (RSV) and generalized infection prevention, specifically related to standards NE1 (Figure 12) and NE2 (Figure 13). Likewise, a lack of an available kitchen to prepare food and increased strain on staff to provide cultural foods were concerns noted (Figure 14). Additionally, confusion regarding the term "primary care provider" was again discussed as a concern of NF2. The fourth mealtime standard, NH1, was very well received with nearly a 95% approval and only two comments stating that the word "bribe" may be too limiting (Figure 15). For example, one facility stated "This is too vague. Not every child is typical. For example, we have a little one coming off a feeding tube that loves books. We encourage her to eat but will tell her we will read a book if she eats some of her food. This is way too limiting the way it is worded." The most frequent comment noted by parents related to healthy mealtime practice amendments were cultural concerns.

Table 4. ECE Provider Feedback of Proposed Healthy Mealtime Practice Standards

		NE1 (%)	NE2 (%)	NF2 (%)	NH1 (%)
No concerns with proposed revisions	Provider	89	70	60	95
No concerns with proposed revisions	Family	-	51	46	60
Lack of funding	Provider	3	7	15	2
	Family	-	12	9	8
Look of accietomac/aumout/limeurlades	Provider	1	6	13	1
Lack of assistance/ support/ knowledge	Family	-	16	17	11
Revisions are too cumbersome to	Provider	5	7	17	2
implement	Family	-	5	5	2
Revisions would add too much stress on	Provider	6	11	28	3
providers/families	Family	-	3	9	3
Other barriers/ concerns:	Provider	7	18	12	5
Other barriers/ concerns.	Family	-	6	6	3

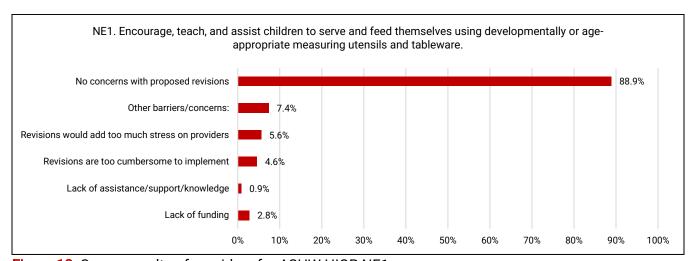


Figure 12. Survey results of providers for ASHW HIOP NE1



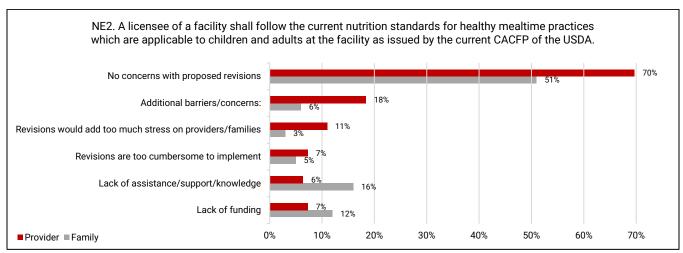


Figure 13. Survey results for ASHW HIOP NE2

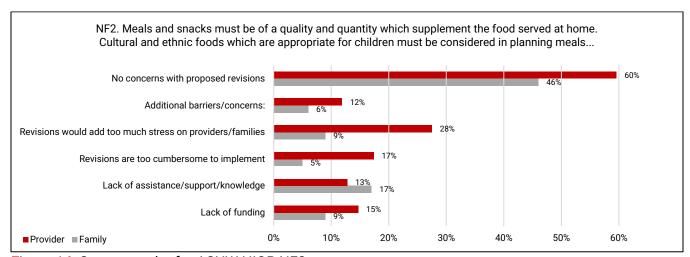


Figure 14. Survey results for ASHW HIOP NF2

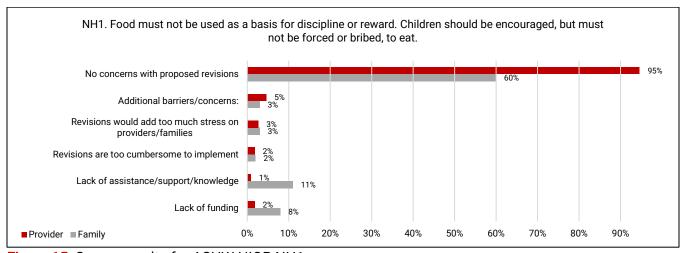


Figure 15. Survey results for ASHW HIOP NH1

Survey Results of Licensed Childcare Providers and Families

Physical Activity

All three of the physical activity standards received greater than 80% approval among childcare facilities and majority approval among families (Table 5). Three respondents noted confusion regarding PA4, as they were unsure whether this referred to the children participating in active games, or if the caregiver was required to participate as well (Figure 16). Likewise, financial costs associated with the outdoor play equipment was a concern frequently noted with all physical activity amendments. Amendments for PC2/PC3 created confusion regarding percent of time that is specifically allocated for physical activity, lack of accounting for 1 to 2-year-olds, and a general lack of time for facilities to implement activities throughout the day (Figure 17). In regard to PE1/PE2, several facilities noted that the terms "crib" and "playpen" are commonly used interchangeably, so a caregiver may be misled to believe that it is ok to leave a child in a "playpen" all day (Figure 18). One facility requested the amendment be reworded as "Infants may not be left in a crib or playpen unless they are actively sleeping". Likewise, "a short period of time" was thought to be vague and needs specific durations.

Table 5. ECE Provider Feedback of Proposed Physical Activity Standards

		PA4 (%)	PC2/PC3 (%)	PE1/PE2 (%)
No concorne with proposed revisions	Provider	85	81	84
No concerns with proposed revisions	Family	56	58	56
Lack of funding	Provider	9	5	4
Lack of fullding	Family	9	8	7
Look of accietoway assessment (see such days	Provider	1	5	5
Lack of assistance/ support/ knowledge	Family	13	12	12
Davisione are too sumbersome to implement	Provider	3	6	5
Revisions are too cumbersome to implement	Family	4	3	5
Revisions would add too much stress on	Provider	5	6	4
providers/families	Family	5	3	5
Other harriers / concerns:	Provider	8	14	10
Other barriers/ concerns:	Family	5	7	7

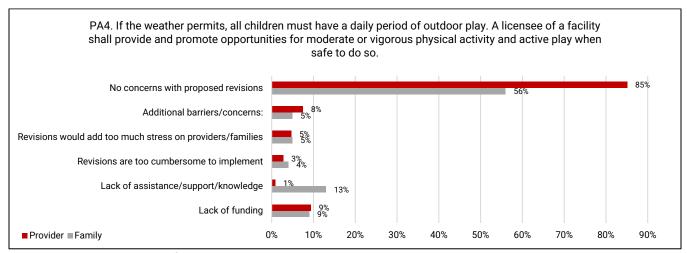


Figure 16. Survey results for ASHW HIOP PA4

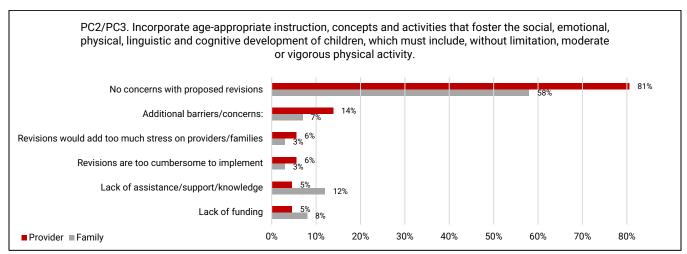


Figure 17. Survey results for ASHW HIOPs PC2 and PC3

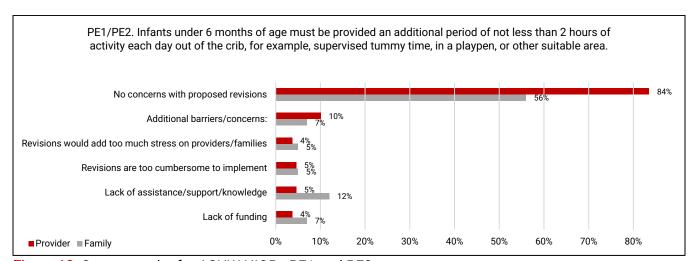


Figure 18. Survey results for ASHW HIOPs PE1 and PE2

Survey Results of Licensed Childcare Providers and Families

Screentime

As there are currently no statewide regulations on screentime in childcare facilities, the proposed standard would eliminate screentime for children under the age of 2 years, while children 2 years and older would be limited to 30 minutes weekly (Figures 19-21). While most facilities did not have considerable objections to this proposal (Table 6), the primary concern related to unnecessary restrictions during holidays or special "movie days" for the kids. An additional concern was that facilities frequently use dance videos and other activity-based clips during summer months when it is too hot to go outside, specifically in Southern Nevada. Families reported a lower approval rate for these revisions, although only two parents provided commentary of their concerns, both of which stating that further specifications of the guidelines should be included.

Table 6. ECE Provider Feedback of Proposed Screentime Standards

		PB1-PB4 Revision 1 (%)	PB1-PB4 Revision 2 (%)	PB1-PB4 Revision 3 (%)
No concerns with proposed revisions	Provider	71	68	78
No concerns with proposed revisions	Family	39	39	38
Look of funding	Provider	6	5	5
Lack of funding	Family	16	20	13
Look of aggistance/ support/ knowledge	Provider	3	4	3
Lack of assistance/ support/ knowledge	Family	13	16	12
Revisions are too cumbersome to	Provider	5	6	5
implement	Family	8	12	10
Revisions would add too much stress on	Provider	8	9	7
providers/families	Family	17	21	18
Other barriers/ concerns:	Provider	7	9	4
Other partiers/ concerns.	Family	4	6	4

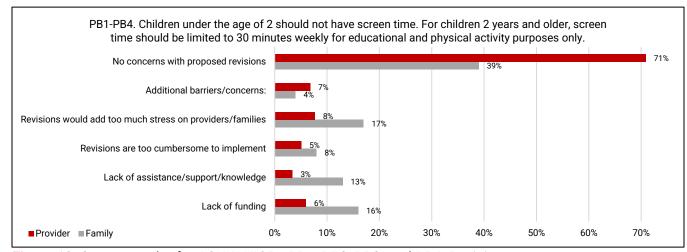


Figure 19. Survey results for ASHW HIOPs PB1, PB2, PB3, and PB4, Revision 1

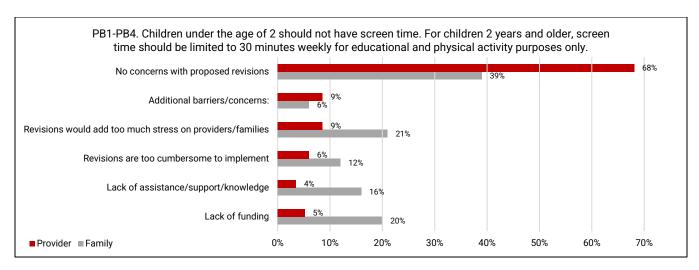


Figure 20. Survey results for ASHW HIOPs PB1, PB2, PB3, and PB4, Revision 2

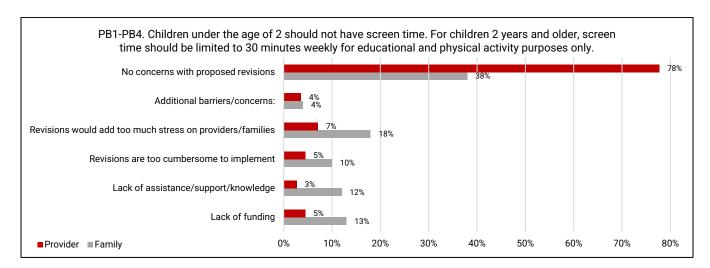


Figure 21. Survey results for ASHW HIOPs PB1, PB2, PB3, and PB4, Revision 3



Survey Results of Licensed Childcare Providers and Families

Conclusions and Recommendations

Childhood obesity is an ever-growing problem for Nevada. As one in three children in Nevada are entering kindergarten with overweight or obesity, it is imperative that meaningful changes are implemented during early childhood. This survey of licensed ECE programs and families of children in these Nevada facilities provides an overview of proposed regulatory changes that encourage recommended infant feeding practices; healthy nutrition standards and mealtime practices; opportunities for active play; and less screentime. Despite most of the amendments receiving approval by the majority, all proposed amendments were provided with valuable written feedback that potentially warrants minor revision. Table 7 below provides a summary of free responses from respondents on each of the proposed revisions.

Table 7. Categorization of Proposed Regulatory Changes by Health and Wellness Topics

Health and Wellness Topic	HIOP(s)	Approval (%)	Most Frequent Written Feedback (Parents and Providers)
	IA1	64.2%	Should be phrased "Child Care" rather than "daycare"; limited space; restrictions from leaving parents unsupervised in facility
Breastfeeding Support	IB3	57.7%	Lack of staff; Developmental concerns
3	IC1, ID1	41.0%, 56.4%	Rephrase "primary care provider" to healthcare provider; parent choice
	ID2	72.6%	Baby-led weaning; parent choice
	NA4	75.0%	Need other non-cow milk/non-dairy options; ECE providers feel this contradicts CACFP; who determines if child is at risk (does not specify)
Nutrition Standards	NB1, NB2, NB3	48.7%, 49.7%, 49.7%	Cost; parent choice; lack of staffing/time; lack of licensed kitchen for prep
	NG1, NG2	66.4%, 64.8%	Too vague; what does "limit" mean?
	NE1	88.9%	Infectious disease/cross-contamination concerns; unclear what "developmentally appropriate" means
Llasithy Masitinas Drastinas	NE2	69.7%	Infectious diseases/COVID restrictions; too vague; lack of prep kitchen
Healthy Mealtime Practices	NF2	59.6%	Places too much stress on ECE providers; Rephrase "primary care provider" to healthcare provider
	NH1	94.6%	Slightly vague; concern with the word "bribe"
	PA4	85.1%	Concern for adaptive staff/students; (1) respondent noted concerns with cost of equipment
Physical Activity	PC2, PC3	80.6%	Unclear whether 60 minutes only applies to PA or all categories combined; time constraints; did not address 1–2-year-olds
	PE1, PE2	83.5%	Too vague – what is "short period of time"; playpens = cribs, need to reword
Screentime	PB1, PB2, PB3, PB4	70.9%, 68.1%, 77.7%	Educational video concerns; exercise videos for indoor activity during inclement weather



Survey Results of Licensed Childcare Providers and Families

Across all proposed amendments, a high percentage of ECE providers and families will likely approve of regulatory changes given the following recommendations are taken into consideration:

- 1. Rephrase any verbiage utilizing the term "primary care provider" to specify healthcare provider and/or childcare provider.
- 2. Specify quantities and/or duration of any amendment which requires an adjusted volume or time component.
- 3. Among all amendments, be mindful of developmental delay and children/caregivers with adaptive needs.
- 4. The biggest barrier among all amendments included financial impacts, as lack of staffing, lack of available equipment/space, and inability to adhere to nutrition guidelines are all hindered by cost.
 - a. As such, IA1 (breastfeeding), NB1-NB3 (nutrition), and PA4 (physical activity) should be modified as to not increase financial burden on facilities and/or families.
- 5. Be mindful as to allow parent guidance for feeding and nutritional needs, specifically in regard to baby-led weaning and dairy consumption.

Future steps include the workgroup reviewing the summary of recommendations and modification of proposed amendments, finalization, and analysis of all results. Once each of the above steps are completed, the workgroup will then develop a timeline consisting of presenting the proposed changes to either the regulatory board and/or withhold until the 2025 Legislative Session.



Survey Results of Licensed Childcare Providers and Families

References

- Cunningham, S. A., Datar, A., Narayan, K. M. V., & Kramer, M. R. (2017). Entrenched obesity in childhood: findings from a national cohort study. *Annals of Epidemiology*, *27*(7), 435–441. https://doi.org/10.1016/J.ANNEPIDEM.2017.05.016
- Fryar, C. D., Carroll, M. D., & Afful, J. (2020). Prevalence of Overweight, Obesity, and Extreme Obesity Among Adults Aged 20 and Over: United States, 1960–1962 Through 2017-2018. *NCHS Health E-Stats*.
- Majcher, A., Czerwonogrodzka-Senczyna, A., Kadziela, K., Ruminska, M., & Pyrzak, B. (2021). Development of obesity from childhood to adolescents. *Pediatric Endocrinology, Diabetes, and Metabolism, 27*(2), 70–75. https://doi.org/10.5114/PEDM.2021.105297
- National Resource Center for Health and Safety in Child Care and Early Education. (2022). Achieving a state of healthy weight 2021 report. https://nrckids.org/HealthyWeight
- Nevada Institute for Children's Research and Policy. (2021). *Health Status of Children Entering Kindergarten in Nevada*. http://www.nic.unlv.edu
- Skinner, A. C., Ravanbakht, S. N., Skelton, J. A., Perrin, E. M., & Armstrong, S. C. (2018). Prevalence of Obesity and Severe Obesity in US Children, 1999-2016. *Pediatrics*, *141*(3). https://doi.org/10.1542/PEDS.2017-3459
- Trust for America's Health. (2020). *The State of Obesity: Better Policies for a Healthier America*. file:///X:/Groups/CHS/NICRP/Current Projects/1. Project Folders/EC Obesity Prevention/Data for Nevada/TFAHObesityReport_2020.pdf



Survey Results of Licensed Childcare Providers and Families

Appendix

Table A1. Full Description of the ASHW Standards Removed from Amendment

		Standards Removed fro	om Consideration
Standard	Current NV Rating*	HIOPS text	Reason to forego amendment
NA1	2	Limit oils by choosing monounsaturated and polyunsaturated fats and avoiding trans fats, saturated fats and fried foods	Per licensing, CACFP should change regulations since oils and fats are not listed in CACFP meal pattern
NA2	3	Serve meats and/or beans - chicken, fish, lean meat, and/or legumes (such as dried peas, beans), avoiding fried meats	Licensing is concerned standards are too strict
NA3	3	Serve other milk equivalent products (yogurt, cottage cheese) using low-fat varieties for 2 years of age and older	Licensing would like to confirm CACFP guidelines – concerned regulations are too rigid
PC1	3	Provide daily for all children, birth to six years, two to three occasions of active play outdoors, weather permitting	Licensing feels this is appropriately addressed in current code, because childcare settings require outdoor play already
PD1	2	Provide daily for all children, birth to six years, two or more structured or caregiver/teacher/ adult-led activities or games that promote movement over the course of the day-indoor or outdoor	No specific reason provided - no states currently have a rating of 4 to follow as an example
		Standards to be updated	l in 2022 by ASHW
Standard	Current NV Rating	HIOPS text	Reason to forego
PA2	2	Provide orientation and annual training opportunities for caregivers/teachers to learn age-appropriate gross motor activities and games that promote physical activity	This should be reconsidered for a 3, as it was rated 2 in 2018. I seems the "or" statement may have tripped up the raters, but I would rate this as a 3 today. We will certainly make the change next year, as it seems like Nevada may have many more upcoming positive changes.
PA3	2	Develop written policies on the promotion of physical activity and the removal of potential barriers to physical activity participation	This was given a 2 in 2018 due to not being specific enough around the PROMOTION piece of physical activity and/or barriers. However, our rating manual is always evolving to match the current best practices and I would mark this for consideration of a 3 during our next rating cycle.
PA5	3	Do not withhold active play from children who misbehave	ASHW will re-evaluate the current NV code for 2022, as it was assessed to be possibly misinterpreted and missing the full regulation.

^{*}ASHW Rating Scale: (4) = Fully Met; (3) = Partially Met; (2) = Unmet



Table A2. Current Nevada Administrative Code and Proposed Changes

ASHW Standard	NAC/NRS Code	Current language	Proposed revision	Updated standard language
IA1	NAC432A.425.14	Each licensee of a facility shall provide an appropriate, private area on the premises where a mother may breastfeed.	The language should be updated to refer to the best practices for the Child and Adult Care Food Program. This practice includes the following: "Support mothers who choose to breastfeed their infants by encouraging mothers to supply breastmilk for their infants while in day care and offering a quiet, private area that is comfortable and sanitary for mothers who come to the center or day care home to breastfeed."	"A licensee of a facility shall follow the current best practices for childcare standards which are applicable to children of ages receiving care at the facility as issued by the Child and Adult Care Food Program of the United States Department of Agriculture."
IB3	NAC432A.385.2	A child who is fed with a bottle and does not hold his or her own bottle must be held by a caregiver while being fed.	This regulation should remove the following: "and does not hold his or her own bottle"	A child who is fed with a bottle must be held by a caregiver while being fed.
IC1/ID1	NAC 432A.385.1(o)	Develop a plan for introducing age-appropriate solid foods with parents of a child	Revision 1. Include "consultation with child's primary care provider" Revision 2. Include the following: formula or milk should not be mixed with cereal, fruit juice, or any other foods in the child's bottle without written documentation from the infant's primary care provider.	Parents will provide a plan, which was developed in consultation with child's primary care provider, for introduction of ageappropriate solid foods when the child is developmentally ready. Formula or milk should not be mixed with cereal, fruit juice, or any other foods in the child's bottle without written documentation from the infant's primary care provider.
ID2	NAC 432A.380.2	The gradual introduction of solid foods may begin at six months of age, or before or after six months of age if it is developmentally appropriate for the infant.	The regulation should specify mashed or pureed foods	The gradual introduction of solid foods that are mashed or pureed may begin at approximately six months of age, if it is developmentally appropriate for the infant.
NA4	NAC 432A.380.2	A licensee of a facility shall follow the current nutrition standards for meals and snacks which are applicable to children of ages receiving care at the facility as issued by the Child and Adult Care Food Program of the United States Department of Agriculture.	The regulation should specify 2% milk for children at risk for hypercholesterolemia or obesity	"A licensee of a facility shall follow the current nutrition standards for meals and snacks which are applicable to children of ages receiving care at the facility as issued by the Child and Adult Care Food Program of the United States Department of Agriculture. A. Provide only unflavored whole milk to children between the ages of 12 and 24 months; provide unflavored reduced fat (two percent) milk for those children who are at risk for hypercholesterolemia or obesity if provided documentation from the child's primary care provider."
NB1/NB2/NB3	NAC 432A.380.2	A licensee of a facility shall follow the current nutrition standards for meals and snacks which are applicable to children of ages receiving care at the facility as issued by the Child and Adult Care Food Program of the United States Department of Agriculture.	Revision 1. NB1. Remove specification of "at least one serving per day" of whole grains Revision 2. NB2. Need to specify a variety of fresh vegetables in addition to following CACFP regulations Revision 3. NB3. Need to specify a variety of fresh fruit in addition to CACFP	"A licensee of a facility shall follow the current nutrition standards for meals and snacks which are applicable to children receiving care at the facility as issued by the Child and Adult Care Food Program of the United States Department of Agriculture. A. Provide a variety of both fruits and vegetables and high portion of whole grain-rich items served per meal and snack each day."
NG1/NG2	NAC 432A.380.5	Foods and beverages which are sweet or have little nutritional value must not be served to children.	Revision 1 NG1. Specify salty foods which is done below by referencing sodium Revision 2 NG2. Specify sweetened drinks and flavored milks which is done below by referencing added sugar	Limit foods and drinks that are high in saturated fats, added sugar, and sodium.



Survey Results of Licensed Childcare Providers and Families

Table A2 (Continued). Current Nevada Administrative Code and Proposed Changes

ASHW Standard	NAC Code	Current language	Proposed revision	Updated standard language
NE1	432A.385.1(d)	Allow, encourage and assist each child to feed himself or herself; encourage a child to hold and drink from a cup, use a spoon and use his or her fingers to feed himself or herself	Regulations should specifically reference "teaching" children, and emphasize serving and feeding themselves	Encourage, teach, and assist children to serve and feed themselves using developmentally or age-appropriate measuring utensils and tableware.
NE2	(No current NAC addresses this standard)	There is currently no NV regulation that discusses family-style meal service in reference to mealtime practices.	Refer to the Child and Adult Care Food Program regulations by the United States Department of Agriculture	A licensee of a facility shall follow the current nutrition standards for healthy mealtime practices which are applicable to children and adults at the facility as issued by the current Child and Adult Care Food Program of the United States Department of Agriculture.
NF2	432A.380.1	Meals and snacks must be of a quality and quantity which supplement the food served at home. Cultural and ethnic foods which are appropriate for children must be considered in planning meals. To the extent possible, information provided by parents concerning their child's eating habits and preferences or special needs regarding food must be considered in planning for meals.	This regulation should also address serving sizes and specific caloric needs in consultation with child's parents and primary care provider. The revised language would include: "Require/encourage serving sizes for children that may need increased or reduced caloric needs as instructed by parents, with written documentation from child's primary care provider."	Meals and snacks must be of a quality and quantity which supplement the food served at home. Cultural and ethnic foods which are appropriate for children must be considered in planning meals. To the extent possible, information provided by parents concerning their child's eating habits and preferences or special needs regarding food must be considered in planning for meals. Adjust serving sizes for children that may need increased or reduced caloric needs as instructed by parents, with written documentation from child's primary care provider.
NH1	432A.380.11	Food must not be used as a basis for discipline or reward. Children should be encouraged, but must not be forced, to eat.	This regulation should add that the child should not be "bribed"	Food must not be used as a basis for discipline or reward. Children should be encouraged, but must not be forced or bribed, to eat.
PA4	432A.390.3	If the weather permits, all children must have a daily period of outdoor play. A licensee of a facility shall provide opportunities for moderate or vigorous physical activity which builds muscles. The quantity and quality of materials and equipment must be sufficient to avoid excessive competition between the children and long waiting periods to use the materials or equipment.	Regulations should specify that caregivers should "promote" children's active play and participate in active games when safe to do so	If the weather permits, all children must have a daily period of outdoor play. A licensee of a facility shall provide and promote opportunities for moderate or vigorous physical activity and active play when safe to do so. The quantity and quality of materials and equipment must be sufficient to avoid excessive competition between the children and long waiting periods to use the materials or equipment.
PC2/PC3	432A.430.4(f)	Incorporate age-appropriate instruction, concepts and activities that foster the social, emotional, physical, linguistic and cognitive development of children, which must include, without limitation, moderate or vigorous physical activity.	The regulation should specify age and duration of physical activity	Incorporate age-appropriate instruction, concepts and activities that foster the social, emotional, physical, linguistic and cognitive development of children, which must include, without limitation, moderate or vigorous physical activity. Allow at least 60 minutes for toddlers and 90 minutes for preschoolers per 8-hour day.
PE1/PE2	432A.425.4(d)	Infants under 6 months of age must be provided an additional period of not less than 2 hours of activity each day out of the crib, for example, in a playpen or other suitable area.	Regulation should specify that swings or stationary seats should only be used for short periods of time.	Infants under 6 months of age must be provided an additional period of not less than 2 hours of activity each day out of the crib, for example, supervised tummy time, in a playpen, or other suitable area. Swings and stationary seats should only be used for short periods of time if at all, such as in transition from one activity to another.
PB1-PB4	(No current NAC addresses this standard)	There are no current NV regulations for this standard.	Revision 1: PB1. Specify that children under 2 should not be having screen time Revision 2: PB2/PB3. Limit screen time for children 2 years and older to 30 minutes weekly, and limit to education and/or physical activity purposes only Revision 3: PB4. Eliminate all screen time during snacks and meals	Children under the age of 2 should not have screen time. For children 2 years and older, screen time should be limited to 30 minutes weekly for educational and physical activity purposes only. Screen time should never be utilized during snacks or meals.

OVERVIEW OF PRIORITY AMENDMENTS TO NEVADA ADMINISTRATIVE CODES AND REGULATIONS: Chapter 432A Services and Facilities for Care of Children

Alignment with National Best Practices through Achieving a State of Healthy Weight

Annually, the University of Colorado collaborates with CDC's Division of Nutrition, Physical Activity, and Obesity, to assess child care licensing regulations in all 50 states and the District of Columbia. The 2023 Achieving a State of Healthy Weight (ASHW) report is the 13th update to the baseline assessment that began in 2010. The report describes how well licensing regulations for early care and education (ECE) programs align with the High-Impact Obesity Prevention Standards (HIOPS). Currently, Nevada is ranked 24th in the nation and is fully meeting criteria for 15 of the 47 standards, partially meeting 17, and does not meet 15 of the standards within its state licensing codes and regulations.

Based on the information provided in Attachments 1 through 3 of this packet, the Nevada Early Childhood Obesity Prevention workgroup has developed an outline of the top priorities for amendment per stakeholder feedback. Each of the below proposed revisions are in relation to the current Nevada Administrative Codes and Regulations, Chapter 432A Services and Facilities for Care of Children.

PROPOSED REVISION 1

ASHW HIOPS IA1:

Encourage and support breastfeeding and feeding of breast milk by making arrangements for mothers to feed their children comfortably on-site.

Current NV Child Care Statues & Regulations [NAC 432A.425(14) / NRS 432A.077 / NRS 432A.1771]:

Each licensee of a facility shall provide an appropriate, private area on the premises where a mother may breastfeed.

Why it fails to meet the standard:

Per ASHW recommendations, the phrase "Encourage and support" must be included in addition to providing a private area. Nevada Childcare Licensing recommended that we adhere to best practices by the Child and Adult Care Food Program (CACFP).

Proposed Revisions:

A licensee of a facility shall adhere to the current breastfeeding standards applicable to the ages of children receiving care, as established by the Child and Adult Care Food Program of the United States Department of Agriculture. As a best practice, the facility must encourage and support breastfeeding and feeding of breast milk by having a designated, private area available. If a permanent designated area is not available, the facility must provide alternative accommodations that ensure the same level of privacy, security, and comfort necessary for breastfeeding.

PROPOSED REVISION 2

ASHW HIOPS NB2:

Serve vegetables, specifically, dark green, orange, deep yellow vegetables; and root vegetables, such as potatoes and viandas.

ASHW HIOPS NB3:

Serve fruits of several varieties, especially whole fruits.

Current NV Child Care Statues & Regulations [NAC 432A.380 / NRS 432A.077]:

A licensee of a facility shall follow the current nutrition standards for meals and snacks which are applicable to children of ages receiving care at the facility as issued by the Child and Adult Care Food Program of the United States Department of Agriculture.

Why it fails to meet the standard:

Current CACFP recommendations do not address serving a variety of fruits and vegetables.

Proposed Revisions:

A licensee of a facility shall follow the current nutrition standards for meals and snacks which are applicable to children of ages receiving care at the facility as issued by the Child and Adult Care Food Program of the United States Department of Agriculture, including the recommendation of serving a variety of fruits and vegetables.

PROPOSED REVISION 3

ASHW HIOPS NH1:

Do not force or bribe children to eat.

Current NV Child Care Statues & Regulations [NAC 432A.380 (11) / NRS 432A.077]:

Food must not be used as a basis for discipline or reward. Children should be encouraged, but must not be forced, to eat.

Why it fails to meet the standard:

Nevada regulations do not specify bribery.

Proposed Revisions:

Food must not be used as a basis for discipline or reward. Children should be encouraged, but must not be forced or bribed, to eat.