2021 Annual Report

Achieving a State of Healthy Weight

National Resource Center for Health and Safety in Child Care and Early Education

University of Colorado Anschutz Medical Campus

National Resource Center for Health and Safety in Child Care and Early Education

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The National Resource Center for Health and Safety in Child Care and Early Education (NRC) is a program of the University of Colorado College of Nursing, Anschutz Medical Campus, Aurora, Colorado.

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Note: The ASHW 2021 Supplements: State Profiles Pages for Child Care Centers, Large Family Child Care Homes, and Small Family Child Care Homes are available at http://nrckids.org/HealthyWeight.

EXECUTIVE SUMMARY

2021 had the greatest number of state licensing regulations in support of obesity prevention best practices since 2012, with family child care more closely aligning with Child and Adult Care Food Program (CACFP) meal patterns.

What Is This Report?

Overweight and obesity often begin in early childhood and can have lifelong negative effects on health and quality of life. Early care and education (ECE) programs serve millions of very young children each week and may promote development of healthy lifestyles to prevent obesity. States can support these programs by establishing child care licensing regulations that encourage recommended infant feeding practices; healthy nutrition standards and mealtime practices; opportunities for active play; and less screen time. Achieving a State of Healthy Weight (ASHW) 2021 reports the level of support, nationally, for 47 high-impact obesity prevention standards (HIOPS) in new child care licensing regulations in 2021.

Use ASHW 2021 to:

1. **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

ASHW 2021 Key Findings:

- 12 states adopted new or revised child care licensing regulations that impacted infant feeding, nutrition, or physical activity.
  - 76% of these revisions increased support for obesity prevention, while 24% weakened support.
- In 2021, the highest number of state licensing regulations were rated since 2012.
- Texas now leads the nation in ECE regulations that support obesity prevention.
- In Alabama, all three care types are now required to comply with CACFP, strengthening infant feeding and nutrition practices.
- Rhode Island made substantial positive changes to family child care regulations impacting infant feeding, nutrition, and physical activity practices for the first time since 2010.

States Can Strengthen Obesity Prevention Policies and Practices in ECE Licensing Regulations By:

1. Maintaining past improvements to state child care regulations that support obesity prevention in ECE.
2. Adopting regulations that explicitly align with CACFP meal patterns.
3. Adopting regulations consistent with CFOC standards for physical activity and screen time.
4. Adopting regulations that support obesity prevention practices in Centers ***and*** Home-based care types.
5. Consulting with local public health officials or licensed child health providers during the revision process.

INTRODUCTION

Pediatric overweight and obesity continues to be a public health crisis in the United States with 1 in 5 children and adolescents considered obese[1] and higher rates in children from low-income families and children from Black, Native American, and Hispanic populations. In preschool aged children, 2-5 years of age, approximately 25% are overweight or obese.[1,2] When developed at an early age, obesity often persists through adolescence[3,4] into adulthood and is associated with increased risk for obesity related health issues and increased morbidity and mortality.[5,6] The COVID-19 pandemic has also negatively impacted and increased childhood obesity rates across age groups.[7] Preventive interventions in early childhood are crucial for instilling behaviors that support healthy weight practices.[8,9]

According to the National Association for Regulatory Administration there are more than 10.5 million licensed child care slots across the nation. These are filled mainly by young children,[10] including vulnerable and at-risk children who receive federally subsidized child care.[11] In licensed child care, children have opportunities to engage in active play, learn healthy mealtime practices, and share daily meals and snacks.[12-18] Therefore, early care and education (ECE) programs become important environments for teaching healthy behaviors and building a foundation for healthy living.[18-21] The CDC developed the *Spectrum of Opportunities for Obesity Prevention in Early Care and Education* to define target areas, such as child care licensing, for actions to support this effort in ECE. The CDC also identified the obesity prevention standards of *Caring for Our Children (CFOC)* as a prime resource to inform promulgation of states' child care licensing regulations.[22,23]

The National Resource Center for Health and Safety in Child Care and Early Education (NRC) conducted a 2010 baseline child care licensing study, *Achieving a State of Healthy Weight: A National Assessment of Obesity Prevention Terminology in Child Care Regulations 2010* (ASHW 2010).[24] The study measured the degree to which all 50 states and the District of Columbia included 47 science-based standards for obesity prevention in ECE settings. The 47 High-Impact Obesity Prevention Standards (HIOPS) were derived from the CFOC health and safety standards presented in *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*).[25] The HIOPS address infant feeding, nutrition, physical activity and screen time practices. Experts in children's health from the American Academy of Pediatrics, American Public Health Association, CDC Division of Nutrition, Physical Activity and Obesity, USDA Center for Nutrition Policy and Promotion, other federal agencies, national organizations and leading universities, as well as child care and licensing stakeholders assisted NRC in selecting and defining the HIOPS.[26]

The 2010 baseline study revealed limited support of the HIOPS on a national level. Annual ASHW reports examined new and revised state licensing regulations (see Table 1, below). The *Achieving a State of Healthy Weight: 2021* report is the 11th update of the 2010 study. Each update has documented gradual inclusion of the HIOPS in licensing regulations since 2010 (see Appendix A: Key Findings in ASHW Assessments: 2010-2020). However, considerable work remains to create a comprehensive regulatory framework that embeds healthy eating, physical activity, and obesity prevention strategies within ECE regulations to benefit our youngest children.

In 2021, NRC screened more than 56 revised regulatory documents. Twelve states (Alabama, Colorado Connecticut, Delaware, Kentucky, Louisiana, Maine, Montana, Ohio, Oregon, Rhode Island, and Texas) made changes that impacted the HIOPS in child care regulations in one or more licensed child care types. This report describes the changes and their impact on state rankings and strength of the HIOPS nationally.

NRC defined the 47 HIOPS with input from representatives of the following:

- AMERICAN ACADEMY OF PEDIATRICS
- AMERICAN PUBLIC HEALTH ASSOCIATION
- CDC DIVISION OF NUTRITION, PHYSICAL ACTIVITY AND OBESITY
- USDA CENTER FOR NUTRITION POLICY AND PROMOTION

ALL YEARS RATED

Table 1. State Assessment Years 2010 to 2021

The table below shows years in which NRC rated states based on revised child care licensing regulations.

State	Years Rated												State	Years Rated										
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Alabama	X		X						X	X		X	Montana	X		X					X					X
Alaska	X		X					X					Nebraska	X		X	X				X					
Arizona	X	X								X	X		Nevada	X		X						X				
Arkansas	X	X				X		X			X		New Hampshire	X							X					
California	X		X					X					New Jersey	X			X				X					
Colorado	X		X			X	X	X				X	New Mexico	X		X		X			X					
Connecticut	X		X					X				X	New York	X				X	X		X					
Delaware	X		X			X		X		X	X	X	North Carolina	X		X	X				X	X				
District of Columbia	X						X	X					North Dakota	X	X		X							X		
Florida	X		X	X				X		X			Ohio	X		X				X						X
Georgia	X		X		X			X			X		Oklahoma	X						X	X					
Hawaii	X		X					X					Oregon	X		X					X					X
Idaho	X												Pennsylvania	X										X		
Illinois	X				X								Rhode Island	X		X	X				X					X
Indiana	X												South Carolina	X		X					X					
Iowa	X		X					X					South Dakota	X												
Kansas	X		X	X									Tennessee	X								X				
Kentucky	X			X					X			X	Texas	X		X		X								X
Louisiana	X		X			X		X				X	Utah	X		X					X					
Maine	X		X					X				X	Vermont	X						X	X					
Maryland	X		X			X		X					Virginia	X		X					X					
Massachusetts	X												Washington	X		X					X		X			
Michigan	X		X		X			X		X			West Virginia	X		X		X								
Minnesota	X		X					X					Wisconsin	X		X							X			
Mississippi	X		X	X							X		Wyoming	X		X	X									
Missouri	X						X																			

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

X — State assessed due to new or revised child care licensing regulations

X — State assessed due to national CACFP updates

2021 RESULTS

2021 saw the greatest number of state licensing regulations in support of obesity prevention best practices since 2012, with family child care more closely aligning with Child and Adult Care Food Program (CACFP) meal patterns.

Status of New & Revised State Licensing Regulations: 2021

- Twelve states made changes to child care licensing regulations that affected High-Impact Obesity Prevention Standards (HIOPS).
    - Alabama, Colorado, Connecticut, Delaware, Kentucky, Louisiana, Maine, Montana, Ohio, Oregon, Rhode Island, and Texas
- Texas and Alabama had significant rating improvements in 2021 with new regulatory requirement of compliance with CACFP meal patterns. Both states made many positive changes to physical activity and screen time rules.
- Rhode Island and Maine made significant revisions in support of the HIOPS for the first time since 2010.
- Colorado's regulations now prohibit misuse of food and withholding physical activity as a disciplinary measure.
- Delaware family child care revisions now prohibit serving juice to infants.
- Kentucky ratings improved for physical activity by strengethening their rules around outdoor play, tummy time for infants, and screen time limits.

National Overview: 2010 vs. 2021

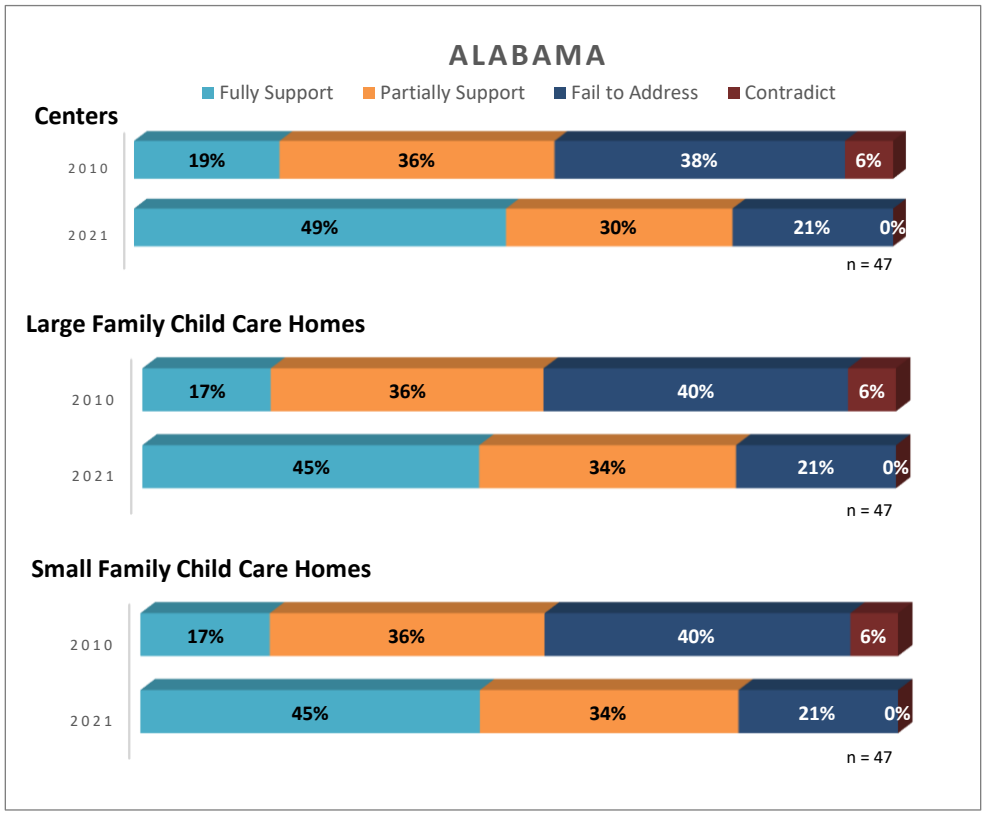
- In 2021, Texas leads the nation in support of HIOPS, followed by Washington and Tennessee.
- Since 2010, 44 states adopted licensing regulations that affect High-Impact Obesity Prevention Standards (HIOPS) and help prevent childhood obesity in licensed Early Care and Education (ECE) facilities.
- State licensing regulations which:
    - Fully support the HIOPS **increased** from 12% to 28%
    - Partially support the HIOPS **increased** from 29% to 31%
    - Fail to address the HIOPS **decreased** from 55% to 40%
    - Contradict the HIOPS **decreased** from 3% to 1%
- Since 2010, states with the most improved support of the HIOPS are:
    - District of Columbia, Florida, Tennessee, Nevada, Texas, and Vermont *(see Figure 6)*
- Support for the HIOPS below continued to improved the most across all child care types:
    - *Serve no fruit juice to children younger than 12 months of age* (ID3)
    - *Serve skim or 1% pasteurized milk to children two years of age and older* (NA5)
    - *Offer juice (100%) only during mealtime* (NC2)

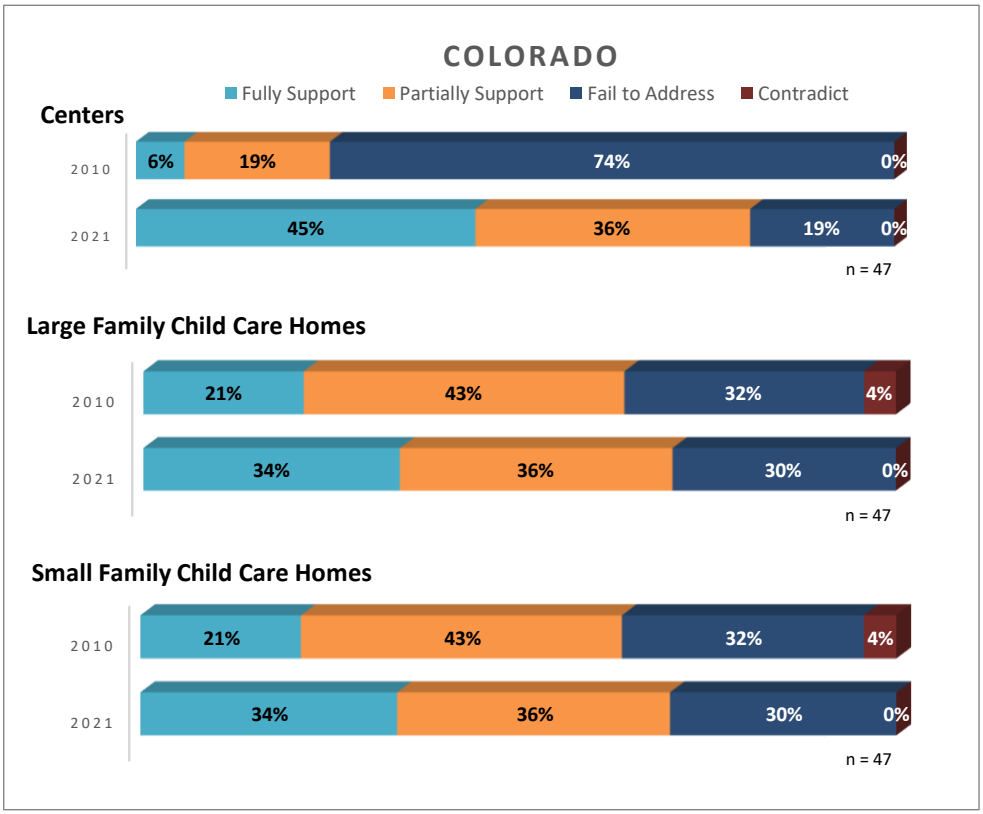
Status of High-Impact Obesity Prevention Standards (HIOPS): 2021

- Nationally, HIOPS are supported in:
    - 64% of Child Care Centers licensing regulations
    - 58% of Large Family Child Care Homes licensing regulations
    - 55% of Small Family Child Care Homes licensing regulations
- The **most supported** HIOPS remain unchanged and are:
    - *Provide children with adequate space for both inside and outside play* (PA1)
    - *Make water available both inside and outside* (ND1)
    - *Serve small-sized, age-appropriate portions* (NF1)
- The **least supported** HIOPS are:
    - *Limit oils by choosing monounsaturated and polyunsaturated fats and avoiding trans fats, saturated fats and fried foods* (NA1)
    - *Limit salt by avoiding salty foods such as chips and pretzels* (NG1)
    - *Require adults eating with children to eat items that meet nutrition standards* (NE2)

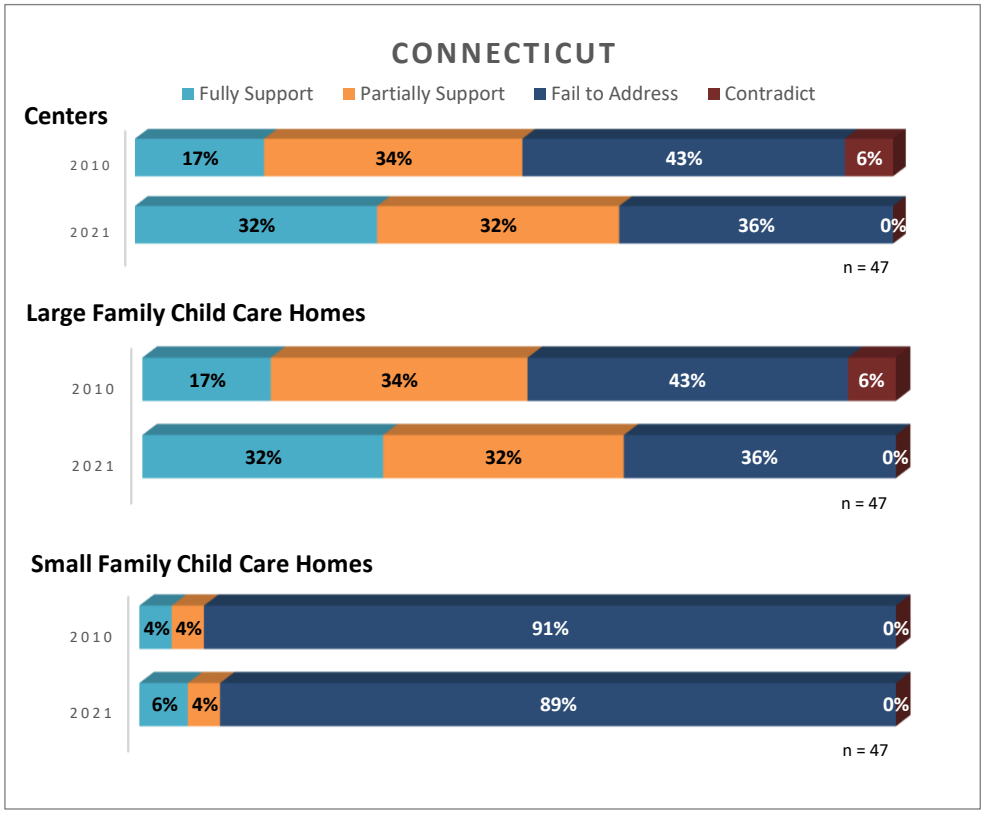
Figure 2. State Progress in 2021

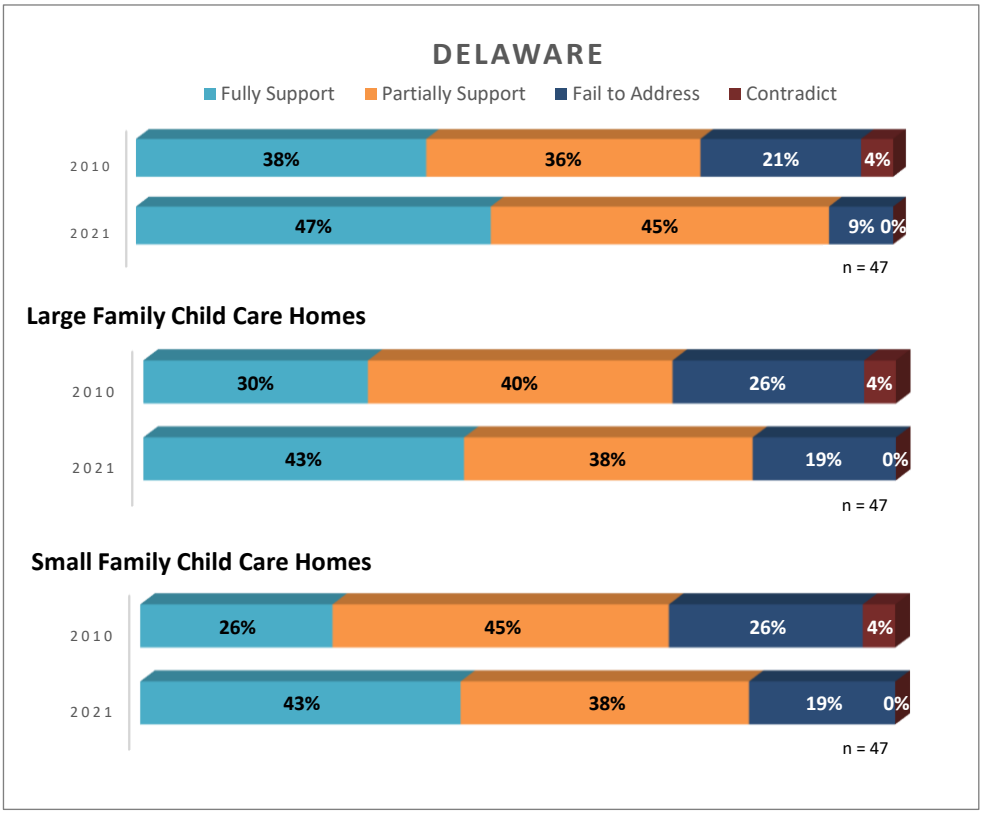
The figure below illustrates differences among states and their support of high-impact obesity prevention standards in licensing regulations for different child care types (2010 vs. 2021).





WHAT'S NEW IN 2021





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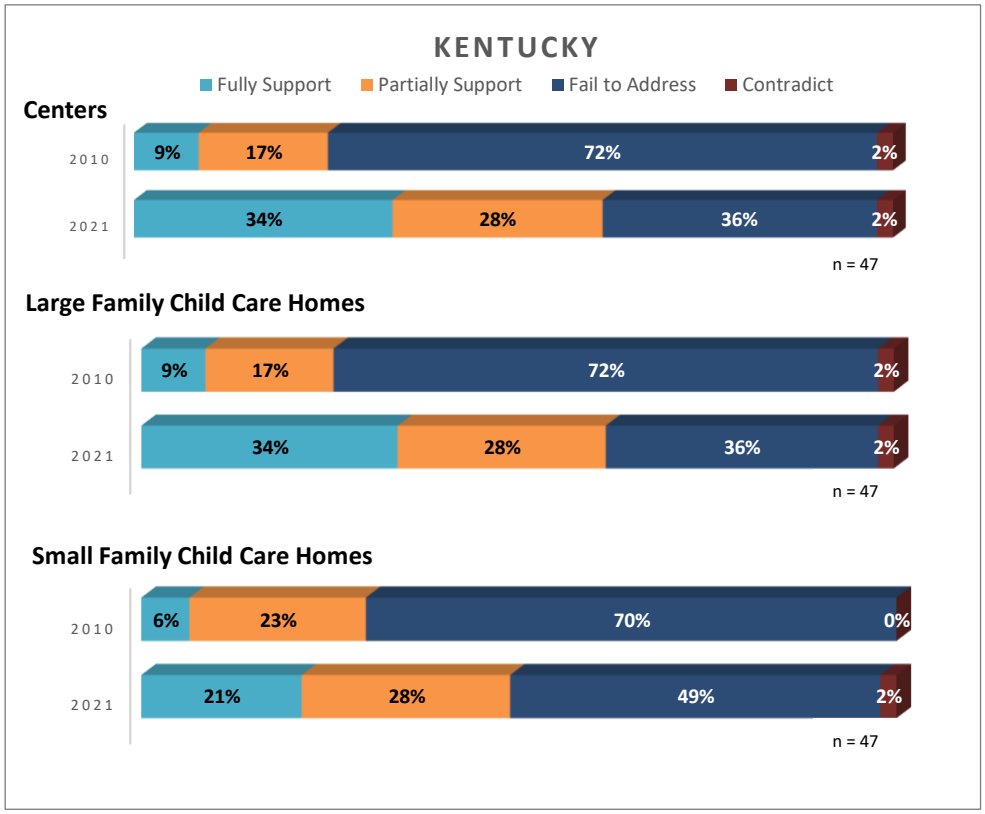

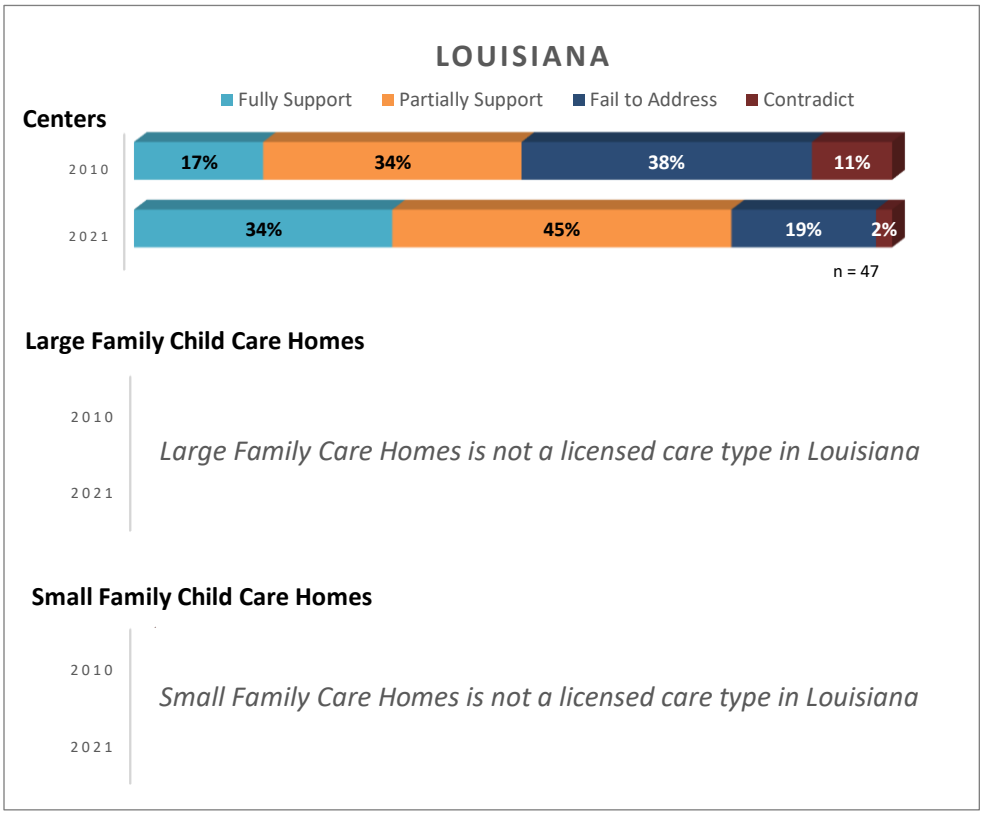

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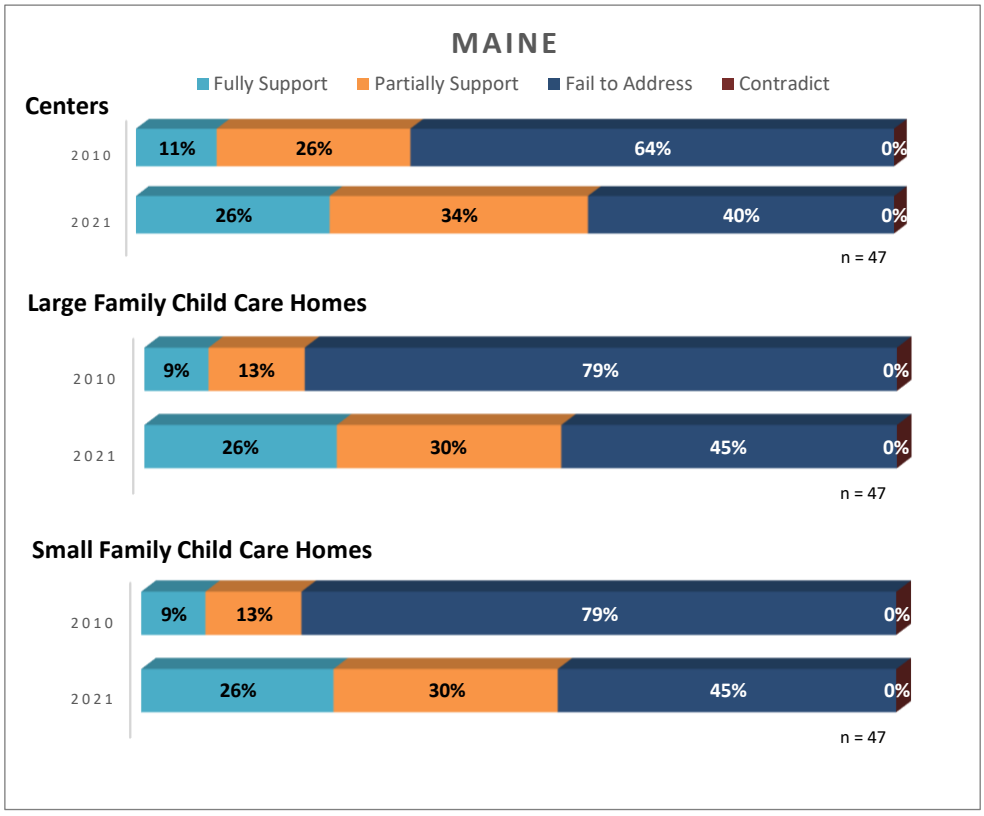

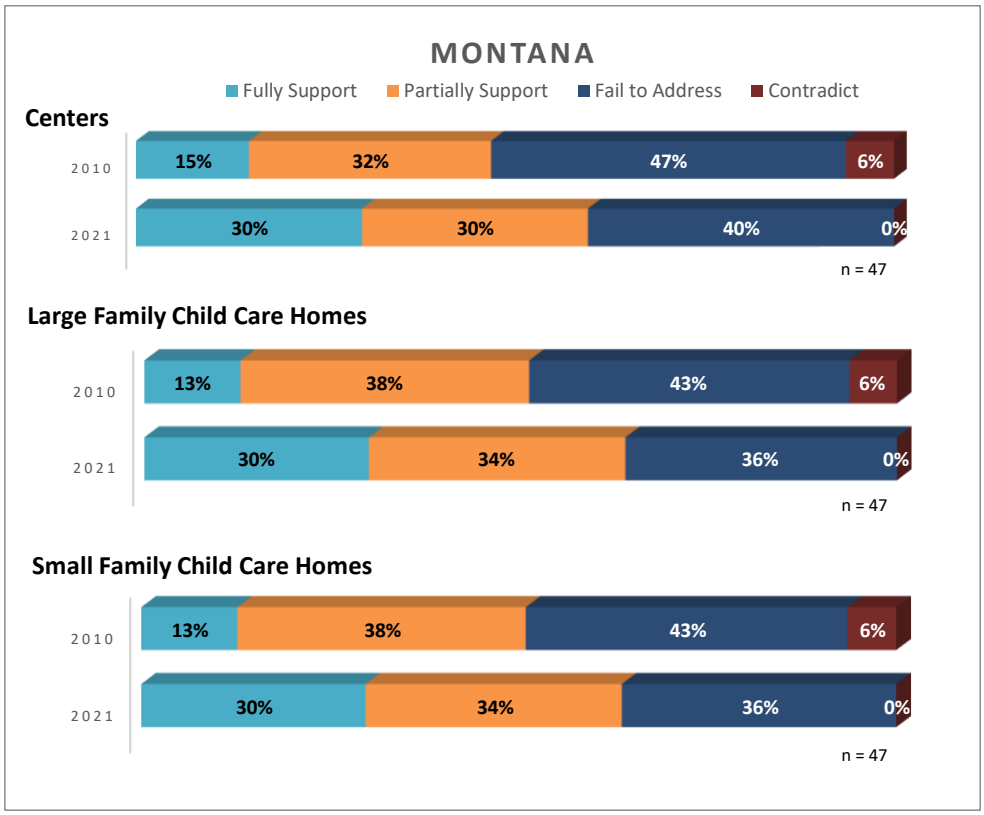

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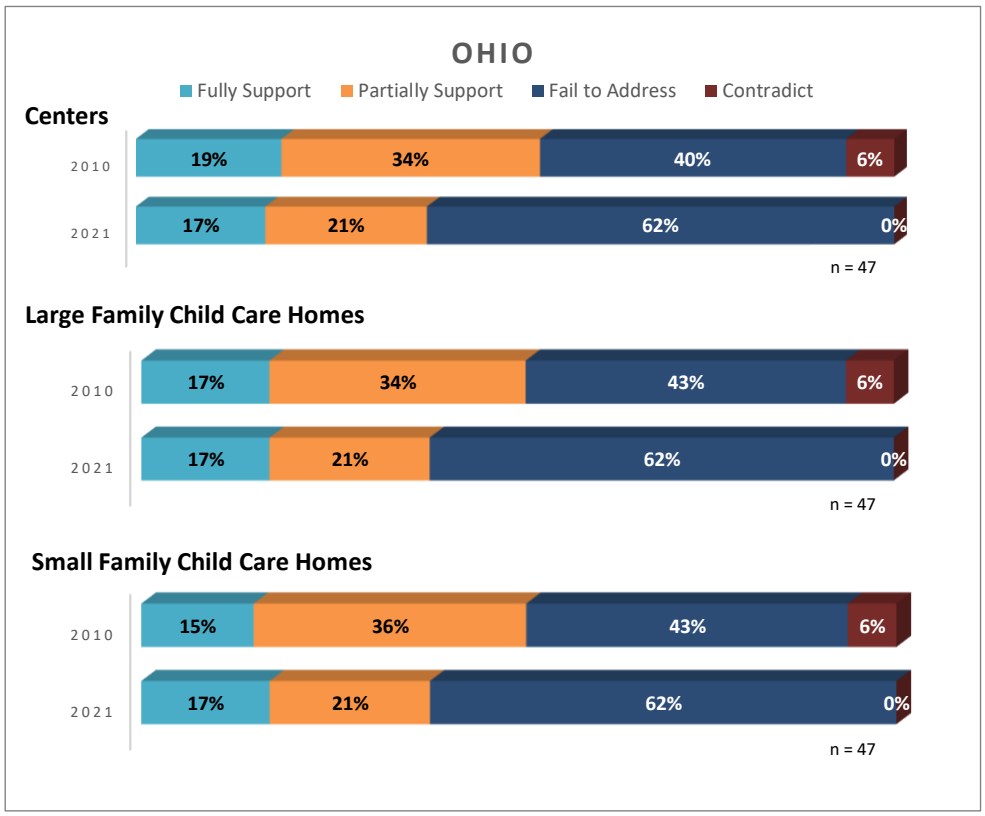
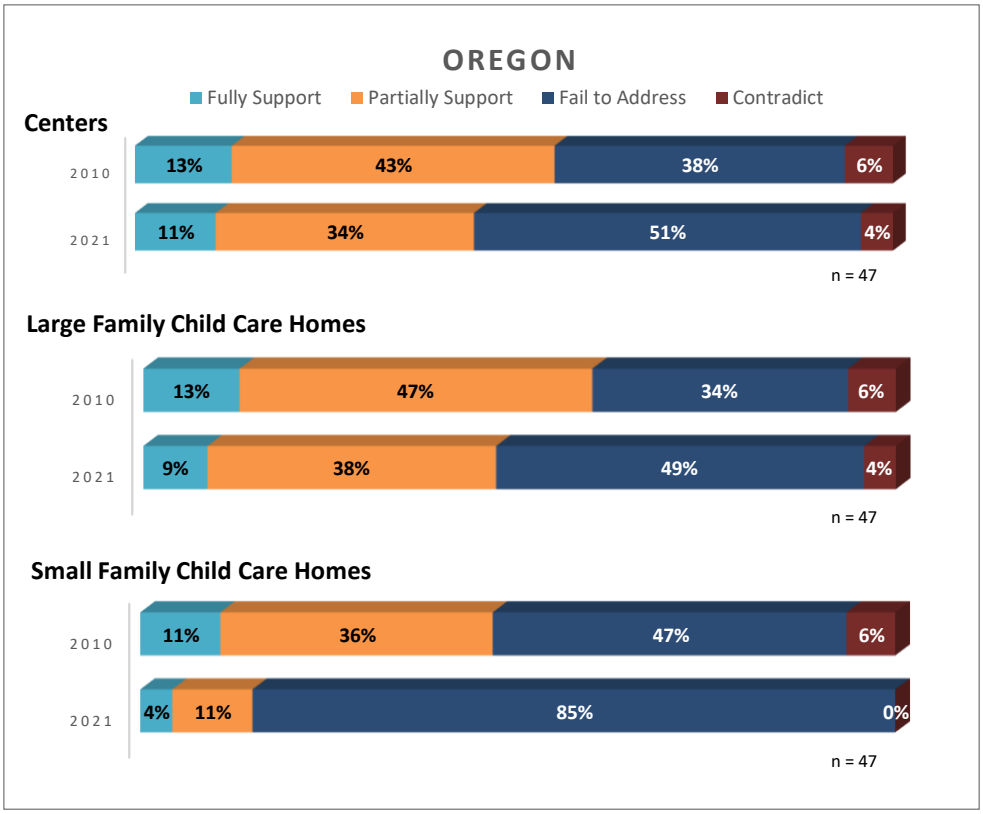
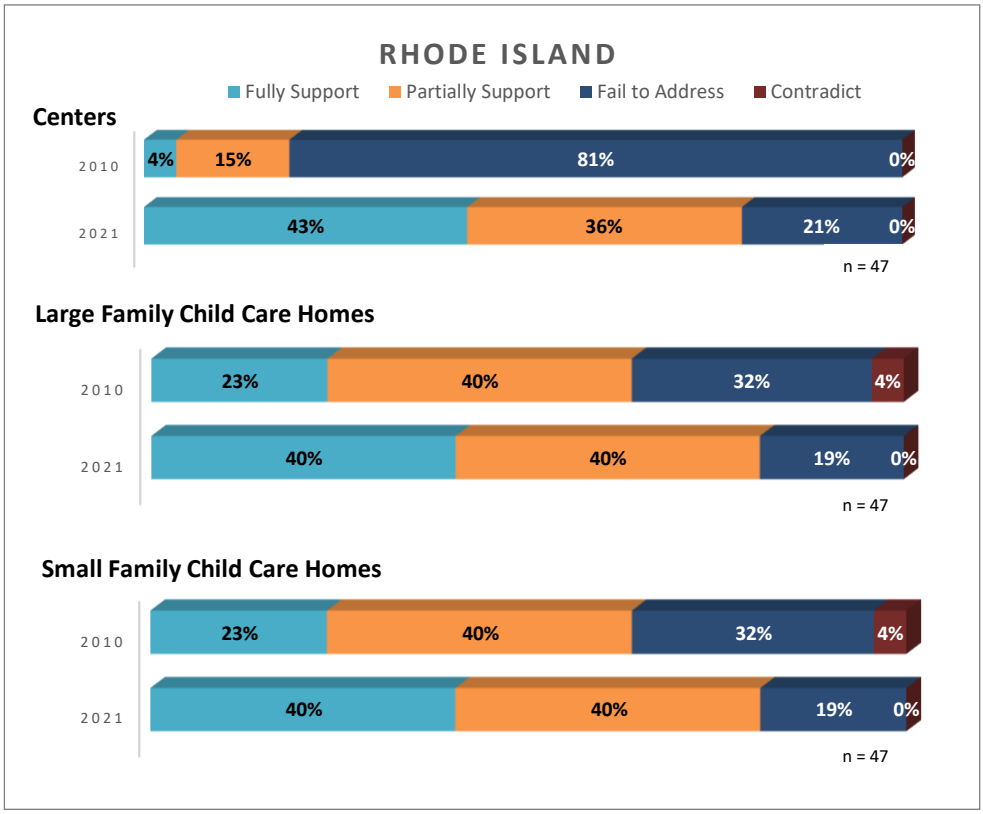




WHAT'S NEW IN 2021



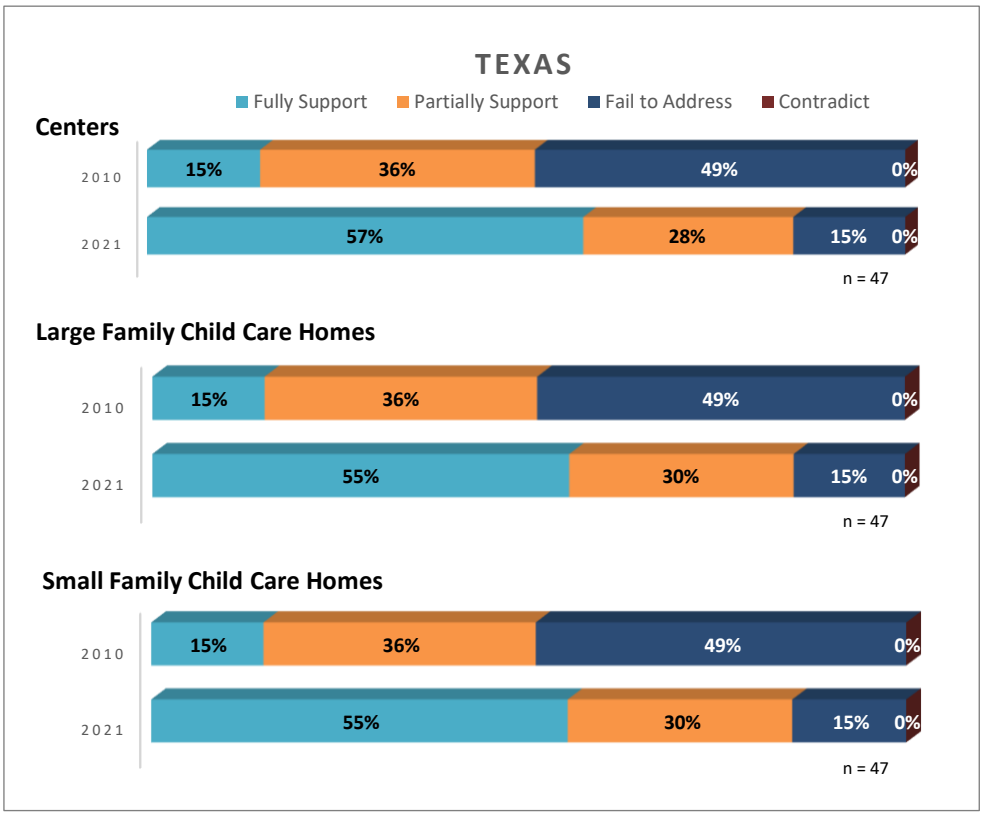


Table 2. State Support of High-Impact Obesity Prevention Standards Across All Care Types

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

State	Contradict HIOPS		Fail to Address HIOPS		Partially Support HIOPS		Fully Support HIOPS		Total Number of Ratings
ALABAMA	0	0%	30	21%	46	33%	65	46%	141
ALASKA	0	0%	36	26%	54	38%	51	36%	141
ARIZONA	2	2%	48	51%	31	33%	13	14%	94
ARKANSAS	0	0%	30	21%	60	43%	51	36%	141
CALIFORNIA	0	0%	94	67%	25	18%	22	16%	141
COLORADO	0	0%	37	26%	51	36%	53	38%	141
CONNECTICUT	0	0%	76	54%	32	23%	33	23%	141
DELAWARE	0	0%	22	16%	57	40%	62	44%	141
DISTRICT OF COLUMBIA	0	0%	27	19%	60	43%	54	38%	141
FLORIDA	0	0%	40	28%	53	38%	48	34%	141
GEORGIA	0	0%	26	28%	35	37%	33	35%	94
HAWAII	0	0%	49	35%	43	30%	49	35%	141
IDAHO	0	0%	137	97%	2	1%	2	1%	141
ILLINOIS	8	6%	45	32%	47	33%	41	29%	141
INDIANA	2	1%	112	79%	19	13%	8	6%	141
IOWA	0	0%	52	37%	44	31%	45	32%	141
KANSAS	3	2%	86	61%	43	30%	9	6%	141
KENTUCKY	3	2%	57	40%	39	28%	42	30%	141
LOUISIANA	1	2%	9	19%	21	45%	16	34%	47
MAINE	0	0%	61	43%	44	31%	36	26%	141
MARYLAND	0	0%	34	24%	56	40%	51	36%	141
MASSACHUSETTS	0	0%	102	72%	24	17%	15	11%	141
MICHIGAN	0	0%	38	27%	57	40%	46	33%	141
MINNESOTA	0	0%	45	32%	56	40%	40	28%	141
MISSISSIPPI	6	4%	28	20%	54	38%	53	38%	141
MISSOURI	0	0%	82	58%	41	29%	18	13%	141
MONTANA	0	0%	53	38%	46	33%	42	30%	141
NEBRASKA	0	0%	57	40%	42	30%	42	30%	141
NEVADA	0	0%	45	32%	51	36%	45	32%	141
NEW HAMPSHIRE	0	0%	42	30%	48	34%	51	36%	141
NEW JERSEY	0	0%	41	44%	26	28%	27	29%	94
NEW MEXICO	0	0%	42	30%	48	34%	51	36%	141
NEW YORK	0	0%	59	42%	48	34%	34	24%	141
NORTH CAROLINA	0	0%	33	23%	45	32%	63	45%	141
NORTH DAKOTA	0	0%	86	61%	32	23%	23	16%	141
OHIO	0	0%	87	62%	30	21%	24	17%	141
OKLAHOMA	2	1%	50	35%	48	34%	41	29%	141
OREGON	4	3%	87	62%	39	28%	11	8%	141
PENNSYLVANIA	0	0%	100	71%	27	19%	14	10%	141
RHODE ISLAND	0	0%	28	20%	55	39%	58	41%	141
SOUTH CAROLINA	0	0%	77	55%	37	26%	27	19%	141
SOUTH DAKOTA	0	0%	124	88%	9	6%	8	6%	141
TENNESSEE	0	0%	18	13%	57	40%	66	47%	141
TEXAS	0	0%	21	15%	41	29%	79	56%	141
UTAH	0	0%	36	26%	57	40%	48	34%	141
VERMONT	0	0%	33	23%	54	38%	54	38%	141
VIRGINIA	0	0%	36	26%	54	38%	51	36%	141
WASHINGTON	0	0%	18	13%	51	36%	72	51%	141
WEST VIRGINIA	4	3%	82	58%	37	26%	18	13%	141
WISCONSIN	0	0%	26	28%	36	38%	32	34%	94
WYOMING	0	0%	102	72%	30	21%	9	6%	141
All States	35	1%	2786	40%	2142	31%	1946	28%	6909

NATIONAL OVERVIEW: 2010 VS. 2021

Figure 3. National Ratings Across Care Types, 2010 vs. 2021

Figure 3 shows the extent to which licensing regulations across all child care types support high-impact obesity prevention standards nationally, 2010 vs. 2021.

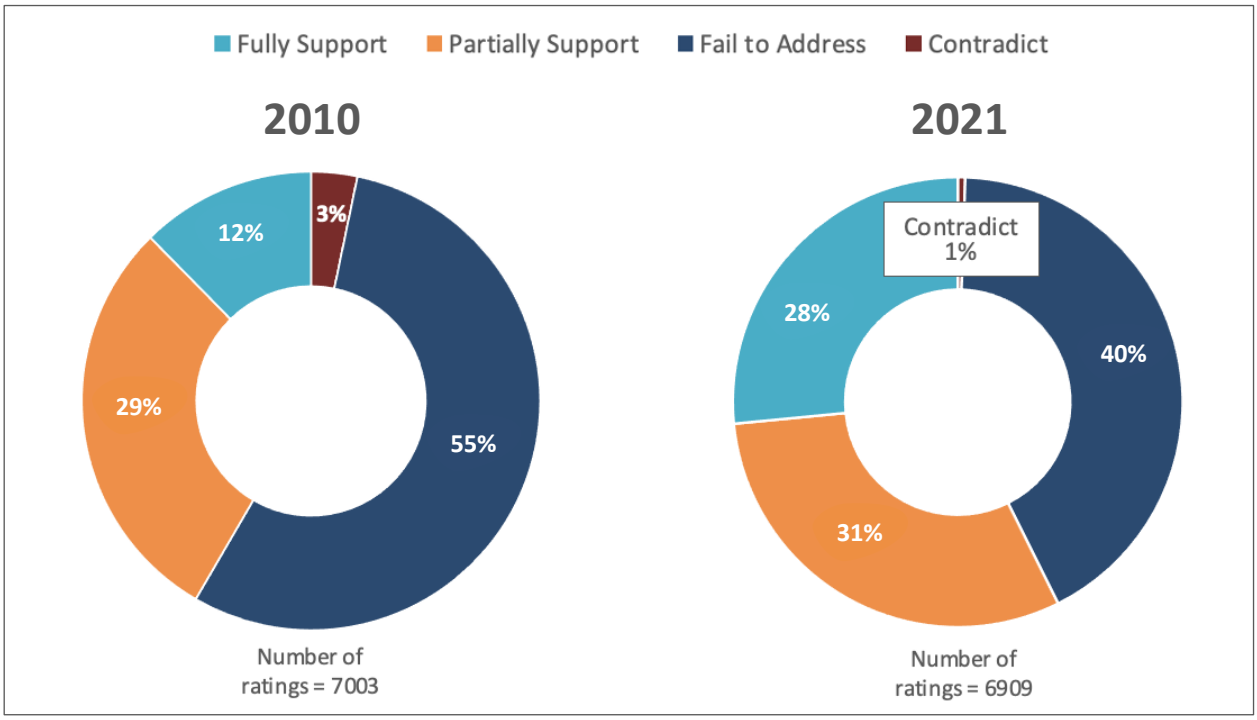
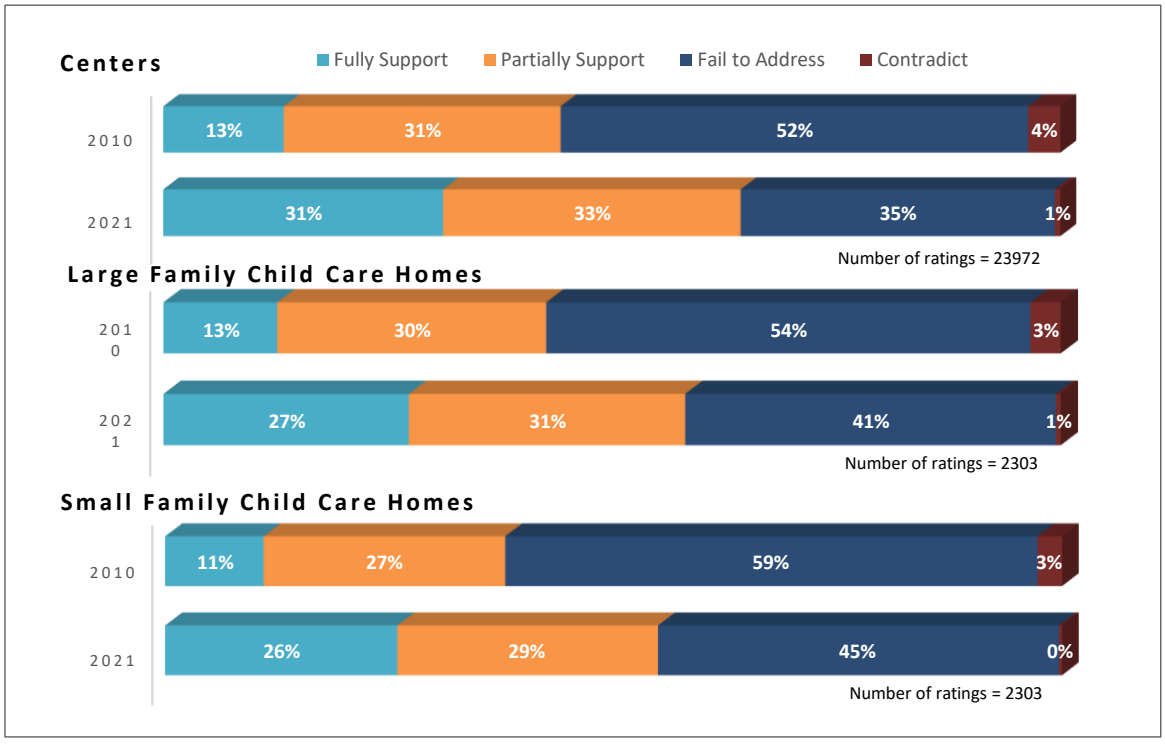


Figure 4. National Ratings by Care Type, 2010 vs. 2021

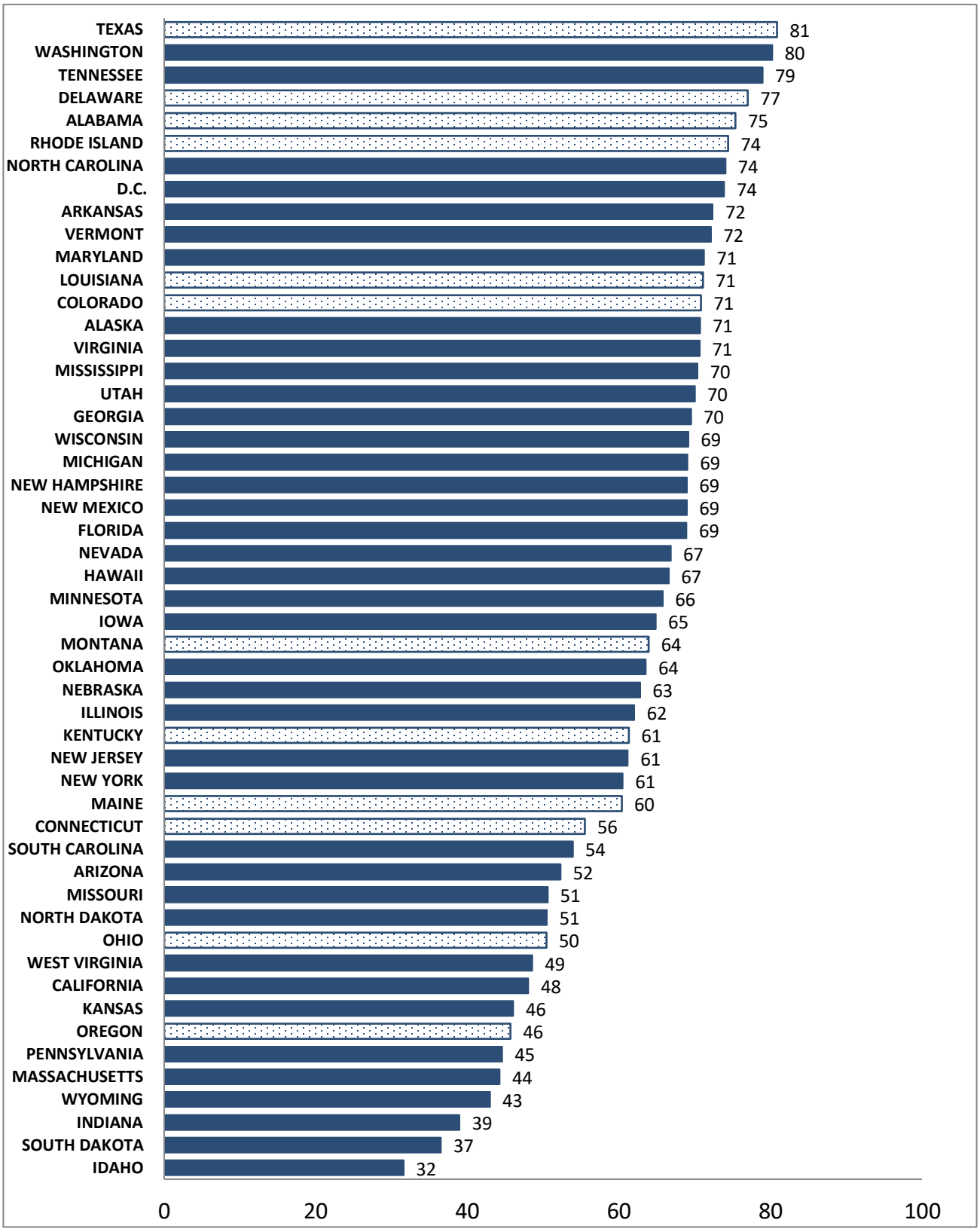
Figure 4 shows the extent to which licensing regulations for Centers, Large Family Child Care Homes, and Small Family Child Care Homes differ in their support of high-impact obesity prevention standards nationally, 2010 vs. 2021.



STATE RANKINGS IN 2021

Figure 5. Ranking of State Obesity Prevention Summary Scores (Highest to Lowest) as of 2021

This figure illustrates national rankings of state obesity prevention summary scores across all child care types (i.e., Centers, Large Family Child Care Homes, and Small Family Child Care Homes) as of 2021. *NOTE: States with lighter, dotted bars were rated in 2021. See Appendix C for information on the state score calculation.*

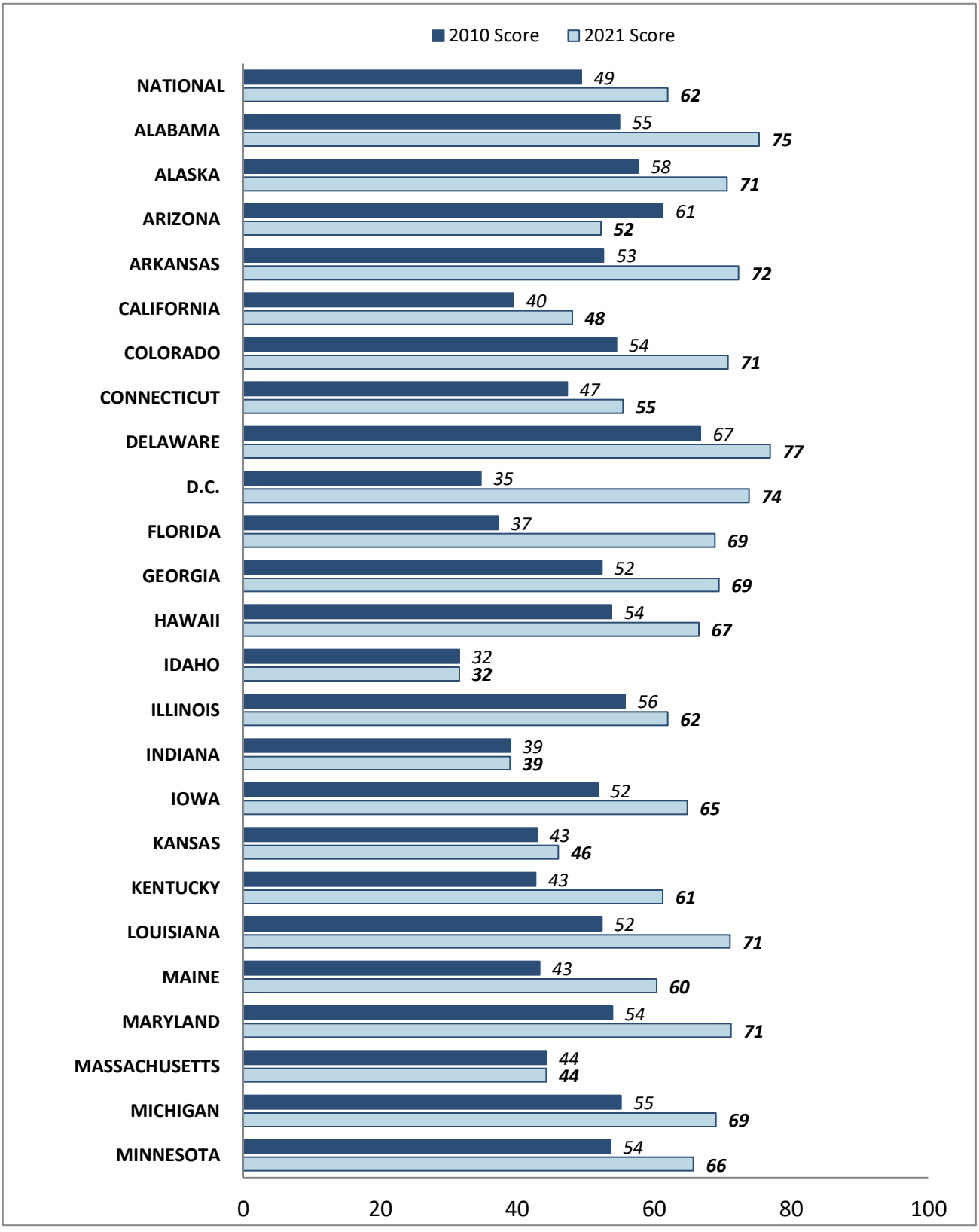


STATE RANKINGS IN 2021

Figure 6. Changes in State Obesity Prevention Summary Scores, 2010 vs. 2021

This figure illustrates changes in state obesity prevention summary scores across all child care types (i.e., Centers, Large Family Child Care Homes, and Small Family Child Care Homes) from 2010 to 2021.

NOTE: See Appendix C for information on the state score calculation.



STATE RANKINGS IN 2021

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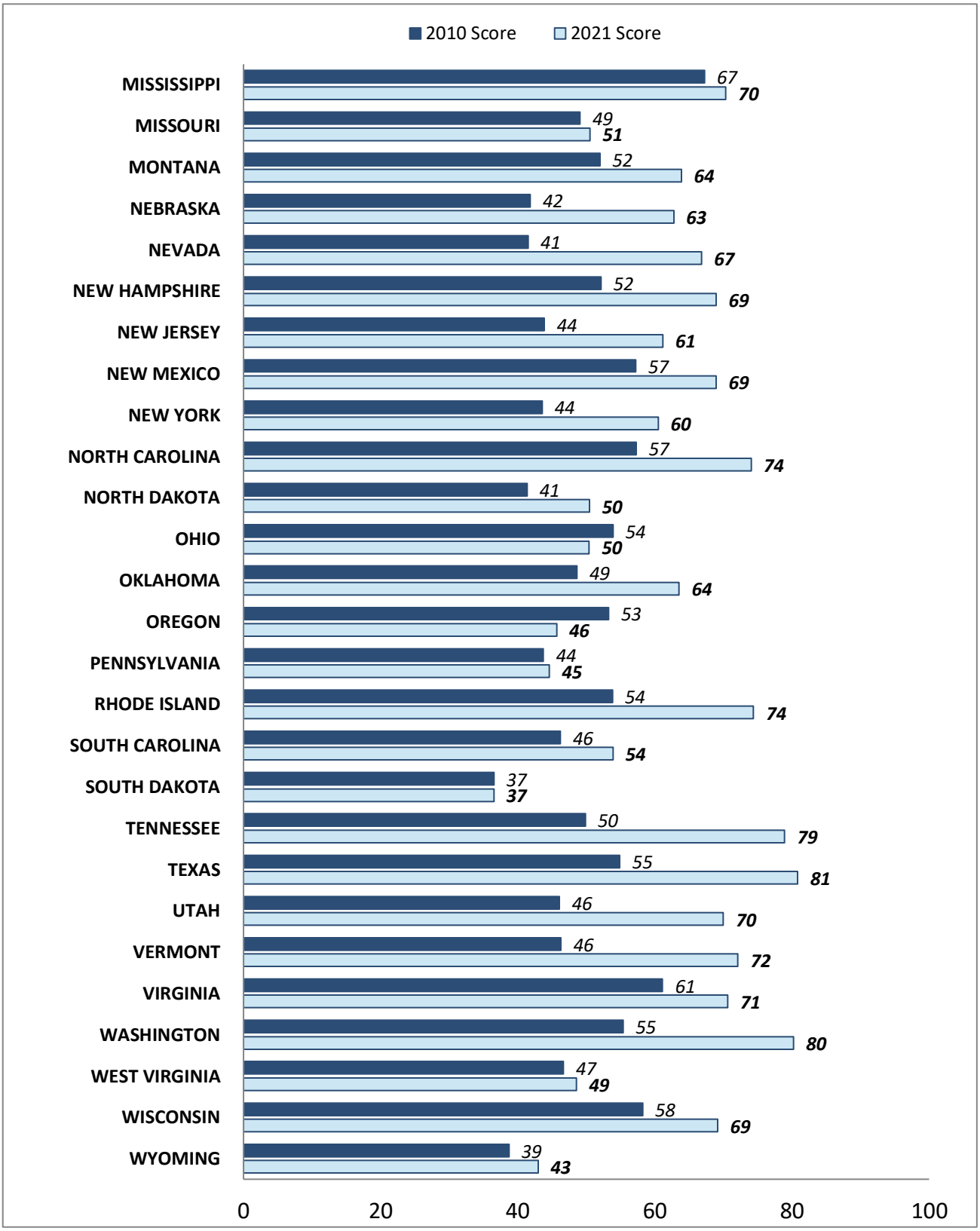
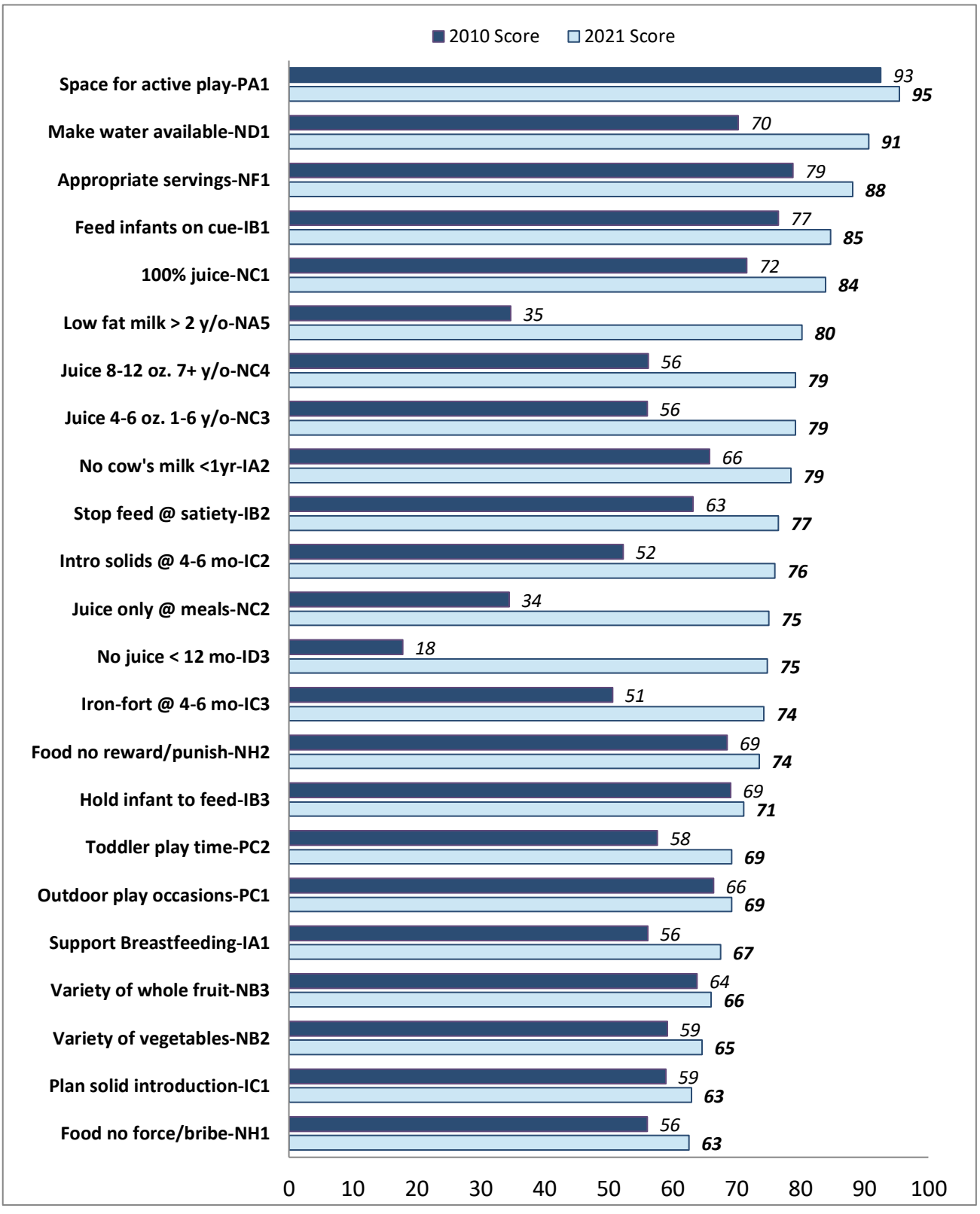


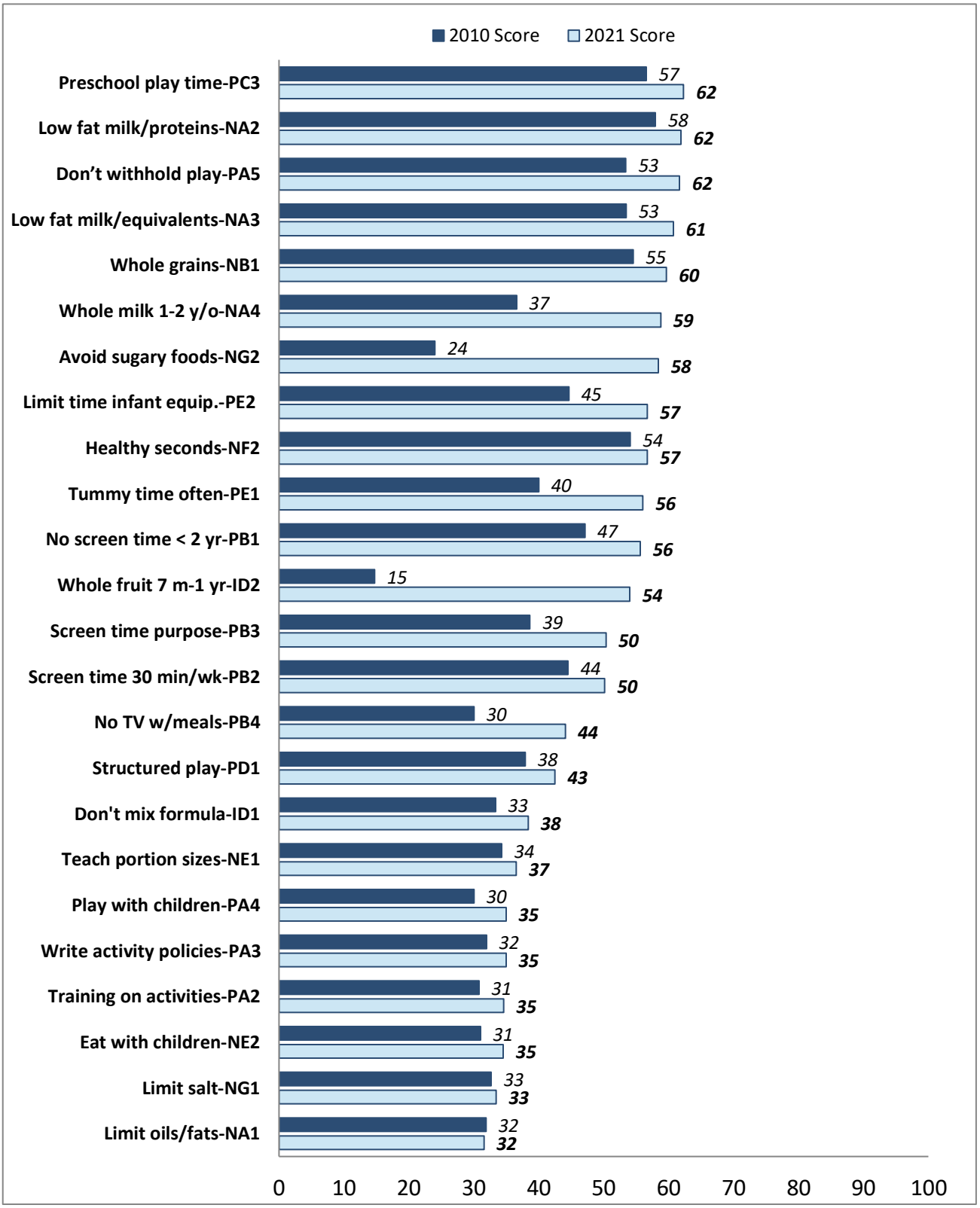
MOST TO LEAST SUPPORTED STANDARDS

Figure 7. Support of High-Impact Obesity Prevention Standards in Licensing Regulations, 2010 vs. 2021
This figure shows the most to least supported high-impact obesity prevention standards in state licensing regulations for Centers, Large Family Child Care Homes, and Small Family Child Care Homes in 2010 versus 2021.
NOTE: See Appendix C for information on the state score calculation.



MOST TO LEAST SUPPORTED STANDARDS

Figure 7. (continued from previous page)



DISCUSSION

2021 had the greatest number of state licensing regulations in support of obesity prevention best practices since 2012, with family child care more closely aligning with Child and Adult Care Food Program (CACFP) meal patterns.

In 2021, regulatory changes by twelve states,

Alabama, Colorado, Connecticut, Delaware, Kentucky, Louisiana, Maine, Montana, Ohio, Oregon, Rhode Island, and Texas, offered further support for High Impact Obesity Prevention Standards (HIOPS) in child care licensing across the nation. Despite positive changes, current findings also indicate that revisions do not consistently build on successful past changes, as 24% of all 2021 ratings lowered support for HIOPS.

2021 State Changes

Texas now leads the nation in HIOPS support by earning substantially stronger ratings for infant feeding and nutrition by newly requiring adherence to USDA Child and Adult Care Food Program (CACFP) meal patterns across all three care types, while also strengthening rules for physical activity and screen time limits. **Alabama** rose in rank from 33rd to 5th nationally this year by also requiring adherence to CACFP for their family child care and making significant improvements to physical activity and screen time limits for all care types. **Rhode Island** now 6th in the nation, up from 21st, made significant improvements to the family child care rules in support of the HIOPS for the first time since 2010. Rhode Island's changes include limiting the use of infant equipment, such as playpens and portable cribs, with family child care strengthening their rules around the consumption of sugar and sweets, misuse of food for discipline, and the promotion of physical activity among staff. **Maine** made changes that affect the HIOPS to child care centers for the first time since 2010, adding substantial content regarding nutrition practices, physical activity, and screen time. Revised family child care homes rules added new language for physical activity and screen time, which there was previously very little content. **Kentucky** made positive changes for centers and large family child care homes by increasing the amount of moderate to vigorous physical activity each day, addition of tummy time for infants, and prohibiting screen time for children under two years of age. **Colorado** made positive changes in regard to the misuse of food for punishment and not withholding physical activity as a disciplinary measure. **Delaware** made a single change that affected large and small child care homes by deleting language that allowed infants to be served juice when they were able to hold their own cup. **Ohio** also altered regulations for all care types to support serving a variety of vegetables and included language to support the development of a plan for introducing age-appropriate solid foods to infants. **Montana** made a change to child care centers by including toddlers in the daily outside play requirement, while **Louisiana** included physical activity education training in their requirements for staff orientation. **Oregon** ratings were lowered since written confirmation of CACFP could not be obtained in time for publication by state licensing personnel. Lastly, for **Connecticut**, a correction was made to a single prior rating for small family child care homes to reflect support for holding infants while bottle feeding.

Lessons Learned

Since 2010,[26] the 11 ASHW studies have found that state actions consistently strengthen Early Childhood Education (ECE) regulations for obesity prevention in four key areas. First, states maintain successes during rule revisions where deletions or enhancements do not diminish support of HIOPS. Second, states align nutrition and infant feeding requirements with CACFP,[12] whether or not the individual programs must formally participate in CACFP. Third, states enact uniform regulations across licensed care types to ensure children have similar ECE support to maintain a healthy weight and acquire beneficial lifestyle behaviors. Finally, they continually collaborate with other subject matter experts in their states. These actions demonstrate best practice options and can be applied to improve regulations, as no state has achieved an Obesity Prevention Summary Score (OPSS) of 100 for their combined ECE regulations.

DISCUSSION

States Can Strengthen Obesity Prevention Policies in ECE Licensing Regulations by:

1. Maintaining past improvements that support obesity prevention.
2. Adopting regulations that explicitly align with CACFP meal patterns.
3. Adopting regulations consistent with CFOC standards for physical activity/screen time.
4. Adopting regulations that support obesity prevention practices in ***all*** care types.
5. Consulting with local public health officials or licensed child health providers during the revision process.

Resources and Strategies for Improvement

There are specific strategies and resources available to strengthen obesity prevention in licensed ECE care.

Use ASHW 2021 Supplements.

- ***Identify states' strengths and weaknesses in supporting each of the 47 HIOPS.*** The three ASHW supplements for Centers, Large, and Small Family Child Care Homes present each state's current ratings for 47 HIOPS in each care type.[27-29] The ASHW state supplements show state ratings as of 2021, and provide the ratings in 2010 to help assess progress over time.

The NRC website presents a comprehensive list of the *State Documents Rated for ASHW: 2010 to 2021*,[30] and ECE licensing regulations for all states are available at the National Center on Early Childhood Quality Assurance.[31]

Review CDC's State Licensing Score Cards on Obesity Prevention in Child Care Centers.[32]
Each state's licensing scorecard can help identify where center-based ECE regulations support high-impact obesity prevention practices, and where there is room to improve. State scores are calculated with a point-based algorithm developed by the CDC and can be used to compare a state's progress to other states and nationally and identify areas for improvement.

Collaborate with state public health departments, as they typically work with the CDC's Division of Nutrition, Physical Activity, and Obesity for obesity prevention efforts.[33] If not already engaged, licensing professionals can reach out to public health and health care professionals to access additional expertise. Together with other state and local organizations, agencies may work towards better coordination of obesity prevention efforts (e.g., in Quality Rating Systems, built environments for encouragement of physical activity, early learning collaboratives).[34]

Review the Caring for Our Children updated special collection, Preventing Childhood Obesity in Early Care and Education Programs (PCO).[35]
PCO presents the HIOPS in context with rationales for the expert and evidence-based best practices, and can help licensing professionals revise regulations to support obesity prevention in all four ASHW domains.

To strengthen support of Nutrition and Infant Feeding Standards, include CACFP requirements in regulations for all child care types.

- ***Replace USDA guidelines (or similar terms) with USDA CACFP*** to direct providers to infant feeding and nutrition requirements.
- ***Cite current CACFP Meal and Snack Patterns,*** or include statements requiring following CFR 226.20 (Code of Federal Regulations of CACFP), in text and/or embedded tables. This strategy overcomes lags between CACFP changes and updates of state regulations. States that rely upon outdated, unidentified, or adapted meal pattern charts, or have rules based upon older versions of CACFP have not received improved ratings associated with the most recent (2017) CACFP revisions.
- ***Include rules for infant feeding and nutrition HIOPS that CACFP does not fully support or does not address at all*** (see Appendix F. CACFP ASHW Ratings). CACFP does not address all of the HIOPS in their meal patterns. Ratings are assigned by also reviewing additional state text that may impact the level of support for HIOPS.

Note to States: *Starting with the ASHW 2022 Report and State Supplements, states must follow one of the three bullets above and explicitly mention USDA CACFP in their child care regulations to receive CACFP ratings for the HIOPS. Regulations that include only "USDA Guidelines," outdated meal pattern charts, or reproducing similar meal pattern charts will not receive CACFP credit for 2022.*

DISCUSSION

How states can use child care licensing regulations to better support breastfeeding parents and their young children in early care and education.

Breastfeeding and Child Care Regulations

As states work to strengthen their child care regulations around breastfeeding practices, it is important to include language that not only supports the feeding of human milk by providers, but to make comfortable and appropriate arrangements for parents to breastfeed or feed their children human milk on-site. While CACFP meal patterns recommend the feeding of human milk, arrangements for breastfeeding are not mentioned.

Examples of additional language that can be used to support comfortable arrangements for the breastfeeding parent in ECE environments:

- Provide a comfortable, adult-sized, chair for the parent to breastfeed.
- Provide a stepstool to help support the parent's feet and prevent back strain.
- Provide a pillow to support the infant in the parent's lap.
- Provide access to an electrical outlet for parents who wish to utilize a breast pump.

2022 Updated AAP Breastfeeding Policy

On June 27, 2022, the American Academy of Pediatrics (AAP) released an updated policy statement and technical report, titled, "Breastfeeding and Use of Human Milk." This AAP update continues to recommend exclusive breastfeeding for the first six months of life, with complementary foods offered around 6 months of age. Under this new policy, the AAP now supports continued breastfeeding until age two or older, as mutually desired by parent and child. There are continued benefits of breastfeeding beyond one year, especially for the parent, including protection against high blood pressure, diabetes, and breast and ovarian cancers.[36,37]

This updated policy statement was released amidst the recent national infant formula shortage. COVID-19 continues to disrupt all sectors of society and supply chain issues from the pandemic have contributed to the current formula shortage. This was worsened by one of the country's largest formula producers voluntarily recalling formula and closing one of its production facilities. This formula shortage has left many families anxious about how they will meet the nutritional needs of their young children. During the formula shortage, many providers, including ECE staff, have increased the promotion of feeding human milk to infants when it is possible.

The Role of ECE in Breastfeeding

Breastfeeding can be challenging for parents and ECE providers can play an important role in promoting breastfeeding among the families they serve. Supportive ECE environments may help more parents begin and continue breastfeeding, leading to increased health benefits for children and parents. Through the relationships they develop with families, ECE staff are uniquely positioned to share up-to-date, evidence-based, information to enable families to achieve their infant-feeding goals.

BREASTFEEDING RESOURCES

Caring for Our Children (CFOC):
4.3.1.1 General Plan for Feeding Infants

Centers for Disease Control and Prevention:
Breastfeeding Report Card, 2022

National Center on Health, Behavioral Health, and Safety:
Breastfeeding: Tips for Head Start Staff

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APPENDIX A: **Key Findings in *Achieving a State of Healthy Weight* Assessments: 2010-2020**

Findings for regulations and regulatory changes related to ASHW High-Impact Obesity Prevention Standards (HIOPS) are reported below.

ASHW 2010 & ASHW 2011

- 2010 baseline study rated all states' regulations for HIOPS in Nutrition, Infant Feeding, & Physical Activity/Screen Time
- In both 2010 & 2011:
  - HIOPS were not substantially better regulated for one care type vs. others
  - Only 13% all ratings nationally indicated regulations fully supporting HIOPS
  - More than ½ of ratings indicated no relevant HIOPS text was identified
  - Physical Activity/Screen Time was the least regulated domain
  - Leading states (with strongest HIOPS regulations) were DE & MS
- AZ, AR & ND enacted 2011 regulatory changes—88% of changes improved HIOPS

ASHW 2012

- 12 states (CA, CO, FL, IA, KS, MD, NV, NM, NC, TX, WA & WY) enacted regulatory changes—94% of rated changes improved HIOPS
- 15% of all ratings nationally indicated regulations fully supporting HIOPS
- Physical Activity/Screen Time HIOPS remained largely unregulated
- Child and Adult Care Food Program (CACFP) guidelines newly supported 2 HIOPS:
  - *Serve 1% or skim milk to children 2 and older*—30 states received higher ratings
  - *Make water available both inside and outside*—25 states received higher ratings
- Leading states were DE, MS

ASHW 2013

- 10 states (FL, KS, KY, MS, NE, NJ, NC, ND, RI & WY) enacted regulatory changes—94% of rated changes improved HIOPS
- 16% of all ratings nationally indicated regulations fully supporting HIOPS
- Physical Activity/Screen Time HIOPS remained least regulated
- COPR scores (weighted summary scores) were introduced to compare states regulations and treatment of HIOPS
- Leading states were DE, MS, NC & RI

ASHW 2014

- 7 states (GA, IL, MI, NM, NY, TX & WV) enacted regulatory changes—100% of rated changes improved HIOPS
- 17% of all ratings nationally indicated regulations fully supporting HIOPS
- Most improved HIOPS were for infant tummy time and prohibiting juice for infants
- Physical Activity/Screen Time HIOPS remained largely unregulated
- Leading states remained DE, MS, NC & RI
- 23 states' regulations re: HIOPS were unchanged since 2010

ASHW 2015

- 6 states (AR, CO, DE, LA, MD & NY) enacted regulatory changes—91% of rated changes improved HIOPS
- 17% of all ratings nationally indicated regulations fully supporting HIOPS
- Most improved HIOPS were serving low-fat milk for children 2+, and use screen media only for educational and physical activity purposes
- Leading states remained DE, MS, NC & RI
- 23 states' regulations re: HIOPS remained unchanged since 2010
- Physical Activity/Screen Time changed more than Infant Feeding and Nutrition

ASHW 2016

- 6 states (CO, DC, MO, OH, OK & VT) enacted regulatory changes—76% of rated changes improved HIOPS
  - DC's HIOPS changes yielded vast "state" improvements
- 18% of all ratings nationally indicated regulations fully supporting HIOPS
- Leading states: DE, MS, NC, & CO
- Regulations often contradict 3 HIOPS: *Avoid sugar, No juice under 12 mos,* and *Serve mashed/pureed whole fruit 7 - 12 mos.*

APPENDIX A: **Key Findings in *Achieving a State of Healthy Weight* Assessments: 2010-2020**

ASHW 2017

- 7 states (DE, FL, ME, NH, NJ, RI & UT) enacted regulatory changes—83% of rated changes improved HIOPS
- 24% of all ratings nationally indicated regulations fully supporting HIOPSs; 1% contradict HIOPS
- Leading "states" were DC, NC, CO, VT & MD
- Most improved states since 2010 were DC, FL, NJ, VT & UT
- 29* states earned nearly 600 positive changes in 2017 to due to mandatory CACFP Meal Pattern improvements
- Most improved HIOPS were *Serve no juice before age 12 mos.* (ID3) and *Serve low-fat milk age 2+* (NA5), due to CACFP changes since 2010
- 15 states' regulations re: HIOPS remained unchanged 2010-2017

**Reflects correction to national dataset in which 2017 CACFP improved ratings were applied for OR Small Family Child Care Home regulations that were not reported in ASHW 2017*

ASHW 2018

- 5 states (AL, KY, NV, NC, and TN) enacted regulatory changes – 83% of rated changes improved HIOPS
- Leading states: TN, NC, DC, CO
- HIOPS were strengthened by 83% of state changes; HIOPS were weakened by 17% of state changes
- HIOPS were most fully supported in Tennessee, North Carolina and Nevada
- From 2010 to 2018:
    - Full regulatory support of HIOPS increased from 12% to 26%
    - Licensing regulations contradicting HIOPS decreased from 3% to 1%
    - Failure to address HIOPS in licensing regulations declined from 55% to 43%
- Most improved HIOPS were *feed infants on cue* (IB1), *use only 100% juice…*(NC1), *make water available…*(ND1), *serve small-sized, age-appropriate portions* (NF1) and *provide children with adequate space…*(PA1)
- Least supported HIOPS were *limit oils…and fried foods* (NA1), *limit salt…*(NG1), *provide orientation and annual training opportunities for caregivers/teachers to…promote physical activity* (PA2), *develop written policies on the promotion of physical activity…*(PA3), and *require caregivers/teachers to…participate in active games* (PA4)

ASHW 2019

- 7 states (AL, AZ, DE, FL, MI, WA, and WI) enacted regulatory changes –74% of these revisions increased support for obesity prevention, while 26% weakened support
- Infant Feeding HIOPS were most successfully included in new 2019 ECE regulations
- Washington led the nation in ECE regulations that support obesity prevention
- States that most fully supported HIOPS across licensed child care types were Washington, Tennessee, and Delaware, with more than 10 states following closely behind
- From 2010 to 2019:
    - Full regulatory support of HIOPS increased from 12% to 26%
    - Licensing regulations contradicting HIOPS decreased from 3% to 1%
    - Failure to address HIOPS in licensing regulations declined from 55% to 42%
- Most supported HIOPS were *provide children with adequate space…*(PA1), *make water available…*(ND1), and *serve small-sized, age-appropriate portions* (NF1)
- Least supported HIOPS were *limit salt…*(NG1), *develop written policies on the promotion of physical activity…*(PA3), and *limit oils…and fried foods* (NA1)

ASHW 2020

- 7 states (AZ, AR, DE, GA, MS, ND, and PA) enacted regulatory changes –81% of these revisions increased support for obesity prevention, while 19% weakened support
- The majority of state revisions to licensing regulations impacted Large and Small Family Child Care Homes.
- Washington continued to lead the nation in ECE regulations that support obesity prevention, followed by Tennessee and Delaware.
- Georgia's Small Family Child Care Homes were required to comply with CACFP, which strengthened their infant feeding and nutrition practices.
- Delaware made revisions that prohibited serving juice to any infant in Child Care Centers.
- Mississippi made positive changes impacting physical activity practices for infants and toddlers, and limited the use of infant equipment, such as swings and strollers.

ASHW 2020 (continued)

- From 2010 to 2020, states with the most improved support of the HIOPS were:
  - District of Columbia, Florida, Tennessee, Nevada, Vermont, and Utah
- The most supported HIOPS continued to be *provide children with adequate space…*(PA1), *make water available…*(ND1), and *serve small-sized, age-appropriate portions* (NF1)
- The least supported HIOPS continued to be *limit salt…*(NG1), *develop written policies on the promotion of physical activity…*(PA3), and *limit oils…and fried foods* (NA1)

Notes

- Several states made changes each year that were not pertinent to ASHW.
- See prior ASHW reports @ https://nrckids.org/HealthyWeight/Archives
- Annual %s of positive change listed below may differ from reports accessed above, as %s were recalculated to account for data adjustments described in ASHW 2017, Appendix C.

APPENDIX B: *Achieving a State of Healthy Weight* Methodology

Achieving a State of Healthy Weight Methodology

The National Resource Center for Health and Safety in Child Care and Early Education (NRC) designed the Achieving a State of Health Weight (ASHW) methodology in 2010 to assess all states' licensing regulations that were in effect for early care and education (ECE) programs during calendar 2010. Licensing regulations of all states and the District of Columbia (*the states*, for convenience) for child care centers (CTRS), large or group family child care homes (LFCCHs), and small family child care homes (SFCCHs) were reviewed and rated. In annual updates, NRC screens new and revised licensing documents and rates those with new or changed rules that pertain to the ASHW 47 high-impact obesity prevention standards (HIOPS).[1] The NRC applies the following method in annual reassessments as described below. Modifications are identified with the year of adoption.

1. **Identification of new and revised child care regulations**. NRC assesses regulations for CTRs, LFCCHs and SFCCHs for licensure or mandatory registration. New and revised regulations made effective January 1 – December 31 of a given year are identified by monitoring states' child care licensing websites and through outreach to state licensing agencies as needed. Final website checks occur by mid-January of the following year (e.g., January 2022 for *ASHW 2021*). NRC downloads regulatory documents directly from the state website. Documents posted after the final check are screened in the next study. Periodically, NRC reviews the National Center for Early Childhood Quality Assurance state pages to identify new/revised or previously missed documents (practice formally adopted 2018). Missed documents are screened and reported in the year of discovery.

2. **Categorization of documents by care type**. Most states define care types consistent with the *Caring for Our Children (CFOC)* definitions (see https://nrckids.org/files/CFOC4GuidingPrinciples.pdf). In other cases, NRC categorizes documents according to the best logical fit with *CFOC*. Prior to *ASHW 2019*, some states' center ratings also were assigned to LFCCHs if there were not separate LFCCH rules and the center definition could encompass care provided in a residence for approximately 7 – 12 children. NRC discontinued this procedure as a general practice in 2019 in collaboration with the CDC Division of Nutrition Physical Activity and Obesity (DNPAO). Exceptions remain for center regulations that recognize a subtype of care that aligns substantially with the LFCCH definition (specifying location in a residence and similar group size). In these cases, center ratings remain assigned to the LFCCH category. Two examples are North Carolina (*10A NCAC Chapter 9 - Child Care Rules*, effective September 1, 2019) and Kentucky (*922 KAR 2:090. Child-Care Center Licensure*, updated August 2018). States for which the center definition could, but does not specifically, align with the *CFOC* LFCCH definition, no longer have LFCCH ratings. The policy change was not retroactive, so that 2010-2018 LFCCH ratings remain in the historical ASHW data sets and in prior reports and supplements.

3. **Document screening.** The NRC screens regulatory documents visually and electronically. Revised documents are compared to the most recently rated version using Adobe® Acrobat Pro to identify new and altered text. If extensive revisions make the Adobe comparison difficult to decipher, screeners scan and search the revised document for key ASHW terms. Screeners scan new documents visually for general organization and information, and follow up with electronic searches. Review of specific sections (e.g., infant care, nutrition, prohibited practices, screen time, and physical activity) often are reread for related language not identified in searches. The NRC screens numerous documents each year (typical range = 40-60). Since the majority of revisions are not relevant to HIOPS, a state may issue several unrated versions.

[1] HIOPS were referred to as *ASHW variables* or *Healthy Weight Practices* until the nomenclature was changed to HIOPS in *ASHW 2019.* This revised appendix replaces previous nomenclature with the term *HIOPS*. For more information on the HIOPS, see Origin of Achieving a State of Healthy Weight high-impact obesity prevention standards. National Resource Center for Health and Safety in Child Care and Early Education. https://nrckids.org/files/HIOPSOrigin.pdf. Published September 18, 2020.

4. **Rater training.** New raters are trained to use the *ASHW Rating Manual* on previously assessed documents and by observing procedures and decisions during rating of a new document by an experienced rater. In the latter case, the new rater would not be assigned to rate a document used for training. ASHW rating teams achieve high inter-rater reliability (typically $r_s > 0.90$).

5. **Document rating and data entry**. Two raters independently rate each regulatory document on 47 ASHW HIOPS using NRC's *ASHW Rating Manual* (last updated October 2018). The manual defines rules for assignment of rating values, with specific guidelines for each HIOPS. The manual uses a four-point scale (1 to 4), where:

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

    If a state does not regulate a specific child care type, ratings of "0" are displayed for the care type for all HIOPS on the state profile page in ASHW Supplements. In instances where states have more than one relevant document for a child care type, all of the documents are rated and entered into an ASHW database, a Microsoft Access database management system. Both raters record her/his ratings for a document in the database, along with text justifying the rating.

6. **Resolution of discrepant ratings**. When raters disagree, the raters meet with the NRC Evaluator to determine the appropriate value. Occasionally, the conferences point to the need to include a new search term or more clarification in the *ASHW Rating Manual*. If new search terms or guidance are added to the manual, the amended guidance is not applied to past ratings. The update rating rules would be applied the next time a state's documents are rated.

7. **"CACFP States."** *CFOC* standard 4.2.0.3: Use of US Department of Agriculture Child and Adult Care Food Program Guidelines (CACFP) encourages following CACFP guidelines. Many states align some nutrition and infant feeding regulations with CACFP by requiring licensed programs to follow the guidelines, whether or not they formally participate in CACFP. NRC refers to these states as "CACFP states." The CACFP Meal and Snack Patterns include guidance related to ASHW HIOPS in nutrition and infant feeding. NRC rated the patterns in 2010 (with subsequent adjustments for CACFP updates in 2011 and 2017). NRC assigns the ratings earned by the CACFP to selected HIOPS for the impacted care type(s), taking into account any state specific regulatory text that may raise or lower the rating. Where CACFP lacks related content, ratings are based upon state text alone.

    In 2011, CACFP added new for the availability of water and serving only skim or 1% milk to children age 2 years and older. NRC revised the *ASHW Rating Manual*, and improved ratings for "CACFP states in ASHW 2012. More CACFP updates became mandatory for participating programs in October 2017. NRC again revised the *ASHW Rating Manual* in ASHW 2017, and CACFP states were assigned improved ratings (no CACFP ratings declined), contingent upon additional state text and the following decision rules.

ASHW 2017 CACFP DECISION RULES

CACFP 2017 improvements were assigned to states that:

a) Reproduce the new patterns or cite the new requirements in regulatory text;
b) Direct the reader to a source for the updated materials (either a state source or the USDA FNS CACFP website);
c) Specify the need to follow the current or most up-to-date Meal Patterns (or similar verbiage), regardless of any out-of-date Meal and Snack Pattern reproductions or text; or,
d) Specify only the CACFP program name or identification in Federal Code (7 CFR § 226.20 - Requirements for meals), requiring the reader to seek the information.

States with older regulations that included only reproduced versions of the earlier Meal Patterns, or only outdated text from the Meal Pattern with no additional information encouraging the reader to seek out updates did not receive the 2017 CACFP improvements. They retained their ratings based on CACFP as of 2012. The NRC's 2017 CACFP decision rules remain in effect for regulatory revisions going forward (*adopted 2018*).

8. **Establishment of annual "final ratings."** ASHW calculations use a single score for each HIOPS for each regulated care type. Where multiple documents regulate a given care type in a state and the ratings differ among documents, the highest rating for the HIOPS prevails as the "final rating" (an *ASHW 2010* policy). The rationale for the policy is that providers must observe all existing pertinent regulations, so the regulation that rates higher supplants a lower-rated one.

9. **Data corrections**. Three types of past errors account for most corrections of previously published data. They are: 1) single rating errors such as data entry errors; 2) missed documents; and, 3) inappropriate award in 2010 of CACFP values based on reference to *USDA Dietary Guidelines* rather than CACFP. When past erroneous ratings are identified, the NRC updates the ASHW database to reflect the corrected values. Through *ASHW 2018*, when the NRC formalized its Data Quality Assurance (QA) Plan, data corrections were retroactive from the year in which they occurred through subsequent years until replaced by ratings of a later revision. From *ASHW 2019* onward, data corrections are no longer retroactive. A correction is made in the year of identification (as determined in collaboration with the CDC DNPAO, 2019). Earlier ASHW reports and supplements posted on the NRC website do not reflect subsequently corrected data.

10. **Data analysis and presentation**. The NRC exports annual ratings from the ASHW Database to Excel for generation of charts and tables and comparison of current year data to baseline data. Team members review the output to determine key findings for the ASHW reports. *ASHW 2010* through *ASHW 2012* were single volume presentations of national findings and included state profile pages (tables of each state's ratings for all 47 HIOPS and all care types). For *ASHW 2013* through *ASHW 2018,* the yearly changes and current national overview were retained in an ASHW report, and the state profile pages were presented separately in an ASHW supplement. Beginning with *ASHW 2019,* state profiles appear in a supplement for each care type (i.e., three supplements): centers, large family child care homes and small family child care homes.

11. **Computation of Summary Scores.** Beginning with *ASHW 2013*, the NRC developed formulas to facilitate comparisons of states' support of HIOPS, and comparisons of support for each HIOPS across all states. Through *ASHW 2018*, the formula computed *Childcare Obesity Prevention Regulation Scores*, or *COPR Scores*. In 2019 in collaboration with the CDC DNPAO, NRC adopted a new formula to calculate summary scores, replacing the *COPR Scores* with *Obesity Prevention Summary Scores*, or *OPSS*.[2] The calculation serves the same functions as *COPR Scores*, allowing comparisons of the states and national treatment of the HIOPS. The OPSS formula weights ASHW ratings as follows, in the formula presented below:

Ratings = 1 (contradict the HIOPS) are weighted 0 points
Ratings = 2 (fail to address the HIOPS) are weighted 30 points
Ratings = 3 (partially support the HIOPS) are weighted points
Ratings = 4 (fully support the HIOPS) are weighted 100 points

Obesity Prevention Summary Score Formula

$$OPSS = \frac{(total\ 1s\ x\ 0\ pts.) + (total\ 2s\ x\ 30\ pts.) + (total\ 3s\ x\ 70\ pts.) + (total\ 4s\ x\ 100\ pts.)}{total\ no.ratings}$$

For example, State X regulates two care types, earning a total of 94 ratings (i.e., 2 care types x 47 HIOPS = 94 ratings), which as are distributed as below:

4 ratings = 1
60 ratings = 2
20 ratings = 3
10 ratings = 4
94 total ratings

Applied to these data, the OPSS for State X equals 45 (44.68, rounded) of a possible 100.

$$OPPS = \frac{(4\ ratings\ x\ 0) + (60\ ratings\ x\ 30) + (20\ ratings\ x\ 70) + (10\ ratings\ x\ 100)}{94\ total\ ratings}$$

Regardless of the number of regulated care types, the *OPSS* range remains 0 - 100 (i.e., *OPSS* = 0 if all ratings = 1, to *OPSS* = 100, if all ratings = 4). Currently, no state has either extreme score for all of their cumulative child care regulations. Similarly, when OPSS are calculated for each HIOPS nationally, the range remains 0 to 100. Nor is any HIOPS completely supported nor unsupported across the nation at present.

Steps 1 -11 were applied as described in ASHW 2019 and continue for future ASHW updates unless further modifications are deemed necessary.

[2] See the COPR formula in the Methodology/Appendices of the 2015-2018 reports. When used on the same data, COPR Score and OPPS formulas produced very similar, but not identical rankings, of states and HIOPS.

APPENDIX C: **Source of *ASHW* High Impact Obesity Prevention Standards in PCO/CFOC Online Standards**

Source of ASHW Healthy Weight Practices in PCO/CFOC Online Standards

The tables below display ASHW High Impact Obesity Prevention Standards (HIOPS) in *PCO/CFOC* standards. Links to the NRC searchable *CFOC Online Standards Database* (@ https://nrckids.org/CFOC/Database) enable viewing the complete standard, rationale, references and related standards for each of the HIOPS.

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 (128 a) 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 7 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 of age.	**4.2.0.4 - Categories of Foods** & **4.2.0.7 - 100% Fruit Juice**

APPENDIX C: **Source of ASHW High Impact Obesity Prevention Standards in PCO/CFOC Online Standards**

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**

APPENDIX C: **Source of ASHW High Impact Obesity Prevention Standards in PCO/CFOC Online Standards**

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

APPENDIX D: **State Documents Searched in 2021**

Although the NRC makes extensive efforts to discover new and revised documents each year through website searches, email request, and calls to state child care licensing agencies, a new regulation may go undiscovered and unrated in the year it is made effective. In such cases, NRC will screen and/or rated the document as appropriate for inclusion in the ASHW report for the year of discovery. If state licensing personnel are aware such missed documents, please inform the NRC at nrckidswebmaster@gmail.com. Child care types: CTR=Centers, LRG=Large Family Homes, SML=Small Family Homes.

Documents rated in 2021 are highlighted.

STATE & Document Status	Document Title	New Document Date	Revision Date	Previous rated version**	Child care types covered by document		
					CTR	LRG	SML
AL	**ALABAMA**						
Rated	Child Care Licensing and Performance Standards for Day Care Centers and Nighttime Centers Regulations and Procedures		9/13/2021	11/30/2018	X		
Rated	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	11/30/2018		X	X
CA	**CALIFORNIA**						
Screened	Title 22, Div 12, Chap 3, Family Child Care Homes		6/02/2021			X	X
Screened	Chapter 3.4 California Child Day Care Act		7/23/2021		X	X	X
Screened	Chapter 3.6 Family Child Care Homes		7/23/2021			X	X
CO	**COLORADO**						
Screened	7.701 General Rules for Child Care Facilities		4/01/2021		X	X	X
Rated	7.702 - Rules Regulating Child Care Centers (Less than 24-Hour Care)		12/01/2021	2/01/2016	X		
Rated	7.702 - Rules Regulating Family Child Care Homes		9/30/2018	6/01/2012		X	X
CT	**CONNECTICUT**						
Rated	Statutes and Regulations for Family Child Care Homes		3/19/2021	7/2009			X
DE	**DELAWARE**						
Screened	DELACARE: Regulations for Early Care and Education and School-Age Centers		3/01/2021		X		
Rated	DELACARE: Regulations for Family and Large Family Child Care Homes		1/10/2021	5/2019		X	X
FL	**FLORIDA**						
Screened	Child Care Facility Handbook		10/2021		X		
Screened	Family Day Care Home and Large Family Child Care Home Handbook		10/2021			X	X
ID	**IDAHO**						
Screened	16.06.02 Rules Governing Standards for Child Care Licensing		7/01/2021		X	X	X
IN	**INDIANA**						
Screened	IC 12-17.2-4 Chapter 4. Regulation of Child Care Centers		7/01/2021		X		
Screened	IC 12-17.2-5 Chapter 5. Regulation of Child Care Homes		7/01/2021			X	X
IA	**IOWA**						
Screened	Chapter 109 Child Care Centers		11/03/2021		X		
Screened	Chapter 110: Child Development Homes		11/03/2021				

**** Please note**: The document date listed in this column is the last version rated for ASHW. Many states may have released intervening revisions that were screened but not rated because the intervening versions did not change rules related to ASHW Healthy Weight Practices.

APPENDIX D: **State Documents Searched in 2021**

STATE & Document Status	Document Title	New Document Date	Revision Date	Previous rated version**	Child care types covered by document		
					CTR	LRG	SML
KY	**KENTUCKY**						
Rated	922 KAR 2:120 - Child-care center health and safety standards		6/16/2021	7/18/2018	X	X	
Screened	922 KAR 2:090 – Child-care center licensure		6/16/2021		X		
LA	**LOUISIANA**						
Rated	Bulletin 137 – Early Learning Site Licensing Regulations		9/2021	7/01/2015	X		
ME	**MAINE**						
Rated	10-148, Chapter 32 - Child Care Facility Licensing Rule		9/27/2021	8/27/2008	X		
Rated	10-148, Chapter 33 - Family Child Care Provider Licensing Rule		5/27/2021	9/20/2017		X	X
MA	**MASSACHUSETTS**						
Screened	606 CMR 7.00: Standards for the licensure or approval of family child care; small group and school age and large group and school age child care		12/24/2021		X	X	X
MN	**MINNESOTA**						
Screened	Chapter 9503 Child Care Center Licensing		10/13/2021		X		
Screened	Chapter 9502 Licensing of Day Care Facilities (Family Day Care and Group Family Day)		10/13/2021			X	X
MO	**MISSOURI**						
Screened	Chapter 500—Licensing Rules for Group Child Care Homes and Child Care Centers		9/30/2021		X	X	
Screened	Chapter 400—Licensing Rules for Family Child Care		9/30/2021				X
MT	**MONTANA**						
Rated	Licensing Requirements for Child Day Care Centers		12/2021	9/01/2006	X		
Screened	Requirements for Registration of Family and Group Day Care Homes		12/2021			X	X
NM	**NEW MEXICO**						
Screened	Title 8 Social Services Chapter 16 Part 2- Child Care Centers, Before and After School Programs Family Child Care Homes and Other Early Care and Education Programs		7/01/2021		X	X	X
NY	**NEW YORK**						
Screened	Part 418-1 - Child Day Care Centers		10/13/2021		X		
Screened	Part 418-2: Small Day Care Centers		10/13/2021		X		
Screened	Part 416: Group Family Day Care		10/13/2021			X	
Screened	Part 417: Family Day Care		10/13/2021				X
Screened	Part 413: Child Day Care Definitions, Enforcement and Hearings		4/21/2021		X	X	X
NC	**NORTH CAROLINA**						
Screened	Chapter 9 - Child Care Rules		7/01/2021		X	X	X
OH	**OHIO**						
Rated	Child Care Center Manual		10/29/2021	12/23/2016	X		
Rated	Family Child Care Manual		10/29/2021	12/23/2016		X	X
OR	**OREGON**						
Rated	Rules For Certified Child Care Centers		6/2021	1/01/2010	X		
Rated	Rules For Certified Family Child Care Homes		10/2021	1/01/2010		X	
Rated	Rules for Registered Family Child Care Homes		4/2021	1/01/2010			X

** **Please note**: The document date listed in this column is the last version rated for ASHW. Many states may have released intervening revisions that were screened but not rated because the intervening versions did not change rules related to ASHW Healthy Weight Practices.

APPENDIX D: **State Documents Searched in 2021**

STATE & Document Status	Document Title	New Document Date	Revision Date	Previous rated version**	Child care types covered by document		
					CTR	LRG	SML
PA	**PENNSYLVANIA**						
Screened	Chapter 3270 – Child Day Care Centers		3/2021		X		
Screened	Chapter 3280 – Group Child Day Care Homes		3/2021			X	
Screened	Chapter 3290 – Family Child Day Care Homes		3/2021				X
RI	**RHODE ISLAND**						
Rated	218-RICR-70-00-1 Child Care Center and School Age Program Regulations for Licensure		4/19/2021	9/18/2017	X		
Rated	218-RICR-70-00-7 Group Family Child Care Home Regulations for Licensure		9/02/2021	10/01/2007		X	
Rated	218-RICR-70-00-2 Family Child Care Home Regulations for Licensure		7/07/2021	10/01/2007			X
SD	**SOUTH DAKOTA**						
Screened	Chapter 67:42:03 Family Day Care Homes		4/19/2021		X		
TX	**TEXAS**						
Rated	Chapter 746: Minimum Standards for Child-Care Centers		10/2021	6/2014	X		
Rated	Chapter 747: Minimum Standards for Licensed and Registered Child-Care Homes		11/10/2021	6/2014		X	X
VA	**VIRGINIA**						
Screened	Standards for Licensed Child Day Centers		10/13/2021		X		
Screened	Chapter 820. General Procedures and Information for Licensure		7/01/2021		X	X	X
Screened	Chapter 800. Standards for Licensed Family Day Homes		7/01/2021			X	X
WA	**WASHINGTON**						
Screened	Chapter 110-300 WAC Foundational Quality Standards for Early Learning Programs		8/12/2021		X		
WI	**WISCONSIN**						
Screened	DCF 250 Licensing Rules for Family Child Care Centers		12/2021		X	X	X

**** Please note**: The document date listed in this column is the last version rated for ASHW. Many states may have released intervening revisions that were screened but not rated because the intervening versions did not change rules related to ASHW Healthy Weight Practices.

APPENDIX E: *Achieving a State of Healthy Weight* Rating of the Child and Adult Care Food Program

Achieving a State of Healthy Weight Rating of the Child and Adult Care Food Plan

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 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 NRC'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 NRC 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 NRC a licensing requirement for adherence to CFR 226.20/CACFP guidelines, NRC 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, NRC 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, NRC 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. The NRC'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), NRC typically reaches out to the state licensing agency for clarification. If no response is obtained, NRC 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 2021, no state's regulations required adherence to the CACFP Best Practices.

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

[2] Origin of Achieving a State of Healthy Weight high-impact obesity prevention standards. National Resource Center for Health and Safety in Child Care and Early Education. https://nrckids.org/files/HIOPSOrigin.pdf. Published September 18, 2020.

[3] ASHW 2017 Report, Appendix C: ASHW 2017 Method Notes (p.33-34) @ https://nrckids.org/files/ASHW.2017_7.23.18.pdf.

[4] See CACFP Best Practices @ https://fns-prod.azureedge.net/sites/default/files/cacfp/CACFP_factBP.pdf.

APPENDIX E: *Achieving a State of Healthy Weight* Rating of the Child and Adult Care Food Program

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 STANDARD (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 7 months up to one year of age.	1/3	-
ID3. Serve no fruit juice to children younger than 12 months of age.	1/4	-

APPENDIX E: *Achieving a State of Healthy Weight* Rating of the Child and Adult Care Food Program

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 STANDARD (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
NC1.	Use only 100% juice with no added sweeteners.	4/4	-
NC2.	Offer juice only during meal times.	2/4	-
NC3.	Serve no more than 4 to 6 oz juice/day for children 1-6 years of age.	3/4	-
NC4.	Serve no more than 8 to 12 oz juice/day for children 7-12 years of age.	3/4	-
ND1.	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	-
NG1.	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.*