

Final Report

Keeping Children Healthy in California's Child Care Environments

Recommendations to Improve
Nutrition and Increase
Physical Activity

CALIFORNIA DEPARTMENT OF EDUCATION
CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
Sacramento, 2010



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Physical Activity



Publishing Information

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A Message from the State Superintendent of Public Instruction and the Secretary of the California Health and Human Services Agency

We are pleased to introduce *Keeping Children Healthy in California's Child Care Environments: Recommendations to Improve Nutrition and Increase Physical Activity*, and we want to extend our thanks to the Strategic Assessment of the Child Care Nutrition Environment Advisory Group, which guided the report's development.

California's children face a future limited by chronic disease and, for the first time in history, shorter life spans than their parents. Children's early years are critical in shaping their physical, emotional, and social well-being. One-third of California's low-income children enter school overweight or obese. Interventions to curb this epidemic must begin before children enter school and before they develop poor health habits that lead to overweight and obesity. Child care settings are ideal environments for promoting healthy eating habits and physical activity.

According to data from the 2007 California Health Interview Survey, 11.2 percent of children in California are overweight for their age, and 27.7 percent of teens and nearly 60 percent of adults are overweight or obese. These medical conditions translate into millions of dollars in health care costs in California, further burdening an overstretched health care system.

Reducing rates of overweight and obesity among all Californians is a priority for both of us, and for Governor Schwarzenegger. We recognize that efforts to change the nutrition and physical activity environments in California cannot be pursued effectively by only one agency or organization. To that end, we joined forces to convene the Strategic Assessment of the Child Care Nutrition Environment Advisory Group—a stakeholder group of child care experts—to develop policy recommendations to create healthier preschool, child care, and after-school environments. We are pleased to share their recommendations in this report.

The report exemplifies the type of collaborative work necessary to achieve the Governor's "Vision for a Healthy California" and to close the achievement gap. Some of the report's recommendations will require additional funding or legislation to implement; others will not. All recommendations merit serious consideration and further discussion. To effect substantive change in California's child care settings, all Californians—policymakers, government representatives, parents, child care providers, and community members—must unite so that every child in the state will have the opportunity to live a long, healthy, and productive life.

Sincerely,

JACK O'CONNELL
 State Superintendent of Public Instruction
 California Department of Education

KIM BELSHÉ
 Secretary
 California Health and Human Services Agency

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The California Department of Education (CDE) and the California Health and Human Services Agency (CHHS) extend their appreciation to the Strategic Assessment of the Child Care Nutrition Environment Advisory Group for its outstanding work in developing this report. The advisory group consisted of the following child care stakeholders, each of whom was appointed by State Superintendent of Public Instruction Jack O’Connell and CHHS Secretary Kim Belshé:

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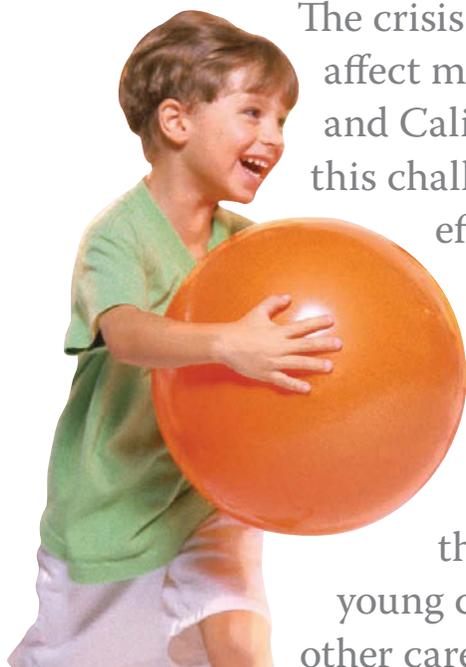
Special commendation is given to **Phyllis Bramson** for her vision and leadership, and to **Lisa Hershey** for her instrumental collaboration in the development of the report’s recommendations.

Grateful recognition is also extended to **M. Jane Heinig**, advisory group facilitator, and to **Jennifer Bañuelos** of the Human Lactation Center at the University of California, Davis. Their expertise and support were vital to the development of this report. Additionally, **Gil Sisneros**, **Angie Keihner**, **Helen Magnuson**, and **Betty Sun** of the California Department of Public Health made valuable contributions by reviewing the report and providing edits and technical assistance.

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Introduction



The crisis of overweight and obesity continues to affect millions of our nation’s youngest children—and California must take the lead in addressing this challenge. Until recently, obesity prevention efforts have been restricted to policies and programs aimed at school-age children, but growing evidence indicates that effective interventions are needed much earlier in children’s lives. Child care providers in California have the potential to influence the nutrition and physical activity habits of young children and to help educate families and other caregivers.

As a result of State Superintendent of Public Instruction Jack O’Connell’s emphasis on student health and nutrition as a top educational priority, the California Department of Education (CDE) became the first state educational agency in the country to allocate Child Care and Development Block Grant “quality” funds to improve the quality of nutrition in child care programs. The CDE used a portion of these funds to collaborate with the University of California, Davis (UCD), on a strategic assessment of nutrition and physical activity in California’s child care programs. Joining forces, Superintendent O’Connell and California Health and Human Services Agency (CHHS) Secretary Kim Belshé convened a state and local stakeholder advisory group to examine current systems and policies and to provide recommendations for action.

The Strategic Assessment of the Child Care Nutrition Environment Advisory Group (advisory group) met six times over a seven-month period and considered information from published reports and from presentations by experts. Working in both small and large groups allowed the advisory group members to share their extensive

knowledge and expertise during their deliberations. Each meeting included time for public comment and insights from visiting experts and community advocates from around the state. Throughout the process, stakeholders offered their input to ensure that recommendations would be realistic and sustainable. This report presents the findings from the strategic assessment.

The Role of Child Care in Promoting Healthy Eating and Active Lifestyles

Child care experiences influence millions of California's children every day. With increasing numbers of parents and caregivers in the workforce, more of California's youngest children spend time in child care settings, many in full-time care—and after they enter school, children often attend school-age child care programs or are cared for by others while their parents or caregivers are at work. These child care experiences contribute to children's physical, emotional, and social development and to the health habits they carry into adulthood.

High-quality child care settings have the potential to make a positive impact on children's lives and to prepare them for success in school. In high-quality child care settings, children learn about the world in safe, supportive environments with a variety of nutritious foods and the opportunity to enjoy hours of active play matched to their unique abilities and interests. All children deserve this kind of care, but thousands of California's children—particularly those from low-income families—may not have access to high-quality care. Unfortunately, some child care providers in California may not know how to meet children's nutritional, physical, and developmental needs. The result is that increasing numbers of children enter school ill-prepared to learn and already overweight or obese. For these reasons, we must make changes to improve and standardize nutrition and increase and standardize physical activity in child care settings so that all of California's children have the opportunity to be healthy, active, and ready to learn.

California’s Diverse Child Care Settings

Fostering change in California’s child care settings is challenging because the term “child care” encompasses a variety of environments that may be governed by different rules, regulations, and agencies. Complex sets of regulations, which may differ based on the type of care provided, can be confusing for providers and difficult for regulators to enforce. Child care providers use a broad range of methods, curricula, and resources as they interact with children. As a result, it may be difficult to find a central point from which to work for improvement. In fact, any efforts to promote change in child care must involve a complicated web of regulatory agencies, community organizations, advocacy groups, and parent and provider organizations. For those unfamiliar with California’s diverse child care system, definitions for key terms are provided below.

Licensed child care

Several types of child care providers and settings—including child care centers and family child care homes—require licensure by the California Department of Social Services Community Care Licensing Division (CCLD). Section 101227 of the *California Code of Regulations, Title 22 (22 CCR)*, which is intended to protect the health and safety of children receiving out-of-home child care, defines the types of providers that require licensure as well as the conditions that licensed providers must meet.

License-exempt child care

Child care providers are “license-exempt” (not required to obtain a California child care license) if they meet specific criteria found in 22 CCR sections 101158 and 102358. Examples of license-exempt providers include nannies, friends, or relatives who care for a child in the child’s own home; caregivers who provide care for children from only one family besides their own; and school-based child care programs.

Subsidized child care

Subsidized child care programs in California, which are governed by Title 5 and Title 22 of the *California Code of Regulations*, involve state or federal funding that assists eligible families by reducing the direct cost of child care. Families must demonstrate that their incomes are at or below 75 percent of the state’s median income, adjusted for family size. To be eligible for programs other than the State Preschool Program, families also must establish a need for child care to be provided (e.g., when the parents or primary caregivers are working or are attending school). The CDE administers child care

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Family child care home

subsidies in California. Nonprofit and for-profit agencies, churches, school districts, and local governments, among others, can operate subsidized child care programs. Subsidies can be used in licensed and license-exempt child care settings.

A family child care home provides care, protection, and supervision of infants, toddlers, preschoolers, and school-age children in a caregiver's own home—for periods of less than 24 hours per day—while the parents or authorized representatives of the children are not present.

Day care home

The U.S. Department of Agriculture (USDA) uses the term “day care home” to refer to a licensed family child care home participating in the Child and Adult Care Food Program (CACFP). A day care home must operate under the auspices of a sponsoring organization.

Child care center

A child care center provides nonresidential group care for infants, toddlers, preschoolers, and school-age children. Child care centers may be operated by independent, nonprofit organizations or by for-profit groups, and they are located in churches, commercial buildings, renovated homes, or on school grounds. Most child care centers are licensed through the CCLD.

Infant/toddler care

Infant/toddler care programs provide care to infants and toddlers from birth to 30 months in child care centers or family child care homes.

Preschool

A preschool program differs from a child care center in that preschool programs typically provide care for three- to five-year-old children in classroom settings. Most preschool programs are part-time, although some do offer full-time care.

Head Start

Head Start is a program of the U.S. Department of Health and Human Services that promotes school readiness and provides comprehensive education, health, nutrition, and parent-involvement services to low-income children from three to five years of age and their families.

School-age care

School-age child care programs provide care to children in kindergarten through grade eight before and/or after school, either on the school property or elsewhere. Many of these programs also provide care during the summer.

Participation in California’s Child Care Settings

Over one million children in California receive care in licensed child care facilities, yet licensed care is available for only 27 percent of children of working parents.¹ For most new parents, obtaining affordable child care is an enormous challenge, particularly because so many families need full-time care. According to the 2005 California Health Interview Survey, more than 40 percent of preschoolers spend 40 hours or more each week in child care (see figure 1).² Child care providers include licensed centers and family child care homes as well as license-exempt providers. However, the majority of families resort to complicated but informal arrangements with multiple caregivers including neighbors, friends, and family members.³ In fact, the majority of individuals who provide care for California’s children are not monitored by the state. The 2007 California Health Interview Survey reports that more than 50 percent of children receive care from more than one type of caregiver (see figure 2).⁴ With so many children in child care, preschools and child care settings present important opportunities to educate young children and model healthy behaviors for them—at a time when the children are most open to learning from adults.

Weekly hours spent in child care: children, birth to age 5 (California)

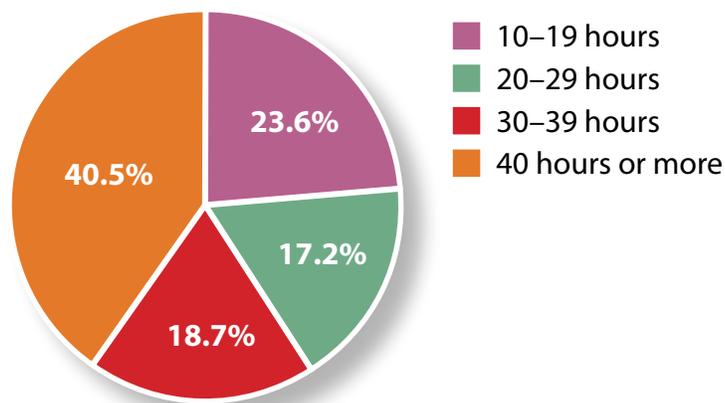


Figure 1. Distribution of children from birth to age five who spend at least 10 hours per week in child care, based on total hours spent in child care. *Source:* 2005 California Health Interview Survey.

Caregiver types for children, birth to age 5 (California)

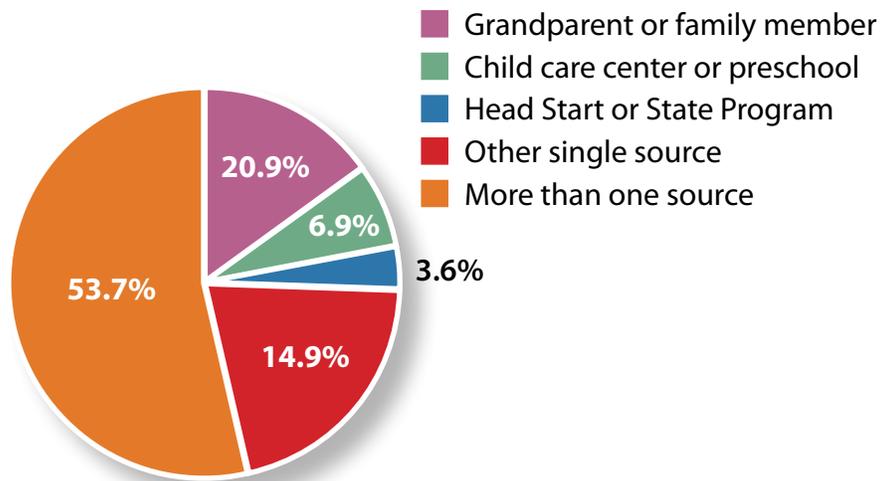


Figure 2. Distribution of children from birth to age five who spend at least 10 hours per week in child care, based on different types of child care settings. *Source:* 2007 California Health Interview Survey.

Enhancing Nutrition in Child Care Settings: The Child and Adult Care Food Program (CACFP)

The federal government initiated the CACFP in the late 1960s to provide federal reimbursement for nutritious meals and snacks served in licensed child care settings. It was later expanded to include other sites such as homeless, runaway, and domestic violence shelters. The CACFP is administered by individual states, which reimburse participating agencies for meals and snacks that adhere to a standardized meal pattern designed to meet children’s nutritional needs. Low-income children are qualified to receive free or reduced-price meals and snacks in child care, depending on their family’s income level. Providers who serve these children are reimbursed at higher rates.

Nationwide, more than 3 million children participate in the CACFP, and the vast majority of them qualify for free and reduced-price meals and snacks. More children participate in the CACFP in California than in any other state.⁵ In federal fiscal year 2008–09, California served more than 700,000 children’s meals and snacks at

participating sites every day. However, it is estimated that less than half of eligible California child care providers participate in the program.^{6,7} This is unfortunate because CACFP participation can improve the diets of children who attend participating centers.⁸ In fact, many low-income working families rely on the CACFP to help meet their children's nutritional needs.⁹

The CACFP poses several challenges. Despite advances in our understanding of nutrition and physical activity requirements for children, the CACFP meal pattern has changed very little in the last 40 years and provides no guidelines for physical activity. Additionally, the federal government has increased the CACFP's accountability, integrity, and compliance requirements, which include a significant amount of detailed recordkeeping and paperwork that are considered costly and labor-intensive for participating providers and sponsoring agencies. Despite these challenges, the CACFP plays a pivotal role in the promotion of good nutrition in child care by requiring that the meals and snacks served meet minimum nutrition requirements.

The Health of California's Youngest Children

A generation ago, the prevalence of obesity among our nation's preschoolers was approximately five percent.¹⁰ Today, overweight and obesity among children of all ages is a national epidemic.* In 2008, over 20 percent of children in the United States between the ages of two and five were overweight or obese.¹¹ In 2007, more than 1.6 million of California's children and teens were obese-for-age or obese, respectively.¹²

According to the 2007 California Health Interview Survey, the prevalence of obesity among California's children increases,

*In December of 2007, the American Academy of Pediatrics published new Body Mass Index (BMI) classifications for children. Children who are \geq 95th percentile for BMI for age are now classified as "obese" and children who are \geq 85th and $<$ 95th percentile are now classified as "overweight"; see Barlow, S. E., and the Expert Committee, "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report," *Pediatrics* 2007; 120; S164–S192. At the time the data were reviewed for this report, these children were classified as "overweight" and "at risk for overweight," respectively. In order to minimize confusion, the new classifications will be used throughout this report even though the data sources may have used the old terminology.

Prevalence of obese-for-age children in California, birth to age 11

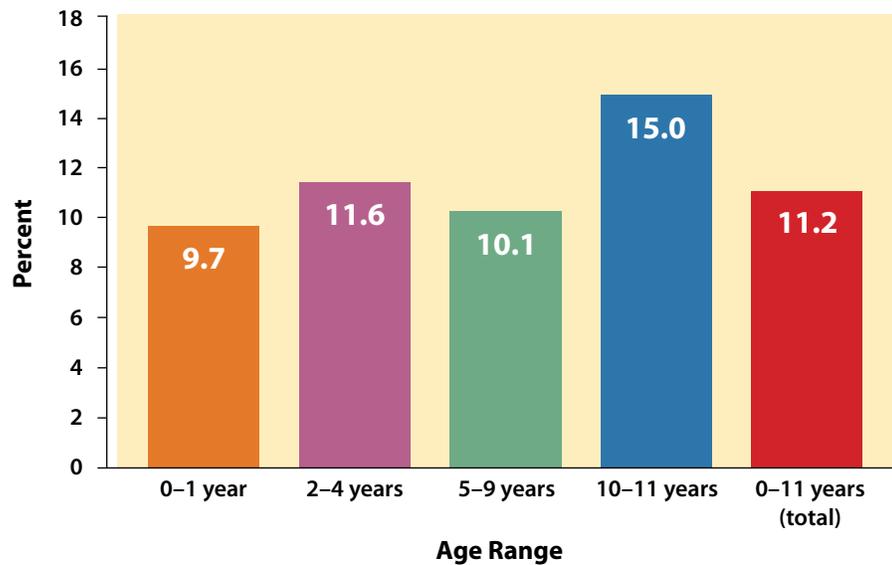


Figure 3. Prevalence of obese-for-age children (weight for age \geq 95th percentile). Based on CDC growth chart percentiles for weight-for-age (2000). *Source:* 2007 California Health Interview Survey.*

in general, with age (see figure 3); and in total, more than 11 percent of children less than twelve years of age are obese.¹³ Hispanic and African American children are most likely to be obese; 13.7 percent of Hispanic children and 14.5 percent of African American children in this age group are obese, compared with 8.2 percent of white children. Rates of childhood obesity also vary by geographic region, with the highest rates occurring in Los Angeles (12.9 percent) and the Central Valley (14.4 percent). The lowest rates occur in the San Francisco Bay Area (8.5 percent).¹⁴ Additionally, rates of overweight and obesity vary by family income level. Higher rates of obesity are found among low-income children of all ethnicities, but particularly among Pacific Islander, Native American, and Hispanic children (see figure 4).

*The California Health Interview Survey (CHIS) uses the term “overweight-for-age” for children at the 95th percentile and above; however, this report uses “obese-for-age” rather than overweight-for-age for children at the 95th percentile and above. This is consistent with the use of the new terms *overweight* (formerly “at risk for overweight”) and *obese* (formerly “overweight”) throughout the report.

Percentages of low-income children in California, ages 2 to 5, who are overweight and obese (by race/ethnicity)

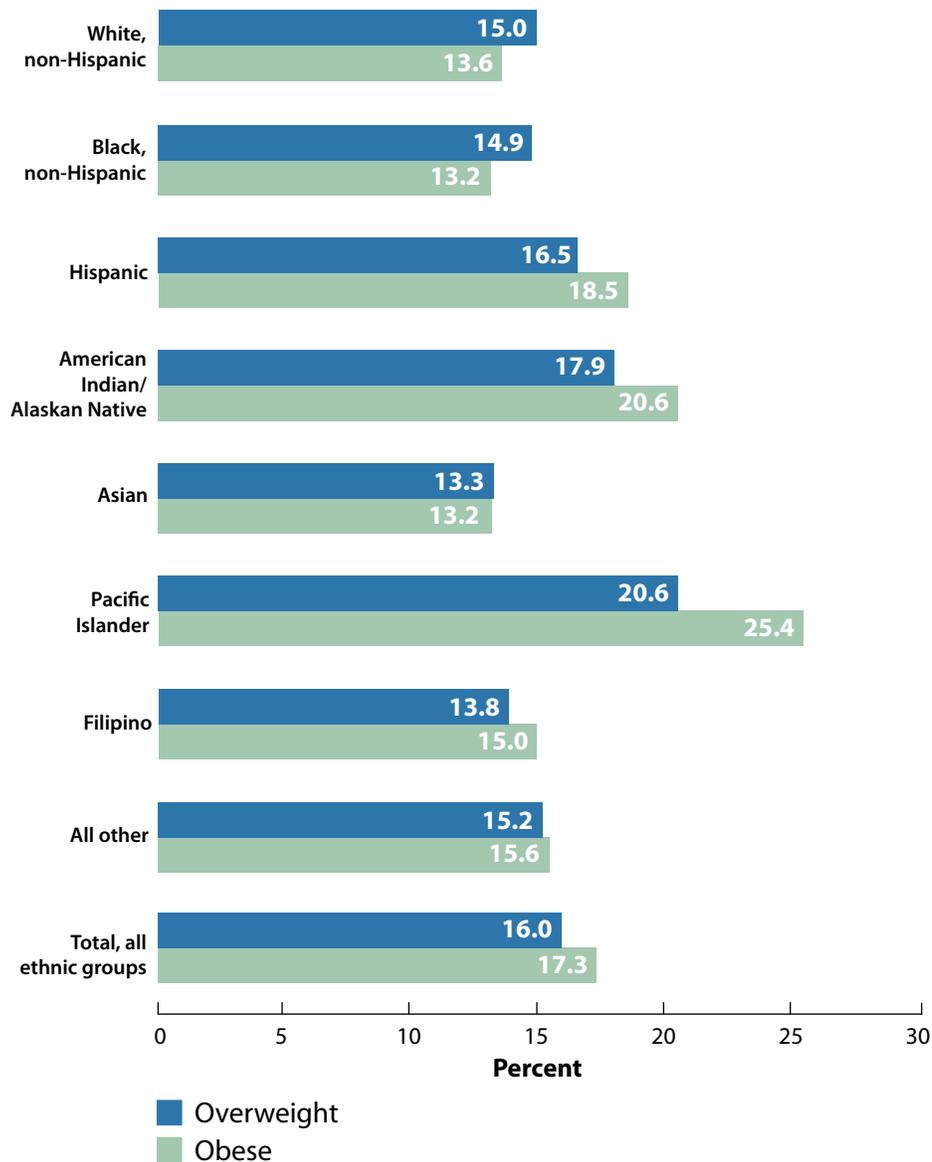


Figure 4. Percentages of low-income children in California, ages two to five, who are overweight (BMI for age \geq 85th percentile and $<$ 95th percentile) and obese (BMI for age \geq 95th percentile). Based on CDC growth chart percentiles for weight-for-age (2000). *Source:* Table 16C, 2008 Pediatric Nutrition Surveillance System (PedNSS), California Department of Health Care Services. <http://www.dhcs.ca.gov/services/chdp/Pages/PedNSS2008.aspx>.

Overweight and obese children are more likely to suffer from sleep apnea and childhood growth disorders, and they are at greater risk for early onset of health problems typically found in adults—such as type 2 diabetes, high blood pressure, high cholesterol, and cardiovascular disease.¹⁵⁻¹⁸ These medical conditions translate into millions of dollars in health care costs in California, further burdening the state’s already overstretched health care system.¹⁹⁻²¹ Unfortunately, many obese children remain obese as adults, which results in even higher costs. In 2006, the estimated cost to California for overweight, obesity, and physical inactivity among adults totaled \$41.2 billion; \$21 billion was attributable to overweight and obesity, and \$20.2 billion was attributable to physical inactivity. If these trends continue, total costs for the state will increase to \$52.7 billion in 2011.²²

Overweight and obesity can affect more than children’s physical health. Children who are severely obese are more likely to struggle academically and have behavioral issues at school.²³ They are more likely to suffer from peer rejection, bullying, and depression.²⁴ Severely obese children miss four times more school days than their peers who are at normal weight levels.²⁵ This absenteeism may serve to perpetuate and expand the achievement gap between obese and normal-weight children that may begin among very young children.^{26,27} Obese kindergartners have significantly lower test scores in math and reading than their normal-weight peers.²⁸

Inactivity also has become a problem for many of California’s children. This is due to a lack of play space, limited availability of age-appropriate equipment, and competition from television, computers, and video games. Some interventions designed to reduce “screen time” and sedentary behaviors have been successful in increasing children’s activity.²⁹⁻³³ Similarly, increasing safe play spaces in neighborhoods also can result in increased physical activity in young children.³⁴ It is therefore likely that introducing guidelines to increase active play and reduce screen time may contribute significantly to children’s fitness and may reduce overweight and obesity. Physical activity policies in child care settings have proven to be an important influence on the overall activity levels of children.³⁵

Quality Child Care—Only Part of the Solution

Child care settings are ideal environments for promoting healthy eating habits and physical activity. Until recently, many actions aimed at improving children's health and fitness have focused largely on schools. However, according to the 2008 Pediatric Nutrition Surveillance System, 33 percent of California's low-income children enter school already overweight or obese. For the most part, attempts to treat childhood overweight and obesity have been unsuccessful—and as a result, recent health recommendations have focused on prevention rather than on treatment of overweight.^{36,37} Interventions to curb this epidemic should begin before children enter school and before they develop poor health habits that lead to overweight and obesity.³⁸

Significant shifts in rates of childhood overweight and obesity will require broad changes far beyond the scope of this assessment. Promotion of healthy eating and active lifestyles for our children requires change throughout society: healthy eating and physical activity habits learned in child care must be reinforced in home environments; children need access to fresh, nutritious foods and safe areas for active play; and policymakers need to ensure that families and child care providers receive consistent, focused, up-to-date messages about healthy eating and adequate physical activity for maintaining children's health. With so many children touched by child care experiences—and because both poor nutrition and physical inactivity in the early years can have such a lasting effect on children's health and academic success—making changes in child care settings can be an important first step in a comprehensive effort to fight childhood overweight and obesity.

Strategic Assessment of Nutrition and Physical Activity in California's Child Care Environments

Reducing rates of overweight and obesity among Californians of all ages continues to be a priority for Governor Schwarzenegger and State Superintendent O'Connell. Both leaders recognize that efforts to change nutrition and physical activity environments in a state as large and diverse as California cannot be pursued effectively by only one agency or organization. Cooperative efforts are already under way to build on public and private partnerships to improve nutrition and increase physical activity in California's schools and communities. Now work is needed to expand these efforts to include child care settings.



The Strategic Assessment of the Child Care Nutrition Environment Advisory Group convened by Superintendent O’Connell and Secretary Belshé consisted of people who know child care best, including representatives from state and local child care and development agencies and advocacy groups. Superintendent O’Connell and Secretary Belshé charged the advisory group with (1) conducting a strategic assessment of factors associated with poor nutrition, physical inactivity, and overweight among young children; and (2) providing recommendations on how best to improve nutrition and increase physical activity in child care settings. This report presents the advisory group’s findings and recommendations.

Goals and Recommendations

The recommendations in this report are intended to be part of a multifaceted strategy initiated by Superintendent O’Connell and Secretary Belshé to reduce overweight and obesity and to promote healthy lifestyles among California’s children and youths. These recommendations are not intended to be independent of each other; rather, they are intended to be implemented together as a comprehensive, coordinated plan involving public and private partners at all stages.

California is one of the largest, most diverse states in the nation. Therefore, the advisory group’s recommendations must be implemented in ways that are linguistically appropriate and sensitive to cultural differences. Furthermore, because all children are different, it is imperative that each child’s unique needs and abilities be considered when the recommendations are implemented.

The success of the advisory group’s chosen approach depends on the achievement of four interdependent goals:*

- 1. Strengthen the Child and Adult Care Food Program (CACFP).**
- 2. Establish nutrition and physical activity requirements for child care programs.**
- 3. Provide consistent messaging related to nutrition and physical activity.**
- 4. Expand nutrition and physical activity training in child care programs.**

*See also the Appendix, “Goals and Recommendations, by Target Audience.”

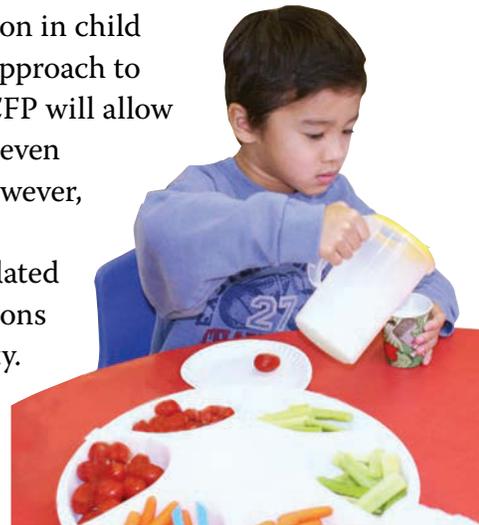
Goal 1

Strengthen the Child and Adult Care Food Program (CACFP).

Strengthen, expand, and revise the federal CACFP to align the program with current scientific evidence related to child nutrition and physical activity.

RATIONALE

The CACFP provides more than 300,000 of California’s children with nutritious meals and snacks every day. The program creates a “basic nutritional safety net” for low-income children and serves as the cornerstone of the USDA’s efforts to standardize and enhance nutrition in child care settings.³⁹ A collaborative approach to expand and strengthen the CACFP will allow the program to effectively serve even greater numbers of children. However, the program’s meal pattern and nutrition standards must be updated to reflect current recommendations for nutrition and physical activity. These changes are urgently needed to address the growing problem of childhood overweight and obesity.



RECOMMENDATIONS

- A. Establish California nutrition and physical activity standards for an improved CACFP.** The California Department of Education (CDE) should convene an expert committee to review and improve the federal CACFP meal pattern with enhanced California nutrition and physical activity standards. This group should examine evidence to determine (1) how the current CACFP meal pattern impacts the nutritional status of children in child care settings and how the meal pattern could be improved; (2) the degree to which behavioral standards for caregivers (such as feeding styles) could be used to improve children’s nutritional

RATIONALE ➤

status; and (3) the potential benefits of physical activity standards.

The nutrition issues affecting children have changed significantly since the federal government developed the CACFP program in the late 1960s. Unlike previous generations, children in California today have a greater risk of becoming overweight than underweight. While hunger still exists in California, today's nutrition programs must address the needs of children who have a broader spectrum of health issues related to poor nutrition and physical inactivity. There has been significant advancement in scientific knowledge related to children's nutrition, feeding practices, and physical activity since the federal government initiated the CACFP. California standards that complement and improve the existing CACFP meal pattern will incorporate this updated information.

Modeling is an influential tool for teaching children appropriate behaviors. Mealtimes offer child care providers opportunities to help children learn about healthy eating behaviors. A study of 24 licensed child care centers in Illinois found that while 69 percent of caregivers sat with children during mealtimes, only 50 percent ate what the children were eating, and the rest ate either nothing or fast food.⁴⁰ Furthermore, only 50 percent of the caregivers made comments about nutrition during mealtime.⁴¹ A review of additional research is needed to indicate how changes in caregiver feeding practices may affect children's nutritional status.

B. Modify the federal CACFP meal pattern. The CDE should work with the USDA and Congress to modify the federal CACFP meal pattern in accordance with the California standards described in Recommendation A.

RATIONALE ➤

A 1999 study showed that the CACFP meal pattern requirements were met by the majority of the sites studied.⁴² In general, children consumed too much fat and sodium in child care settings, but not enough iron.⁴³⁻⁵² Higher intake of calories, fat, and sodium may be associated with increased risk of child overweight and obesity. The CACFP nutrition guidelines should be updated to reflect current knowledge of child nutrition and physical activity, and should address caregiver feeding practices.

C. Streamline the CACFP compliance requirements to increase agency participation. The CDE should work with state and community agencies to address their CACFP participation challenges by (1) advocating changes to federal compliance requirements; (2) continuing to modernize and streamline compliance reporting requirements; and (3) continuing to develop guidance for CACFP agencies to help them meet federal program requirements.

RATIONALE ➤

Between 1996 and 2008, nationwide participation in the CACFP among child care centers increased by nearly 48 percent while participation among family day care homes decreased by just over 27 percent.⁵³ In a survey conducted at the Child Care Food Program Roundtable's 16th Annual CACFP Conference (2007), 60 respondents reported that excessive paperwork and insufficient funding to cover food and administrative costs were significant barriers to participation in the CACFP.⁵⁴

In order to encourage greater participation in the CACFP, especially in family day care homes, these concerns must be addressed. Long-term changes to compliance requirements are needed at both the federal and state levels, but child care providers also need practical guidance to follow current program requirements in a more cost-effective manner.

D. Collaborate on a CACFP marketing plan. The CDE, the California Department of Social Services Community Care Licensing Division (CCLD), and the California Department of Public Health (CDPH) should collaborate to develop and implement a marketing plan that encourages child care providers to participate in the CACFP. The plan should emphasize the CACFP's benefits and the efforts under way to streamline federal paperwork requirements. The marketing plan should also provide the general public with basic information about the CACFP, nutrition, and physical activity.

RATIONALE ➤

In order to decrease perceived CACFP participation barriers, the state needs a coordinated marketing plan aimed at child care providers and sponsors. Efforts are under way to streamline and reduce burdensome paperwork, and it is necessary to publicize this information to encourage greater participation in the CACFP.

RATIONALE ➤

- E. Evaluate nutrition and physical activity education during CACFP monitoring visits.** The CDE should receive sufficient resources to expand monitoring-visit requirements so that child care providers can be evaluated on the quality of nutrition and physical activity education that they offer to children.

CACFP family day care home and child care center sponsors monitor their sites three times annually. At this time, there are no CACFP guidelines for physical activity, so monitoring visits do not assess physical activity. Because of the vast number of regulations that must be evaluated during each monitoring visit, it is not surprising that monitoring staff do not have sufficient time or resources to evaluate the quality of nutrition or physical activity in child care settings. It may be efficient to use existing monitoring visits to improve the quality of nutrition and physical activity; however, the procedures and allotted time for these visits would have to be changed to include evaluation of and education about nutrition and physical activity. Any additional requirements or increased frequency of monitoring visits would involve significant increases in program staffing and resources.

RATIONALE ➤

- F. Require CACFP participation for state-funded child care providers.** All eligible child care providers receiving state funds should be required to participate in the CACFP.

An updated meal pattern, combined with physical activity standards and timely and effective training, will improve the CACFP's effectiveness and efficiency. Streamlining and modernizing compliance and reporting requirements will reduce the costs to participating agencies. As the culminating step in the efforts to strengthen and expand the CACFP, extending the reach of this key program through required participation will improve nutrition and promote healthy lifestyles among young children in child care.

Goal 2

Establish nutrition and physical activity requirements for child care programs.

Develop, implement, and align program standards and requirements to improve nutrition and increase physical activity in child care settings.



RATIONALE

Children are put at risk by the lack of uniform nutrition and physical activity standards in California's child care settings. Actual or perceived conflicts involving guidelines and requirements can confuse providers and reduce compliance. All programs involved in California's child care settings should adopt guidelines and requirements that are supported by the latest scientific research. Efforts to update and improve the CACFP should be extended to other child care programs so that providers will understand how to improve nutrition and increase physical activity in their settings.

RECOMMENDATIONS

A. Include nutrition and physical activity standards in the child care licensing requirements. The CCLD should collaborate with the CDE and the CDPH to modify child care licensing requirements so that all licensed child care providers comply with the new California nutrition and physical activity standards recommended by the expert committee. (See Goal 1, Recommendation A.)

RATIONALE ➤

The California nutrition and physical activity standards will serve as the foundation for efforts to improve nutrition and increase physical activity in all licensed child care settings, even those that do not participate in the CACFP. These new standards will reflect the latest scientific evidence related to children's needs and will allow more children to have access to good nutrition and active play in child care.

RATIONALE ➤

B. Require nutrition-related training for initial child care

licensure. The CCLD and the California Emergency Medical Services Authority (EMSA) should collaborate with the CDE and the CDPH to develop and integrate evidence-based nutrition, physical activity, and wellness education into the preventive health training required for initial licensure of child care providers.

Currently, California licensure for family child care requires 15 hours of health and safety training focusing on a broad range of topics related to child care regulations. Lack of provider knowledge about nutrition and physical activity may result in inappropriate feeding practices and limited opportunities for active play in child care settings. In a survey conducted at the Child Care Food Program Roundtable's 16th Annual CACFP Conference (2007), lack of provider knowledge was reported as one of the most common barriers to improved nutrition in child care settings.⁵⁵ Therefore, education and training of child care providers must be a cornerstone of any effort to improve nutrition and increase physical activity in child care settings. Because all licensed providers must complete initial training, the integration of nutrition and physical activity with the preventive health portion of the training will significantly increase the proportion of providers having a basic understanding of nutrition and physical activity requirements for children.

RATIONALE ➤

C. Incorporate nutrition and physical activity into training

required for maintaining child care licensure. The CCLD and the EMSA should collaborate with the CDE and the CDPH to incorporate nutrition and physical activity education into the ongoing cardiopulmonary resuscitation (CPR) classes that are required for maintaining licensure.

Nutrition and physical activity recommendations for children change as scientists learn more about what children need to stay healthy and fit. Therefore, education related to nutrition and physical activity must be ongoing to be effective. Licensed providers are required to renew their CPR certification on an annual basis, and therefore those CPR training sessions offer an excellent opportunity to educate providers about any new nutrition and physical activity information.

RATIONALE ➤

D. Align child-care-related nutrition and physical activity standards. All relevant state and federal agencies should align their child-care-related nutrition and physical activity standards and requirements to ensure that they do not conflict.

Although all licensed child care settings must meet requirements for health and safety, regulations related to nutrition, physical activity, training, and staffing differ depending on whether providers participate in the CACFP and whether they receive state subsidies. These different requirements often confuse providers and occasionally conflict with each other. Although efforts to align requirements will necessitate cooperation across many levels of state and federal programs, such efforts will result in consistent and more effective regulations.

E. Report key nutrition and physical activity outcomes for child care. All appropriate state and community agencies should work together to identify, track, and publicly report key nutrition and physical activity outcomes for child care settings. As part of this effort, relevant state and community agencies should do the following:

- Identify key outcomes to evaluate interventions for improving nutrition and increasing physical activity in child care settings.
- Identify or create statewide data-collection systems to track key nutrition and physical activity outcomes and to complete periodic data analysis.
- Report statewide outcomes at least every three years, making reports and key findings available to the public through the Internet, print media, public service announcements, and other forms of communication.

RATIONALE ➤

California has very little public information regarding childhood overweight and obesity in child care programs—such as quality of meals served, nutrient intake, and physical activity. There are no ongoing, centralized efforts to collect or review nutrition and physical activity outcomes in child care settings. Data collected through an ongoing tracking system could be used to identify areas of child care programs that are successful and those that need improvement.

Goal 3

Provide consistent messaging related to nutrition and physical activity.

Collaborate on targeted social marketing and health education campaigns to provide consistent messaging to families, providers, children, and the general public about improving nutrition and increasing physical activity in child care settings.



RATIONALE

Preventing childhood overweight and obesity requires a consistent, focused, and coordinated approach. Good nutrition and an adequate amount of physical activity are important to curbing this epidemic; however, current messages about these critical factors are inadequate and inconsistent, and they are being sent to parents, caregivers, and child care providers from many directions. In order for health-related information to be useful, messages must be practical and consistent among all sources and should describe effective tools that are available to families and providers.

RECOMMENDATIONS

A. Collaborate on the development and delivery of consistent messaging. All relevant state agencies—including the CHHS, the CDE, First 5 California, the California Department of Food and Agriculture, and others as appropriate—should collaborate on social marketing and health education strategies to provide consistent messaging about nutrition and physical activity.*

RATIONALE ➤

Social marketing strategies and health education campaigns are proven methods for promoting health messages among the general public, and such strategies may be effective at

*The CHHS includes a number of organizations that impact child care: the CDPH, the California Department of Health Care Services, the EMSA, and the CCLD.

reaching working parents and caregivers.⁵⁶ Coordinating these campaigns would maximize the impact of their associated messages and would allow for the most effective use of limited resources.

B. Establish nutrition and physical activity foundations for preschool. The CDE should incorporate nutrition and physical activity components into the health-related Preschool Learning Foundations.

RATIONALE ➤

Preschool-age children are much more likely than their older peers to look to adult role models—including parents, caregivers, and teachers—for guidance and support. During preschool years, children are in the process of developing eating patterns and other health habits. The California Preschool Learning Foundations were created to establish core learning goals for preschool-age children.[†] Beyond the Foundations, high-quality preschool program goals must be established to promote sound nutrition and physical activity practices and to include parent-involvement activities.

[†]For more information about the California Preschool Learning Foundations, consult the following CDE Web site: <http://www.cde.ca.gov/sp/cd/re/psfoundations.asp>.



The CDE recognizes the integral part that a child's health can play in his or her ability to succeed in school, and the Department's Child Development Division (CDD) has developed preschool learning foundations for health and physical development for children at around 48 and 60 months of age. These foundations describe what preschool children typically know and are able to do in the areas of health, including nutrition, physical development, and physical activity. The CDD is currently developing a preschool curriculum framework for health and physical development that will provide overall guidance for teachers and caregivers.

- C. Include nutrition-related criteria in child care ratings.** As efforts to develop child care ratings in California move forward, the CDE should collaborate with appropriate state and community agencies to include nutrition, physical activity, and parent-involvement criteria in these ratings. Minimally, these criteria must be aligned with the California nutrition and physical activity standards described in Goal 1, Recommendation A. Further recommendations and best practices should be incorporated into criteria used for higher ratings.

RATIONALE ➤

A rating system offers parents and other caregivers a way to evaluate and compare child care environments. Ratings have been used to promote and improve quality child care in several states.⁵⁷ Most of these ratings include various levels, including an initial classification that requires a child care setting to meet a set of minimum requirements. Settings that exceed these standards achieve higher ratings. Efforts to initiate a California child care rating system have begun in Southern California and have been supported by a Legislative Analyst's Office report recommending a system of that kind.⁵⁸ The inclusion of nutrition and physical activity standards in any rating system developed in California will result in improved health among children in child care settings.

Goal 4

Expand nutrition and physical activity training in child care programs.

Create and expand effective, accessible training programs, ensuring that child care providers and families develop the skills and knowledge needed to foster optimal nutrition, physical activity, and wellness in children.

RATIONALE

California's early childhood education workforce includes about 130,000 people serving 750,000 preschool-age children. About 25 percent of these children are in family child care homes, with the rest being cared for in licensed centers.⁵⁹ For most child care workers, pay is low and benefits are almost nonexistent. The annual turnover rates in the profession are high, particularly in child care centers: 22 percent for center-based teachers and 26 percent for assistant teachers. The average tenure for licensed family child care home providers is eight to 12 years.⁶⁰ Training such a transient workforce is an enormous challenge. Even for those who remain in the child care workforce, ongoing training is needed because nutrition information and guidelines continually change as researchers gain greater knowledge of nutrient requirements, risk factors, and healthy outcomes. For providers who work with different age groups, additional education is needed to better understand the changing needs of growing children. Nutrition and physical activity needs differ depending on each child's age and individual abilities. Therefore, while basic training in nutrition and physical activity is needed for all providers, ongoing training is equally essential.

RECOMMENDATIONS

A. Strengthen relevant community-college curricula by emphasizing the importance of nutrition and physical activity in child care programs. The CDE should work with California community colleges to include relevant nutrition and physical activity information in all levels of child-care-related curricula. Students should have the opportunity to increase their skills, knowledge,

RATIONALE ➤

and understanding of their role in helping each child meet his or her unique nutrition and physical activity needs.

Community colleges represent an important venue for reaching thousands of providers employed in California's child care centers. Most workers in California's child care centers complete their required initial training at local community colleges. A 2006 study showed that more than 70 percent of family child care home providers, 88 percent of assistant teachers, and 100 percent of teachers in child care centers had attended some college courses related to child care.⁶¹ However, although proper nutrition and physical activity are crucial for children's health, a random sample of California community colleges showed that only 10 percent of the schools offered a dedicated child-nutrition course.⁶² Seventy percent of the selected colleges provided some nutrition education as part of a single "Health, Safety, and Nutrition" course. Only 11 of the 20 colleges reviewed (55 percent) offered courses specifically related to physical activity for young children, and nine of those 11 colleges offered a standardized course called "Music and Movement." Child care staff need courses dedicated to early childhood nutrition and physical activity in order to gain the specific skills and competencies necessary for improving nutrition and increasing physical activity in child care centers.

- B. Incorporate nutrition and physical activity into continuing education for child care providers.** The CDE and the CHHS should collaborate with other appropriate entities—such as resource and referral agencies, local planning councils, and community agencies—to incorporate effective nutrition, physical activity, and wellness education into training programs offered to child care providers.

RATIONALE ➤

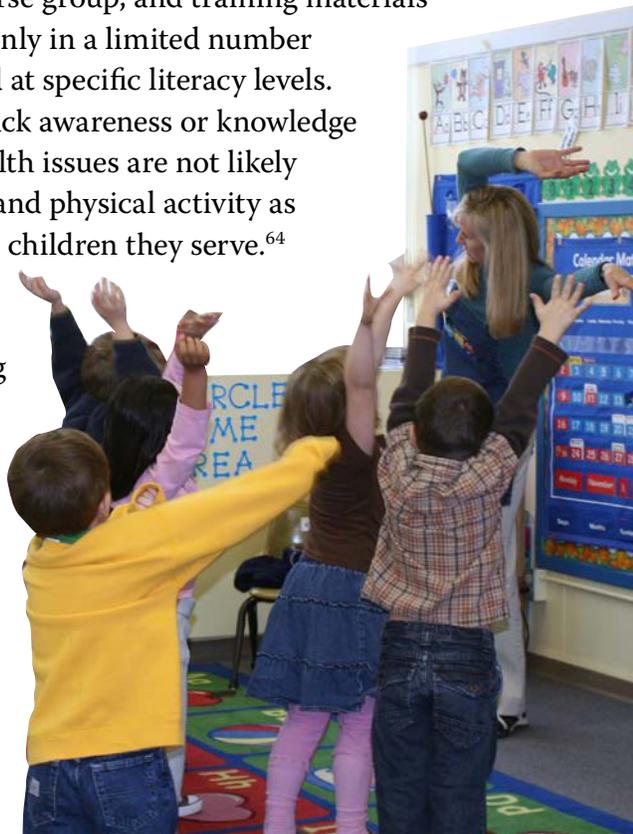
Although community-college classes are important for reaching much of California's child care workforce, other educational venues are needed—particularly for family child care home providers who might not attend college classes. Many agencies and groups offer ongoing health-related educational opportunities for child care providers. However, resources for these programs are rarely shared because of funding restrictions, resulting in duplication of efforts and the

communication of mixed messages to providers. Additionally, agencies receiving state and federal child care subsidies often receive only minimal funding for staff training related to children’s nutrition and physical activity needs.

Continuing education is important for offering the latest early childhood health information to child care providers. Unfortunately, economic, geographic, and other constraints prevent many providers from taking advantage of educational opportunities offered by state and community agencies. Family child care providers may perceive these constraints as insurmountable. For example, many family child care home providers struggle economically, earning low wages, yet only one-third of the sponsoring agencies that were surveyed offered any compensation to the providers who received training.⁶³

Because of California’s large and diverse population, linguistic and cultural differences also present significant barriers for child care providers seeking training. Child care providers are a culturally diverse group, and training materials may be offered only in a limited number of languages and at specific literacy levels. Providers who lack awareness or knowledge of their own health issues are not likely to see nutrition and physical activity as a priority for the children they serve.⁶⁴

Therefore, any efforts to increase training requirements for child care providers must also include steps to address the barriers providers face and should include tools to assist providers in



RATIONALE ➤

making healthier choices in their own lives. Considering the many challenges that child care providers face, innovative ideas are needed to increase the accessibility of training opportunities and to attract child care providers to those opportunities.

C. Incorporate nutrition and related topics into parent and caregiver education. The CDE and the CHHS should collaborate with agencies and groups serving families with young children to incorporate nutrition, physical activity, and wellness topics into educational opportunities for parents and other caregivers.

Teaching children about healthy lifestyles requires cooperation between child care providers and families. Without education about proper nutrition and without access to healthier food choices, parents and other caregivers may send their children to child care with inappropriate foods.⁶⁵ Even parents who understand the importance of providing healthy foods and adequate physical activity may lack the resources to do so.⁶⁶ Parents and child care providers might assume that any deficiencies in the meals they serve will be offset by meals children eat elsewhere.^{67,68}

Federal food- and nutrition-assistance programs, along with community-based, nongovernmental programs, have been shown to improve nutrition and food security.⁶⁹ Child care providers should be educated on how to access food-assistance programs for which they may be eligible, such as the CACFP. Additionally, providers should inform parents and other caregivers about governmental and nongovernmental food-assistance programs such as WIC, the Supplemental Nutrition Assistance Program (SNAP), and food banks.

Parental involvement is also needed to establish and reinforce healthy habits. Bringing parents and other caregivers into child care settings to participate in the children's activities and education can be an important way to engage parents and other caregivers; however, Head Start is the only child care organization that currently requires parental involvement. There are no current CACFP or state licensing regulations addressing parental involvement. Innovative methods are needed to provide culturally and linguistically appropriate information that is practical and engaging for parents, other caregivers, and child care providers.

Call to Action

Implementing the recommendations presented in this report will create healthier child care environments in California. Improvements in the quality of nutrition and physical activity in California's child care settings are possible with the collaborative efforts of state agencies; however, preventing childhood overweight and obesity is not the sole responsibility of the state. To bring about meaningful change, all Californians must be involved. Parents, policymakers, child care providers, and community members must contribute to this effort to ensure that current and future generations of California's children have every opportunity to enjoy long, active, and healthy lives.



APPENDIX

Goals and Recommendations, by Target Audience

The responsibility for achieving the goals contained in this report varies by recommendation. To facilitate action, the advisory group's recommendations are organized into three categories to help identify the primary target audience for each objective. The categories and their associated target audiences are:

1. **State Policy**—targeting legislators, agency and department directors, and the Governor
2. **State Business Practices**—targeting agency and department directors
3. **Federal Policy**—targeting Congress and the United States Department of Agriculture (USDA)

Four Interdependent Goals

Goal 1: Strengthen the Child and Adult Care Food Program (CACFP). Strengthen, expand, and revise the federal CACFP to align the program with current scientific evidence related to child nutrition and physical activity.

Goal 2: Establish nutrition and physical activity requirements for child care programs. Develop, implement, and align program standards and requirements to improve nutrition and increase physical activity in child care settings.

Goal 3: Provide consistent messaging related to nutrition and physical activity. Collaborate on targeted social marketing and health education campaigns to provide consistent messaging to families, providers, children, and the general public about improving nutrition and increasing physical activity in child care settings.

Goal 4: Expand nutrition and physical activity training in child care programs. Create and expand effective, accessible training programs, ensuring that child care providers and families develop the skills and knowledge needed to foster optimal nutrition, physical activity, and wellness in children.

State Policy

Goal 1, Recommendation A: Establish California nutrition and physical activity standards for an improved CACFP. The California Department of Education (CDE) should convene an expert committee to review and improve the federal CACFP meal pattern with enhanced California nutrition and physical activity standards. This group should examine evidence to determine (1) how the current CACFP meal pattern impacts the nutritional status of children in child care settings and how the meal pattern could be improved; (2) the degree to which behavioral standards for caregivers (such as feeding styles) could be used to improve children's nutritional status; and (3) the potential benefits of physical activity standards.

Goal 1, Recommendation E: Evaluate nutrition and physical activity education during CACFP monitoring visits. The CDE should receive sufficient resources to expand monitoring-visit requirements so that child care providers can be evaluated on the quality of nutrition and physical activity education that they offer to children.

Goal 1, Recommendation F: Require CACFP participation for state-funded child care providers. All eligible child care providers receiving state funds should be required to participate in the CACFP.

Goal 2, Recommendation A: Include nutrition and physical activity standards in the child care licensing requirements. The California Department of Social Services Community Care Licensing Division (CCLD) should collaborate with the CDE and the California Department of Public Health (CDPH) to modify child care licensing requirements so that all licensed child care providers comply with the new California nutrition and physical activity standards recommended by the expert committee. (See Goal 1, Recommendation A above.)

Goal 2, Recommendation B: Require nutrition-related training for initial child care licensure. The CCLD and the California Emergency Medical Services Authority (EMSA) should collaborate with the CDE and the CDPH to develop and integrate evidence-based nutrition, physical activity, and wellness education into the preventive health training required for initial licensure of child care providers.

Goal 2, Recommendation C: Incorporate nutrition and physical activity into training required for maintaining child care licensure. The CCLD and the EMSA should collaborate with the CDE and the CDPH to incorporate nutrition and physical activity education into the ongoing cardiopulmonary resuscitation (CPR) classes that are required for maintaining licensure.

Goal 3, Recommendation C: Include nutrition-related criteria in child care ratings. As efforts to develop child care ratings in California move forward, the CDE should collaborate with appropriate state and community agencies to include nutrition, physical activity, and parent-involvement criteria in these ratings. Minimally, these criteria must be aligned with the California nutrition and physical activity standards described in Goal 1, Recommendation A. Further recommendations and best practices should be incorporated into criteria used for higher ratings.

State Business Practices

Goal 1, Recommendation C: Streamline the CACFP compliance requirements to increase agency participation. The CDE should work with state and community agencies to address their CACFP participation challenges by (1) advocating changes to federal compliance requirements; (2) continuing to modernize and streamline compliance reporting requirements; and (3) continuing to develop guidance for CACFP agencies to help them meet federal program requirements.

Goal 1, Recommendation D: Collaborate on a CACFP marketing plan. The CDE, the CCLD, and the CDPH should collaborate to develop and implement a marketing plan that encourages child care providers to participate in the CACFP. The plan should emphasize the CACFP's benefits and the efforts under way to streamline federal paperwork requirements. The marketing plan should also provide the general public with basic information about the CACFP, nutrition, and physical activity.

Goal 2, Recommendation D: Align child-care-related nutrition and physical activity standards. All relevant state and federal agencies should align their child-care-related nutrition and physical activity standards and requirements to ensure that they do not conflict.

Goal 2, Recommendation E: Report key nutrition and physical activity outcomes for child care. All appropriate state and community agencies should work together to identify, track, and publicly report key nutrition and physical activity outcomes for child care settings. As part of this effort, relevant state and community agencies should do the following:

- Identify key outcomes to evaluate interventions for improving nutrition and increasing physical activity in child care settings.
- Identify or create statewide data-collection systems to track key nutrition and physical activity outcomes and to complete periodic data analysis.
- Report statewide outcomes at least every three years, making reports and key findings available to the public through the Internet, print media, public service announcements, and other forms of communication.

Goal 3, Recommendation A: Collaborate on the development and delivery of consistent messaging. All relevant state agencies—including the California Health and Human Services Agency (CHHS), the CDE, First 5 California, the California Department of Food and Agriculture, and others as appropriate—should collaborate on social marketing and health education strategies to provide consistent messaging about nutrition and physical activity.*

Goal 3, Recommendation B: Establish nutrition and physical activity foundations for preschool. The CDE should incorporate nutrition and physical activity components into the health-related Preschool Learning Foundations.

Goal 4, Recommendation A: Strengthen relevant community-college curricula by emphasizing the importance of nutrition and physical activity in child care programs. The CDE should work with California community colleges to include relevant nutrition and physical activity information in all levels of child-care-related curricula. Students should have the opportunity to increase their skills, knowledge, and understanding of their role in helping each child meet his or her unique nutrition and physical activity needs.

*The CHHS includes a number of organizations that impact child care: the CDPH, the California Department of Health Care Services, the EMSA, and the CCLD.

Goal 4, Recommendation B: Incorporate nutrition and physical activity into continuing education for child care providers.

The CDE and the CHHS should collaborate with other appropriate entities—such as resource and referral agencies, local planning councils, and community agencies—to incorporate effective nutrition, physical activity, and wellness education into training programs offered to child care providers.

Goal 4, Recommendation C: Incorporate nutrition and related topics into parent and caregiver education. The CDE and the CHHS should collaborate with agencies and groups serving families with young children to incorporate nutrition, physical activity, and wellness topics into educational opportunities for parents and other caregivers.

Federal Policy

Goal 1, Recommendation B: Modify the federal CACFP meal pattern. The CDE should work with the USDA and Congress to modify the federal CACFP meal pattern in accordance with the California standards described in Goal 1, Recommendation A in the “State Policy” section of this appendix.

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Glossary

before- and after-school programs. Programs for children offered before and after school that provide learning opportunities and child care with peers and teachers. Before- and after-school programs may be located on school property, in churches or homes, or at other locations.

Body Mass Index (BMI). A number calculated from a person's weight and height that provides a reliable indicator of body fatness for most people. It is used to screen for weight categories that may lead to health problems. Note that BMI is not used for children under age two.

California Department of Education (CDE). The state agency responsible for overseeing the public school system in California. The Department also provides nutrition services, funds early care and education programs, enforces education laws and regulations, and works through state and local partnerships to provide optimal educational opportunities for all Californians.

California Department of Public Health (CDPH). The state agency dedicated to optimizing the health and well-being of the people of California. The CDPH is responsible for diverse program areas including infectious disease, chronic disease, health care quality, environmental health, family health, emergency preparedness, health equity, and health information.

California Department of Social Services Community Care Licensing Division (CCLD). The state office that oversees licensure of child care centers and eligible family child care home providers in California. The CCLD monitors child care centers and family child care homes to ensure the health and safety of the children in those facilities.

California Emergency Medical Services Authority (EMSA). The state department responsible for administering a coordinated statewide system of emergency medical care, injury prevention, and disaster medical response. The EMSA coordinates and assists with paramedic licensure; regulations for emergency medical technicians; trauma center and trauma system standards; and ambulance services. It also facilitates and oversees first aid, cardiopulmonary resuscitation (CPR), and preventive health training programs that are required for child care providers who work in licensed child care, foster family, and other congregate-care homes and facilities.

California Health and Human Services Agency (CHHS). The state agency that provides leadership to, and oversight of, the 15 California government entities (12 departments, one board, and two state offices) responsible for health care, social services, public assistance, and rehabilitation for California's most disadvantaged and at-risk residents. The CHHS works closely with many partners to promote the health and well-being of California's diverse population.

California Health Interview Survey (CHIS). A telephone survey conducted every two years by the UCLA Center for Health Policy Research that provides a comprehensive source of health-related information on the people of California. The survey gathers data on children, adolescents, and adults and is used by lawmakers, researchers, health departments, and other groups. It is the largest statewide health survey and is one of the largest health surveys in the United States.

California Preschool Learning Foundations. Developed by the CDE for all preschool children, including English learners and children with disabilities, the foundations represent the knowledge and skills that all preschool children typically attain in high-quality preschool programs, regardless of funding sources or formats. The foundations are based on current research and evidence about preschool children's development and they define age-appropriate expectations about what children should know and be able to do at approximately 48 and 60 months of age (the end of their first and second year of preschool).

Centers for Disease Control and Prevention (CDC). The primary federal agency responsible for conducting and supporting public health activities in the United States. It is part of the U.S. Department of Health and Human Services and is composed of several coordinating centers and offices. The CDC oversees many national health programs involving public education and the prevention and control of disease, injury, and disability.

Child and Adult Care Food Program (CACFP). A federal food program funded by the USDA. The CACFP is a key source of support for serving nutritious meals and snacks in child care centers, family day care homes, before- and after-school programs, shelters, and adult day care centers. The child care portion of the CACFP provides reimbursement for food and meal service costs; offers ongoing training in the nutritional needs of children; and provides on-site assistance and monitoring for meeting the program's requirements. The CACFP plays a vital role in creating and maintaining affordable, high-quality care for preschool and school-age children. The California Department of Education Nutrition Services Division administers the CACFP in California.

child care center. A facility that provides nonresidential group care for infants, toddlers, preschoolers, and school-age children. Child care centers can be operated by independent, nonprofit organizations or by for-profit groups, and they are located in churches, commercial buildings, renovated homes, or on public- or private-school grounds. Most child care centers are licensed through the CCLD.

Child Care Food Program Roundtable. A membership organization composed of child care agencies sponsoring the Child and Adult Care Food Program (CACFP) and other interested stakeholders. It was established in 1977 as the "voice" of child care agencies sponsoring the CACFP in California and nationally. The organization works with other

advocacy groups to improve the quality and integrity of the CACFP and serves as an advocate for program sponsors, providers, parents, and children.

child care provider. An individual who provides care for a single child or several children. Care may be provided in many settings including the child’s own home, a child care center, or a private home.

child care stakeholders. Individuals who have an interest in, or work in, child care settings.

day care home. An organized nonresidential child care program in a private home, licensed or approved as a family or group day care home and operating under the auspices of a sponsoring organization. The USDA uses the term “day care home” to refer to a licensed family child care home participating in the CACFP.

family child care home. A caregiver’s own home that provides care, protection, and supervision of children for periods of less than 24 hours per day while the parents or authorized representatives of the children are not present.

food security. As defined by the USDA, “food security for a household means access by all members at all times to enough food for an active, healthy life.” At a minimum, it includes the ready availability of safe, nutritionally adequate foods; and the “assured ability to acquire acceptable foods in socially acceptable ways”—that is, without scavenging, stealing, relying on emergency food supplies, or using other coping strategies. *Source:* <http://www.ers.usda.gov/Briefing/FoodSecurity/measurement.htm#what> (accessed October 7, 2010).

First 5 California. Also known as the California Children and Families Commission, First 5 California is an organization that works to improve the lives of young children (birth to age five) and their families through a system of health services, education, child care, and other vital programs. First 5 programs, which operate both statewide and within California counties, are funded by a tobacco tax that was initiated in 1998.

Head Start. A nationwide program that serves low-income families and promotes school readiness by creating environments in which children learn math, science, and nutrition while developing social, educational, and emotional skills.

licensed child care. Child care providers and settings licensed by the CCLD to protect the health and safety of children receiving out-of-home care. Section 101227 of the *California Code of Regulations, Title 22*, defines the types of providers that require licensure as well as the conditions that licensed providers must meet.

license-exempt child care. Child care providers and settings that do not require licensure by the state. Examples include nannies, friends, or relatives who care for a child in the child’s own home; caregivers who provide care for children from only one family besides their own; and school-based child care programs. Sections 101158 and 102358 of the

California Code of Regulations, Title 22, set forth the criteria that must be met by a provider or setting in order to be classified as license-exempt.

Network for a Healthy California. A network of local, state, and national partners working to increase fruit and vegetable consumption, physical activity, and food security among low-income Californians; its ultimate goal is to prevent obesity and chronic diseases related to diet and physical activity. The Network is administered by the CDPH and is funded primarily by the USDA. It works with Local Incentive Awardees (LIAs) in a variety of community channels—including low-resource school districts, local health departments, county offices of education, and others—to administer innovative local-assistance projects such as the Children’s Power Play! Campaign; retail and work-site programs; and campaigns targeting special populations such as African Americans and Latinos.

Pediatric Nutrition Surveillance System (PedNSS). A data-surveillance system created by the CDC in the 1970s to collect and provide data on the nutritional status of low-income infants, children, and women in federally funded maternal and child health programs. The PedNSS collects and reports data from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program; and Title V Maternal and Child Health (MCH) programs. Nationally, the majority of the data come from WIC; however, in California the data source is preventive health exams billed to EPSDT or the state-funded program, Child Health and Disability Prevention.

resource and referral (R&R) agencies. Agencies that assist families in selecting quality child care through consumer education, training, and referral to child care providers—including licensed centers, family child care homes, and license-exempt providers who are cleared by a TrustLine background check.* R&R agencies also provide technical assistance and ongoing professional development or training opportunities to help providers implement quality child care programs and meet licensing requirements. Some R&R agencies also sponsor Alternative Payment (AP) programs.

subsidized child care. Child care programs involving state or federal funding that assists eligible families by reducing the direct cost of child care. These programs are governed by Title 5 and Title 22 of the *California Code of Regulations*. Families must demonstrate that their incomes are at or below 75 percent of the state’s median income, adjusted for family size. To be eligible for programs other than the State Preschool Program, families also must establish a need for child care to be provided when the parents or primary caregivers are not available (e.g., while they are working or in school). The CDE administers child care subsidies in California. Nonprofit and for-profit agencies,

*TrustLine is a database of nannies and babysitters who have cleared criminal background checks in California. For more information, visit <http://www.trustline.org>.

churches, school districts, local governments, and other entities can operate subsidized child care programs. Subsidies can be used in licensed and license-exempt child care settings.

Supplemental Nutrition Assistance Program (SNAP). Formerly known as the Food Stamp Program, SNAP is a federal nutrition-assistance program administered by the USDA. Its goal is to alleviate hunger and malnutrition in the United States by providing monthly benefits to eligible low-income families. The program helps low-income families buy nutritious food. In California, the SNAP is known as CalFresh.

University of California, Davis (UCD) Human Lactation Center. A center providing a focal point for communication among researchers, clinicians, policymakers, and educators to ensure that the latest research-based information is made available to those working with lactating women and their infants.

U.S. Department of Agriculture (USDA). A federal agency responsible for managing natural resources related to food and agriculture through public policy and effective science. The USDA promotes economic development and new agricultural markets; provides leadership in the development and infrastructure of rural America; enhances domestic food safety; and promotes nutrition and health through education.

Women, Infants, and Children Supplemental Nutrition Program (WIC). A federal program serving a specific population of low-income women and children who have nutritional risks: the women must be pregnant, breastfeeding, or postpartum, and the children must be under age five. WIC is unique among federally administered programs in that it provides specific supplemental nutritious foods and nutrition education to a targeted population as a short-term intervention—an average of two years—to complement ongoing health care. The supplemental foods provided by the WIC program are designed to meet the participants' needs for specific nutrients during brief but critical periods of physiological development.