Improving Health through Nutrition and Physical Activity in Child Care Settings

Policies and Practices Survey Report

Choose Health LA Child Care

Child Care Resource Center™
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Report by the Child Care Resource Center Prepared for Maternal, Child and Adolescent Health Programs of the Los Angeles County Department of Public Health

December 2016

Acknowledgements

The Choose Health LA Child Care (CHLA CC) policies and practices evaluation was conducted by the Child Care Resource Center (CCRC) and was supported by a contract with the Los Angeles County Department of Public Health (REDUCING EARLY CHILDHOOD OBESITY IN LOS ANGELES COUNTY - LOS ANGELES REDUCING OBESITY IN CHILD CARE SETTINGS (LA ROCCS), CONTRACT #PH-002373). The project is supported by First 5 LA (the contract between First 5 LA and DPH is entitled the EARLY CHILDHOOD OBESITY PREVENTION INITIATIVE, CONTRACT #08379.1). We would like to acknowledge our funders for their continued support. This report was prepared by Dr. Susan Savage and Olivia Pillado with contributions from Donald Jay Gravink, Janet Scully, Helen O'Connor, Zoe Phillips, and Dr. Robert Gilchick (DPH); Ashley Henderson, Andrea Giese, and Jeanie Park (Child Care Alliance of Los Angeles); and David Bloom, Stephanie Cortez, and Vanessa Guerrero (CCRC); and Morgan Pareja, Sallie Yoshida, and Jeremiah Garza (Sarah Samuels Center for Public Health Research and Evaluation). The author would like to thank the Coaches and management at the Child Care Alliance of Los Angeles, Child Care Resource Center, the City of Norwalk, Connections for Children, Crystal Stairs Inc., Drew Child Development Corporation, International Institute of Los Angeles, Mexican American Opportunity Foundation, Options for Learning, Pathways, and Pomona Unified School District for their commitment to increasing the nutrition and physical activity environments of child care settings throughout Los Angeles County. We are indebted to the numerous early care and education professionals for their participation in this project and the work they do with children to help them achieve healthier lifestyles. For questions about this report please contact Olivia Pillado at 818.717.1000, x8101 or opillado@ccrcca.org or Susan Savage at 818.717.1040 or ssavage@ccrcca.org.

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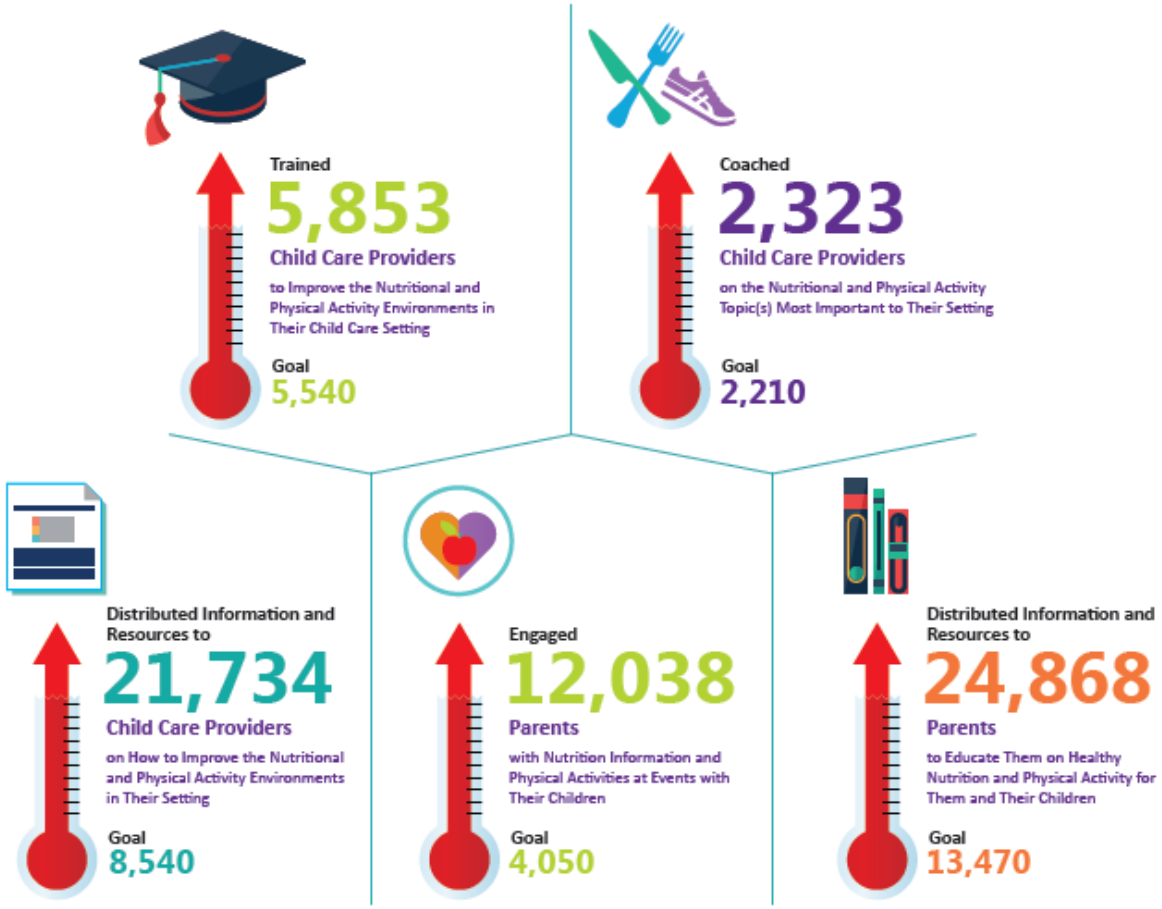
From **October 2013** through **June 2016**

the Choose Health LA Child Care program:



Made possible with funding by First 5 LA through the Los Angeles County Department of Public Health

Executive Summary

Teaching young children healthy habits not only gives them a good start early in life, it also has the potential to reduce the individual and societal burden of health risks related to obesity later in life. Early childhood settings can thus be critical environments for intervention. The Choose Health LA Child Care (CHLA CC) program offers nutrition and physical activity training and one-on-one coaching to licensed center- and family child care providers, equipping providers with the knowledge, tools, and technical support to instill healthy habits in the children in their care.

> To measure the impact of training and coaching with the participating child care providers, a Policies and Practices Self-Assessment Questionnaire was developed and mailed out to collect information at two points – at baseline to gain an understanding of providers' policies and practices before participating in CHLA CC training and coaching, and at 6-months follow-up.

A total of 602 center- and home-based child care providers returned self-report baseline surveys (after training but before coaching) and follow-up surveys (after coaching, for those who received coaching). Most surveys (77.9%) were returned by center-based staff, and 22.1% of surveys were returned by licensed Family Child Care providers (FCC or Licensed Home providers). Most providers reported English as their primary language (73.4% English and 26.6% Spanish). Of those who attended the training and returned the survey, 55.0% (331) received at least an initial coaching session and 22.1% (133) received a second coaching session.

Nutrition: Feeding Practices. When reporting on their feeding practices, more family child care providers report serving meals and snacks than center-based staff, particularly morning snack and dinner. There were a number of areas that may have been impacted the most by the training and coaching intervention, resulting in statistically significant increases in programs engaging or making progress in these areas when comparing baseline to follow-up. These areas included:

- Parents receive written nutrition policies upon enrollment.
- Parents are given information about what their children are eating.
- Parents are given information about what their children are offered (menus).
- Children decide which foods they will eat from the foods offered.
- Foods that are served reflect the ethnicity and cultures of the children in the center/home.
- Parents are provided information on child nutrition and healthy eating.

Although these areas showed a statistically significant increase from baseline to follow-up, further intervention may be merited because of the lower percent of providers engaging in these practices at follow-up compared to other feeding practices:

- Children serve themselves from serving dishes at mealtime. (72.0%)
- Special occasions and holidays are celebrated with healthy foods or with non-food treats. (79.3%)

Items that had lowest rates of participants reporting engagement in and high rates of participants stating the item does not apply to their site (even if their site serves infants/toddlers), indicating areas for further intervention include:

- Breastfeeding mothers are provided access to a private area for breastfeeding or pumping with appropriate seating.
- Staff are trained in proper handling and storage of breast milk.
- Parents are aware that they could leave breast milk at the child care site for their child.

Nutrition: Food Served. There was positive change in the foods served with 20% to 62% providers reporting positive change in the foods they serve in their programs. The greatest amount of change was reported in serving flavored or sweetened milk with 62.3% of participants reporting that they serve less of it at follow-up than at baseline . With about 23% of providers still serving processed meats 2-3 times a week or more, this may be an area to consider for intervention.

Physical Activity There were relatively high rates of participants who reported recommended amounts of structured and unstructured play with children and staff participating in physical activities with the children (over 90% at follow-up). These areas seem to be a strength for these programs. Fewer participants reported sending information home to parents about the physical activities their children engage in during the day or information to encourage physical activity at home (less than 85% at both baseline and follow-up). The least common form of information going out to parents was a written physical activity policy at enrollment (less than 60% at baseline and about 70% at follow-up) with center-based providers more likely to report engaging in this practice than family child care providers. Finally, limiting screen time to 30 minutes per week was the area reported by the smallest percentage of participants with less than 60% reporting doing this at their child care setting and approximately one-third reported that it was not applicable to their site (at baseline and follow-up).

Areas that may have been impacted the most by the interventions and showed statistically significant increases in the percentage of participants engaging in the activities from baseline to follow-up include:

- Parents receive written physical activity policy upon enrollment.
- Children have at least 60 minutes of structured or teacher-led, physical activity time (or 30 minutes in a half-day program.
- Information is provided to parents about their child's physical activity while in child care.
- Staff participate in physical activities with children.
- Parents were provided information that encourages physical activity at home.

Preparedness to Change Policies and Practices. Feelings of preparedness or efficacy to change practice were high at both baseline and follow-up ranged from greatest to least in the following order at follow-up:

- Physical activity/playtime practices (94.4%)
- Food and beverage practices (90.5%)
- Creating or improving written guidelines about health (86.6%)
- Screen time practices (82.9%)
- Breastfeeding practices (69.8%)

Group differences were detected in two areas. Spanish-speaking providers were more likely to state that they were prepared to make changes to their breastfeeding practices than English-speaking participants. English-speaking participants were more likely than Spanish-speaking participants to report that they are prepared to make changes in their screen time practices.

Knowledge Change. The percent of participants indicating activities queried about have an effect on children's growth and health was high at both baseline and follow-up with no significant differences in the percent of providers endorsing each activity as influencing children's growth and health between baseline and follow-up. At follow-up, the percent of participants indicating each activity has an effect in a child's growth and health was as follows:

- Eating a variety of healthy foods (95.3%)
- Having active free play (93.8%)
- Drinking beverages with no added sugar (91.6%)
- Doing teacher-led physical activity (87.5%)
- Drinking breast milk as an infant (75.4%)

Results from the **drinking breast milk as an infant** question dovetail with other report findings. Just as lower percentages of participants reported already doing or making progress in breastfeeding practices than other areas, the lowest percent of participants perceived a connection between drinking breast milk as an infant and a child's growth and health.

Challenges. At follow-up, 66.6% of providers reported at least one challenge and close to 30% of participants reported having no challenges in **creating healthy practices or routines** in their child care program. The areas cited most frequently as an area of challenge at follow-up included:

- Lack of support from parents (34.7%)
- Not enough money to make changes (33.4%)
- Not enough equipment to make changes (20.4%)
- Not enough training to make changes (20.3%)

There were no significant changes in the percent of providers reporting each challenge from baseline to follow-up. However, when examining the mean number of challenges reported by provider, there were differences by site type and by coaching status such that center-based participants reported a greater number of challenges at follow-up than family child care providers, and participants who received coaching reported a greater number of challenges than participants who did not receive any coaching at follow-up. It is possible that participants experiencing greater challenges were more likely to seek out coaching, thus self-selecting into the coaching group, than participants who did not experience as many challenges at baseline.

At follow-up, 46.6% of participants identified at least one challenge and 37.0% of participants reported no challenges in creating **written rules or guidelines** in their child care program. At follow-up the most frequently cited challenges were:

- Lack of support from parents (21.6%)
- Not enough time to write rules or guidelines (17.9%)
- Not enough training to make changes (16.8%)

Furthermore, there were no statistically significant differences in individual items from baseline to follow-up. However, when summed at both baseline and follow-up, center-based participants reported more challenges in this area at follow-up than family child care providers, and participants who received CHLA CC coaching reported more challenges at follow-up than participants who did not receive coaching.

When asked what resource could help them the most in their efforts to create a healthy child care environment, more materials for parents and more printed information were the options

most frequently selected by participants. Given that providers perceive lack of support from parents as challenges in creating healthy practices or routines and creating written rules or guidelines, it is possible that providers are seeking resources to address the challenge of lack of parental support in order to implement positive changes in their child care programs.

Economics and Marketing. One third (33.1%) of participants indicated that creating healthy practices or guidelines in their programs increased their costs, while 5.5% reported that creating healthy practices and guidelines decreased their costs. However, only 12.4% charge more or are considering charging more. Specific factors leading to increased costs are not known but worth exploring to help providers implement and sustain healthy practices and policies in their programs without an added burden of cost.

About a fifth of participants used program information in their marketing and over three quarters shared rules and guidelines with parents. The majority (73.0%) reported that parents were generally positive about the rules and guidelines for healthy practices of their program and 35.1% saw an increased interest in their child care program.

Recommendations for the future are included in the Conclusions and Recommendations section of this report.

Introduction and Background

The dire consequences of childhood obesity are evident given that children who are obese have a greater risk of:

- High blood pressure and high cholesterol, risk factors for cardiovascular disease.[i]
- Impaired glucose tolerance, insulin resistance, and type 2 diabetes.[ii]
- Breathing problems, such as sleep apnea, and asthma.[iii iv]
- Joint problems and musculoskeletal discomfort.[v vi]
- Fatty liver disease, gallstones, and gastro-esophageal reflux (i.e., heartburn).[vii viii]
- Psychological stress such as depression, behavioral problems, and issues in school. [ix x xi]
- Low self-esteem and low self-reported quality of life.[xii xiii xiv xv]
- Impaired social, physical, and emotional functioning.[xvi]

These health risks continue into adulthood resulting in negative consequences for the individual and their family, as well as economically. Nationally, excess weight in childhood is estimated to result in $3 billion per year in medical costs.[xvii]

Much of the research conducted with children focuses on the school age years, with less information available on the 0-5 year age group. However, in recent years there has been an increase in understanding that to prevent long-term negative effects of obesity more attention needs to be focused on the earliest years, well before children enter elementary school. The 0-5 year age span is a critical time for developing healthy food preferences and motor skills.[xviii] Locally 19% of 3- and 4-year-old children in the WIC (Women Infants and Children) program in Los Angeles County were overweight in 2014.[xix] This data source also shows that Hispanic children have higher obesity rates than children of other ethnic groups (21.1% in 2014).[xx]

According to the Center for Disease Control and Prevention, one of the many community environmental factors that contributes to childhood obesity is variation in licensing regulations for child care. Given that nearly 11 million children under age 5 in the US[xxi] and 36.5% of children 0-5 in Los Angeles County (312,000) are in some form of regular child care arrangement,[xxii] the child care environment may be a key setting in which to provide intervention. In one review of state regulations it was found that most preschoolers may consume half or more of their recommended caloric intake in child care settings.[xxiii] Additionally, 30.8% of preschoolers watch more than two hours of television per day, increasing their likelihood to become overweight or obese.[xxiv] As a result, there is a lot of potential for intervention in these early years.

Given these statistics, the child care setting is obviously a pivotal context for establishing either healthy or unhealthy habits in young children. However, an observational study released in 2008 revealed deficiencies in the quality of the nutritional environment in licensed child care settings in Los Angeles County.[xxv] Two levers that can foster positive change in the healthy environments in child care settings include policy change and education for the child care workforce.

Recent Policy Environment

Recent political movements have focused attention on the importance of healthy habits in the early years and could move the needle toward higher quality nutritional and physical activity environments in child care settings. On the national stage, First Lady Michelle Obama has brought attention to the importance of nutrition and physical activity through her *Let's Move* and *Let's Move Child Care* Initiatives. In addition, with the recent reauthorization of the Child Care and Development Block Grant at the national level, there is increased recognition of the importance of nutrition and physical activity as seen in the following excerpts:

SEC. 658E (c) I (ii) "[States] may include requirements relating to nutrition, access to physical activity, or any other subject area determined by the State to be necessary to promote child development or to protect children's health and safety."

SEC. 658G. (b) Activities.—Funds reserved under subsection (a) shall be used to carry out no less than one of the following activities that will improve the quality of child care services provided in the State:
(1) Supporting the training and professional development of the child care workforce through activities such as those included under section 658E(c)(2)(G), in addition to— (A) offering training and professional development opportunities for child care providers that relate to the use of scientifically-based, developmentally-appropriate and age-appropriate strategies to promote the social, emotional, physical, and cognitive development of children, including those related to nutrition and physical activity, and offering specialized training for child care providers caring for those populations prioritized in section 658E(c)(2)(Q) [low-income], and children with disabilities;
(9) Supporting State or local efforts to develop or adopt high-quality program standards relating to health, mental health, nutrition, physical activity, and physical development.

Unfortunately, the language of "may" rather than "shall" is leaving much of this as optional to states to incorporate in their state plan at various levels. This will likely result in differences in nutrition and physical activity policies across states. More locally in California, AB 2084 (2010) created more stringent requirement for beverages served in child care settings and AB 290

(2013) requires all new subsidized child care providers to complete one hour of nutrition education. Other legislation was proposed but did not pass. AB 598 included a component that would have resulted in the monitoring of select family child care homes to ensure certain requirements were met including, but not limited to basic health, nutrition, and quality standards.

To help this movement, there are resources available to guide programs in developing nutrition and physical activity interventions in preschool settings. The Robert Wood Johnson Foundation published a report on obesity prevention programs in these settings.[xxvi] This review of multiple intervention programs found that successful strategies include integrating opportunities for physical activity in the child care setting, modifying food service practices, providing nutrition education, and engaging parents through activities and newsletters. These activities have been designed into a local program in Los Angeles County referred to as Choose Health LA Child Care (CHLA CC).

Educating the Child Care Workforce

Funded by First 5 LA, The Los Angeles County Department of Public Health's Early Childhood Obesity Prevention Initiative (ECOPI) has three program components - Choose Health LA Kids, Choose Health LA Moms, and Choose Health LA Child Care- intended to focus on different environments that influence children. These community-based programs are designed to support First 5 LA's Strategic Plan Goal for children to maintain a healthy weight. The Choose Health LA Child Care program was designed to: 1) Reduce obesity among preschool age children, 2) Improve nutrition and increase physical activity in child care settings, 3) Identify barriers that child care providers face in their efforts to promote good nutrition and active play, and 4) Promote development of healthy habits early in life. To accomplish this, Public Health's mission is to reach as many people as possible with a brief but impactful message as opposed to reaching a smaller number of people with a more intensive program.

The following are program targets were specified for the life of the program (October 2013 to June 2016):

- Hold 462 training sessions for child care providers
- Train 5,544 child care providers
- Coach 2,212 child care providers in one or two sessions
- Provide print materials and information to:
    - 4,704 licensed child care providers
    - 3,843 license-exempt child care providers
    - 13,474 parents

- Hold events focused on nutrition and physical activity for 4,050 parents

The California Resource and Referral Network published data from 2014 on child care in Los Angeles County that shows 266,676 licensed spaces in 10,161 licensed sites (centers and family child care homes). These numbers suggest an average of 26 children per site, resulting in 143,000 children experiencing a child care setting that was impacted by this program over time. Given that children enroll and dis-enroll due to aging out and moving to kindergarten, moving, new children being born and needing care, etc., there is a continual flow of children in and out of these programs. Because of this continual flow, many more children will benefit from the changes to the child care provider's knowledge, policies and practices.

Who are the providers reached and what methods were implemented?

This program was intended to reach staff who work in licensed child care centers, licensed family child care providers, and license-exempt child care providers. Complete definitions of these types of child care can be found in Appendix A. The two-hour training sessions provided by CHLA CC focused on the following topics: breastfeeding, food and drinks, physical activity, screen time, and child care environment and policy. This report focuses on results of the CHLA CC Self-Assessment Policies and Practices Questionnaire, which measures the impact of training and coaching on child care providers' policies and practices related to health and nutrition.

Dissemination of the Policies and Practices Survey began in September 2014 to collect baseline data from child care providers who recently attended a CHLA CC training session. Included in the packet was a self-addressed pre-paid return envelope, which encouraged participation in the survey. Surveys continued to be mailed out monthly throughout the fiscal year to collect information at two points – baseline and 4-6 months after participating in the program.

Baseline surveys were mailed after the training session because providers do not RSVP for trainings (as is the normal practice in the community-based training sessions), thus making it difficult to mail the survey prior to the training. As a result, the survey was not a true baseline (taken prior to any program participation). However, the surveys were mailed to participants within 40 days of the training session and participants were asked to think back to their knowledge and practices prior to the training session. The return rate was about 32% for the baseline surveys and roughly 72% (of those who returned a baseline survey) for the follow-up surveys. The surveys were provided in English and Spanish. Providers who returned a completed survey were mailed a $10 Target Gift Card and encouraged to purchase health-related items for their site. Participants were informed that their participation was completely voluntary and there were no consequences if they did not complete the survey. See Appendices B1 and B2, respectively for the baseline and follow-up surveys in English. Please contact the

author for the Spanish versions. See Appendix B3 for methods of ensuring participant confidentiality.

Coaches connected with participants who attended the training in a variety of different ways in order to provide one-on-one coaching services. Some coaches signed participants up for a coaching session automatically after attending a training, while others used lists from the training sessions to call participants to offer coaching services some time after the training. Participants were offered one or two coaching visits to develop goals around nutrition, physical activity, breastfeeding, screen time, or create policies in these areas. During these one-on-one sessions the coaches guided the participant and offered resources and expertise to achieve the participants' goals.

During life of the program, 611 training sessions were held, surpassing the goal of 462, and 5,853 participants were trained, surpassing the goal of 5,544. Of those trained, 2,323 (reaching the goal of 40% of those trained) also received at least one one-on-one coaching services, surpassing the goal of 2,212. 753 of those who received a first coaching visit also received a second coaching visit.

The targeted timeframe for distribution of the survey was from 8/1/2014 to 2/29/2016 for the baseline survey. This time frame encompassed the full implementation of the training session and survey (8/1/14). The endpoint was prior to the end of the program, allowing for time to organize, complete data entry and cleaning (2/29/16). This end date was also selected as a result of reaching the goal number of matched survey baseline and follow-up pairs. The number of participants trained in this window was 3,618.

A total of 2,694 surveys were mailed to eligible participants (an average of 40 days after the participant attended a CHLA CC training session). A total of 924 (26%) trainees were ineligible to receive a survey because they did not meet the eligibility criteria developed by the program and research leadership. Eligibility criteria included: 1) participants trained within the last calendar month, 2) those employed in a center, family child care home, or license-exempt caregiver (excluding those in support roles of child care and students), 3) those whose primary language was English or Spanish (due to the survey language availability), and 4) those who provided complete mailing address information. Due to the very low number of license-exempt caregivers, this group was not included in the final analyses. Of the 2,694 surveys mailed 874 returned a baseline survey (32% response rate). A small number of these (14 of the 874) returned their baseline survey beyond the time to be included in the analyses (4-6 months after training). As a result, 860 follow-up surveys were mailed and 617 were returned for a 72% return rate (215 participants were mailed a second follow-up survey). As a result of the additional follow-up survey mailing, a total of 640 providers returned both the baseline and the

follow-up survey. However 602 of these providers returned both the baseline and the follow-up surveys with enough data to match the baseline to the follow-up responses. The analyses in this report are based on this group of 602 providers.

The Choose Health LA Child Care training curriculum was modified and adapted from a pilot study conducted by DPH a few years ago and incorporates evidence-based guidelines and curricula - such as ones developed by Nemours- recommendations from the Institutes of Medicine (IOM), and standards set by the USDA. The curriculum also includes State standards such as the Child Care Beverage Law, which requires child care providers to serve low-fat or non-fat milk to children over two years old, eliminate sugar sweetened beverages, and provide water to children throughout the day. The curriculum is comprehensive covering the following five main topic areas: breastfeeding, food and beverages, physical activity, screen time, and policy/environment.

The Policies and Practices survey tool was modified and adapted from the CHOICE Self-Assessment for Child Care Providers[xxvii], developed by the Contra Costa Child Care Council and NAP SACC, created by the University of North Carolina at Chapel Hill. Discussions with the developers of the CHOICE tool revealed that many users of the tool conduct an item-by-item analysis. Discussions are currently underway with developers and other users regarding the methods used in this report. Methods for data analysis are briefly described in the following sections. Given the categorical and ordinal nature of the data, standard inferential statistics such as t-test are not appropriate. Most of the analyses include frequencies and where relevant chi-squares or odds ratios for group comparisons. The internal group designing the survey also took into consideration the information covered in the curriculum to ensure the survey aligned well with what child care providers learned during the workshops. The group designing the survey included staff from Los Angeles County Department of Public Health, evaluators from the Child Care Resource Center and the Sarah Samuels Center for Public Health Research and Evaluation, and program staff from the child care sector (Child Care Alliance of Los Angeles and Child Care Resource Center).

Who are the study participants and children and what is the general nutritional environment?

Most of the surveys (77.9%) were returned by center-based staff with 22.1% of surveys returned by Family Child Care providers (FCC). Most providers reported English as their primary language (73.4% English and 26.6% Spanish). Of those who returned the survey 55.0% (331) received at least an initial coaching session and 22.1% (133) received a second coaching session.

The greatest percentage of providers received coaching in physical activity at both coaching sessions as seen in Table 1.

Table 1. Percent Goal Type in Each Coaching Session

Goal Type	Coaching Session 1 (n=331)	Coaching Session 2 (n=133)
Nutrition	38.7%	37.6%
Physical Activity	59.5%	61.7%
Other	1.8%	0.8%

Table 2 illustrates one of the main differences between center-based and home-based child care. In centers there are classrooms devoted to single age groups and infant care is expensive to provide and is therefore less available in centers than in homes. In a home environment there is opportunity to care for multiple age groups within the same home. As indicated in Table 2, large percentages of licensed homes served children under 2 years old, 2-5 year olds and children 6 years or older. However, only a third of center-based programs served children under 2 years old and less than a quarter served children 6 years or older. The percentages in Table 2 sum to over 100% because programs serve more than one age group. Given licensed homes' higher rates of serving infants and toddlers under 2 years of age, any program designed to impact children at the youngest ages should include family child care homes.

Table 2. Percentage of Licensed Centers and Homes That Serve Each Age Group

	Full Sample n=594		Licensed Centers n=465		Licensed Homes n=129	
Age Group Served	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up
Under 2 Years Old	32.9%	33.4%	21.7%	22.2%	73.4%	73.6%
2-5 Years Old	93.4%	93.4%	92.9%	93.3%	95.3%	93.8%
6 Years or Older	24.5%	23.1%	12.7%	10.7%	67.2%	67.4%

As seen in Table 3, Licensed Homes served a greater diversity of age groups with greater percentages of family child care providers reporting serving more than one age group than providers in Licensed Centers. Conversely, a greater percentage of Licensed Centers served one single age group compared to Licensed Homes.

Table 3. Percentage of Licensed Centers and Homes That Serve One or Multiple Age Groups

	Full Sample n=593		Licensed Centers n=465		Licensed Homes n= 129	
Age Group Served	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up
One Age Group	64.1%	65.5%	77.4%	78.9%	15.6%	17.8%
Two Age Groups	21.1%	19.0%	17.8%	16.1%	32.8%	29.5%
Three Age Groups	14.8%	15.4%	4.7%	5.0%	51.6%	52.7%

More family child care providers reported serving meals and snacks than center-based staff as seen in Table 4. In general, private centers (those not funded through direct contracts with the California Department of Education or through Head Start) often require parents to pack meals for their children compared to family child care providers. This is particularly evident for morning snack and dinner in the sample below. Additionally, centers often close by 6:00 PM while some family child care homes are open late and/or on weekends to serve parents who work non-traditional hours. In fact, only 3% of child care centers in Los Angeles County offer evening, weekend or overnight care compared to 56% of licensed family child care homes.[xxviii]

Table 4. Percent of Child Care Settings That Serve Meals and Snacks

	Full Sample n=602		Licensed Centers n=469		Licensed Homes n=133	
Meal/Snack Served	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up
Breakfast	79.0%	79.6%	77.1%	76.8%	86.3%	89.5%
Morning Snack	48.0%	49.0%	40.3%	42.0%	75.6%	73.7%
Lunch	84.0%	83.7%	81.9%	81.0%	91.6%	93.2%
Afternoon Snack	92.2%	91.7%	93.0%	91.9%	89.3%	91.0%
Dinner	18.3%	16.4%	4.7%	3.8%	67.2%	60.9%
No Food is Served	2.0%	1.7%	1.3%	1.5%	4.6%	2.3%

Nutrition

Feeding practices: What is the general picture and does coaching make a difference? Does it differ by care type?

The following set of results are based on questions that asked participants to select whether they were "*Already Doing," "Making Progress," "Planning to Do," "Not Planning to Do"* a given practice at their care site. Participants were also given the option of "*Does Not Apply to My Site.*" Participants who answered an item with "*Already Doing"* and *"Making Progress"* represent the "*Doing*" category in Figure 1. Those who selected *"Planning to Do"* and *"Not*

Planning to Do" represent the *"Not Doing"* category, and those who answered "*Does Not Apply to My Site*" are reported as is. These categories were collapsed in this manner because many of the cells would otherwise have frequencies of less than 5% and therefore would violate statistical assumptions, preventing the use of tests to evaluate group differences. This method of collapsing categories was used in all analyses presented in this report.

Based on a set of research questions, analyses were conducted to explore if baseline and follow-up responses differed. Tests to explore differences were done using chi-square analyses unless assumptions for chi-square analyses were violated and then Fisher's Exact Tests were conducted in those instances. Additionally, group differences were tested to determine if site type (center-based or home-based), goal type (nutrition or physical activity), or coaching/no coaching was related to the percentage of participants who reported doing/not doing these practices at baseline and follow-up. Percentages of participants doing/not doing/does not apply are presented.

Figures 1 and 2 show the percent of child care providers engaging in each nutrition practice and/or policy during baseline and follow-up. To facilitate referencing the items on the baseline and follow-up survey, the item number corresponding to each area is indicated in parentheses to the left of the item description on the graph. An asterisk (*) denotes items for which there were significant differences in providers engaging in the practice or policy between baseline and follow-up. As seen in both figures, large percentages of child care providers and teachers are making progress or already doing the following with greater than 90% reported making progress or already doing these at both baseline and follow-up:

- Parents are given information about what their children are eating.
- Parents are given information about what their children are offered (menus).
- Meals and snacks are scheduled at a consistent time each day.
- Mealtimes are relaxed, calm, and with shared conversation.
- Food is served in a form that young children could eat without choking.
- Adults sit with children at mealtime.
- Drinking water is feely available throughout the day.

These areas could have already been in practice prior to the CHLA CC program, or the participants could have learned these from the CHLA CC training they attended. Although the instructions on the survey asked participants to think about their child care program prior to the training and answer questions about their program before the training, it is possible that their knowledge at the time of completing the survey (after participating in the training) may have influenced their perception of their program prior to the training. It was not logistically

possible for providers to complete the survey prior to the participating in the training due to the length of the survey as there was already a good deal of time devoted to paperwork during the training.

Figure 1. Nutrition and Feeding Practices at Baseline and Follow-Up Items 1 through 10

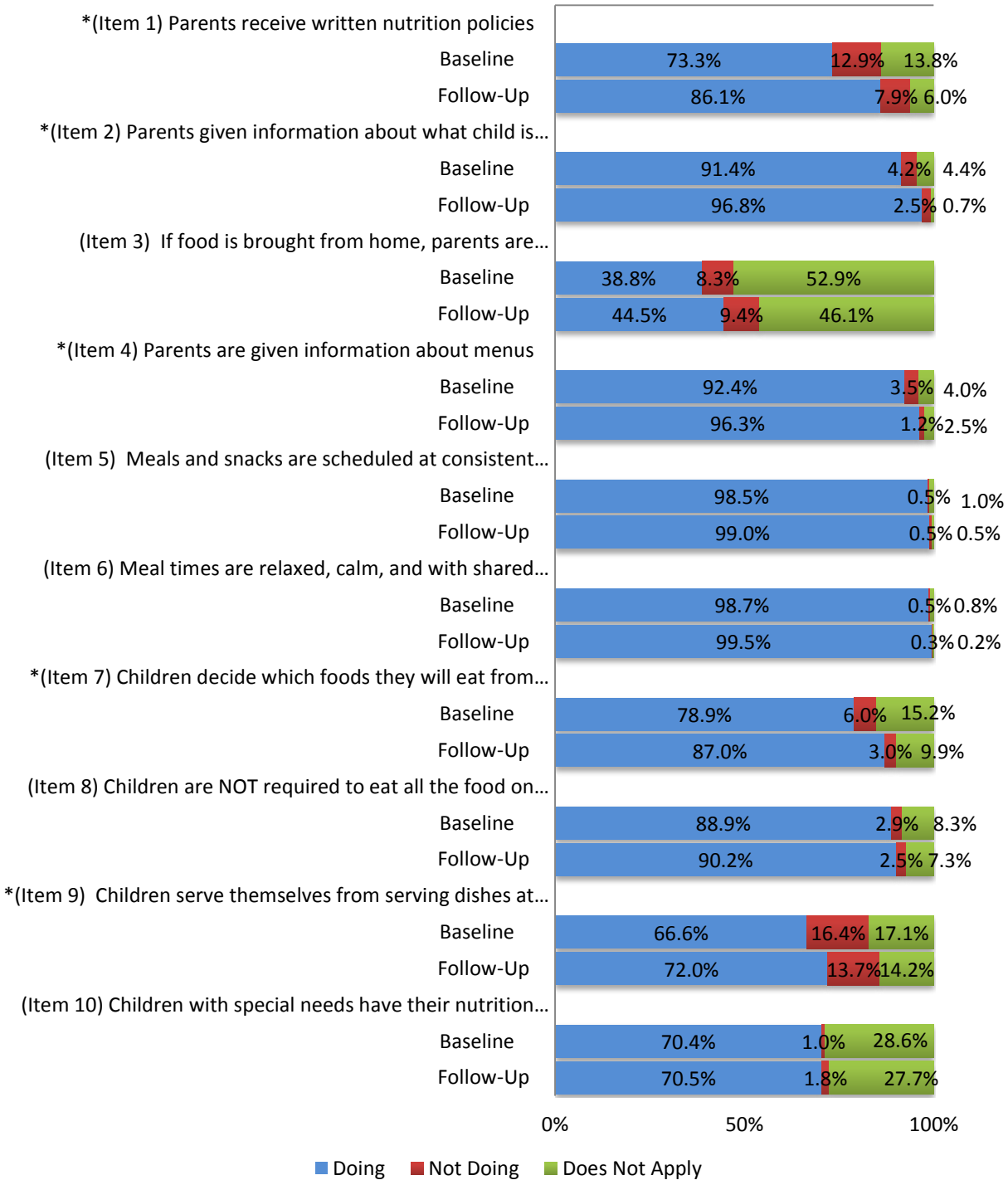
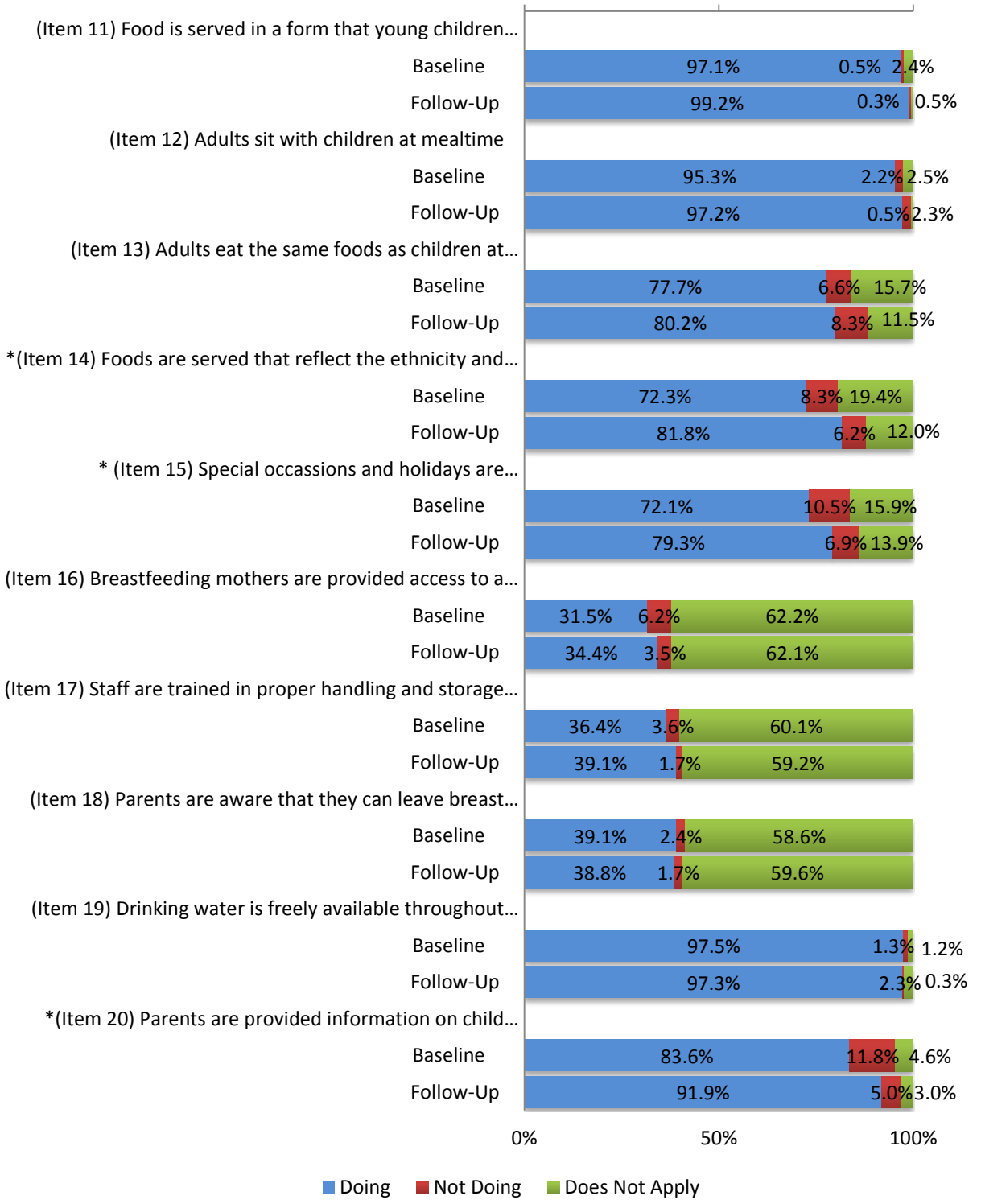


Figure 2. Nutrition and Feeding Practices at Baseline and Follow-Up Items 11 through 20



Between 70% and 89% of child care providers and teachers are making progress or already doing the following at follow-up:

- Parents receive written nutrition policies.
- Children decide which foods they will eat form the food served.
- Children serve themselves from serving dishes at mealtime.
- Children with special needs have their nutrition needs met.
- Adults eat the same foods as children at mealtime.
- Foods that are served reflect the ethnicity and the cultures of the children in the center/home.
- Special occasions and holidays are celebrated with healthy foods or non-food treats.

The items which had the smallest percentages of providers and teachers reporting already making progress or doing the activity at follow-up were also the areas that had the greatest percentages of participants reporting that those items did not apply to their programs. Items with less than 45% of participants doing at follow-up include:

- If food is brought from home, parents are provided with guidelines.
- Breastfeeding mothers are provided access to a private area for breastfeeding or pumping with appropriate seating.
- Staff are trained in proper handling and storage of breast milk.
- Parents are aware that they could leave breast milk at the child care site for their child.

There were items providers did not see as relevant to their programs. Compared with other survey items the following had slightly larger percentages of participants selecting *"Does not apply to my site"* at both baseline and follow-up (10% to approximately 50%):

- Children serve themselves from serving dishes at mealtime.
- Children with special needs have their nutrition need taken into account.
- Adults eat the same foods as children at mealtime.
- Foods are served that reflect the ethnicity and cultures of the children in the center/home.
- Special occasions and holidays are celebrated with healthy foods or with non-food treats.

Children serving themselves from dishes and adults eating the same foods as children at mealtime would not be applicable in programs where parents take food for their children into the program. Furthermore, those programs might also indicate that serving food that reflected the ethnicity and cultures of the children in the center or home does not apply to their program

if they do not serve food and/or parents bring in food. In regards to adults eating the same food as children at mealtime, it is possible that because the food program does not pay for staff meals, providers may not see this question as relevant to them. The large percentage of programs indicating that nutrition needs of children with special needs are taken into account may not be serving children with special needs and this item would be not applicable to their site.

Large percentages of participants (50% or more) reported that the following items did not apply to their site:

- Breastfeeding mothers are provided access to a private area for breastfeeding or pumping with appropriate seating.
- Staff are trained in proper handling and storage of breast milk.
- Parents are aware that they could leave breast milk at the child care site for their child.

This result may be reflective of the sample of programs who responded to this survey. About 33% of programs responding to the survey serve children 0-2 years old, which is in line with the 34.4% to 39.1% of programs who indicated they are *"Doing"* the activities stated above. It is possible that providers who do not currently serve children younger than 2 years perceive these items as irrelevant to them. Nevertheless, given the importance of breastfeeding to the child's development, this may be an area for further intervention.

Findings from this survey are not unique to this sample. A recent study in Philadelphia conducted a survey of child care centers and found that although a very high percentage of centers (95%) would not feed an infant anything other than breast milk, only 40% of centers surveyed provided training for their staff on how to prepare or store human milk. [xxix] In addition, a needs assessment of child care providers' knowledge, attitudes and behaviors on infant feeding practices, specifically breastfeeding indicated that infant room teachers and directors reported low knowledge on ways to store breast milk and formula.[xxx]

Items which showed a significant increase in the percent of providers *"Doing" the* activity from baseline to follow-up were:

- Parents receive written nutrition policies upon enrollment.
- Parents are given information about what their children are eating.
- Parents are given information about what their children are offered (menus).
- Children decide which foods they will eat from the foods offered.
- Children serve themselves from serving dishes at mealtime.

- Foods that are served reflect the ethnicity and cultures of the children in the center/home.
- Special occasions and holidays are celebrated with healthy food or with non-food treats.
- Parents are provided information on child nutrition and healthy eating.

Specifically, participants were more likely to be providing written nutrition policies to parents at their enrollment at follow-up (92.6%) than at baseline (85.2%), McNemar p <.001 (n = 485). In addition, of the 72 participants *"Not Doing"* this at baseline, 54 (75.5%) reported they were doing this at follow-up. More providers reported giving parents information about what their child are eating at follow-up (98.0%) than at baseline (95.6%), McNemar p=.026 (n=564). Of the 25 providers *"Not Doing"* this at baseline, 24 (96.0%) indicated that they were *"Doing"* this at follow-up. There was also a significant change in the percent of providers reporting parents are given information about what their children are offered (menus) from baseline (96.6%) to follow-up (98.7%), McNemar p =.031 (n=561). Of the 19 providers who indicated they were *"Not Doing"* this at baseline, all 19 (100%) indicated they were *"Doing"* this at follow-up. More providers reported that children decide which foods they eat from the foods offered at follow-up (97.4%) than at baseline (93.1%), McNemar p=.002 (n=465). Out of the 32 providers who indicated they were "not doing" this at baseline, 28 (87.5%) reported they were doing this at follow-up. More providers reported that children serve themselves from serving dishes at mealtime at follow-up (87.3%) than at baseline (82.0%), McNemar p=.008 (n=456). Specifically, out of 82 providers who reported *"Not Doing"* this at baseline, 49 (59.8%) indicated they were doing this at follow-up. There was also change in the percent of providers who indicated foods are served that reflect the ethnicity and cultures of the children in the center/home from baseline (90.0%) to follow-up (94.3%), McNemar p=.01 (n=442). Of the 44 providers who indicated they were *"Not Doing"* this at baseline, 34 (77.3%) reported they were *"Doing"* this at follow-up. There was also a positive change in the practice of celebrating special occasions and holidays with healthy food and non-food treats such that more providers reported doing this at follow-up (92.5%) than at baseline (86.7%), McNemar p=.003 (n=453). Specifically, of the 60 providers who indicated they were *"Not Doing"* this at baseline, 48 (80.0%) indicated they were doing this at follow-up.

Some of the areas that showed the greatest room for growth resulted in statistically significant changes from baseline to follow-up. This often occurs when the baseline level is low, leaving room to see significant change. For example, "Parents received written nutrition policies upon enrollment" was low at baseline with 73.5% of providers indicating doing this at baseline. Similarly, "Children serve themselves from serving dishes at mealtime" had one of the lowest percent of participants reporting doing this at baseline (66.6%).

Training, and particularly coaching, may have contributed to these positive changes in child care practices. Items that did not change from baseline to follow-up tended to fall into one of these categories: 1) Items where participants reported high levels at baseline leaving little room for change, 2) Items where participants reported high levels of *"Not Applicable to My Site"* at both baseline and follow-up, and 3) Items related to breastfeeding. Cultural values and norms may play a role in whether or not change is realized in some of these areas. For example, there are many factors including cultural norms, values, and perceived 'hassles' that could prevent child care sites from progressing to provide access and services for breastfeeding mothers. In addition, to dispel stereotype and misinformation about topics such as allowing children to decide what foods to eat may require long-term interventions across multiple domains.

Potential areas to continue to target are: 1) providing parents with guidelines for when food is brought from home. As demonstrated in Figure 1, less than 45% of providers are doing this at baseline and follow-up. While this low percent is in part due to the high percentage that indicated this item did not apply to their program, this was an area that showed no significant change in providers *"Doing"* from baseline to follow-up. 2) Children serve themselves from serving dishes at mealtime. There was a significant positive change in this area from baseline to follow-up. However, the percent of providers reporting *"Doing"* this is still relatively low at 72%. Furthermore, when looking closely at just the participants who reported "not doing" this at baseline, only 59.8% changes to *"Doing"* at follow-up. All other areas in which positive change was made ranged from a total of 75% to 100% of participants *"Doing"* at follow-up. 3) Special occasions and holidays are celebration with healthy foods or with non-food treats is another area which may merit further attention. While there was a significant difference in percent of providers *"Doing"* this at follow-up compared to baseline, the percent of providers doing this at follow up is still less than 80%.

An examination of differences between site type indicated that there were significant differences in providers reporting *"Doing"* on items at baseline and at follow-up. For a proportion of items showing differences, the difference was only evident at follow-up. However, for other items the differences existed at both baseline and at follow-up. Across all items, more center-based staff than family child care providers reported engaging in the practices. Detailed analyses are included in Appendix C. Differences between site types were as follows:

At baseline only, Fisher's Exact tests revealed that more center-based staff than family child cares providers were doing the following:

- Parents receive written nutrition policies upon enrollment. Center-based participants were 4.43 times more likely than family child care providers to report *"Doing"* this.

- If food is brought from home, parents are provided with guidelines. Center-based participants were 3.34 times more likely than family child care providers to report "Doing" this.
- Parents are given information about what their children are offered (menus). Center-based participants were 5.04 times more likely than family child care providers to report *"Doing"* this.
- Children serve themselves from serving dishes at meal times. Center-based participants were 4.91 times more likely than family child care providers to report *"Doing"* this.
- Breastfeeding mothers are provided access to a private area for breastfeeding or pumping with appropriate seating. Center-based respondents were 2.18 more likely to report *"Doing"* this than family child care providers.

At baseline and follow-up, more center-based staff than family child care providers were doing the following:

- Meals and snacks are scheduled at consistent times each day. Center-based participants were 26.22 times more likely at baseline and 25.87 more likely at follow-up to report *"Doing"* this than family child care participants.
- Children with special needs have their nutrition needs taken into account. Center-based participants were 12.10 times more likely at baseline, and 5.52 at follow-up to be *"Doing"* this than family child care participants.
- Drinking water is freely available throughout the day. Center-based respondents were 9.23 times more likely to report "Doing" this than family child care providers at baseline and, 17.68 times more likely to report "Doing" this at follow-up.

At follow-up only, more centers than family child cares were doing the following:

- Meal times are relaxed, calm, and with shared conversation. Center-based participants were 17.81 times more likely to be *"Doing"* this than family child care participants.
- Adults sit with children at mealtime. Center-based participants were 6.79 times more likely to report *"Doing"* than family child care participants.

While there was a difference between center-based staff and family child care providers on 8 of the items at baseline, the difference persisted only in three of those items at follow-up, indicating a possible closure in gap in policies and practices between the two program types. The difference between the two groups of programs at baseline and similarity at follow-up elucidates the great effect CHLA CC training and coaching may have had on family child care providers.

Food Served: What is the general picture and does coaching make a difference? Does it differ by care type?

Participants were asked about the food served in their programs and frequency in which they serve it (Items 22-27). See Table 5 for a general description of providers' practices in food served at baseline and follow-up. A subsequent table, Table 6, focuses specifically on the movement from less healthy to healthier behavior (positive change).

Table 5. Food served: Frequency of Food Served at Baseline and Follow-Up

Area of Food Served	Frequency Served				
Item 21. 100% fruit juice was offered:	More than 1 time per day	1 time per day	Less than 1 time per day	Never	Does not apply to my site
Baseline	14.2%	34.0%	25.4%	12.1%	14.3%
Follow-Up	14.3%	26.9%	29.3%	13.3%	16.2%
Item 22. Chicken nuggets, fish sticks, hot dogs, corn dogs, bologna or other lunch meat, sausage, or bacon were offered:	1 time per day or more	2-3 times per week	1 time per week or less	Never	Does not apply to my site
Baseline	8.7%	16.7%	41.8%	15.5%	17.2%
Follow-Up	10.4%	12.7%	43.6%	15.3%	18.0%
Item 23. Whole grain bread, oatmeal, whole grain cereal, brown rice, whole wheat tortillas, corn tortillas or other whole grains were offered:	3 times per day or more	2 times per day	1 time per day or less	Never	Does not apply to my site
Baseline	23.2%	33.4%	36.6%	3.1%	3.7%
Follow-Up	24.3%	33.7%	36.9%	1.7%	3.4%
Item 24. Vegetables including fresh, frozen, or canned, were served:	3 times per day or more	2 times per day	1 time per day or less	Never	Does not apply to my site
Baseline	25.6%	31.2%	38.5%	1.2%	3.4%
Follow-Up	29.2%	29.3%	37.9%	1.2%	2.4%
Item 25. Fruit including fresh, canned in water or own juice, frozen, or dried, was served:	3 times per day or more	2 times per day	1 times per day or less	Never	Does not apply to my site
Baseline	33.8%	38.8%	22.7%	1.5%	3.2%
Follow-Up	35.8%	38.6%	22.6%	0.8%	2.2%
Item 26. Unflavored milk or non-dairy alternative served to children aged 2 years and older was:	Whole or regular	2% reduced fat	1% reduced fat or non-fat	Non-dairy alternative	Does not apply to my site
Baseline	12.8%	29.5%	41.4%	4.8%	11.6%
Follow-Up	12.5%	28.0%	45.3%	3.1%	11.1%

Item 27. Flavored or sweetened milk was served:	1 time per day or more	2-3 times per week	1 time per week or less	Never	Does not apply to my site
Baseline	6.4%	2.5%	4.9%	57.1%	29.1%
Follow-Up	6.2%	2.7%	5.4%	54.9%	30.9%

To determine whether providers made positive or negative changes in the food they served from baseline to follow-up, change scores were analyzed. First a numeric value corresponding to each ordinal category was assigned with the healthiest behavior assigned higher numbers. For example, a response of *"Never"* to Item 27 would have been coded as a 3. The highest possible score for each item was a three and the lowest possible score was a zero. All participants who achieved a three at baseline were removed from the analysis on an item-by-item basis as they had no room to improve. Also, only participants who completed both a baseline and follow-up survey were included. A change in the desired direction was categorized as "Positive Change" in Table 6; if the participant provided the exact same response at baseline and follow-up they were categorized as "No Change;" if a participant provided a response in their follow-up which was less desirable than what they selected during the baseline, they were categorized as "Negative Change."

As seen in Table 6, 21% to 62% of providers who had room for growth experienced positive change. The area that showed the greatest amount of positive change was in serving flavored or sweetened milk, which showed the least amount of positive change last year. Specifically, 62.3% of participants showed positive change, serving less flavored or sweetened milk at follow-up. This compares to a 12.9% positive change last year (serving less frequently) from baseline to follow-up. Positive changes were also seen in the other areas (36.0% of participants showed positive change in the serving of fruit, 34.6% of participants showed positive change in the serving of whole grain foods, 32.9% in the serving of vegetables, 26.8% made a positive change in serving of processed meats, 24.9% made positive change in the serving of 100% juice, and 21.6% made positive change in serving unflavored milk or non-dairy alternative to children age 2 and older). Nevertheless, 11% to 18% of participants reported negative change from baseline to follow-up. Why the negative changes are so high is not clear. Is it due to faulty estimations of how often or how much is served, or was there true negative change? This area may merit further exploration.

Table 6. Percent of Participants Who Show Positive, Negative, and No Change from Baseline to Follow-up in Food Served in Their Child Care Program

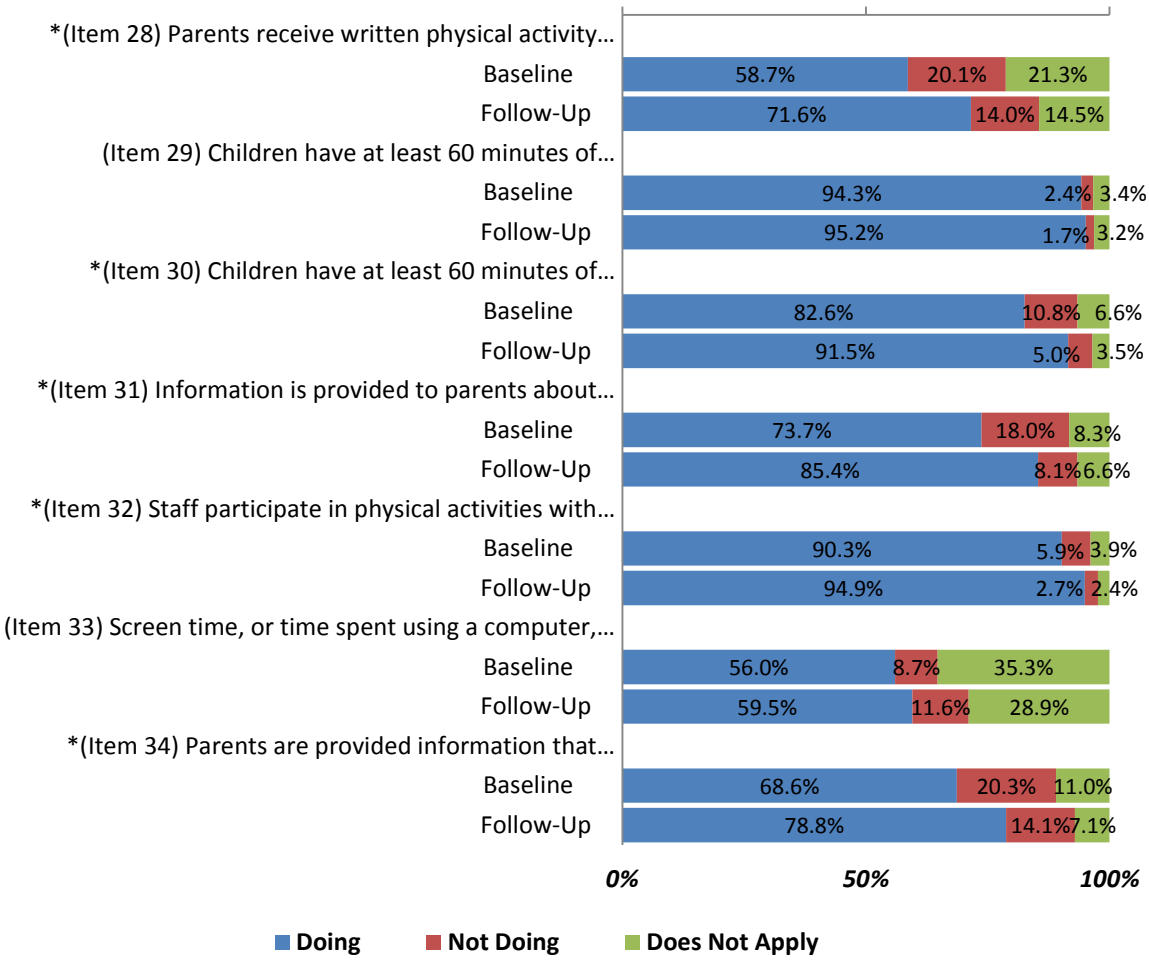
Area of Food Served	Percent of Participants Who Show		
	Positive Change	Negative Change	No Change
Item 21. 100% fruit juice is offered (n=389)	24.9%	16.2%	58.9%
Item 22. Chicken nuggets, fish sticks, hot dogs, corn dogs, bologna, or other lunch meat, sausage, or bacon are offered (n=365)	26.8%	17.3%	55.9%
Item 23. Whole grain bread, oatmeal, whole grain cereal, brown rice, whole wheat tortillas, corn tortillas, or other whole grains are offered (n=416)	34.6%	13.5%	51.9%
Item 24. Vegetables including fresh, frozen, or canned are served (n=407)	32.9%	16.0%	51.1%
Item 25. Fruit including fresh, canned in water or own juice, frozen, or dried, is served (n=367)	36.0%	11.4%	52.3%
Item 26. Unflavored milk or non-dairy alternative served to children age 2 and older (n=436)	21.6%	16.5%	61.9%
Item 27. Flavored or sweetened milk is served (n=61)	62.3%	18.0%	19.7%

Physical Activity

What is the general picture of physical activity in these child care environments and does coaching make a difference? Does it differ by care type?

Questions 28-34 asked participants to select whether they were "*Already Doing," "Making Progress," "Planning to Do," or "Not Planning to Do"* a given practice at their care site. Participants were also given the option of "*Does Not Apply to My Site*." Participants who answered an item with *"Already Doing"* and *"Making Progress"* represent the "*Doing*" category in Figure 3. Those who selected *"Planning to Do"* and *"Not Planning to Do"* represent the *"Not Doing"* category, and those who answered "*Does Not Apply to My Site*" are reported as is.

Figure 3. Physical Activity at Baseline and Follow-Up Items 28 through 34



*Denotes item with statistically significant change between baseline and follow-up.

There were relatively high rates of participants who reported recommended amounts of structured and unstructured play with children and staff participating in physical activities with the children (over 90% at follow-up). These areas seem to be a strength for these programs. Fewer participants reported sending information home to parents about the physical activities their children engage in during the day or information to encourage physical activity at home (less than 85% at both baseline and follow-up). The least common form of information going out to parents was a written physical activity policy at enrollment (less than 60% at baseline

and about 70% at follow-up). It is unclear why 15% of participants felt that a physical activity policy for parents at enrollment was not applicable to their site. Finally, limiting screen time to 30 minutes per week was the area reported by the smallest percentage of participants with less than 60% reporting doing this at their child care setting and approximately one-third reported that it was not applicable to their site (at baseline and follow-up). It is possible that those who report this question was not applicable may not allow any screen time in their site as part of their practices or may not have screen time devices available in their programs, which would be a positive finding. However, we cannot determine that from the survey as it is currently written.

Fisher's Exact Tests were conducted for each question (separately for baseline and follow-up), testing for differences by site (center/home), language, and coaching/no coaching.

There was a significant difference by site type at baseline for one item. Specifically, center-based providers were 9.59 times more likely that family child care providers to indicate that they were *"Already Doing"* or *"Making Progress"* in "parents receive written physical activity policy upon enrollment."

Table 7. Physical Activity: Relationship at Baseline between Site Type and Response to item 28: "Parents receive written physical activity policy upon enrollment."

	Center	Licensed Home
Doing	283 (78.4%)	59 (60.2%)
Not Doing	78 (21.6%)	39 (39.8%)
P < .001, FET (n=459). Odd's ratio = 9.59. Numbers in parentheses indicate column percentages.		

There were also significant changes in participants' physical activity practices and policies from baseline to follow-up. Items which showed significant change in the percent of providers "doing" are:

- Parents receive written physical activity policy upon enrollment.
- Children have at least 60 minutes of structured or teacher-led, physical activity time (or 30 minutes in a half-day program.
- Information is provided to parents about their child's physical activity while in child care.
- Staff participate in physical activities with children.
- Parents were provided information that encourages physical activity at home.

McNemar tests were conducted to evaluate these differences from baseline to follow-up. More participants reported providing parents with written physical activity policies upon enrollment at follow-up (84.6%) than at baseline (74.5%), p <.01 (n=416). Of the 106 participants not doing this at baseline, 65 (61.3%) changed to doing this at follow-up. Additionally, more participants

reported children have at least 60 minutes of structured or teacher-led, physical activity time (or 30 minutes in a half-day program) at follow-up (95.0%) than at baseline (88.4%), p<.001 (n=537). Of the 62 providers who indicated they were not doing this at baseline, 51 (82.3%) indicated they were doing this at follow-up. More participants indicated that information is provided to the parents about their child's physical activity in child care at follow-up (91.4%) than at baseline (80.7%), p<.001 (n=512). Of the 99 who were not doing this at baseline, 74 (74.7%) reported doing this at follow-up. In terms of staff participation in physical activities with children, more providers indicated doing this at follow-up (97.3%) than at baseline (93.9%), p=.004 (n=555). Of the 34 providers who indicated staff were not participating in physical activities with children at baseline 29 (85.3%) indicated doing this at follow-up. Lastly, more providers indicated that parents were provided with information that encourages physical activity at home at follow-up (85.4%) than at baseline (77.0%), p<.001 (n=495). Of the 114 providers who indicated they were not doing this at baseline, 80 (70.2%) indicated they were doing this at follow-up.

One of the items that did not show statistically significant differences between baseline and follow-up was the item that showed the highest percentage of participants engaging in the practice at baseline with 94.3% of participants indicating they had 60 minutes of unstructured play at baseline. Therefore, the lack of significant change may have been to the lack of room for growth such that a majority of participants were already engaging in this practice at baseline. The final item which showed no significant change from baseline to follow-up was limiting screen time – time spent using a computer, smart board, or watching TV up to 30 minutes per week for the children. This is also an item which the largest percent of providers thought did not apply to their program. If the percent of providers who limit screen time for children to 30 minutes per week was low because those who indicated this did not apply are also limiting screen time (e.g. because there are no screen time devices in the program, screen time is unavailable, etc.), then this could be a positive finding. However, given that amount of screen time can be inversely related to the amount of physical activity and/or educational time that is spent by a child in a given day, this may be an area to explore for further intervention. Indeed, the LA County Department of Public Health reports that 74.8% of children 6-23 months watch TV daily and 22.7% of children 2-17 years watch 3 or more hours of TV each day.[xxxi] However, preliminary findings from an analysis of qualitative data indicate that some providers who received CHLA CC coaching are making concerted effort to reduce screen time by increasing physical activity.

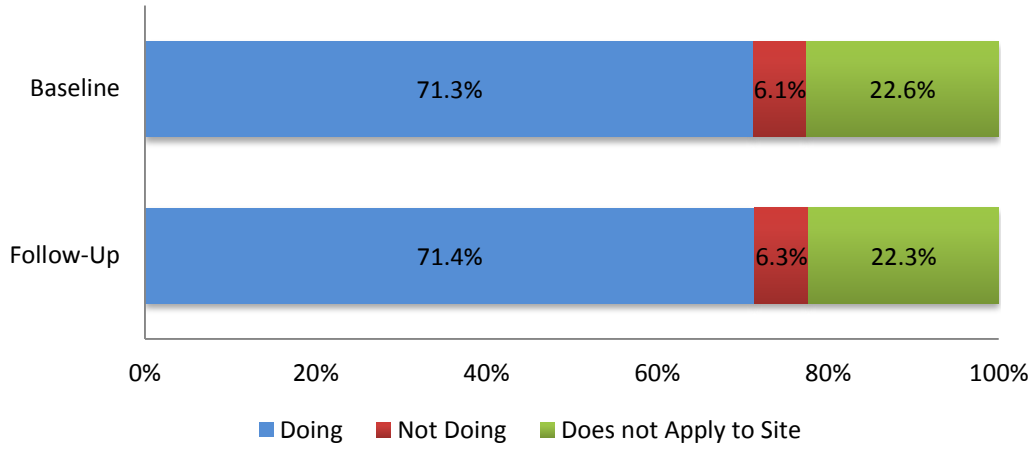
CACFP Participation

What is the general picture of participation in CACFP at baseline and follow-up?

Question 35 asked participants to select whether they were "*Already Doing," "Making Progress," "Planning to Do," or "Not Planning to Do"* a federal food program (CACFP) at their site. Participants were also given the option of "*Does Not Apply to My Site*". In Figure 1, participants who answered an item with "*Already Doing"* and *"Making Progress"* represent the "*Doing*" category, those who selected *"Planning to Do"* and *"Not Planning to Do"* represent the *"Not Doing"* category, and those who answered "*Does Not Apply to My Site*" are reported as is. To help in referencing the figures with the survey questions, the question number relevant to the figure is in parentheses at the end of the figure title. This was done throughout the report.

Approximately three-fourths of providers report their site participates in CACFP (Child and Adult Care Food Program) at both baseline and follow-up. There were no significant group differences or change between baseline and follow-up. There are a number of providers (almost one-fifth at baseline and follow-up) who reported that participation in CACFP does not apply to their site. While it is not clear why participants indicated that this question does not apply to their site, this survey does not ask participants to report whether they have been part of the CACFP program in the past. It is possible that participants may have been part of CACFP in the past but are no longer, and therefore selected *"Does Not Apply."* Furthermore, while the program is identified as the Food Program on the survey, it is also possible that some participants were not familiar with the program and therefore did not see CACFP as relevant to them. Anecdotally, qualitative notes regarding coaching sessions indicate that some of the participants in CHLA CC, while licensed, were new to the profession. Therefore, there may be a subset of participants not yet familiar with the program. Finally, a report on the status of the CACFP program in Los Angeles County from 2010 indicated that there misconceptions around CACFP program eligibility such that some licensed family home providers reported erroneous information about the program including inaccurate perceptions of eligibility requirements.[xxxii] If participants knew about the program but did not think they were eligible, it is possible that they did not see CACFP as relevant to their program. Given the link between CACFP participation and more nutritious foods and beverages in child care, further exploration is merited.[xxxiii]

Figure 4. CACFP Participation at Baseline and Follow-Up
Item 35



Self-Efficacy

How prepared do participants feel to change their health and physical activity practices at their child care site and does coaching make a difference? Does it differ by care type?

Questions 36a-36e asked participants "How prepared do you feel to make changes in the following areas at your child care site?" along five practices (*Breastfeeding practices, Food and beverage practices, Physical activity/playtime practices, Screen time practices, Creating or improving written guidelines about health for your child care*) with the categorical options of "*Very Prepared,*" "*Somewhat Prepared,*" "*Not Prepared,*" or "*Not Sure.*"

As seen in Figure 5, feelings of preparedness or efficacy to change practices ranged from greatest to least in the following order at follow-up, indicated by those who reported being somewhat prepared or very prepared to make changes in each of these areas:

- Physical activity/playtime practices (94.4%)
- Food and beverage practices (90.5%)
- Creating or improving written guidelines about health (86.6%)
- Screen time practices (82.9%)
- Breastfeeding practices (69.8%)

The largest percentage of providers reporting they were not prepared or not sure were in screen time practices and breastfeeding practices. These findings may be related to earlier

findings in the report in which large percentages of providers indicated screen time and breastfeeding policies and practices did not apply to their program. Because the policy does not apply to their program, a provider may not have received training or be aware of best practices for that area of care.

As indicated in Tables 8 and 9, there were significant differences by language between English- and Spanish-speaking providers on two items at follow-up:

- Spanish speaking providers were 1.62 times more likely to indicate feeling very or somewhat prepared to make changes in breast feeding practices at their child care site at follow-up than English-speaking providers.
- English-speaking providers were 2.24 times more likely to indicate feeling somewhat or very prepared to make changes in screen time practices at their child care site at follow-up.

The higher level of preparedness to make changes in breastfeeding practices Spanish-speaking participants reported may be due to providers' own cultural norms and not necessarily training she may have received through the ECE field. A recent study published in Pediatrics examining racial and ethnic disparities in breastfeeding found that having a family history of breastfeeding mediated racial / ethnic gaps in breastfeeding outcomes, and that Latinas were more likely to have reported a familial history of breastfeeding[xxxiv]. As such, Spanish-speaking providers may also feel a greater sense of preparedness to apply that to their program. In terms of the disparity in level of preparedness between English- and Spanish-speaking participants regarding screen time practices, this may also be related to the providers' own level of experience with technology. A county-wide study in Los Angeles of early childhood educators in a professional development coaching program demonstrated that Spanish-speaking participants show lower levels of computer and technology literacy than English-speaking participants.[xxxv] Lower levels of computer and technology literacy skills may contribute to providers' feelings of preparedness in managing screen time practices.

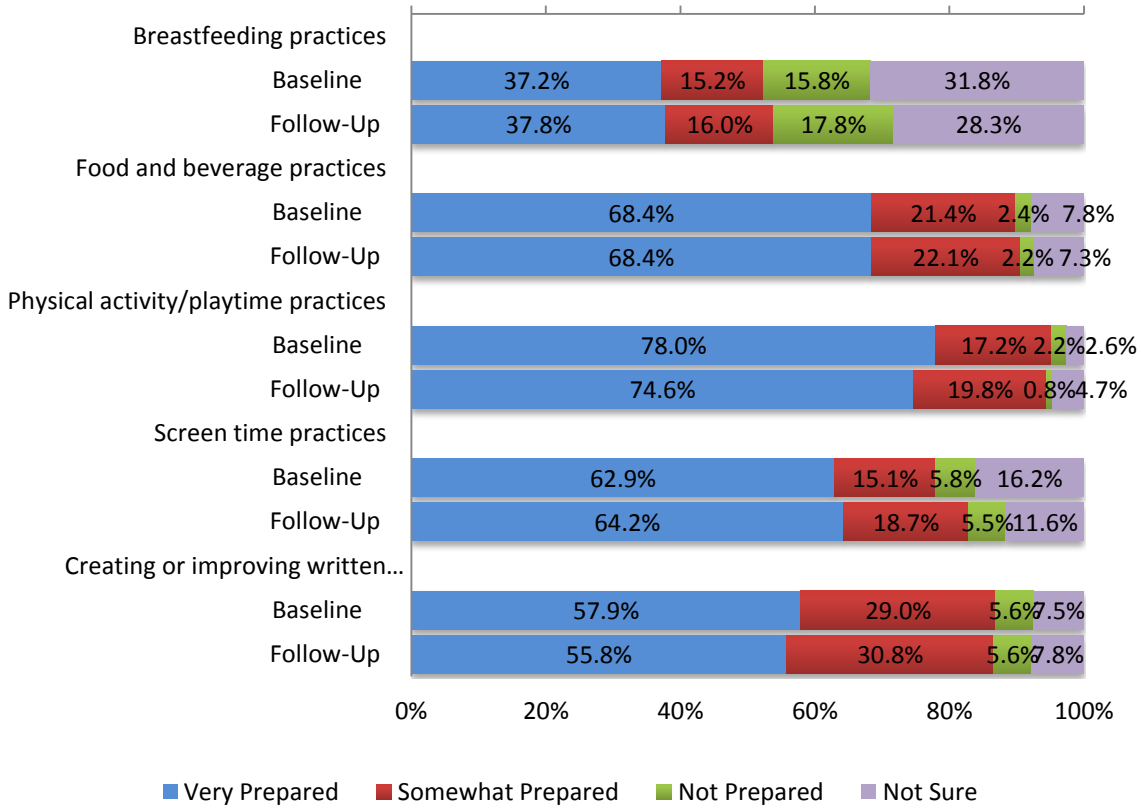
Table 8. Self-Efficacy: Relationship at Follow-up between Survey Language and Response to Question 36a. "How prepared do you feel to make changes in the [breastfeeding practices] at your child care site?"

How Prepared	English	Spanish
Very/Somewhat Prepared	206 (50.6%)	96 (62.3%)
Not Prepared/Not Sure	201 (49.4%)	58 (37.7%)
Note. P = .014, FET (n=561). Numbers in parentheses indicate column percentages. OR=1.62		

Table 9. Self-Efficacy: Relationship at Follow-up between Survey Language and Response to Question 36d. "How prepared do you feel to make changes in the [screen time practices] at your child care site?"

How Prepared	English	Spanish
Very/Somewhat Prepared	365 (86.3%)	115 (73.7%)
Not Prepared/Not Sure	58 (13.7%)	41 (26.3%)
Note. P = .001, FET (n=579). Numbers in parentheses indicate column percentages. OR=2.24		

Figure 5. Self-efficacy at Baseline and Follow-Up Items 36a-36e



To assess the impact of coaching on the participant's sense of preparedness, chi-square analyses were conducted comparing those who received nutrition coaching and those who did not, and compared those who received physical activity coaching with those who did not. No

group differences were found in level of preparedness to change for any of the questions. It may be that the one or two sessions did not provide enough program intensity to result in group differences. Past research conducted at the Child Care Resource Center has shown that it takes a minimum of six coaching sessions and six months for changes to the child care environment to be seen. It is recommended therefore that future program design include a higher level of coaching intensity to be able to evaluate its effectiveness.

Knowledge Change

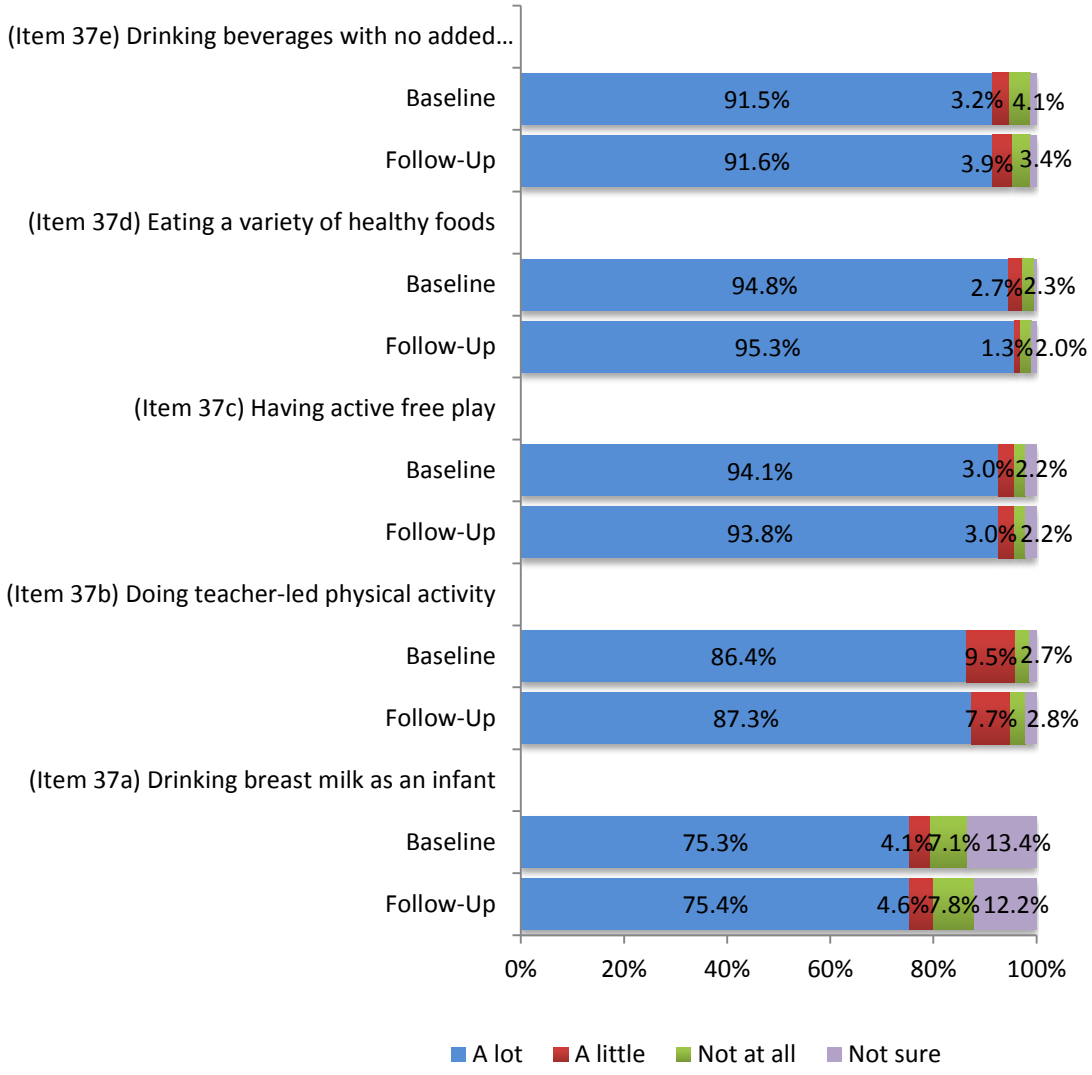
To what extent does knowledge change as a result of the program and does coaching make a difference? Does it differ by care type?

Questions 37a-37e asked participants "In your opinion, how much does each of the following activities in child care affect a child's growth and health?" along five activities (*Drinking breast milk as an infant, Doing teacher-led physical activity, Drinking beverages with no added sugar, Eating a variety of healthy foods, Having active free play*) with the categorical options of "*Not at All,*" "*A Little,*" "*A Lot,*" or "*Not Sure.*"

The percent of participants who endorsed each of the five activities as having an influence on the child's growth and health was similar between baseline and follow-up. The percent of participants who agreed that these areas affect a child's growth and health from highest to lowest at follow-up are indicated below as seen in Figure 6:

- Eating a variety of healthy foods (95.3%)
- Having active free play (93.8%)
- Drinking beverages with no added sugar (91.6%)
- Doing teacher-led physical activity (87.5%)
- Drinking breast milk as an infant (75.4%)

Figure 6. Knowledge at Baseline and Follow-Up Items 37a-37e



Recall prior results in this report of participants making less progress in breastfeeding practices than in other areas. Those results dovetail with the results above where breast milk and is perceived by participants as less critical to a child's growth and health than other areas. The item "Drinking breast milk as an infant" had the lowest percent of providers indicating this had a lot of influence on the child's growth and health (75.4%), and also had the highest percent of participants indicating they were not sure (12.2%) if this had an effect on the child's growth and

health. Because this belief may affect breastfeeding policies and practices in the child care environment, this may be an area which would merit further intervention. Research on factors related to breastfeeding discontinuation indicates that women who encounter multiple barriers to breastfeeding are more likely to cease breastfeeding, while those who have a perceived support system are more likely to continue breastfeeding.[xxxvi] Therefore, it is important to foster supportive environments for breastfeeding women, particularly those who may just be returning to work as the return to work is often cited as a reason for why women stop breastfeeding.[xxxvii]

There were no site-based, language-based, or difference by coaching for these knowledge areas, indicating a need for and potential making a positive impact for all providers in this area in the future.

Challenges

What challenges do participants face and does coaching make a difference? Does it differ by care type? Which challenges are more common at baseline compared with follow-up? Are there fewer challenges at follow-up?

Questions 38a-38k asked respondents "What are some challenges that you face or have faced while taking steps towards creating **healthy practices or routines**?" with a "check all that apply" instruction. Any participant who checked *"Does not apply: I did not create healthy practices or routines*" or "I did not face any challenges to creating healthy practices or routines" did not have any other checked items included in the percentages reported in Table 10.

Challenges in **creating healthy practices or routines** reported at baseline and follow-up were very similar with no significant differences in the percent of participants reporting each item at baseline or follow-up. At both baseline and follow-up, 66.0% of participants identified at least one challenge in creating healthy practices or routines, and close to 30% reported no challenges. The areas of greatest challenge in **creating healthy practices or routines** at both baseline and follow-up included (starting with greatest challenge) with approximately 20% or more citing these challenges were:

- Lack of support from parents (34.7%)
- Not enough money to make changes (33.4%)
- Not enough equipment to make changes (20.4%)
- Not enough training to make changes (20.3%)

The greatest challenges reported this year were similar to last year's with the top 4 challenges sited in the same order of frequency as described above.

Table 10. Percent of Participants Reporting Challenges Faced in Creating Healthy Practices or Routines

Challenges Faced Creating Healthy Practices/Routines	Baseline (n=600)	Follow-Up (n=602)
Lack of support from management/leadership staff	12.8%	15.0%
Lack of support from other child care staff	10.2%	9.8%
Lack of support from parents	31.5%	34.7%
Not enough money to make changes	32.2%	33.4%
Not enough time to make changes	16.7%	17.1%
Not enough training to make changes	22.2%	20.3%
Not enough space to make changes (kitchen, play space)	14.8%	17.9%
Not enough equipment to make changes (play structures, kitchen utensils)	20.0%	20.4%
Other	2.8%	2.2%
I did not face any challenges to creating healthy practices or routines.	27.3%	27.7%
Does not apply: I did not create healthy practices or routines.	6.7%	6.3%

As previously indicated, individual questions did not show a statistically significant change from baseline to follow-up. However, the number of challenges reported by each participant was summed at both baseline and follow-up to compare differences between groups in mean number of challenges reported by participants.

There were differences in the mean number of challenges reported by site type such that center-based participants reported greater number of challenges (M = 1.810, SD = 1.946) than family child care participants (M = 1.248, SD = 1.653), t (245.399) = 3.322, p < .001 at follow-up as demonstrated by an independent sample t-test.

Table 11. Comparison of Mean Number of Challenges Reported on Item 38 by Center-Based and Family Child Care Participants at Follow-up.

Center	Licensed Home	*t*	*df*
1.810 (1.946)	1.248 (1.653)	3.322*	245.399

Questions 39a-39h asked respondents "What are some challenges that you face or have faced while taking steps towards creating **written rules or guidelines** about healthy practices?" with a "check all that apply" instruction. Any participant who checked "Does not apply: I did not create

any written rules or guidelines about healthy practices" or "I did not face any challenges to creating written rules or guidelines about healthy practices" did not have any other checked items included in the percentages reported in Table 12.

The percent of providers reporting each challenge were similar at baseline and follow-up. At follow-up, 46.6% of participants reported at least one challenge and 37.0% indicated they did not face any challenges creating **written rules or guidelines** about healthy practices. The areas of greatest challenge in creating written rules or guidelines at both baseline and follow-up, with approximately 20% or more citing these challenges, were the following:

- Lack of support from parents
- Not enough time to write rules or guidelines
- Not enough training to make changes

Similar to the prior question about challenges in creating healthy routines and practices, the most frequently cited challenge was lack of support from parents with 21.6% of participants citing this challenge at follow-up.

Table 12. Percent of Participants Reporting Challenges in Creating Written Rules or Guidelines about Healthy Practices

Challenges Faced Creating Written Guidelines	Baseline (n=600)	Follow-Up (n=602)
Lack of support from management staff	10.7%	12.8%
Lack of support from other child care staff	6.7%	8.0%
Lack of support from parents	19.7%	21.6%
Not enough training to make changes	18.7%	16.8%
Not enough time to write rules or guidelines	18.7%	17.9%
Other	2.7%	2.3%
I did not face any challenges to creating written rules or guidelines about healthy practices.	32.8%	37.0%
Does not apply: I did not create any written rules or guidelines about healthy practices.	19.3%	16.4%

Individual questions did not show a statistically significant change from baseline to follow-up. However, there were group differences in the mean number of challenges providers reported. Specifically, center-based staff reported more challenges ($M = 0.855$, $SD = 1.260$) than family child care providers ($M = 0.474$, $SD = 0.840$), $t(317.95) = 4.089$, $p < .001$ at follow-up as demonstrated by an independent samples t-test.

Table 13. Comparison of Mean Number of Challenges Reported on Item 39 by Center-Based and Family Child Care Participants at Follow-Up

Center	Licensed Home	*t*	*df*
0.855 (1.260)	0.474 (0.840)	4.089*	317.95

Table 14. Comparison of Mean Number of Challenges Reported on Items 38 and 39 by Coaching Status

		Coaching	No Coaching	*t*	*df*
Item 38. Challenges faced creating healthy practices or routines.	Baseline	1.75 (2.00)	1.42 (1.55)	-2.198*	596
	Follow-Up	1.70 (1.90)	1.67 (1.90)	ns	600
Item 39. Challenges faced creating written rules or guidelines about healthy practices.	Baseline	0.85 (1.25)	0.62 (0.98)	-2.489*	598
	Follow-Up	0.82 (1.24)	0.72 (1.13)	ns	598

*p<.05

At baseline, there were also significant differences in the mean number of challenges reported by providers who received coaching and those who did not receive coaching. Composite scores were created by summing the number of challenges each provider reported for items 38 and 39 and independent samples t-tests were conducted to identify differences in the mean number of challenges provided in each area. On average, participants who received coaching reported a greater number of challenges at baseline than those who did not receive coaching in regards to creating healthy practices or routines and in creating written rules or guidelines. This finding is important to consider In light of the findings throughout this report demonstrating no significant differences in policies and practices at follow-up between CHLA CC training participants who received coaching and those who did not receive coaching. It is possible that those who received CHLA CC coaching sought out or more readily agreed to receive coaching because they were facing a greater number of challenges in the areas targeted by the CHLA CC program than participants who did not participate in coaching. Therefore, when analyses were conducted to examine whether participants who received coaching experienced greater positive change than participants who did not receive coaching, the number of challenges experienced at baseline may have confounded the results. As described in earlier sections of this report, there were many positive changes in providers' policies and practices between baseline and follow-up. However, when analyses were conducted to determine if participants who had received coaching experienced greater positive change than participants who received no coaching, no effects of coaching were found. If participants who received coaching had less

support from management staff, lack of support from other child care staff, lack of support from parents, and not enough time or training to implement changes they learned about through their coaching than participants not receiving coaching, it is possible the effect of coaching would wash out in the analyses. Further analyses to take the number of challenges faced at baseline into account may be considered for teasing out the effect of coaching on participant behavior.

What are needed resources at baseline compared with follow-up? Does this differ by care type and for those who receive coaching?

Questions 40a-40h asked participants "What resources would be helpful for creating healthy practices or guidelines?" with instruction to "check all that apply." As seen in Table 15, participants were very consistent in what they reported as helpful resources at baseline and follow-up. The following items, with those most frequently selected as helpful and selected by more than 25% of participants, included:

- More materials for parents
- More printed information
- Newsletters
- More training
- Websites
- Time with a Choose Health LA Child Care Coach
- Meeting with other child care providers making similar changes

The fact that materials for parents was the most highly endorsed item for helping to create healthy practices or guidelines aligns with other results from this survey and with findings from other evaluation components of CHLA CC. In this survey, lack of support from parents was the area most frequently endorsed by participants when asked about challenges in creating healthy practices and routines and in creating written rules or guidelines. Given that providers perceive lack of support from parents as a challenge in creating healthy practices or routines and creating written rules or guidelines, it is possible that providers are seeking resources to address that challenge order to implement positive changes in their child care programs. That the providers are seeking resources for parents may also be a positive finding in that providers may be seeking resources for parents because they recognize the importance of healthy practices at home and with the parents' engagement. Large scale issues such as health, poverty, and education require a multi-pronged intervention strategy. The need for intervening with both child care environments and home environments is not surprising. CHLA CC has collaborated with Choose Health LA Kids to connect parents and license-exempt providers to a 6-week Healthy Parenting Workshop series.

Table 15. Percent of Participants Reporting Which Resources would be Helpful for Creating Healthy Practices/Guidelines at Baseline and Follow-up

Resources	Baseline (n=600)	Follow-Up (n=602)
More printed information	54.0%	51.7%
More materials for parents	71.3%	67.4%
Websites	33.8%	38.0%
Newsletters	44.2%	46.3%
Time with a Choose Health LA Child Care coach	37.2%	33.2%
More training	43.3%	37.9%
Meeting with other child care providers making similar changes	28.7%	24.8%

No differences were found between baseline and follow-up, by site-type, language, or by coaching status.

How helpful was the program and does this vary by Coaching/provider/language?

In an effort to understand how the various services of the program helped participants create healthy environments, they were asked to rate how helpful each of the aspects of the program was. Seen in Table 16, these questions were asked only at follow-up. The training and materials were rated as the most helpful, followed by coaching. Given the investment CHLA CC has made in developing materials that providers can take to their program and use, it is no surprise that materials were rated as the second most helpful aspect. Providers are able to take the materials including yoga cards, physical activity kits, recipe cards, books, plates, cups and cooking kits back to their program and continue to implement ideas and activities they have learned about through the training or with their coach longer after the coaching and training have ended. Informal review of participants' comments on a coaching satisfaction survey for this program corroborates this finding with providers indicating they find the training materials valuable. The helpfulness of coaching was not much higher than that of the support from other staff at their site. The least helpful was support from parents, mirroring other findings in this report. The lower rating for coaching may reflect the fact that there were only one or two sessions possible under the current funding. Generally it takes a minimum of six sessions to realize environmental changes. No differences were found by group (provider type, language, coaching group).

Table 16. Percent of Participants Rating Helpfulness of Each Aspect of Services in Their Efforts to Create a Healthy Child Care Environment

Helpfulness of Services	Very Helpful	Somewhat Helpful	Not Helpful	Not Sure/Does Not Apply
Choose Health LA Child Care training (n=571)	81.1%	11.2%	1.1%	6.7%
Choose Health LA Child Care training materials (n=566)	77.4%	14.1%	1.2%	7.2%
Choose Health LA Child Care coaching sessions (n=555)	70.5%	14.1%	1.8%	13.7%
Support from other staff at your child care site (n=554)	66.8%	19.0%	2.7%	11.6%
Support from parents (n=559)	55.3%	25.2%	9.7%	9.8%

Changes to Economics, Marketing and Demand

Economics of the site were explored to assess if changes resulted in more expenses (considering healthy foods can cost more) or if expenses were reduced as a result of participating in the program. These questions were asked only at follow-up. As seen in Figure 6, 33.1% stated their expenses increased at least a little, 5.5% reported at least some reduction in expenses, 26.9% were unsure of any changes, and 20.4% indicated there were no change in their economics as a result of creating healthy practices and guidelines. 14.1% reported that the question did not apply to their site.

In terms of changing fee structures as a result of the changes made to the program because of CHLA CC participation, as seen in Figure 7, the majority (38.3%) indicated there was no change, 26.6% reported they did not know, 8.0% are considering charging more, and 4.4% charge more. Very small percentages of providers reported that they were considering charging less (0.3%) or already charging less (0.8%).

Interestingly, while 33.1% of providers indicated that their costs have increased a little or a lot as a result of creating healthy practices or guidelines, only 12.4% reported they either charge more or are considering charging more in terms of their fee structure. From this survey, it is not known what factors resulted in a higher cost as a result of creating healthy practices or guidelines, but will be important to understand in order to help providers implement and sustain healthy practices and policies in their programs. Understanding the conditions under which creating healthy practices or guidelines can have an economic impact on providers and families or create a barrier to making changes is important and worth further exploration.

Figure 7. Percent of Participants Reporting Change in Economics at their Site as a Result of Creating Healthy Practices or Guidelines (Item 42)

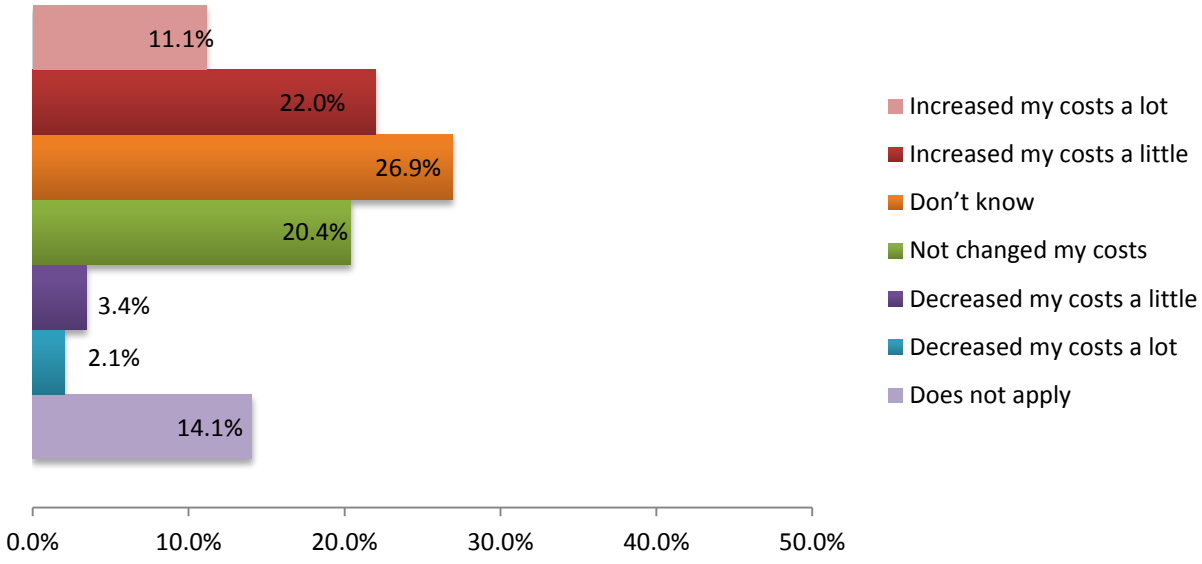
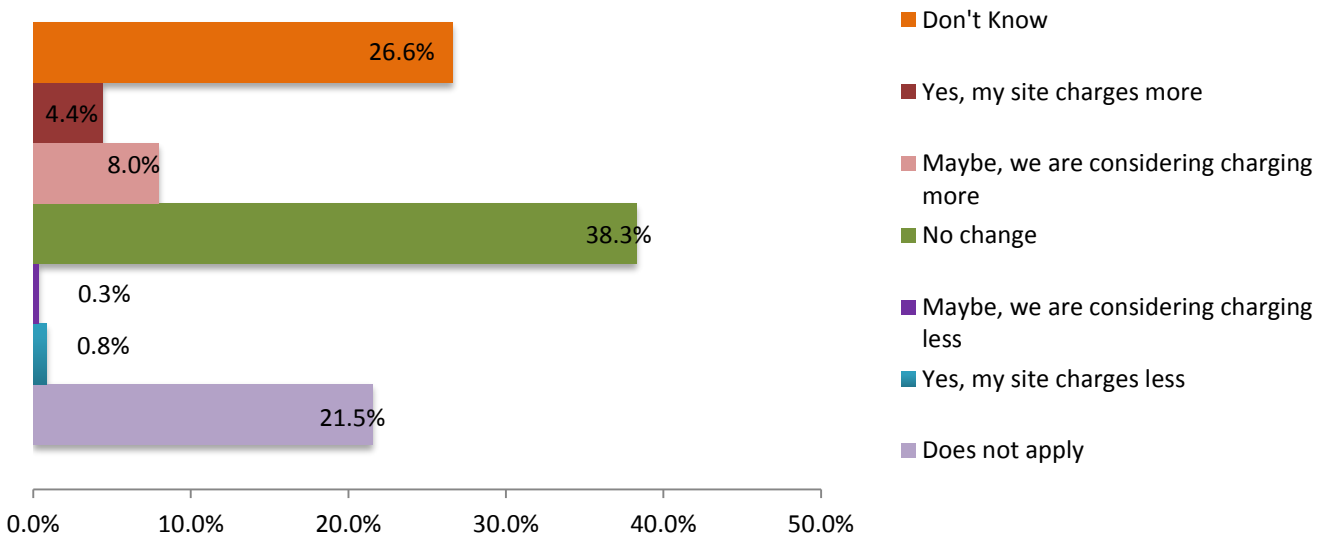


Figure 8. Percent of Participants Changing Fee Structures as a Result of the Changes Made Because of CHLA CC (Item 43)



It was anticipated that participants could use their experiences in the program to market their site differently and attract more families. When asked if they used their participation in the program in any marketing materials for their program, 19.7% said yes and 76.6% said they shared their rules or guidelines with parents (See Figure 9.) Figure 10 shows how parents reacted to the healthy practice rules or guidelines. Overwhelmingly, parents reacted positively to the healthy rules or guidelines. In addition, Figure 11 illustrates that participants have noticed greater interest by families in their program as a result of their program participation or changes to healthy practices. Given this positive reaction, the lack of parent support cited earlier in this report merits further exploration. Under what conditions are parents supportive, and under what conditions is there a lack of support for changes in healthy practices?

Figure 9. Marketing and Sharing Information with Parents (Items 44 and 45)

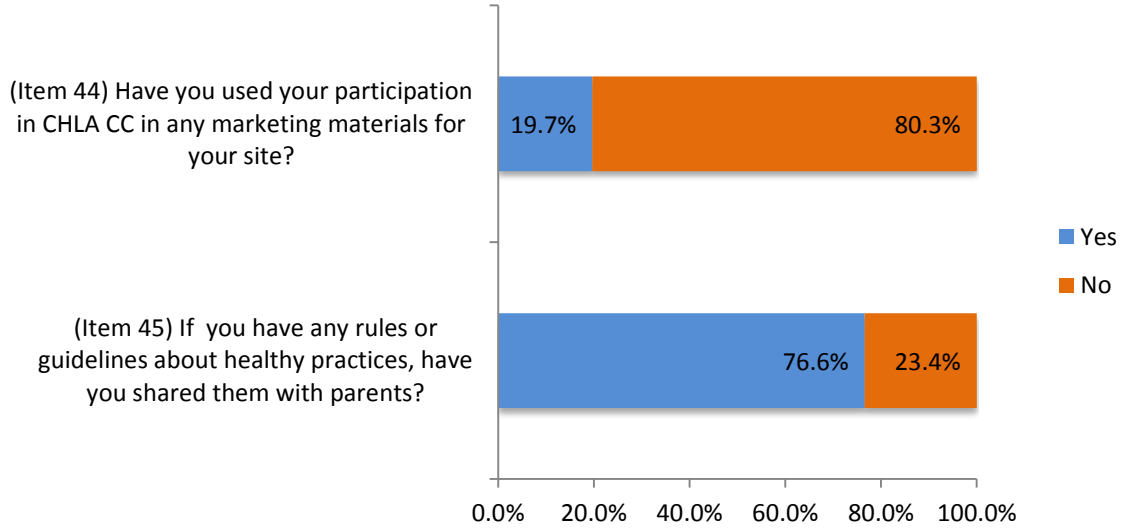


Figure 10. Parents' Reaction to Rules or Guidelines for Healthy Practices (Item 45b)

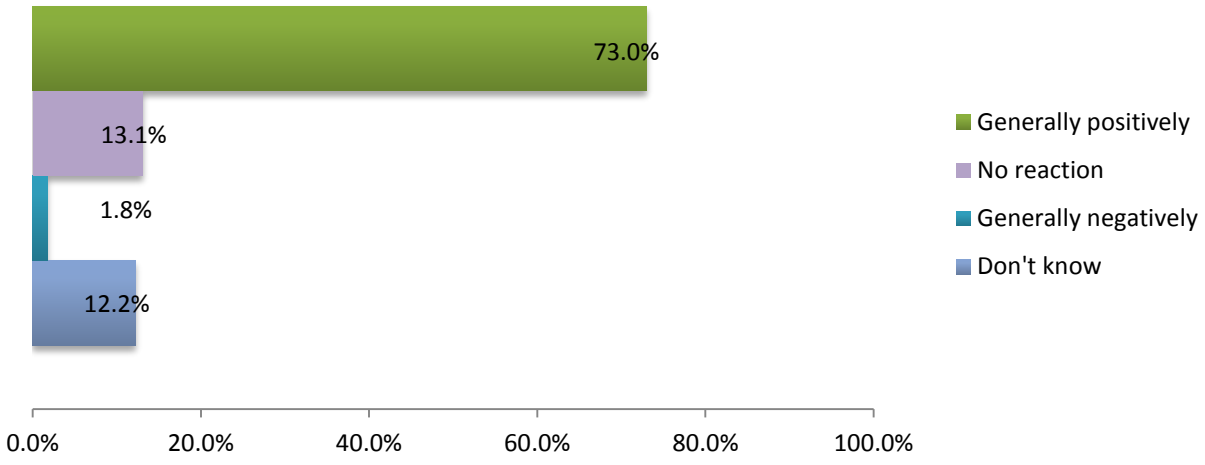
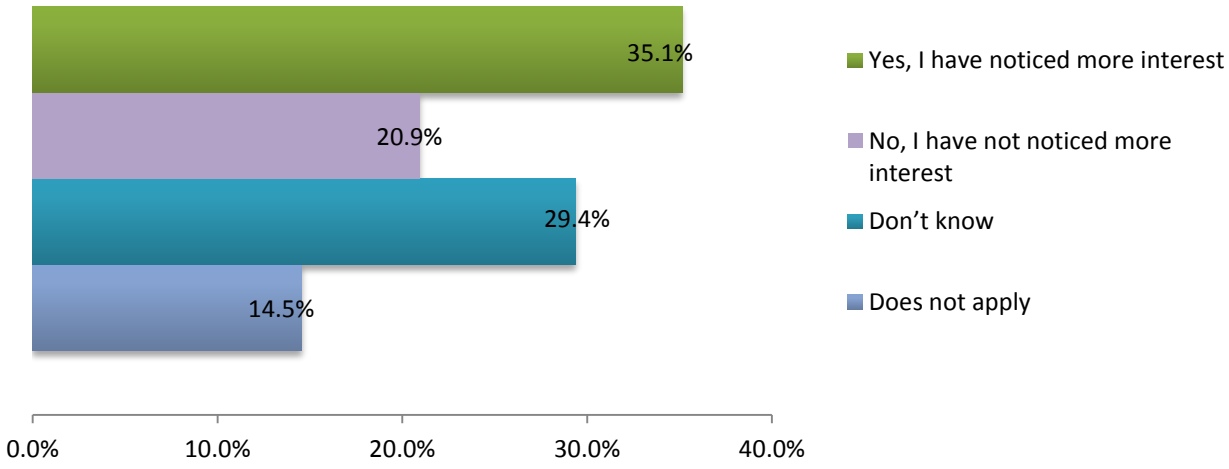


Figure 11. Change in Demand For or Interest in the Program as a Result of Participation or Changes to Healthy Practices (Item 46)



Conclusions and Recommendations

The county-wide Choose Health LA Child Care program in Los Angeles has reached many licensed child care providers and as a result has reached a substantial number of children. This program has trained 5,853 and coached 2,323 child care providers from 2013 to 2016. With each child care program having an estimated average of 26 child care spaces per site, this suggests that the program has impacted approximately 152,178 children over the life of the program. Moreover, it is expected that the children providers will serve in the future will also benefit from Choose Health LA Child Care as provider knowledge and practice is maintained over time.

Findings from the Policies and Practices Survey have served to: 1) Provide a snapshot of providers' knowledge about policies and practices before and after participating in CHLA CC training and coaching, 2) Identify areas of strength in providers' health knowledge, policies and practices, and readiness to make changes in those areas, and 3) Identify areas that may merit further intervention to support providers in creating or maintaining a healthy child care environment. All factors were examined paying attention to specific strengths and needs by child care provider primary language and program type (center-based or home-based).

There are a few limitations to this research that should be considered when interpreting the results. First, even though they were asked to reflect on their knowledge and practice before participating in any CHLA CC component, the baseline survey participants responded to may not have been a true baseline survey because participants completed it after participating in the training. It is possible that not all providers completed the survey with their knowledge, readiness, and practices before participating in the training as the point of reference. Due to multiple reasons related to participant recruitment, knowing who was going to be participating in training before the training occurred was not always feasible in order to administer the baseline survey at that point. Second, the Policies and Practices Survey is a self-report instrument and relies on participants' recollection and perception of their own knowledge and practices. Reporting specifics on the food they serve may have been challenging for some participants and if there were inaccuracies in their self-report, the change in practice captured in this survey may not have been a true reflection of the change that occurred. Observational assessments recently completed may shed some light on findings from this report. A final limitation of this study is that the results are based on participants who self-selected into the program and who chose to return a survey. There may be inherent differences between participants who chose to attend Choose Health LA Child Care trainings and those who did not, participants who chose to receive Choose Health LA Child Care coaching and those who did not, and participants who sent in a survey and those who did not.

Overall, providers who participated in Choose Health LA Child Care training and coaching reported high levels of knowledge, are engaging in practices to create a healthy child care environment, showed positive change in policies and practices targeted by CHLA CC, and are prepared to make changes. Specifically, there were significant increases in the percent of providers who engaged in positive nutrition policies and practices, positive changes were made in food served, and there were significant increases in providers engaged in positive physical activity policies and practices from before participating in CHLA CC to after participating in CHLA CC.

It was expected that participants who received a greater intensity of the program (i.e. coaching in addition to training) would show greater positive change in aspects targeted by CHLA CC than participants who only attended the training. This expectation was not supported by findings in this survey. However, factors which could explain this finding were identified: 1) At baseline, there were differences between participants who received coaching and those who did not, as demonstrated in post-hoc analyses such that providers who received coaching reported more challenges in creating healthy practices and routines and creating written rules or guidelines about healthy practices than providers who did not receive coaching. However, that group difference did not persist at follow-up, indicating a possible gap closure between groups and reduction in challenges experienced by CHLA CC coaching participants during follow-up. 2) Participants who received coaching received at most 2 coaching sessions lasting approximately one hour. Longer and more frequent sessions may be necessary to affect change above and beyond that made by training alone. Finally, 3) The coaching sessions participants received through CHLA CC were very specific and focused on one goal while the Policies and Practices survey measures change in multiple areas.

Based on findings from this survey, four main areas of need were identified:

- *Breastfeeding knowledge and policies*. Compared to other areas of healthy policies and practices assessed with this survey, participants' implementation, knowledge, and efficacy or readiness to change in regards to breastfeeding practices and policies was low, suggesting this area may merit further attention. Breastfeeding exists in a value system that may be difficult to change. Myths about the difficulty of dealing with breastfeeding and breast milk or lack of understanding of its importance may be challenging to overcome. Furthermore, qualitative analyses of program data indicate that mothers move their children to formula before enrolling children in child care. Therefore, being able to support parents who have already made the shift from breast feeding to formula may present an additional challenge. Other possibilities to

implementing breastfeeding policies and practices should be explored in future research to better support providers in this area.

- *Support in engaging parents to create a healthy child care environment.* A lack of parent support was the most frequently cited challenge in healthy practices and routines and in creating written rules or guidelines. In addition, when asked what would help them create a healthy environment, participants selected "materials for parents" as the top choice. Given this consistent trend across multiple questions, parent engagement seems to be a particular challenge. Helping providers engage parents is an ongoing struggle in many programs and is a mandate in some (e.g., Head Start, State Preschool). Perhaps the lessons learned from already existing programs in how to engage parents could be gathered and offered as a resource to providers. In addition, connecting with the other branches of the Choose Health LA program, which includes a parent or family component, might be an area to explore.

- *Economic costs in creating healthy changes in child care program*. When asked to report on the economic impact of creating healthy practices on their costs, one third of participants indicated that creating healthy practices increased the cost of their program. More information about factors that impact the increase in costs should be explored to support providers in implementing and sustaining healthy practices in their program. Is there an accurate perception of healthy food affordability? What exactly is making costs rise? Knowing this would allow programs to better support providers in implementing and sustaining positive behavior.

- *Family child care homes as fertile ground for making positive change in healthy practices and policies*. While this evaluation identified differences between center–based care and family child care at baseline on a variety of nutrition and feeding practices such that lower percentages of family child care providers were engaging in positive nutrition policies and practices, the differences did not persist at follow-up suggesting positive change for family child care providers. Amenability to change, coupled with autonomy in setting rules and guidelines in their programs as autonomous business owners - compared to center-based programs, particularly those that have government contracts and are either required to provide healthy practices or are limited in any changes they can make- make family child care homes fertile ground for making positive change regarding health and nutrition. Most importantly, as illustrated in this report, because a large percent of family child care programs are open evenings and /or weekends, they are responsible for serving more meals, including snack and dinner,

than center-based programs, making it imperative to ensure healthy nutrition practices are implemented.

Results from this survey did demonstrate positive changes in participating providers from baseline to follow up. However, to expect a program to result in sustained change after one training session and one or two coaching sessions might not be realistic. With increased funding, future program design might consider a smaller intervention group with more one-on-one coaching sessions available in order to realize sustained change. With limited resources there is always the struggle between serving the most people possible (breadth of program) versus serving fewer people more intensively (depth of program). Nevertheless, The CHLA CC program may have helped providers sustain their positive behaviors.

As illustrated by findings from this survey, there were areas for improvement. However, there were also areas of strength demonstrated by the large percentages of providers already engaging in positive practice at baseline. Nevertheless, with the exception of a couple of items, there was either positive change or no change. Because of the nature of this program and the intent to reach as many providers as possible, there was no 'control group' – that is, there is not data on participants who did not participate in CHLA CC to compare findings from this survey. It is possible that without participating in CHLA CC there may have been a negative change in participants' policies and practices between baseline and follow-up.

While effecting positive change is important, so is providing tools and resources to support and sustain behavior. CHLA CC provided participants with tools to continue to implement healthy policies and practices in their program. Tools and resources included yoga cards, recipe cards, plates, cups, cooking kits, and a breastfeeding toolkit. (See Appendix D for more information about resources provided.) Indeed, participants who completed this survey reported that the training and training materials were 2 of the most helpful aspect of services provided by CHLA CC.

Given the extremely broad reach of this program across Los Angeles County in the program's span from 2013 to 2016, it is expected that a substantial number of children will continue to benefit from this program. It is estimated that 153,000 children will participate in an early care and education program that has been part of the Choose Health LA Child Care program. Together with the other components of the First 5 LA-funded Early Childhood Obesity Prevention Initiative (ECOPI), LA County's children will have a greater likelihood of achieving one of First 5 LA's Strategic Plan Goals – to maintain a healthy weight.

Appendix A: Types of Child Care Settings in California

Child Care Center (CCC). Provides care for infants, toddlers, preschoolers, and/or school-age children all or part of the day. These facilities may be large or small and can be operated independently by nonprofit organizations or for- profit companies, or by churches, school districts, and other organizations. Most are licensed by the California Department of Social Services (DSS), Community Care Licensing (CCL). For licensed CCCs, information on requirements can be found at the Community Care Licensing Division's web site at: http://ccld.ca.gov. Click on "Title 22 Regulations."

Licensed Family Child Care Home. Family Child Care (FCC) means regularly provided care, protection and supervision of children, in the caregiver's own home, for periods of less than 24 hours per day, while the parents or authorized representatives are away. Care offered in the home of the provider, often a parent. Small family child care homes have one provider and can accept up to eight children, depending on their ages. Large family child care homes have two adults and can take up to 14 children, depending on their ages. Care is often provided for children of different ages. The homes are licensed by CDSS/CCL. See Title 22 regulations at the Community Care Licensing Division's web site at: http://ccld.ca.gov.

License-Exempt Child Care. Many child care providers are license-exempt (both home- and center-based), including: An individual provider who cares only for his/her relatives, an individual provider who only cares for the children of one other family (other than the provider's own children, if he or she has any children), cooperative agreements (Co-ops) in which parents share responsibility for child care, public recreation programs, and before- and after-school programs run by schools. Other categories of license exempt programs can be found in Health and Safety Code § 1596.792.4 6

Appendix B1: Choose Health LA Child Care Baseline Survey

Choose Health LA Child Care: Policies and Practices Survey

You were randomly chosen to receive this survey because you took part in a training about improving nutrition and physical activity in your child care program, and we want to know more about your child care site. Please answer the questions on this survey and mail it in the enclosed envelope.

Send the COMPLETED survey back to us, and we'll send you a $10 gift certificate as a THANK YOU for your participation!

A. What is the age of the children you serve? Please check ☑ all that apply:
- 1 ☐ Under 2 years old
- 2 ☐ 2-5 years old
- 3 ☐ 6 years or older

B. Which of the following do you offer at your child care site? Please check ☑ all that apply:
- 1 ☐ Breakfast
- 2 ☐ Morning snack
- 3 ☐ Lunch
- 4 ☐ Afternoon snack
- 5 ☐ Dinner
- 6 ☐ No food is served, and children bring their own food.
- 7 ☐ Other: _____

Please think about your child care program BEFORE you enrolled in the nutrition and physical activity training, and answer the next group of questions about practices at your child care.

Please check the box ☑ that best describes your practice BEFORE you took the training.

Nutrition: Feeding Practices	I was already doing	I was making progress in doing	I was planning to do	I was not planning to do	Does not apply to my site
	Please select ☑ one box for each row.				
1. Parents received written nutrition policies upon enrollment.	☐1	☐2	☐3	☐4	☐5
2. Parents were given information about what their children are eating.	☐1	☐2	☐3	☐4	☐5
3. If food is brought from home, parents were provided with guidelines.	☐1	☐2	☐3	☐4	☐5
4. Parents were given information about what their children were offered (menus).	☐1	☐2	☐3	☐4	☐5
5. Meals and snacks were scheduled at consistent times each day.	☐1	☐2	☐3	☐4	☐5
6. Mealtimes were relaxed, calm, and with shared conversation.	☐1	☐2	☐3	☐4	☐5
7. Children decided which foods they would eat from the foods offered.	☐1	☐2	☐3	☐4	☐5

Nutrition: Feeding Practices, continued:	I was already doing	I was making progress in doing	I was planning to do	I was not planning to do	Does not apply to my site
	Please select ☑ one box for each row.				
8. Children were **not** required to eat all the food on their plates.	☐1	☐2	☐3	☐4	☐5
9. Children served themselves from serving dishes at mealtime.	☐1	☐2	☐3	☐4	☐5
10. Children with special needs had their nutritional needs taken into account.	☐1	☐2	☐3	☐4	☐5
11. Food was served in a form that young children could eat without choking.	☐1	☐2	☐3	☐4	☐5
12. Adults sat with children at mealtime.	☐1	☐2	☐3	☐4	☐5
13. Adults ate the same foods as children at mealtime.	☐1	☐2	☐3	☐4	☐5
14. Foods were served that reflected the ethnicity and cultures of the children in the center/home.	☐1	☐2	☐3	☐4	☐5
15. Special occasions and holidays were celebrated with healthy foods or with non-food treats.	☐1	☐2	☐3	☐4	☐5
16. Breastfeeding mothers were provided access to a private area for breastfeeding or pumping with appropriate seating.	☐1	☐2	☐3	☐4	☐5
17. Staff were trained in proper handling and storage of breast milk.	☐1	☐2	☐3	☐4	☐5
18. Parents were aware that they could leave breast milk at the child care site for their child.	☐1	☐2	☐3	☐4	☐5
19. Drinking water was freely available throughout the day.	☐1	☐2	☐3	☐4	☐5
20. Parents were provided information on child nutrition and healthy eating.	☐1	☐2	☐3	☐4	☐5
Nutrition: Food Served	**Please select ☑ one box for each row.**				
21. 100% fruit juice was offered:	☐ More than 1 time per day	☐ 1 time per day	☐ Less than 1 time per day	☐ Never	☐ Does not apply to my site
22. Chicken nuggets, fish sticks, hot dogs, corn dogs, bologna or other lunch meat, sausage, or bacon were offered:	☐ 1 time per day or more	☐ 2-3 times per week	☐ 1 time per week or less	☐ Never	☐ Does not apply to my site

Nutrition: Food Served, continued:	**Please select ☑ one box for each row.**				
23. Whole grain bread, oatmeal, whole grain cereal, brown rice, whole wheat tortillas, corn tortillas or other whole grains were offered:	☐ 3 times per day or more	☐ 2 times per day	☐ 1 time per day or less	☐ Never	☐ Does not apply to my site
24. Vegetables including fresh, frozen, or canned, were served:	☐ 3 times per day or more	☐ 2 times per day	☐ 1 time per day or less	☐ Never	☐ Does not apply to my site
25. Fruit including fresh, canned in water or own juice, frozen, or dried, was served:	☐ 3 times per day or more	☐ 2 times per day	☐ 1 times per day or less	☐ Never	☐ Does not apply to my site
26. Unflavored milk or non-dairy alternative served to children aged 2 years and older was:	☐ Whole or regular	☐ 2% reduced fat	☐ 1% reduced fat or non-fat	☐ Non-dairy alternative	☐ Does not apply to my site
27. Flavored or sweetened milk was served:	☐ 1 time per day or more	☐2-3 times per week	☐ 1 time per week or less	☐ Never	☐ Does not apply to my site
Physical Activity	**I was already doing**	**I was making progress in doing**	**I was planning to do**	**I was not planning to do**	**Does not apply to my site**
	Please select ☑ one box for each row				
28. Parents received written physical activity policy upon enrollment.	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
29. Children had at least 60 minutes of unstructured or child-led, physical activity time (or 30 minutes in a half-day program).	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
30. Children had at least 60 minutes of structured or teacher-led, physical activity time (or 30 minutes in a half-day program).	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
31. Information was provided to parents about their child's physical activity while in child care.	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
32. Staff participated in physical activities with children.	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
33. Screen time, or time spent using a computer, smartboard, or watching TV, was limited to 30 minutes per week for children.	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
34. Parents were provided information that encourages physical activity at home.	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$

The Food Program (CACFP): a federal meal program offered to public and private child care sites.	I was Already doing	I was making progress in doing	I was planning to do	I was not planning to do	Does not apply to my site
	Please select ☑ one box for each row.				
35. My child care center/site participated in the Food Program.	☐1	☐2	☐3	☐4	☐5

Please answer questions 36 and 37 by checking one box for each row.

36. How prepared do you feel to make changes in the following areas at your child care site?	Please select ☑ one box for each row.			
	Very prepared	Somewhat Prepared	Not prepared	Not sure
a. Breastfeeding practices	☐1	☐2	☐3	☐4
b. Food and beverage practices	☐1	☐2	☐3	☐4
c. Physical activity/playtime practices	☐1	☐2	☐3	☐4
d. Screen time practices	☐1	☐2	☐3	☐4
e. Creating or improving written guidelines about health for your child care	☐1	☐2	☐3	☐4

37. In your opinion, how much does each of the following activities in child care affect a child's growth and health?	Please select ☑ one box for each row.			
	A lot	A little	Not at all	Not sure
a. Drinking breast milk as an infant	☐1	☐2	☐3	☐4
b. Doing teacher-led physical activity	☐1	☐2	☐3	☐4
c. Having active free play	☐1	☐2	☐3	☐4
d. Eating a variety of healthy foods	☐1	☐2	☐3	☐4
e. Drinking beverages with no added sugar	☐1	☐2	☐3	☐4

38. What are some challenges that you face or have faced while taking steps towards creating **healthy practices or routines**? Please check ☑ all that apply.

A☐ Lack of support from management/leadership staff
B☐ Lack of support from other child care staff
C☐ Lack of support from parents
D☐ Not enough money to make changes
E☐ Not enough time to make changes
F☐ Not enough training to make changes
G☐ Not enough space to make changes (kitchen, play space)
H☐ Not enough equipment to make changes (play structures, kitchen utensils)
I ☐ Other: _____
J ☐ I did not face any challenges to creating healthy practices or routines.
K☐ Does not apply: I did not create healthy practices or routines.

39. What are some challenges that you face or have faced while taking steps towards creating **written rules or guidelines** about healthy practices? Please check ☑ all that apply.

A☐ Lack of support from management/leadership staff
B☐ Lack of support from other child care staff
C☐ Lack of support from parents
D☐ Not enough training to make changes
E☐ Not enough time to write rules or guidelines
F☐ Other: _____
G☐ I did not face any challenges to creating written rules or guidelines about healthy practices.
H☐ Does not apply: I did not create any written rules or guidelines about healthy practices.

40. What resources would be helpful for creating healthy practices or guidelines? Please check ☑ all that apply.

A☐ More printed information
B☐ More materials for parents
C☐ Websites
D☐ Newsletters
E☐ Time with a Choose Health LA Child Care coach
F☐ More training
G☐ Meeting with other child care providers making similar changes
H☐ Other: _____

Thank you so much for your time in taking this survey!

Send the COMPLETED survey back to us, and we'll send you a $10 gift card to buy something new for your child care!

Please look out for a final survey in the mail <u>in six months with another opportunity to get a $10 gift card.</u>

Appendix B2: Choose Health LA Child Care Follow-up Survey

Choose Health LA Child Care: Policies and Practices Survey

You have received this survey because you took part in a training about improving nutrition and physical activity at your child care site, and you completed a similar survey about 6 months ago. This is the final survey related to that training. Please answer the questions on this survey and mail it in the enclosed envelope.

Send the COMPLETED survey back to us, and we will send you a $10 gift certificate as a THANK YOU for your participation!

A. What is the age of the children you serve? Please check ☑ all that apply:
   - 1 ☐ Under 2 years old
   - 2 ☐ 2-5 years old
   - 3 ☐ 6 years or older

B. Which of the following do you offer at your child care site? Please check ☑ all that apply:
   - 1 ☐ Breakfast
   - 2 ☐ Morning snack
   - 3 ☐ Lunch
   - 4 ☐ Afternoon snack
   - 5 ☐ Dinner
   - 6 ☐ No food is served, and children bring their own food.
   - 7 ☐ Other: _____

The next group of questions asks you to describe some practices at your child care.
Please check the box ☑ that best describes your current practice.

Nutrition: Feeding Practices	Already doing	Making progress	Planning to do	Not planning to do	Does not apply to my site
	Please select ☑ one box for each row.				
1. Parents receive written nutrition policies upon enrollment.	☐1	☐2	☐3	☐4	☐5
2. Parents are given information about what their children are eating.	☐1	☐2	☐3	☐4	☐5
3. If food is brought from home, parents are provided with guidelines.	☐1	☐2	☐3	☐4	☐5
4. Parents are given information about what their children are offered (menus)	☐1	☐2	☐3	☐4	☐5
5. Meals and snacks are scheduled at consistent times each day.	☐1	☐2	☐3	☐4	☐5
6. Mealtimes are relaxed, calm, and with shared conversation.	☐1	☐2	☐3	☐4	☐5
7. Children decide which foods they will eat from the foods offered.	☐1	☐2	☐3	☐4	☐5

Nutrition: Feeding Practices, continued:	Already doing	Making progress	Planning to do	Not planning to do	Does not apply to my site
	Please select ☑ one box for each row.				
8. Children are **not** required to eat all the food on their plates.	☐1	☐2	☐3	☐4	☐5
9. Children serve themselves from serving dishes at mealtime.	☐1	☐2	☐3	☐4	☐5
10. Children with special needs have their nutrition needs taken into account.	☐1	☐2	☐3	☐4	☐5
11. Food is served in a form that young children can eat without choking.	☐1	☐2	☐3	☐4	☐5
12. Adults sit with children at mealtime.	☐1	☐2	☐3	☐4	☐5
13. Adults eat the same foods as children at mealtime.	☐1	☐2	☐3	☐4	☐5
14. Foods are served that reflect the ethnicity and cultures of the children in the center/home.	☐1	☐2	☐3	☐4	☐5
15. Special occasions and holidays are celebrated with healthy foods or with non-food treats.	☐1	☐2	☐3	☐4	☐5
16. Breastfeeding mothers are provided access to a private area for breastfeeding or pumping with appropriate seating.	☐1	☐2	☐3	☐4	☐5
17. Staff are trained in proper handling and storage of breast milk.	☐1	☐2	☐3	☐4	☐5
18. Parents are aware that they can leave breast milk at the child care site for their child.	☐1	☐2	☐3	☐4	☐5
19. Drinking water is freely available throughout the day.	☐1	☐2	☐3	☐4	☐5
20. Parents are provided information on child nutrition and healthy eating.	☐1	☐2	☐3	☐4	☐5
Nutrition: Food Served	Please select ☑ one box for each row.				
21. 100% fruit juice is offered:	☐ More than 1 time per day	☐ 1 time per day	☐ Less than 1 time per day	☐ Never	☐ Does not apply to my site
22. Chicken nuggets, fish sticks, hot dogs, corn dogs, bologna or other lunch meat, sausage, or bacon are offered:	☐ 1 time per day or more	☐ 2-3 times per week	☐ 1 time per week or less	☐ Never	☐ Does not apply to my site

Nutrition: Food Served, continued:	Please select ☑ one box for each row.				
23. Whole grain bread, oatmeal, whole grain cereal, brown rice, whole wheat tortillas, corn tortillas or other whole grains are offered:	☐ 3 times per day or more	☐ 2 times per day	☐ 1 time per day or less	☐ Never	☐ Does not apply to my site
24. Vegetables including fresh, frozen, or canned, are served:	☐ 3 times per day or more	☐ 2 times per day	☐ 1 time per day or less	☐ Never	☐ Does not apply to my site
25. Fruit including fresh, canned in water or own juice, frozen, or dried, is served:	☐ 3 times per day or more	☐ 2 times per day	☐ 1 times per day or less	☐ Never	☐ Does not apply to my site
26. Unflavored milk or non-dairy alternative served to children aged 2 and older is:	☐ whole or regular	☐ 2% reduced fat	☐ 1% reduced fat or non-fat	☐ non-dairy alternative	☐ Does not apply to my site
27. Flavored or sweetened milk is served:	☐ 1 time per day or more	☐2-3 times per week	☐ 1 time per week or less	☐ Never	☐ Does not apply to my site
Physical Activity	**Already doing**	**Making progress in doing**	**Planning to do**	**Not planning to do**	**Does not apply to my site**
	Please select ☑ one box for each row.				
28. Parents receive written physical activity policy upon enrollment.	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
29. Children have at least 60 minutes of unstructured or child-led, physical activity time (or 30 minutes in a half-day program).	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
30. Children have at least 60 minutes of structured or teacher-led, physical activity time (or 30 minutes in a half-day program).	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
31. Information is provided to parents about their child's physical activity while in child care.	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
32. Staff participate in physical activities with children.	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
33. Screen time, or time spent using a computer, smartboard, or watching TV, is limited to 30 minutes per week for children.	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$
34. Parents are provided information that encourages physical activity at home.	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$

The Food Program (CACFP): a federal meal program offered to public and private child care sites.	Already doing	Making progress in doing	Planning to do	Not planning to do	Does not apply to my site
	Please select ☑ one box for each row.				
35. My child care center/site participates in the Food Program (CACFP).	☐1	☐2	☐3	☐4	☐5

Please answer questions 36 and 37 by checking one box for each row.

36. How prepared do you feel to make changes in the following areas at your child care site?	Please select ☑ one box for each row.			
	Very prepared	Somewhat Prepared	Not prepared	Not sure
f. Breastfeeding practices	☐1	☐2	☐3	☐4
g. Food and beverage practices	☐1	☐2	☐3	☐4
h. Physical activity/playtime practices	☐1	☐2	☐3	☐4
i. Screen time practices	☐1	☐2	☐3	☐4
j. Creating or improving written guidelines about health for your child care	☐1	☐2	☐3	☐4

37. In your opinion, how much does each of the following activities in child care affect a child's growth and health?	Please select ☑ one box for each row.			
	Not at all	A little	A lot	Not sure
f. Drinking breast milk as an infant	☐1	☐2	☐3	☐4
g. Doing teacher-led physical activity	☐1	☐2	☐3	☐4
h. Having active free play	☐1	☐2	☐3	☐4
i. Eating a variety of healthy foods	☐1	☐2	☐3	☐4
j. Drinking beverages with no added sugar	☐1	☐2	☐3	☐4

38. What are some challenges that you face or have faced while taking steps towards creating **healthy practices or routines**? Please check ☑ <u>all that apply</u>.

A☐ Lack of support from management/leadership staff
B☐ Lack of support from other child care staff
C☐ Lack of support from parents
D☐ Not enough money to make changes
E☐ Not enough time to make changes
F☐ Not enough training to make changes
G☐ Not enough space to make changes (kitchen, play space)
H☐ Not enough equipment to make changes (play structures, kitchen utensils)
I ☐ Other: _____
J ☐ I did not face any challenges to creating healthy practices or routines.
K☐ Does not apply: I did not create healthy practices or routines.

39. What are some challenges that you face or have faced while taking steps towards creating **written rules or guidelines** about healthy practices? Please check ☑ all that apply.

A☐ Lack of support from management staff
B☐ Lack of support from other child care staff
C☐ Lack of support from parents
D☐ Not enough training to make changes
E☐ Not enough time to write rules or guidelines
F☐ Other: _____
G☐ I did not face any challenges to creating written rules or guidelines about healthy practices.
H☐ Does not apply: I did not create any written rules or guidelines about healthy practices.

40. What resources would be helpful for creating healthy practices or guidelines? Please check ☑ all that apply.

A☐ More printed information
B☐ More materials for parents
C☐ Websites
D☐ Newsletters
E☐ Time with a Choose Health LA Child Care coach
F☐ More training
G☐ Meeting with other child care providers making similar changes
H☐ Other: _____

41. How helpful, if at all, have the following been in your efforts to create a healthy child care environment?	**Please select ☑ one box for each row.**			
	Very helpful	**Somewhat helpful**	**Not helpful**	**Not sure/ does not apply**
a. Choose Health LA Child Care training	☐1	☐2	☐3	☐4
b. Choose Health LA Child Care training materials	☐1	☐2	☐3	☐4
c. Choose Health LA Child Care coaching sessions	☐1	☐2	☐3	☐4
d. Support from other staff at your child care site	☐1	☐2	☐3	☐4
e. Support from parents	☐1	☐2	☐3	☐4

42. Based on your participation in Choose Health LA Child Care, would you say that creating healthy practices or guidelines has impacted your costs in the following ways? Please check ☑ one.

A☐ Increased my costs a lot
B☐ Increased my costs a little
C☐ Not changed my costs
D☐ Decreased my costs a little
E☐ Decreased my costs a lot
F☐ Don't know
G☐ Does not apply: I have not created healthy practices or guidelines.

43. If you have made healthy changes at your child care site, have you been able to change your fees for families? Please check ☑ one.

A☐ Yes, my site charges more
B☐ Yes, my site charges less
C☐ Maybe, we are considering charging more
D☐ Maybe, we are considering charging less
E☐ No change
F☐ Don't know
G☐ Does not apply: I have not created healthy practices or guidelines.

44. Have you used your participation in Choose Health LA Child Care in any marketing materials for your child care? Please check ☑ one.

A☐ No
B☐ Yes; Please describe: _____

45. If you have any rules or guidelines about healthy practices, have you shared them with parents?

A☐ No
B☐ Yes
↘ If so, how have parents reacted?

1 ☐ Generally positively
2 ☐ No reaction
3 ☐ Generally negatively
4 ☐ Don't know

46. Based on your participation in Choose Health LA Child Care and/or any healthy practices or guidelines that you have, has there been a change in demand for or interest in your child care services?

A☐ No, I have not noticed more interest
B☐ Yes, I have noticed more interest
C☐ Don't know
D☐ Does not apply: I have not shared any healthy written rules or guidelines

Thank you for your participation in this survey and in Choose Health LA Child Care!

Send the COMPLETED survey back to us, and we'll send you a $10 gift card to buy something new for your child care!

Appendix B3: Methods for Ensuring Participant Confidentiality

Participant confidentiality was protected through the following methods. After participants signed-in for a training session their information was entered into a countywide database by the trainers or an assistant and the database assigned a unique ID to the participant. The R&R agency then requested a training roster report for that training from the Research and Evaluation team at one of the R&R agencies (Child Care Resource Center). A Research Specialist pulled a report with the provider information (name, ID, etc.) and sent this information to each of the Coaches at the individual R&R agencies. The Coaches then entered the information into an MS Access-based database, accessible to the Los Angeles County Department of Public Health (DPH). An Analyst from DPH reviewed this database for those eligible providers who had attended trainings in the last month and mail merged their participant number onto a survey and matched each survey to an envelope that was printed with the correct address for the participant. The return envelope was addressed to the Research and Evaluation team at the Child Care Resource Center and a Research Specialist entered the survey data into the MS Access-based database. The Analyst at DPH designed a mechanism to ensure that those who completed and mailed their baseline survey would then receive a follow-up survey 4-6 months following their original training workshop date.

Appendix C: Nutrition and Feeding Practices: Differences by Site Type

Tables for Differences by Site Type

Table C1. Nutrition Feeding Practices: Relationship at baseline between site type and response to item 1: "Parents receive written nutrition policies upon enrollment."

	Center	Licensed Home
Doing	359 (90.0%)	73 (67.0%)
Not Doing	40 (10.0%)	36 (33.0%)
P < .001, FET (n=508). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 4.43**
        - Center-based respondents were 4.43 times more likely than family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 1.

Table C2. Nutrition Feeding Practices: Relationship at baseline between site type and response to item 3: "If food is brought from home, parents are provided with guidelines"

	Center	Licensed Home
Doing	187 (87.0%)	42 (66.7%)
Not Doing	28 (13.0%)	21 (33.3%)
P = .001, FET (n=278). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 3.34**
        - Center-based respondents were 3.34 times more likely than Family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 3.

Table C3. Nutrition Feeding Practices: Relationship at follow-up between site type and response to item 4: "Parents are given information about what their children are offered (menus)"

	Center	Licensed Home
Doing	457 (99.3%)	121 (96.8%)
Not Doing	3 (0.7%)	4 (3.2%)
P = .041, FET (n=585). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 5.04**
        - Center-based respondents were 5.04 times more likely than Family child care providers to indicate that they are "Already Doing" or "Making Progress" on Item 4.

Table C4. Nutrition Feeding Practices: Relationship at baseline between site type and response to item 5: "Meals and snacks are scheduled at consistent times each day."

	Center	Licensed Home
Doing	466 (100%)	124 (97.6%)
Not Doing	0 (0%)	3(2.4%)
P = .010, FET (n=593). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 26.22**
        - [*0.5 added to each cell to compute odds ratio per Haldane (1955) and Gart & Zweifel* (1967)].
            - Citation refers to standard practice of adding .5 to each cell when computing an Odds Ratio with "0" in numerator or denominator.
        - Center-based respondents were 26.22 times more likely than Family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 5.

Table C5. Nutrition Feeding Practices: Relationship at follow-up between site type and response to item 5: "Meals and snacks are scheduled at consistent times each day."

	Center	Licensed Home
Doing	467 (100%)	126 (97.7%)
Not Doing	0 (0%)	3(2.3%)
P = .010, FET (n=596). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 25.87**
        - [*0.5 added to each cell to compute odds ratio per Haldane (1955) and Gart & Zweifel* (1967)].
            - Citation refers to standard practice of adding .5 to each cell when computing an Odds Ratio with "0" in numerator or denominator.
        - Center-based respondents were 25.87 times more likely than family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 5.

Table C6. Nutrition Feeding Practices: Relationship at follow-up between site type and response to item 6: "Mealtimes are relaxed, calm, and with shared conversation."

	Center	Licensed Home
Doing	468 (100%)	131 (98.5%)
Not Doing	0 (0%)	2 (1.5%)
P = .049, FET (n=599). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 17.81**
        - [*0.5 added to each cell to compute odds ratio per Haldane (1955) and Gart & Zweifel* (1967)].
            - Citation refers to standard practice of adding .5 to each cell when computing an Odds Ratio with "0" in numerator or denominator.
        - Center-based respondents were 17.81 times more likely than Family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 6.

Table C7. Nutrition Feeding Practices: Relationship at baseline between site type and response to item 9: "Children serve themselves from serving dishes at mealtime."

	Center	Licensed Home
Doing	341 (86.1%)	53 (55.8%)
Not Doing	55 (13.9%)	42 (44.2%)
P > .001, FET (n=491). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 4.91**
        - Center-based respondents were 4.91 times more likely than family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 9.

Table C8. Nutrition Feeding Practices: Relationship at baseline between site type and response to item 10: "Children with special needs have their nutrition needs taken into account."

	Center	Licensed Home
Doing	357 (99.4%)	59 (93.7%)
Not Doing	2 (.6%)	4 (6.3%)
P > .005, FET (n=422). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 12.10**
        - Center-based respondents were 12.10 times more likely than family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 10

Table C9. Nutrition Feeding Practices: Relationship at follow-up between site type and response to item 10: "Children with special needs have their nutrition needs taken into account."

	Center	Licensed Home
Doing	345 (98.6%)	75 (92.6%)
Not Doing	5 (1.4%)	6 (7.4%)
P > .008, FET (n=431). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 5.52**
        - Center-based respondents were 5.52 times more likely than family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 10

Table C10. Nutrition Feeding Practices: Relationship at follow-up between site type and response to item 12: "Adults sit with children at mealtime"

	Center	Licensed Home
Doing	460 (98.9%)	122 (93.1%)
Not Doing	5 (1.1%)	9 (6.9%)
P = .001, FET (n=596). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 6.79**
        - Center-based respondents were 6.79 times more likely than family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 12.

Table C11. Nutrition Feeding Practices: Relationship at baseline between site type and response to item 16: "Breastfeeding mothers are provided access to a private area for breastfeeding or pumping with appropriate seating. "

	Center	Licensed Home
Doing	126 (87.5%)	61(76.3%)
Not Doing	18 (12.5%)	19(23.8%)
P = .039, FET (n=596). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 2.18**
        - Center-based respondents were 2.18 times more likely than family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 16.

Table C12. Nutrition Feeding Practices: Relationship at baseline between site type and response to item 19: "Drinking water is freely available throughout the day. "

	Center	Licensed Home
Doing	456 (99.6%)	123 (96.1%)
Not Doing	2 (.4%)	5 (3.9%)
P = .007, FET (n=586). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 9.23**
        - Center-based respondents were 9.23 times more likely than family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 19.

Table C13. Nutrition Feeding Practices: Relationship at follow-up between site type and response to item 19: "Drinking water is freely available throughout the day. "

	Center	Licensed Home
Doing	454 (100%)	128 (98.5%)
Not Doing	0 (0%)	2 (1.5%)
P = .049, FET (n=584). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 17.68**
        - [*0.5 added to each cell to compute odds ratio per Haldane (1955) and Gart & Zweifel* (1967)].
            - Citation refers to standard practice of adding .5 to each cell when computing an Odds Ratio with "0" in numerator or denominator.
        - Center-based respondents were 17.68 times more likely than family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 19.

Table C14. Physical Activity: Relationship at baseline between site type and response to item 28: "Parents receive written physical activity policy upon enrollment."

	Center	Licensed Home
Doing	283 (78.4%)	59 (60.2%)
Not Doing	78 (21.6%)	39 (39.8%)
P < .001, FET (n=459). Numbers in parentheses indicate column percentages.		

- (FET) is Fisher's Exact Test. Only the P value is reported for this test.
    - **Odds Ratio = 9.59**
        - Center-based respondents were 9.59 times more likely than Family child care providers to indicate that they are "Already Doing" or "Making Progress" on item 28.

Appendix D: Resources and Tools Provided

Newsletter

Measuring Cup and Plate

Apron

Breastfeeding Toolkit

Calendar

Yoga Cards

Physical Activity Kit

Appendix E: Endnotes

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