Challenges and Opportunities Related to Implementation of Child Care Nutrition and Physical Activity Policies in Delaware

Findings From Focus Groups with Child Care Providers and Parents

May 2010
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David Bowman, the Director of the Delaware Child and Adult Care Food Program (CACFP), and Patricia Quinn, the Administrator of Delaware’s Office of Child Care Licensing (OCCL), were very helpful in discussing CACFP and child care licensing policy and implementation issues, reviewing the focus group discussion guides, and sharing program data. Without the leadership of these two state officials, we could not have successfully carried out this focus group research. Thanks also go to the child care licensing monitors from OCCL, and staff from Catholic Charities, Children and Families First, and the Delaware Parents Association who spent time with us to explain how they work with individual centers and homes to help them implement state policies. Special thanks to the directors and staff at the three local child care centers who spent considerable time with our research team recruiting parents and were very gracious hosts.

Our appreciation also goes to Dr. Katherine Christoffel of Children’s Memorial Medical Center and the Consortium to Lower Obesity in Chicago Children who reviewed and provided comments on a draft of this report. Her insights and perspective as a pediatrician, researcher and childhood obesity prevention advocate greatly improved this report.

Lastly, this study would not have been possible without the generous support of the directors and administrators from 59 child care centers and child care homes and the 24 parents from across the state of Delaware who took time out of their busy schedules to share their first hand experiences with us on Delaware’s nutrition and physical activity policies and provide their personal insights into how to make it easier for providers to comply with these policies.
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1. Introduction

The childhood obesity epidemic is affecting millions of U.S. children, their families, the institutions that serve them, the communities in which they live, and the overall health and welfare of our nation. Obesity trends among young children are particularly alarming. Over the past 30 years, the prevalence of obesity among 2- to 5-year-olds has more than doubled. Currently, one in four preschool children is overweight or obese. Pediatric onset of obesity is a strong predictor of persistence of obesity into adulthood, in part because eating and activity habits and preferences are formed during early years. The prevention of obesity among young children is therefore an important strategy for curbing this epidemic. Child care centers and family child care homes provide a crucial opportunity to support and promote healthy growth in children. In the United States, 62% of preschool children with working mothers were enrolled in full-time (35 or more hours per week) or part-time (15–34 hours per week) child care in 2002. Those 3- to 6-year-olds who attend child care centers spend an average of 24.8 hours per week there.

As a result of spending a large percentage of time in child care, many children consume a substantial portion of their total daily caloric intake in these settings. In addition to contributing to consumption habits, child care settings can also have a significant impact on the activity levels of children. Some studies are finding that children are spending very little time being active or are not sufficiently active to promote good health. One research study found that children spent only 2–3% of their time in child care centers engaged in physical activity that could be classified as moderate or vigorous. This indicates proportionately more time is being spent engaged in sedentary behaviors, such as television viewing. Extensive research has documented an association between increased television viewing and obesity, and a recent study of preschool children found both increased body fat and less physical activity associated with increased minutes of television viewing. There is an opportunity through both state and local child care licensing bodies and the Child and Adult Care Food Program (CACFP) to enhance nutrition and physical activity standards for the millions of children nationwide who spend a large portion of their days in licensed child care facilities.

Opportunities for Child Obesity Prevention Standards through the CACFP

The Child and Adult Care Food Program (CACFP) is a federal program that reimburses child care providers for meals and snacks served to children in licensed homes and centers. The program is administered at the federal level by the Food and Nutrition Service (FNS) of the U.S. Department of Agriculture (USDA). At the state level, CACFP is usually overseen by state departments of education or health. It serves more than 3 million children each year. To be eligible to participate, child care providers must have at least 25% of their enrolled children come from households with annual income of 185% or less of the federal poverty level. Other requirements of provider participation include CACFP-specific training and reporting.

At the federal level, FNS sets minimum meal quality standards for CACFP participating child care providers. The current federal CACFP meal standards focus on ensuring that a minimum number of foods from the meat, dairy, fruit and vegetable, and grain food groups are regularly provided. The federal regulations have not yet been updated to reflect recommendations in the 2005 Dietary Guidelines for Americans⁹ or to focus on nutrition standards that can promote lifelong healthy eating habits and prevent child obesity. For example, the CACFP standards do not place limits on added sugars or sugar-sweetened beverages, require or recommend the use of low-fat or skim milk, or discourage the use of energy-dense foods in child care settings. In order to ensure that children in child care are receiving healthy meals and snacks more in line with the most recent 2005 Dietary Guidelines for Americans, the Institute of Medicine is reviewing the CACFP standards and it is very likely that within several years the federal regulations on CACFP meal standards will be modified. However, recognizing the need for more timely improvements in the CACFP nutrition standards, many state CACFP agencies are moving ahead in this area. To date, Arizona, Delaware, Florida, Kentucky, New York State, and the District of Columbia have issued additional child nutrition requirements for CACFP providers. West Virginia and other states are currently in the process of finalizing or considering enhanced CACFP nutrition requirements.

Opportunities for Child Obesity Prevention through Child Care Licensing Bodies

In addition to state policy action to establish CACFP nutrition standards that go beyond federal guidance, the other major mechanism currently being used to promote nutrition and physical activity in child care settings is the adoption of relevant child care licensing regulations. Each state, and some cities, set their own standards of care and program operation for licensing child care facilities. These licensing standards are commonly established by state- and city-level departments of health or human services. States and communities that have recently implemented new child care licensing standards for nutrition, physical activity or screen time include Alaska, Delaware, Massachusetts, New York City and the City of Chicago. While a few states have taken action in this area, currently most states lack adequate healthy eating and physical activity child care licensing regulations for child care centers and fewer still have such regulations for family child care homes.

Nutrition and Physical Activity Child Care Policies in Delaware

Delaware’s policies governing nutrition and physical activity in child care settings are among the most comprehensive in the nation. Delaware was the first state to implement comprehensive guidelines for child care through both CACFP and the Delaware Office of Child Care Licensing (OCCL) and to have the same guidelines apply to both licensed child care centers and child care homes. Delaware is the second smallest state in the nation, with a total area of 1,982 square miles and a total population of 873,092. There are 443 licensed child care centers and 1,159 licensed child care homes across the state. Together these centers and homes serve up to 52,666 children.

In 2007, OCCL first promulgated revisions to child care licensing rules regarding nutrition and physical activity. The amended rules require all licensed child care facilities to comply with the state’s CACFP nutrition guidelines, new physical activity requirements, and screen time limitations. These rules were designed to promote improved child nutrition, increase the amount of moderate to vigorous physical activity, and limit the time children spend sedentary while in child care. In 2008, Delaware’s Department of Education announced nutrition guidelines for the state’s CACFP with implementation of the new nutrition standards encouraged, but still voluntary. The CACFP nutrition guidelines officially went into effect in January 2010 with issuance of formal policy guidance by the state agency.

Delaware’s nutrition guidelines, minimum requirements for physical activity opportunities, and screen time limits in child care settings are summarized in Table 1. The sections that follow provide an overview and justification for the policies in each of these three areas.

- **Nutrition Guidelines**

The state’s CACFP nutrition guidelines are designed to promote the serving of meals and snacks that are consistent with the 2005 Dietary Guidelines for Americans. These guidelines are in addition to the current federal nutrition standards for CACFP. They apply not only to child care facilities participating in CACFP but to all licensed programs.

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10 Chicago’s Board of Health recently passed a resolution with new nutrition and physical activity standards for licensed child care centers. The standards are currently voluntary and are expected to become mandatory regulations in 1 to 2 years.


13 Data on number of licensed child care facilities and available child care slots in these centers (personal communication, Patti Quinn, Delaware Office of Child Care Licensing, March 22, 2010).
Physical Activity Regulations

Delaware’s child care licensing rules for centers and homes build on research findings, and are designed to promote physical activity as an important component of overall healthy growth and development for children. They aim to promote the development of gross and fine motor skills, agility, and other skills, and to increase physical activity and prevent future incidence of chronic diseases.

Screen Time Regulations

Delaware’s child care licensing rules pertaining to television, DVD, and video watching are consistent with the American Academy of Pediatrics\textsuperscript{14} and the National Association for Sports and Physical Education\textsuperscript{15} screen time recommendations. In fact, they can be considered conservative compared to recent model state child care regulations for physical activity released by the Robert Wood Johnson Foundation, which call for limiting all screen time to 30 minutes per week.\textsuperscript{16}

Need for and Purpose of this Focus Group Research

Delaware’s child care policy changes were driven in large part by advocacy from Nemours Health and Prevention Services, a nonprofit organization based in Newark, Delaware that works with families and community partners to help children grow up healthy. Nemours is working in Delaware to address child obesity using a multisector approach. This includes working with child care centers, schools, primary care, and the community to promote healthy eating and physical activity. The goal is to reduce the prevalence of overweight and obesity in children 2–17 years old by 2015. Results from Nemours’ 2008 Delaware Survey of Children’s Health indicate that the prevalence of childhood overweight and obesity is leveling off. However, the survey found that rates remain very high, particularly

\begin{itemize}
  \item NASPE, op. cit.
  \item Benjamin SE, Gillman MW, Traub AE, Finkelstein J. Preventing Childhood Obesity in the Child Care Setting: Enhancing State Regulations. Boston, MA: Harvard Medical School and Harvard Pilgrim Health Care; 2009.
\end{itemize}
Table 1. Delaware’s Enhanced Nutrition and Physical Activity Policies for Children in Child Care Centers and Large and Small Child Care Homes

<table>
<thead>
<tr>
<th>Enhanced Nutrition Guidelines for Meals and Snacks</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk</td>
<td></td>
</tr>
<tr>
<td>■ Children 1–2 years of age must get whole milk.</td>
<td></td>
</tr>
<tr>
<td>■ Children over 2 years of age must get 1% or fat-free (skim) milk.</td>
<td></td>
</tr>
<tr>
<td>Fruits and Vegetables</td>
<td></td>
</tr>
<tr>
<td>■ No more than one serving per day of 100% juice may be served to children.</td>
<td></td>
</tr>
<tr>
<td>■ Non-100% juice (juice drink or cocktail) is not allowed.</td>
<td></td>
</tr>
<tr>
<td>■ No baked pre-fried or fried fruits or vegetables (e.g. French fries and tater tots) will be allowed unless no more than 35% of their total calories are from fat. It is highly recommended not serving fried foods at all.</td>
<td></td>
</tr>
<tr>
<td>Meat or Meat Alternates</td>
<td></td>
</tr>
<tr>
<td>■ Processed meats (e.g. hot dogs, sausage, bologna etc.) shall be used only 1 time per cycle (1 X in 2-weeks). It is highly recommended not serving processed meats at all.</td>
<td></td>
</tr>
<tr>
<td>■ No baked pre-fried or fried food items shall be allowed (e.g. chicken nuggets, fish sticks) unless no more than 35% of their total calories are from fat. It is highly recommended not serving fried foods at all.</td>
<td></td>
</tr>
<tr>
<td>■ Only real cheese may be served—no cheese product or cheese food.</td>
<td></td>
</tr>
<tr>
<td>Grains</td>
<td></td>
</tr>
<tr>
<td>■ A whole grain product must be served at least 1x per day. The food label for whole grain products lists a whole grain as the first ingredient. Examples include whole wheat flour, oatmeal, whole cornmeal and brown rice.</td>
<td></td>
</tr>
<tr>
<td>■ Cereals must contain fewer than 6 grams of sugar per serving. Whole grains are highly encouraged.</td>
<td></td>
</tr>
<tr>
<td>■ Sweet grains/baked goods (e.g. cookies, cakes, donuts, Danishes, etc.) may be served once per cycle (1X in 2-weeks) for snack only. It is highly recommended not serving sweet baked goods at all.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screen Time Limitations and Physical Activity Requirements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Screen Time Limitations**</td>
<td></td>
</tr>
<tr>
<td>■ Television, DVD, video cassette, and computer viewing are prohibited for children younger than 2 years of age.</td>
<td></td>
</tr>
<tr>
<td>■ Television, DVD, and video cassette viewing is limited to age-appropriate and educational materials, must have the written approval of each child’s parent or guardian, and cannot exceed 1 hour daily per child or group of children.</td>
<td></td>
</tr>
<tr>
<td>■ Computer viewing is limited to age-appropriate and educational programming and must have protections from exposure to inappropriate Web sites, have the written approval of each child’s parent or guardian, be supervised by a staff member, and not exceed 1 hour daily per child or group of children.</td>
<td></td>
</tr>
<tr>
<td>Minimum Requirements for Offering Moderate to Vigorous Physical Activity Opportunities</td>
<td></td>
</tr>
<tr>
<td>■ Each child, according to his or her ability, must be provided the opportunity for a minimum of 20 minutes of moderate to vigorous physical activity indoors or outdoors for every 3 hours the child is in attendance (equal to 60 minutes daily for a full 8- to 9-hour day).</td>
<td></td>
</tr>
</tbody>
</table>

* In Delaware, licensed child care homes are divided into “small” child care homes, which are allowed to serve 1–6 children; and “large” child care homes, which are allowed to serve 7–12 children.

** The OCCL licensing rules limiting screen time apply to child care centers but not to child care homes.
among non-white children, with the prevalence of childhood overweight and obesity ranging from 40% to 46% across Delaware’s three counties and the city of Wilmington.17

In spring 2009, Nemours invited researchers from Altarum Institute to assist in convening a group of partners involved in the implementation of Delaware’s new nutrition and physical activity guidelines. The goal of the meeting was to learn what Delaware partners who are working to implement these child care policies felt that they needed to advance their shared efforts. State partners in attendance included the CACFP, OCCL, and the University of Delaware’s Institute for Excellence in Early Childhood Education. At the meeting, partners expressed a sense of urgency to move forward with expanded training on the new guidelines to help providers implement the new policies, but they also expressed concern regarding the challenges that child care providers will face in implementing the new guidelines. From the time of the initial announcement and distribution of the voluntary enhanced CACFP guidelines in 2008, state agency partners had already received anecdotal reports of both successes and challenges providers were experiencing. The challenges were reported to include issues related to accessing the nutritious foods now required, perceived higher food costs in a time of economic recession, and parental resistance to some of the new nutrition policies. However, no formal assessment of providers’ needs in implementation had yet been conducted.

Altarum agreed to conduct a series of focus groups of child care providers and parents in Delaware to (1) inform state agencies on the perceptions of providers and parents concerning changes to policies regulating nutrition and physical activity in child care and (2) identify the types of training, tools, and other resources that child care providers need in order to comply effectively with these policy changes. This formative assessment was to be conducted under the auspices of Altarum’s Childhood Obesity Prevention Mission Project, a 2-year, self-funded initiative designed to catalyze systems changes that promote health and prevent obesity among young children.

Format of the Focus Group Report

This report details the findings from a series of focus groups with providers and parents conducted by Altarum in 2009, as well as conclusions and recommendations based on these findings. The report is organized into chapters. The following chapter describes the methodology that Altarum used to develop, carry out, and analyze the focus groups in collaboration with the Delaware partners. Chapters 3–8 contain the input of child care home and center providers as well as parents of children attending child care centers. These chapters also highlight specific challenges to implementation; strategies currently in use to mitigate these challenges; and focus group participants’ suggestions for information, tools, and other supports that they believe will help them comply with Delaware’s nutrition, physical activity, and screen time rules. Chapters 3–6 specifically address the nutrition guidelines. Chapter 7 addresses the OCCL physical and screen time regulations. Training of child care providers is addressed in Chapter 8. The final chapter summarizes the findings with brief conclusions and recommendations, based on the focus group findings.

Altarum hopes that this report is useful in Delaware and other states and localities that are exploring systems change efforts to support childhood obesity prevention in child care settings.

2. Methodology

Overview

Altarum Institute conducted a total of 10 focus groups across the state of Delaware during July and August 2009. Focus groups were held with four separate populations: CACFP-participating child care center providers, non-CACFP-participating child care center providers, child care home providers, and parents of children attending care centers. For the purposes of this study, the term “child care provider” is defined as the child care administrator or staff person who is responsible for the meal planning and overseeing the provision of care at the center. In most cases, this was the child care center director, though in a few cases it was the center cook or a center staff supervisor. For the child care homes, the “provider” is the sole person responsible for all aspects of the meal quality and provision of care, including physical activity opportunities for the children in their care.

Focus groups were used as the data collection method, as they are an excellent method for providing insights into people’s perceptions and beliefs and for identifying challenges and brainstorming potential solutions. The open-ended discussion questions and group dynamics of focus groups help facilitate rich discussions as individuals are inspired by one another’s ideas and comments. This qualitative data collection method also allows the input of many individuals to be collected over a short period in a cost-efficient manner.18

Focus Group Context and Study Design

Delaware is divided into three counties: New Castle, Kent, and Sussex. New Castle County is more urban than the other two counties and contains the state’s two largest cities: Wilmington and Newark. Kent County is in the middle of the state and includes Dover, the state capital. Sussex County covers the southern and eastern portions of the state and includes expansive rural areas.

To obtain the perspective of providers and parents in these varying regions, three to four focus groups were conducted in each of the three counties. In each county, one focus group was conducted with center providers, one group with child care home providers, and one with parents whose children attend child care centers. The providers and parents in each of these groups were from centers or homes that participated in Delaware’s CACFP. The 10th group was conducted in New Castle County with licensed child care center providers who did not participate in CACFP. This group of providers serves a population of families with somewhat higher incomes. Under Delaware’s child care regulations, these centers are still subject to the same nutrition and physical activity rules as the CACFP participating providers.

Figure 1 represents the focus group study design for the seven provider groups, displaying the distribution by participant type and across the counties.

**Figure 1. Summary of Focus Groups by Location and Participant Type**

Overall, 83 individuals participated in 10 focus groups. Seven focus groups were conducted with child care providers from a total of 32 child care centers and 27 child care homes across the state. Four of the seven child care provider focus groups were held with providers from centers, and three with providers from child care homes. Participants from six of the seven provider focus groups were recruited from child care centers participating in CACFP, and one group of participants was recruited from centers not participating in CACFP. Characteristics of the centers and homes these individuals served are provided in Table 2.

**Table 2. Child Care Provider Focus Group Participants by Type and Location, With Facility Descriptors**

<table>
<thead>
<tr>
<th>Type of Group Participants</th>
<th>County</th>
<th>Number of Providers/Child Care Facilities *</th>
<th>Meals Provided**</th>
<th>Average Number (Range) of Children Enrolled at Each Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Care Center Providers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CACFP Child Care Center Providers</td>
<td>Kent</td>
<td>8 BLAS</td>
<td></td>
<td>76 (28–200)</td>
</tr>
<tr>
<td>CACFP Child Care Home Providers</td>
<td>Sussex</td>
<td>8 BLAS</td>
<td></td>
<td>42 (25–66)</td>
</tr>
<tr>
<td>Non-CACFP Child Care Center Providers</td>
<td>New Castle</td>
<td>10 BLAS</td>
<td></td>
<td>92 (39–250)</td>
</tr>
<tr>
<td><strong>Total Child Care Center Providers</strong></td>
<td></td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child Care Home Providers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CACFP Child Care Home Providers</td>
<td>Kent</td>
<td>7 BLASD</td>
<td></td>
<td>6 (4–9)</td>
</tr>
<tr>
<td>CACFP Child Care Home Providers</td>
<td>Sussex</td>
<td>10 BLASD</td>
<td></td>
<td>8 (5–12)</td>
</tr>
<tr>
<td>CACFP Child Care Home Providers</td>
<td>New Castle</td>
<td>10 BLAS</td>
<td></td>
<td>7 (3–9)</td>
</tr>
<tr>
<td><strong>Total Child Care Home Providers</strong></td>
<td></td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Providers</strong></td>
<td></td>
<td>59 Providers</td>
<td></td>
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</tbody>
</table>

*Only one provider participated from each child care center or child care home.

**Meals provided: B = Breakfast L = Lunch D = Dinner AS = Afternoon snack
Three focus groups were conducted with parents, with a total of 24 parents participating. Characteristics of the centers and homes these individuals had children enrolled in are provided in Table 3.

**Table 3. Parent Focus Group Participants by Location, With Facility Descriptors**

<table>
<thead>
<tr>
<th>County</th>
<th>Number of Parents*</th>
<th>Meals Provided*</th>
<th>Average Number (Range) of Children Enrolled at Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent</td>
<td>8</td>
<td>P</td>
<td>165</td>
</tr>
<tr>
<td>Sussex</td>
<td>7</td>
<td>C</td>
<td>180</td>
</tr>
<tr>
<td>New Castle</td>
<td>9</td>
<td>C and P</td>
<td>86</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24 Parents</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Each focus group included parents from one child care center
** P = Parents pack meals  C = Center provides meals

**Instrumentation**

Focus group discussion guides with key discussion questions were developed with input from, and in coordination with OCCL, CACFP, and Nemours. Separate discussion guides were developed for the provider focus groups and parent focus groups. Focus group facilitators were trained to follow these guides in order to promote uniformity among the various lines of inquiry explored in the groups, follow-up questions (or probes), and subsequent coding and data analysis.

**Child Care Provider Focus Group Guide**

The purposes of the provider focus groups were to (1) obtain a comprehensive view of how providers perceive and address the new nutrition guidelines and physical activity standards and (2) explore their recommendations for how implementation could be best supported by the state.

The provider discussion guide addressed the following specific topics:

- How providers are implementing the new nutrition standards, including challenges with implementation and strategies to overcome these challenges (specific probes explored issues related to transitioning to low-fat milk, unprocessed cheese and meats, nonfried foods, and whole grains);
- How providers are working with food suppliers to implement the nutrition standard changes;
- Whether and how providers are working to engage staff and parents in supporting the new nutrition guidelines;
- How providers currently encourage moderate to vigorous physical activity, including changes that they have made to meet the new standards, challenges that they encounter, and strategies that they have employed to overcome these challenges;
- Ease or difficulty in implementing the screen time standards and accompanying challenges and strategies;
- Feedback on past nutrition and physical activity trainings (specific probes explored what providers liked and disliked in terms of both content and format);
- Ideas for how future trainings could support implementation of the standards in terms of both content and format, as well as training recommendations specific to either nutrition or physical activity; and
Ideas for other resources to support implementation of the nutrition and physical activity standards, including topics for toolkits (e.g., sample menus), recipe books, charts, and newsletters.

While the same guide was used with both center and home providers, the discussion questions were somewhat tailored during the groups with home providers, given that these individuals are usually not only the owner and food purchaser of their facility but also the sole cook and caregiver for the children whom they serve. Additionally, screen time limits were not discussed with the home providers, since they are not subject to this state licensing rule.

Parent Focus Group Guide

The parent focus group guide was designed to obtain a comprehensive picture of parents’ understanding and perceptions of the new policies for child care, ways in which they would like to be engaged in learning more about the policies, and how best to support nutrition and physical activity in their homes. The parent discussion guide addressed the following specific topics:

- Whether and how child care centers communicated the new nutrition, physical activity, and screen time policies to parents;
- How parents perceive the new policies (probes explored parents’ understanding of the rationale for the policies); and
- Ways in which the child care centers have engaged parents in supporting healthy eating and physical activity and recommendations for how centers could effectively engage parents. Probes explored parent preferences on the content and format of the desired activities.

Recruitment and Eligibility

Recruitment for provider focus groups was conducted by Altarum staff. Individuals were recruited to participate in one focus group based on type of operation (child care center versus child care home) and the county location where they provide child care services. Mailing lists of CACFP participating centers were obtained from the state CACFP. Mailing lists of licensed family child care homes were obtained from the state’s three largest CACFP-sponsoring agencies that administer and monitor these homes in Delaware. A mailing list to recruit for the one group of non-CACFP providers was obtained from OCCL. Using these lists, providers serving child care centers and homes were mailed a recruitment letter signed by the state director of CACFP and the administrator of OCCL explaining the purpose of the needs assessment and encouraging their involvement in the focus groups. The letter instructed interested providers to contact Altarum via email or a toll-free number to sign up to participate.

Eight to 10 participants per group were desired, with recruitment of up to 14 individuals per group to allow for dropouts. If too few participants responded to the initial recruitment letter for a particular group, Altarum staff recruited participants with phone calls to providers on the lists provided by the state CACFP, CACFP-sponsoring agencies, and OCCL.

Providers who expressed interest in participating were screened for eligibility during the recruitment process. For the focus groups with centers, the individual who administers the center and purchases the food (but not necessarily the person who prepares the meals and/or acts as the direct educator) was the desired participant. Only one individual could participate from each center.

Center and home providers were eligible for participation in the focus groups if they met the following criteria:

- Have preschool children (2–5 years of age) enrolled,
The study successfully sought to include providers with a range of enrollment capacity, as shown in Table 2.

Parent focus group recruitment was conducted by three child care centers selected by Nemours staff. Nemours selected one center for the focus groups in each county based on their previous participation in Nemours’ trainings and capacity and willingness to assist in focus group recruitment over the summer months. Two of the groups of parent participants were recruited from centers that prepare lunches and snacks for the children, and one group was recruited from a center where parents pack their child’s lunch. Parents were eligible to participate if they had a preschool child (2–5 years of age) currently enrolled in child care.

Focus Group Administration

Focus groups lasted approximately 90 minutes each. Before participating, each provider or parent read and signed an informed consent statement. All participants were informed of the purpose of the focus groups, discussion topics, their rights as voluntary participants, and an overview of the measures taken to ensure confidentiality. Focus group discussions were tape recorded with the consent of all participants. Typed notes were taken as backup. Each group was moderated by one of two experienced focus group facilitators from Altarum Institute who are very familiar with Delaware’s nutrition, screen time, and physical activity policies. They had worked closely with child care providers in previous early childhood research, and in the conduct of needs assessments and technical assistance efforts.

All focus group participants received a lunch or dinner meal at the focus group and a $30 department store gift certificate. Participants in the child care center groups received an additional $25 gift card from a regional online educational supply company to purchase supplies for their center.

Data Analysis

Recorded focus group discussions were transcribed into Microsoft Word and imported into NVivo version 8 qualitative analysis software. After reviewing the transcripts, a coding structure was created and all transcripts were coded and analyzed in NVivo. From coded text, themes were identified and participants’ quotes were selected for inclusion in the findings chapters that follow.
3. General Perceptions of the Nutrition Guidelines

This chapter presents the overall impressions and perceptions of providers and parents about the new nutrition standards. Findings are organized according to positive and negative perceptions of the guidelines.

Positive Perceptions

In general, both child care providers and parents had positive reactions to the content of the state’s enhanced nutrition guidelines and understand the overall goals of improving young children’s diets to improve child health. The fact that providers and parents have embraced the overall goal of Delaware’s new nutrition guidelines is very important and lays the groundwork for successful implementation.

They Promote Health

In discussing the new guidelines, it is evident that focus group participants have adopted a big-picture view of the guidelines and how they will help prevent health conditions such as diabetes. Providers also frequently talked about the importance of initiating healthy eating habits in young children so that these habits would continue throughout the school years and into adulthood. In particular, they felt as though they were giving young children a healthful start in life, moving them away from “white, processed everything” and serving them more child-appropriate portions. In the view of one provider,

“I think we have to look at the bigger picture. I think we have to look at the fact that if we start teaching the younger generations now how to eat right, then when they grow up, we’re not going to have, ‘Well, we can dream.’ We won’t have the obesity problems we have now. We won’t have the health care issues we have now. So if we are teaching them, introducing them to more fruits and vegetables, and teaching them how to eat healthy—I mean, I know when they get to school, they have the option...[to]say, ‘Oh, I’ve had those peas before; I ate them at daycare, so I’ll try them.’”

They Increase Children’s Desire to Try New Foods

A few providers reported receiving positive feedback from parents about the healthfulness of the foods served. Parents talked about how the changes their center is making had a positive impact on their children:

“I am happy [that my daughter] is being exposed to different foods.”

“My daughter is very picky. I found that since she has been going here, she has been eating a whole lot more different things as opposed to at home. She’s eating a bigger variety.”

“You would see it instantly. We can make some wonderful changes as far as the child’s behavior just by changing their diet.”

—child care home provider
Many home providers talked about the way the guidelines help them model positive behaviors to show parents that healthy eating is in their child’s best interest. In the words of one provider:

“If we bring nutritious foods to their [parents’] attention, we are helping them, and that is part of our job doing daycare.”

Parents and providers frequently expressed the opinion that by giving children the opportunity to try many different kinds of healthy foods at child care, they are more likely to develop a taste for these foods and more likely to eat them at home or school. Several parents at centers that are implementing the nutrition guidelines said that they were pleased at the positive spillover effect at home. One parent whose child attends a center where the food is prepared on site said:

“Yeah, I’m probably as guilty as any parent. I work all day, and by the time I get home, it’s pushing 6:00.... But I think if she has that opportunity to eat healthy at school, you know, my husband and I need to eat healthy as well. It could turn into a family thing, and we will all eat better, and I think it’s wonderful.”

Nearly all the parents who pack their children’s lunches also said that the new nutrition guidelines have positively affected the way that they shop for their whole family. In the words of one parent:

“[With the new rules,] I got used to buying those things for lunch every day. It makes it easier on the weekend to eat healthy, and we keep those lists for all our shopping.”

Despite feeling positively about introducing healthy habits to kids at a young age, many child care providers also had some negative perceptions. Some talked about the fact that these policy changes are occurring in an environment that may not be supportive of healthy eating. Some also expressed concern that if the children will not eat the foods that they offer, then they will go home hungry. This was of particular concern among parents of underweight children and children with picky eating habits, but it also resonated with providers. Providers serving low-income children in particular noted that for some of the children, the meals received at child care are their primary source of nutrition and the only balanced meals that these children receive daily. The negative perceptions that were repeatedly brought up are discussed below.
Concern About the Change From Whole to Low-Fat or Skim Milk

Providers uniformly understand the importance of drinking milk for child health, but the focus group findings indicate that many providers—and some of the parents they serve—have concerns about the new policy requiring low-fat or skim milk. The Delaware child care standard for milk states that children over age 2 must get 1% or fat-free (skim) milk. This is consistent with the 2005 Dietary Guidelines for Americans and the American Academy of Pediatrics (AAP) recommendations. This recommendation recognizes both the continued importance of milk for child growth and development after age 2, and the fact that children at this age no longer need the high amounts of saturated fat in whole or reduced-fat milk.

Many providers reported that the parents or their children did not want to drink lower-fat milk. Though we did not hear this concern in the three parent focus groups, it did consistently come up from a couple of providers in the majority of the groups:

“That’s my pet peeve I came with: the milk. I’m having a terrible time with that. My kids are saying, ‘What is this, water?’... But yeah, the ones that have to drink the low-fat milk are not drinking it. They’re putting it back on the counter or dumping it in the sink.”

A few providers clearly stated that they did not understand the rationale behind the change from whole to low-fat milk for children over age 2. “I want to know the research,” said one provider. Another said,

“In our food program, for 1-to-2s, it says that they need it for their brain development—the extra fat...but brain was the big thing up to 5...so my question is, why isn’t it [whole milk] required up to 5?”

Providers voiced a variety of other misunderstandings about the benefits of whole milk versus low-fat milk, including that whole milk has more calcium or other nutrients than low-fat milk, and consequently that it is better for bone development, arthritis prevention, and muscle development. A few providers reported that parents strongly believe that whole milk is superior in promoting healthy child development and report that their doctors say that their children should drink whole milk.

Restricting Foods Through the Guidelines May Cause Some Children to Go Hungry

Another strong concern expressed by several home providers and a few parents was whether the children would get enough to eat under the new nutrition guidelines if they did not like the new foods. A few parents were concerned that their child might not eat all day and would come home hungry and anxious at dinner time. This issue was a major concern for those providers who felt that they were many children’s only source of complete meals each day. Because of that, the providers want to encourage the children to eat. This may include allowing second and third helpings if children ask for them, cooking less healthful and more child-friendly food, and having the added fat in whole milk.

Inconsistencies Between the Child Care and School Meal Standards

Several home and center providers expressed concern that having these nutrition guidelines in child care settings without parallel standards for the school meals program is sending a mixed message. Their view is that making these changes for toddlers and preschool children is positive but will not be enough to sustain healthy eating behaviors if they are not supported once the child reaches school age. In the words of one provider,

“So what’s the point, then, of doing this for this age group...[if] when they grow up and go to school, they get all that garbage?”

You’ve got to understand [that] to some of these kids, we’re the only source of their food during the day.”

—child care center provider

4. Implementation of the Nutrition Guidelines

This chapter addresses food service issues that child care center and home providers have faced since Delaware’s CACFP enhanced guidelines were first introduced in 2008. These include changes in the ways that providers plan, purchase, and prepare meals and snacks. Because food service issues were a major topic of discussion in the provider focus groups but not in the parent groups, the summary of findings in this chapter is derived solely from provider input. Input from both child care centers and homes is included. The findings in this chapter are organized in sections according to three major themes related to food service. They are:

- Meal planning and food preparation,
- Food shopping, and
- Food costs.

The information presented for each section is organized into the following subsections: (1) challenges to implementation, (2) strategies that providers are using to address or alleviate these challenges, and (3) provider recommendations for furthering state support in implementing enhanced nutrition guidelines in child care settings. Recurring ideas within each subsection are bulleted and bolded for emphasis.

Meal Planning and Food Preparation

Menu planning and food preparation were the most frequently cited food service-related challenges of providers. Among these challenges was difficulty developing menus, incorporating variety, cooking, modifying existing recipes to meet Delaware’s new guidelines, and interpreting food labels. Delaware’s child care providers have had information on the nutrition guidelines since they were first developed in 2008. Several providers were able to highlight simple strategies they have used to mitigate new challenges and to come into compliance with enhanced CACFP guidelines that became fully effective in January 2010. Many providers and parents also offered concrete recommendations for informational and training materials and methods that the state could offer to better overcome challenges and address providers’ needs in the areas of meal planning and food preparation. Providers felt strongly that they need assistance not simply to meet the guidelines, but also to be able to respond to the tastes of the young children whom they serve and become more effective in promoting new healthy eating behaviors.
Challenges

- **Generating Appealing New Menu Ideas and Providing Variety**

Child care providers frequently cited difficulties in generating ideas for a variety of menu items. They also discussed challenges in preparing meals and snacks that are both appealing to children and in compliance with the limitations on fat and sugar content stipulated in the guidelines. The providers who mentioned these challenges said that the guidelines limited what they could serve. This limitation was discussed most frequently in relation to meat: “chicken, chicken, chicken,” as one provider put it. Several providers also expressed challenges in finding suitable meat category replacements for children’s favorites, such as chicken nuggets, hot dogs, and processed cheese slices.

The challenge in identifying suitable options for snacks was also mentioned often. Some providers and parents believe that they are limited by the new guidelines in what they can offer the children for snacks. The requirement that all grain products (including cereals) must contain no more than 6 grams of sugar per serving was cited as a particular challenge to overcome. Center and home operators reported that they served children certain types of graham crackers, biscuits, and muffins before the new guidelines were released, and they were surprised to learn that these items were no longer allowable because they exceed the sugar limit. A few providers commented that they were further surprised that many of the prepackaged snacks branded as “healthy” and “whole grain” were similarly too high in sugar to be allowable under the new guidelines. In addition to identifying appropriate snack options, providing a variety of snacks that meet the new guidelines was a challenge. Some reported easily identifying a few allowable snacks, including fresh fruits and crackers, that meet the guidelines, but they wanted ideas for more options. In the words of one provider, “Kids get tired of the same snacks.”

- **Cooking From Scratch**

Locating healthy, prepackaged foods that meet the guidelines was a challenge identified by the groups. Nearly all providers said that they addressed this challenge by preparing more meals and snacks themselves. However, providers explained how cooking from scratch generates an entirely new set of challenges, including additional time to prepare foods, lack of confidence in cooking skills, lack of interest of some providers in cooking, insufficient recipes, and the time burden of developing new recipes. Providers most commonly said that the greatest challenge of cooking more foods from scratch is the increased time required. Child care home providers expressed this concern more frequently than center providers. Some of the home providers found cooking from scratch especially burdensome and reported feeling that it takes time away from being with the children:

“It takes a lot more time, because, for example, with the french fries… now you’re using the regular whole potatoes instead of a bag. You have to actually peel it, cut it, dice it down, and season it up. Maybe if you’re lucky, you can get them to eat it.”

“Do you want us to spend time with the children, or do you want us to spend time in the kitchen? You can’t be in two different places and watching babies and trying to do preschool and monitoring what the kids are doing when you are in the kitchen baking a ham and all this stuff.”

Now that many providers are preparing more foods from scratch, some noted that they are experiencing difficulties in calculating the amounts of sugar, fat, etc., in each child-size portion of homemade dishes with multiple ingredients (e.g., casseroles). A few providers also noted that the increased time burden of cooking from scratch relates to not only the cooking time but also the time required to write up and send their recipes into the state CACFP or child care licensing offices to confirm that they are meeting the guidelines.
Another challenge, mentioned by a few home providers, is that they do not enjoy cooking. These providers clearly said that they had not seen nutrition and cooking as taking on so important a role in their work as child care providers. They asked for help so that cooking does not become a burdensome part of their work.

Modifying and Scaling Up Recipes to Meet the Guidelines

As providers are preparing more foods themselves, they are looking to existing recipes to find healthy alternatives for favorite and/or common dishes. However, several providers reported that they are having difficulties coming up with substitutions for recipes that are higher in fat or sugar than the guidelines permit that will also appeal to children. A couple of center and home providers said that experimenting with substitutions can be time consuming.

Many center providers also talked about difficulties that they were experiencing in adapting healthful recipes that they do find, which are typically for a small number of servings, to serve to the large number of children that they care for at their facility.

Strategies to Address Meal Planning and Food Preparation Challenges

Even as they voiced concerns about finding alternative foods that the children will eat and preparing them in a timely way, providers offered strategies that they are employing to mitigate these challenges. These are described below.

Advanced Menu Planning

To cope with the challenges of meal planning that came with the new foods and recipes that they were using, several center and home providers said that they are now planning menus much farther in advance. Some mentioned planning menus that include the same nutritious items multiple times, but served in different ways. One center provider reported that she now uses software that allows her to develop a set of menus in advance using prewritten recipes, as is done in many school districts that participate in FNS’ School Lunch and Breakfast Programs:

“So I started doing my menus, like, 4 or 5 months in advance and sending them in to make sure that if there is anything incorrect, I can change it. Now I have all my menus for the rest of the year.”

Advanced Meal Preparation

As noted above, most providers report doing more of their own cooking from scratch to comply with the new guidelines. One way that providers have been reducing preparation time has been to cook food ahead of time, such as the night before or by using a crock pot. One child care home provider explained why she is cooking lunches the evening before:

“You want to plan this healthy, big, nutritious lunch and dinner, but you don’t have the time during the day with all the kids, so a lot of [my cooking] is done the evening before.”

Another provider from a large child care center described how her agency is able to bake large quantities of chicken and then freeze it in smaller portions for meals to be served later:

“I just picked up an order at the food bank. I got 100 pounds of chicken. She is cooking all that chicken today and then she’ll refreeze it. You just pull it out, and it’s already cooked; you bread it and serve it.”

“Years ago, CACFP actually gave out cookbooks and made it for 60 kids or 100 kids…and some of the Web sites have recipes we could use, but it’s more for, like, individual families. But it’s not easy to do on a larger scale.”

—child care center provider
Preparing Foods That Are Kid-Friendly

Providers also discussed ways to entice the children to eat healthier menu items. In addition to sharing recipes and preparation tips with other providers, they talked about specific strategies that they are using. These include substituting mozzarella for the processed cheese slices and hiding “the brown” of whole-wheat items in a casserole or in a shepherd’s pie. Some providers gave ideas for how to increase kid appeal with a “cool” name for dishes or interesting ways of presenting the food.

Additionally, many center and home providers frequently reported that to comply with the limits on how often they can serve processed meats and fried meats, they have had success using “meat alternates” for the CACFP. They reported using cheese, yogurt, beans, and eggs more often in the main dish for lunches. They also noted that serving these nonmeat protein alternatives helps them reduce food costs.

Transitioning to New Foods Gradually

Several providers talked about gradually transitioning to healthier foods required in the new guidelines, because they believe that children would otherwise reject new foods such as skim milk or whole-wheat bread. As an example, one center provider discussed mixing whole wheat with white pasta before eventually progressing to all whole wheat:

“We did start with mixing the pastas, because, of course, when they saw it was brown, [they said,] ‘We—I don’t want that.’ So then we started mixing them gradually. Now the kids are pretty much on whole wheat across the board.”

Several providers mentioned making the change first from serving whole milk to 2% milk and then moving to 1% or skim. Others emphasized the importance of introducing new food items to the children one at a time.

Recommendations for Improving Menu Planning and Meal Preparation

Provide More Opportunities for Providers and Cooks to Share Menus and Recipes

A couple of home providers talked about attending a potluck recipe exchange organized by their CACFP-sponsoring agency. This included tasting new dishes and exchanging recipes prepared by their peers (other home providers) along with a group discussion on the nutrition guidelines. Yet these were the exceptions rather than the rule, and providers overwhelmingly voiced a desire for an ongoing mechanism to share their successful recipes and menus that meet the guidelines with each other.

Many providers from homes and centers were interested in obtaining recipes that other providers had used or tested to better ensure that the recipes would be kid friendly, but not too expensive. One recommendation was to have them disseminated in a print periodical, like a newsletter. Several providers described newsletters issued by food program sponsors that regularly published recipes sent in by other providers. A more common recommendation was for the CACFP state and sponsoring agencies to provide them with a forum for recipe sharing and networking in person, either as an accompaniment to a cooking demonstration or in the form of a potluck recipe tasting:

“If there was [sic] some way for some of these cooks and chefs to get together and just have some kind of network so that they can share ideas and recipes and substitutions.”

“My food group went one night to a class, and everybody brought a covered dish…what they like, what their kids eat, and what the kids can help them with. That was really good, because then everybody could taste the different things, and you got new recipes.”

—child care home provider
Providers thought that they would get more out of sharing as part of a hands-on activity as opposed to simply sending the information as an electronic or paper document. Many providers said that they would be more likely to prepare a new recipe if they had tasted it or watched a demonstration on how to prepare it.

- **Develop User-Friendly Resources to Be Displayed at Child Care Facilities**

To assist them in calculating nutritional components of recipes and portion sizes, several center providers suggested having large colorful charts or posters that they could display at the center for the cook, teachers, and parents to use as a reference. They like the portion size posters that have been produced by Nemours. They recommend that the state provide similar ones to child care providers with charts of allowable amounts of fat, sugar, etc., and information on reading food labels. They believed not only that this would help them in menu planning and cooking, but that the posters or bulletin board displays would help convey the importance of the new guidelines to staff and parents.

**Food Shopping**

When asked whether and how they have changed the way that they shop for food as a result of the enhanced nutrition guidelines, providers overwhelmingly reported that they have difficulty finding foods from their traditional suppliers that comply with the guidelines. A few noted a shortage of some of the needed food products, such as whole-wheat bread, from their traditional suppliers (e.g., institutional food distributors, food-buying clubs, grocery stores).

**Challenges**

- **Identifying Locations That Sell Allowable Foods**

Nearly all providers reported struggling with learning what products are available and where to purchase them. Even when they do locate an allowable product, they are not necessarily able to count on establishments to continually stock needed items. For example, they reported that when shopping at stores like Sam’s Club, the store may carry a food that they need to meet the guidelines one month, but they may not find the same item there the next month. In the words of one home provider:

> “The greatest challenge is really knowing what products are available and at what places.”

- **Institutional Food Distributors Offering a Limited Supply of Allowable Food Items**

Many of the larger center providers mentioned that they use large distributors, such as Sysco and ProFoods, for their purchasing. However, some providers felt that the distributors with whom they had worked in the past provided little inventory and support for implementing the nutrition guidelines. These focus group participants assumed that this is because vendors were unaware of the new guidelines. Some providers reported that they could not find enough “allowable” foods to even merit continuing to order from the distributors that they had used in the past. As explained by one center director:

> “I have used US Foods, but since the new guidelines, there is [sic] so many foods I can’t get from them, so now that’s very limited what I can get.”

Finding allowable foods at distributors also did not necessarily mean that they would get that item. Several providers reported that their suppliers would be out of the requested foods and substitute other unallowable foods at delivery. For example, one provider
noted that she ordered whole-wheat grain products, but the delivery that came to her center did not have whole wheat listed as the first ingredient, as is consistent with the guidelines. Another provider said that the prepared foods that were delivered to her center had a higher sugar and fat content than was allowable under the guidelines.

■ **Time Costs of Shopping at Multiple Suppliers or Stores**

Many providers said that in trying to comply with the new nutrition guidelines, they now have to turn to more and different suppliers or grocery stores to get all the food that they need, even if the location of these stores is not as convenient for them. They noted that they end up searching multiple stores for certain items, because they do not know which products are sold or still available at each store.

The time cost associated with shopping at multiple grocery stores was perceived by a few center providers as a hidden and burdensome cost related to implementation of the new guidelines. These providers noted that while having to shop at multiple locations may not increase food costs, it does increase the time cost of shopping.

Several providers from smaller centers, and those operating family child care homes, also complained about the significantly increased amount of time that they need to spend shopping at each store. In the words of one child care home provider:

> “I went after class to the store, and I planned on spending as long as I needed so I could say, ‘Okay, I can do this’…. I was 2 hours in the store, and it was ridiculous.”

Many of these providers reported that they end up searching multiple stores for certain items because they do not know which products are sold or still available at each store. Additionally, a few providers mentioned that having to shop at multiple stores requires more time to reconcile multiple receipts that providers must submit to document their food costs in order to obtain reimbursements from the state CACFP agency. One center provider and cook explained:

> “I found that if you have to go to so many different places, at the end of the month, you have all these different receipts. That’s a lot of time adding up food and nonfood costs.”

■ **Reading Labels and Calculating Nutritional Contents**

Child care providers frequently reported having difficulty reading nutrition labels and calculating fat and sugar contents in the grocery store aisles. A few providers talked about bringing calculators to the stores. Several center and home providers complained that the need for label reading and calculating the nutritional content of food items makes their shopping trips last much longer—in some cases, up to three or four times as long as trips prior to implementation of the regulations. One home provider complained about how long it now takes her to do her shopping to find foods that comply with the standards:

> “Now you need a calculator to calculate the fat content and this content. They have made shopping work in addition to the work that we are already doing. Where you would have gone to the supermarket and been in and out in 30 minutes, now you are going to be there for an hour or hour and a half, because you have to read all the labels and calculate all the content.”

> “That’s the problem. You have to go to so many different places; you’re here; you’re everywhere to find what you need.”

—child care center provider
Strategies to Alleviate Food Shopping Challenges

■ Using Lists of Allowable Foods Provided by CACFP-Sponsoring Agencies

Despite the frustrations reported in purchasing allowable foods, a few child care providers also mentioned that they are already getting some assistance in food shopping in the form of lists of “allowable” foods from individual CACFP-sponsoring agencies. These agencies provide lists of allowable foods and information on which stores carry particular food products. Specifically, they talked about receiving short flyers with food lists, either in newsletters or from trainings offered by their CACFP-sponsoring agencies, and said that they carry these resources with them while shopping. One example was cited by a home provider:

“And a good thing about Delaware Parents Association is, they send us a newsletter, and if they find something that we can use [that meets the guidelines], they’ll put it in.”

■ Seeking Direct One-on-One Assistance From Suppliers

Several center providers in the focus groups in New Castle County spoke approvingly of the help that they have received from certain food suppliers in selecting foods to meet the guidelines. Some discussed using supports provided by ProFoods, including a book that provides the nutrition facts about each product and a list of company products that meet the state’s enhanced nutrition guidelines. Multiple large center providers in the Wilmington area also talked about the helpfulness of their food distributor in ensuring that the food that they ordered met the recommendations.

Several providers were enthusiastic about a nutritionist on staff at Shop Rite, who they said was very familiar with the state’s enhanced child care nutrition guidelines and had helped them shop according to menus in compliance with the guidelines. A couple of center providers who use this assistance from Shop Rite reported that they do all or most of their shopping now with this one grocer and thus save time while also complying with the guidelines.

Recommendations for State Supports to Address Food Shopping and Purchasing Challenges

■ Distribute Sample Menus With Specific Product and Shopping Information

Despite the availability of some training materials from the state and CACFP-sponsoring agencies, many providers are not receiving enough information to help them identify what they can buy and where. In fact, whenever providers in the focus groups talked about what foods could be found at various locations, other participants rapidly jotted down notes. These providers voiced a desire for the state agencies or others to collect and distribute this kind of information more systematically. Providers in the majority of the focus groups said that they would like to have a list of allowable foods or alternatives to popular but unallowable foods. However, they were careful to say that in order for these lists to be useful, they must be specific. That is, they would like to know specific brands; what stores or suppliers in their area carry these brands; what sources are the least expensive; and, in the case of the larger child care centers, what specific products are available for purchase in bulk or larger size containers.

Several providers also suggested that they would have information to contribute to such food lists if the state put them together, and they would be pleased to share this information with other providers. One home provider suggested that the state CACFP monitors could routinely collect and distribute this kind of information:

“Maybe let them make up the menus. Then along with the menus, they can make suggestions of where you can purchase these things and where you can get it at cheaper prices.”

—child care center provider
“Maybe when our monitor comes out to us next time, maybe we can all say, ‘Okay, this is what I found at this store,’ and if they take that in and then publish it to send out to everybody and list which stores have which stuff, that’s allowable.”

Inform Suppliers and Make It Easier for Them to Offer Assistance to Providers

While several providers in New Castle County spoke positively about the assistance that they had received from specific food suppliers, most providers from the other counties did not report receiving similar help. Providers from these areas repeatedly suggested that the state of Delaware better inform suppliers of the child care nutrition guidelines so that the suppliers could take a more active role in helping child care providers shop for foods that meet the guidelines.

In one focus group with child care center providers, participants recommended that the state work with food suppliers to label certain foods as recommended or allowable for CACFP, similar to the way that grocers label certain foods as “WIC foods” and the way that large institutional food distributors label foods that are eligible for or consistent with the school meal program’s guidelines. One center director suggested:

“Just like the WIC stickers in the grocery store, if it [a store label on foods] said ‘CACFP compliant’...”

Food Costs

Challenges to Implementation

Many providers, who overwhelmingly support the intent of the nutrition guidelines, reported that the single greatest challenge that they face in implementing the nutrition guidelines is the higher cost of healthy foods. Several providers expressed worries about the impact of rising food costs on their very limited budgets. They specifically mentioned the expense of purchasing other foods in place of some of the cheaper but less nutritious alternatives for snacks and meals, including fresh fruit, fish, and real cheese. In the words of one of the home providers,

“I don’t mind the requirements, because you are dealing with the most precious things. I mean, my children are the most precious things in the world to me. But you have to be realistic. I don’t have health care insurance. I don’t have a 401(k). But you want me to put out more money to meet your regulations. That’s just not fair.”

To emphasize his concern with rising food costs, a representative from one small CACFP-participating center in Sussex County brought a copy of his center’s recent food bills to the focus groups. He shared the average monthly food bills for his center and how they have risen in the last 2 years, and he attributed this rise in part to the new guidelines.
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Food Costs

Challenges to Implementation

Many providers, who overwhelmingly support the intent of the nutrition guidelines, reported that the single greatest challenge that they face in implementing the nutrition guidelines is the higher cost of healthy foods. Several providers expressed worries about the impact of rising food costs on their very limited budgets. They specifically mentioned the expense of purchasing other foods in place of some of the cheaper but less nutritious alternatives for snacks and meals, including fresh fruit, fish, and real cheese. In the words of one of the home providers, “I don’t mind the requirements, because you are dealing with the most precious things. I mean, my children are the most precious things in the world to me. But you have to be realistic. I don’t have health care insurance. I don’t have a 401(k). But you want me to put out more money to meet your regulations. That’s just not fair.”

To emphasize his concern with rising food costs, a representative from one small CACFP-participating center in Sussex County brought a copy of his center’s recent food bills to the focus groups. He shared the average monthly food bills for his center and how they have risen in the last 2 years, and he attributed this rise in part to the new guidelines. “Well, they’d better make sure the suppliers know what our new regs are so they are not telling her that it’s okay for the food program if it’s not.”

—child care center provider

“The grocery bill—it is more expensive, and we don’t get any more money, any more reimbursement for these changes, because it seems like to eat healthy, you’ve got to spend money for them to take stuff out like sugar or leave the wheat in.”

—child care home provider
Strategies to Contain Food Costs

- **Comparison Shopping, Finding the Deals, and Buying in Bulk**
  
  To help manage food costs, many providers offered tips to each other on where the lowest prices were for certain food products. They described spreading out the shopping among multiple stores and suppliers, despite the time costs of this strategy (as discussed above). Providers also mentioned reducing costs by clipping coupons, watching for sales, using discount cards, and buying wholesale.

  Buying in bulk was the strategy used to manage costs by those center providers and a few home providers who said that they have the capacity to store foods in larger quantities:

  “I go to Sam’s Club and buy meats and have them cut it down, or I take it home and cut it down myself meal-size, and then I repackage it and freeze it and pull out what I need.”

- **Shopping at Food Banks**
  
  Several providers in Sussex County reported using the local food bank to cut down on costs. One provider noted that the food bank offers online lists of foods available each week from which providers can choose. Most of the food bank foods do not meet the CACFP nutritional standards and thus could not be depended on for the majority of child care providers’ shopping needs. However, a few providers routinely purchased foods from these sources that would meet CACFP guidelines, such as canned fruits and vegetables, frozen meats, and 100% juice.

- **Shopping at Farmer’s Markets and Roadside Stands**
  
  To obtain fresh produce at lower costs, several child care home providers and providers from smaller centers said that they are doing more shopping at farmer’s markets and roadside stands when they are available. Their stated intent was to save money so that they could afford to serve more fruits and vegetables. Similarly, others discussed scouring the local papers for sales on produce and developing close relationships with farmers to gain access to inexpensive, fresh produce.

**Recommendations for State Supports to Help Reduce Food Costs**

Many providers at the focus groups noted that there would be much less resistance to the new guidelines if the state could help lower their food costs. These providers asked for a higher meal reimbursement rate from CACFP. As described below, home providers and parents offered suggestions for other ways that the state might help reduce providers’ food costs, such as special arrangements with food distributors, grocery stores, and/or farmers.

- **Increase the CACFP Meal Reimbursement Rate**
  
  Six of the seven focus groups with centers and homes included only providers who participate in CACFP. The budgets that these providers have for food depend to a large extent on the per meal reimbursement rate that they receive from the state CACFP agency, which is funded through the federal program and determined by federal regulations. Many home providers voiced frustration that the current CACFP meal reimbursement rate is not sufficient to defray all the additional costs incurred by providers in complying with enhanced nutrition guidelines. These providers asked for a change in policy to increase reimbursement rates to defray the increased costs. In the words of one child care home provider:
“Because of the changes, the price has gone up, so I find myself spending much more money making sure they get a variety of things now, so I think they need to increase the food program[reimbursement].”

- **Work With Suppliers to Negotiate Discounts for CACFP Providers**

A couple of center and home providers and parents recommended that, given the amount of food that child care providers purchase in Delaware or any state, state CACFP agencies might have leverage to work with suppliers to provide child care facilities with discounted prices for the foods that they buy for children in their care. They suggested that food distributors, grocery chains, and local wholesalers should offer discounts that would allow licensed providers to purchase allowable foods at a lower cost. One center provider simply suggested:

“What if they could get a bunch of Delaware businesses together and say, ‘If you are part of this CACFP, you get [even] a 3% discount on all the food that you buy for the program’?”

- **Provide Subsidies to Farmers to Encourage Farm-to-Child Care Programs**

As noted above, a few providers from centers in Kent and Sussex Counties mentioned that they are taking advantage of the lower costs of local produce at local farms or farmers markets. One parent from a more rural area of the state suggested that the state could work with farmers to expand these connections by directly subsidizing the farmers to support lower prices for local child care centers:

“There should be some sort of support out there that the state gives...subsidies to the farmers to support the local daycare and adult care establishments to provide the healthy alternatives, so they don’t have to make contracts with food distributors that are coming from Pennsylvania, New Jersey....”

This approach, while novel in the area of child care food program policy, has already achieved considerable success in schools through FNS. For several years, FNS has been funding states and school districts through the Fruit and Vegetable Program to help them purchase locally grown fresh and dried fruits and vegetables. USDA is also bringing local food suppliers together with school food service departments nationwide to build stronger viable partnerships through USDA’s Farm-to-School Initiative.20,21

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20 Information on the USDA Farm to School activities can be found at http://www.fns.usda.gov/cnd/F2S/Default.htm.

5. Staff Engagement in Implementation

This chapter addresses the necessity of building enthusiastic staff support for implementation of the guidelines. Both child care center providers and parents repeatedly warned that, in the absence of support and involvement of direct caregivers, effective implementation would prove difficult if not impossible. Child care center providers pointed out that even though directors can change menus to meet the guidelines, it is up to direct caregivers to communicate and demonstrate the importance of healthy eating habits to young children both during meals and in the classrooms. It is obviously important to engage the cooks and teachers in implementing these policies, because these individuals will be the ones who ultimately are able to do the following:

- Expose the children to healthy food choices through the foods that they are served,
- Model healthy eating behaviors to the children in their care, and
- Introduce the children (and through them their parents and guardians) to healthy eating messages through educational programming.

The focus group findings that follow are presented in three sections:

- Challenges to staff engagement,
- Promising strategies that providers have used to involve staff in implementation of the guidelines, and
- Specific recommendations for state action to promote staff support for the guidelines.

Challenges to Staff Engagement for Center Providers

Focus group participants are in broad agreement that successful implementation of the guidelines hinges on the extent to which direct caregivers in child care homes and staff embrace them as fundamental to the well-being of the children in their care. Child care center providers specifically said that they felt that a child’s acceptance of new foods and long-term dietary behavior changes are far more likely if the caregivers eating at the center and teaching in the classrooms were seen to enjoy the new foods and model healthy behaviors themselves. However, both providers and parents shared the concern that because many staff members working at the centers lack healthy eating habits, the staff will inadvertently project negative attitudes about the new foods that are being offered to meet the nutrition guidelines.

Many child care administrators reported that overcoming staff resistance has been among their greatest challenges in effectively implementing the state’s enhanced nutrition and physical activity policies:

“The biggest people that fought us were the staff.”
—child care center provider
Some center operators reported that children will not try new foods when the staff send negative messages about these foods or are eating other foods in front of the children that do not meet the guidelines. Several center providers also highlighted the importance of teacher engagement in physical activity during indoor and outdoor activity time. In the words of one child care center director:

“When [children] see the teacher involved and the teacher is having just as much fun as they are, then the kids are more apt…. They aren’t worried about being tired or anything like that.”

Strategies That Centers Have Used to Educate and Engage Staff

While providers recognized the challenges of staff resistance to implementation, some also offered examples of strategies that they have used to overcome those challenges in child care centers. A common theme of each strategy is the necessity of involving staff in every facet of implementation. Several successful ways that child care center providers have tried to promote positive staff involvement are described below.

■ Making Staff In-Service Trainings Fun

A couple of center providers talked about the importance of presenting the nutrition guidelines and their rationale in a fun and engaging way to help foster a positive attitude among staff, and motivate them to promote healthy habits for children. One described how, at her center, they used a game format to make the in-services fun and educational:

“It can’t just be a lecture to get your staff on board. So we [played] a lot of games with the staff. We played Jeopardy! I had prizes for them, and they really enjoyed it.”

■ Involving Staff in Menu Planning and Recipe Development

One provider, who was both the administrator and cook at her center, described how she got her staff directly involved in meal planning. This included asking them to taste and refine new recipes to make sure that they will be appealing to the children. Other center operators mentioned that they have involved staff in reviewing the menus as they are being planned or in reviewing the food trays before they are offered. When this strategy was used, the stated goal was to make sure that the center was compliant with the guidelines. Participants said that this strategy serves the dual purpose of being educational for the staff and helping them feel that they are an integral part of the decisions being made for the children at the center.

■ Having Staff Implement Fun Activities

Center providers spoke about the benefits of engaging staff in a variety of nutrition education activities to help them become more supportive of the guidelines. They reported that by doing so, they were more able to positively influence children’s and parents’ attitudes about the implementation of the new policies. Several parents in two of the focus groups praised their child care staff’s efforts to make healthy eating fun and noted the positive spillover effect that had at home. Several parents pointed out that the child care center is making it more fun for their children to make healthful food and drink choices, not only at the center, but also while shopping with their parents and when eating snacks and meals at home. One parent explained:
“I came home one day, and it’s like I heard, ‘Fruits and vegetables make you go, “Ahhhh,” and candy makes you go, “Aarghh!”’ And it really turned into a family conversation at dinner about foods that are good for your body and things we should only eat on occasions.”

Examples of how an engaged and supportive staff can promote the new guidelines include offering tastings and contests involving children in trying healthy snacks. One parent shared how teachers at her child’s center are getting children actively involved in fun ways to try new healthful snacks:

“[At the center,] she had a different fruit every day, and all the kids looked at it and talked about it, and then they cut it up, and everybody tried it. So I think that helped my daughter...just doing songs and learning about fruit, and it was a fun thing for her.”

A director from another child care center described how her teachers and center staff engage the children in preparing healthy meals or snacks with foods that meet the new nutrition guidelines. She felt that by engaging the children in food preparation they were more interested in trying new foods.

“...[T]he children are involved in making their snacks once a week. So we make fruit kabobs, or today it was pizza. We use the multigrain rice cakes and put peanut butter and then jelly on them—things like that, and it turns into an educational activity, too.”

—child care center provider
Provider Recommendations for State Actions to Engage Teachers and Cooks

While the different strategies described previously are very promising, it is important to note that they were all carried out by the larger centers participating in the focus groups. Many other center providers in the focus groups looked to the state or others for ways to build support for the guidelines among their own staff. Their specific recommendations are summarized below.

- **Expanding the Reach of Past Trainings**

  Many center and child care home operators spoke positively about the classroom training that they received when the new guidelines were first being discussed. Those that participated in trainings involving both staff and directors gave particularly high praises to the content and format of the sessions that they attended. These comments referred to trainings held by CACFP staff, CACFP-sponsoring agencies, Nemours, and the Cooperative Extension Agency.

  While many focus group participants who had attended trainings in the past provided positive feedback, there was a consistent recommendation from center providers to expand the reach of these trainings to more direct caregivers. Focus group participants recommended including the staff and teachers in child care centers. While a few directors from larger centers had conducted this kind of training for staff, most of these providers emphasized that they need help to motivate positive staff involvement in this area.

- **Linking Staff Training on the Guidelines to Continuing Education Requirements and Child Care Quality Ratings**

  Center directors attending the focus groups pointed out that child care staff have limited time available to attend trainings, but for staff to maintain their certification, they must obtain a minimum of 18 hours of continuing education (CE) credits each year. These providers recommended that CE credits routinely be offered if CACFP or another agency provides trainings on nutrition and physical activity. They also recommended that such training be more widely available throughout the state to allow more staff members seeking CE credits to participate. A couple of providers suggested that an accredited class on nutrition and physical activity not only offer CE credits but also be considered mandatory for initial and continuing education of child care professionals.

  A couple of providers noted that both the state and child care providers might place a higher priority on assuring child care teacher training on nutrition and physical activity if this were incorporated as a standard of quality professional development in the state’s child care Quality Rating and Improvement System (QRIS). In Delaware, this system is called Stars for Early Success.22

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22 A QRIS is a method used to assess, improve, and communicate the level of quality in early care and education and school-age settings. Delaware Stars for Early Success establishes quality standards for programs and provides technical assistance and limited financial support to programs involved in Stars as they engage in quality improvement efforts. Delaware Stars is designed as a voluntary system that expects programs to work on improving quality by moving up the Stars levels.
6. Parental Engagement

Many providers in the focus groups stressed that to ensure success in the implementation of the state’s child obesity prevention policies, it is also important to reach out to the parents to educate them on the importance of the healthy food and physical activity policies. Several providers noted that many parents of young children look to their child care providers for information about child development, including methods to improve child eating habits. Thus, they believe that involving the parents in these new policy changes is particularly important. These providers and the parents in the parent focus groups said that directly engaging and educating parents would not only minimize parental confusion or concerns about the guidelines but may also encourage parents to more actively support positive nutritional behavior changes in their children.

This chapter presents input from both providers and parents at the focus groups, with findings organized into four sections:

- Challenges that providers face in gaining parental support for the guidelines,
- Promising strategies that providers are using to engage parents,
- Parents’ recommendations for informing and engaging them, and
- Provider recommendations for how the state can help them in communicating with parents.

Challenges to Parental Engagement

After the issues discussed in the previous chapter (food preparation and cost issues and staff resistance), parent resistance was most frequently mentioned as a principal challenge to effective implementation of the new policies. For example, many providers in the focus groups reported that the parents of the children they care for have strong opinions about what their children should or should not eat. The providers reported that parents are concerned their children will not eat or drink enough and will come home hungry from child care. Family home providers in particular emphasized that parental resistance to the policy changes can also often encourage resistance from their children.

Providers consistently noted two kinds of challenges that they face in engaging parents and getting their buy-in to the new nutrition policies:

- Parents think that because the foods that their provider is serving are different from what the children eat at home, they will not try them; and
- Parents continue to bring in foods that are not in compliance with the new guidelines.

“We are the highway of information for parents. So what I did was, I got a whole bunch of things from Nemours, and I handed out the pamphlets and talked to them about that. That is our job.”
—child care home provider

“We got the new rules, and we explained it to parents; but then, of course, some show up with breakfast like boxes of donuts and ‘This is for our kids.’”
—child care center provider
Promising Strategies That Providers Have Used to Engage Parents

Several center and home providers offered the following strategies that they had used successfully to engage parents in understanding the new guidelines.

- **Informational Materials Distributed by the Providers**

Several providers mentioned providing information for the children’s parents or caregivers in standalone flyers or as part of regular newsletters that go home in the children’s cubbies. Some talked about posting the weekly menus on bulletin boards where parents would see them. Others talked about nutrition posters on classroom bulletin boards.

Two examples of ways child care centers have translated the new rules into informational materials for parents were described by center directors:

- “I include a flyer for my families because the parents pack meals… giving them ideas…. ‘Okay, these are things you can give your child that are not expensive and [are] healthy.’”

- “We created a whole nutrition policy, which we added to the parent handbook this year, because we figured if we’re giving them the tools they need, then they can also try to feed their children better at home.”

- **Family Events and Meetings**

Several providers said that they have organized or are considering organizing family events to inform and engage parents. These providers aim to help parents understand why and how their center or home is changing menus and promoting healthy eating behaviors. They say that these events are designed to be fun and to show parents how to prepare new nutritious foods and to see for themselves that their children can respond positively to new foods.

One home provider said that she holds a picnic or dinner where the parents of the children for whom she cares can see what she serves. Several other center providers talked about holding family activity nights where parents were engaged in preparing and serving meals and learned about the new nutrition guidelines. One center director described her “healthy eating” parent open-house event:

- “We did a healthy eating kickoff instead of an open house last year. We made a vegetable soup all together as a center, and each room had to find a different vegetable on a scavenger hunt. And at the end, everybody got together and made the soup.”

One provider from a center where parents bring lunches noted that she experienced strong resistance to the new nutrition guidelines until she held a meeting with parents. She felt that she had some success after she explained the rationale for the guidelines and how families could reduce their food bills while providing healthier lunches:

- “We had a parent nutrition meeting, because it was such a struggle when I got here. There were “contraband”[foods] coming in…and I went through the guidelines and gave them specific ideas…. ‘Choose the turkey slices, real cheese slices and crackers, and juice or milk. It costs about a third of what it does when you buy those Lunchables. Putting it there for them, something tangible for them instead of what you can’t do.’ And that helped.”

“...Have, like, a family activity night, where you could come...you know, make it a teaching time for the parents as well as for the kids, but it’s fun, and everyone is getting together...just to learn something and have a good time in a healthy way.”

—parent
Parent Recommendations

Parents who attended the focus groups emphasized how they do want information on the new child obesity prevention standards, including what the centers are doing for their children and what they can do at home.

Parents at the focus groups overwhelmingly liked the idea of family events after work. They suggested that at these events, parents and children should be invited to learn more about the new nutrition guidelines while engaged in fun healthy eating activities together. Parents also talked about the benefits for them of meeting with other parents of preschool children and learning new information together and sharing common experiences with each other. Parents noted that they could more easily attend such meetings or classes if they knew that the center would feed dinner to their child and take care of them.

Parents of children at centers that do not prepare meals also gained from family educational events. Parents from one center where all meals are brought from home reported that they learned about the new nutrition guidelines first through handouts. However, others who also attended an in-person parent meeting at that center found that method more informative. As one parent explained,

“Getting us (parents) together would allow us to have time to talk with other parents to see if they have the same issues we are having, like we are doing now.”

Parents who pack their children’s meals (which are also subject to the state’s CACFP guidelines) said it would be helpful if centers could provide sample lunch menus featuring low-cost foods that require little preparation time. These parents also said that they would like lists of allowable brands (e.g., of whole-wheat bread) and information on where to buy these foods at lower prices so that they can prepare lunches that are consistent with the nutrition guidelines and stay within the limits of their household budgets.
Provider Recommendations for State Supports to Help Obtain Parent Buy-In

In addition to the strategies individual providers are using to engage parents, many providers, including a large number of the home providers, recommended that the Delaware CACFP or OCCL communicate directly with parents.

- **Direct Communications From the State to Parents**

Several providers, stressing the challenges of parent resistance, recommended that the state take a leading role in educating parents about the new guidelines. They felt that it was important for the state to provide information to parents regarding the rationale and content of the guidelines, as they do on many other child care policy issues. Several providers from both centers and homes said that this would help them point to the official nature of this change and not have to “take the blame” for making changes. These providers suggested that the state directly distribute information to the parents on the nutrition and physical activity regulations. While providers did not think that simply mailing information to the parents would be sufficient to overcome all parental resistance to the nutrition guidelines, they did agree that parents receiving information from a state agency could ease stress for providers who have to justify and explain the new policies to each parent themselves.

- **Materials for Centers to Distribute to Parents**

Both providers and parents suggested that the state or some other agency provide child care providers with more and better information about the new nutrition guidelines. A few providers and parents also suggested that the state create educational materials with recipes and other practical tips for parents. They wanted to be able to distribute these materials to help promote parent buy-in and support for the new nutrition guidelines, and to encourage them to try out new affordable and healthful foods and recipes at home. This information should be presented at the reading level of the parents who are being targeted. For parents who are not literate, information could be provided on CDs or through other media.

As noted in Chapter 3, many parents might agree with the nutrition guidelines’ overarching goal of improving early childhood nutrition and health. However, they may also take issue with specific guidelines, such as the limitation on the kind of milk that can be served or restrictions that discourage parents from giving children donuts and cupcakes as special treats. Providers asked for materials that are specifically targeted to the guidelines that might produce the most parental resistance.

“*What licensing needs to do is send these rules and regulations to each parent, and then maybe it would help us. They need to let these parents know it’s not us making the rules, but it’s policy.*”

—child care home provider
7. Screen Time and Physical Activity Regulations

This chapter presents provider and parent focus group findings related to the Delaware child care licensing regulations limiting screen time and establish minimum requirements for physical activity. The term “screen time” in this report refers to time spent watching television, DVDs, or video cassettes or using a computer. Screen time and physical activity are interrelated due to their influence on children’s time spent engaged in active and sedentary behaviors.

The screen time section below presents child care center providers’ and parents’ attitudes about this rule, the challenges that some providers are facing in implementing it, and how providers are changing practices and policies to implement the rule. In this section, unlike the others in this report, focus group participants did not have any input on how the state can help them implement this rule. Thus, no provider recommendations are included.

The section on increasing opportunities for physical activity discusses the most common challenges providers are facing in implementing the minimum requirement rule. It also identifies strategies some providers are using to increase daily physical activity in centers and homes, and highlights providers’ recommendations for how the state can help provide relevant training and other supports.

Screen Time Limitation

Delaware’s child care licensing rules for screen time, outlined in Chapter 1, include the following:

- Television, DVD and video watching are prohibited for children under the age of 2 and restricted to 1 hour of age-appropriate, educational content for children ages 2 and older (with an exception for special events such as holidays);
- Use of computers is prohibited for children under the age of 2; and
- Computer usage is restricted to 1 hour per day for children ages 2 and older (with an exception for special projects such as homework).

Child care providers generally found the Delaware screen time standards easy to implement. The majority of center providers reported restricting television exposure in some way prior to the introduction of the Delaware regulations. This has included keeping the television outside of the children’s play area and having the television turned off during the day. Providers generally stated that the children themselves, particularly in the 2- to 5-year-old age group, have also not reacted negatively to screen time limitations.

23 In Delaware, child care homes are not subject to this licensing rule.
Parents in the focus groups overwhelmingly supported the limits on screen time for their children. Many said that the child care setting is not a place for television or videos. They felt that teachers should be the ones constantly engaging and educating their children.

**Challenges to Implementation**

**Some Providers Use Television as an Easy Way to Occupy Children**

Providers expressed how it is not uncommon for television to be used in centers as a strategy for occupying children while staff tend to various activities. According to one center director:

> “I think one view may be that a lot of times, teachers get lazy, and it’s easy to do. They don’t know what else to do, so it’s just easy to put that on and not have to worry about what the kids are doing.”

Child pickup and dropoff times were reported to be specific instances where some providers said that they allowed children to watch television to keep them busy while other children are arriving or waiting for parents. Providers reported that those children who arrive early or leave late may sit in front of the television for up to 1.5 hours per day during these time points.

A few parents have noticed this practice and are unhappy with it. For example, one parent said:

> “I would like my daughter not to watch TV here. It’s difficult to come in [at the end of the day] and see her. She’s just glued to that TV, and I think there are so many other activities that could be done in this facility if they do not have that TV on.”

**Parent Expectations for Computer Exposure**

Several providers and parents reported that parents often have very positive views about exposing their young children to computers and are not necessarily open to restrictions on computer time for only educational purposes. As a result, some providers said that they have struggled in determining the amount of computer time that children should have. While parents did not frequently express concern about limits on computer time, several parents did. For example, one parent said:

> “I don’t know if [screen time restrictions] should apply to computers, though, because there is a lot of learning.... I walk in, and she’s on the computer here, and she learns more on that computer than I can even believe.”
Strategies for Overcoming Challenges

Center providers mentioned several ways that they have made changes to limit screen time. The three strategies most commonly cited are summarized below.

- **Eliminating the Television**

  To reduce screen time at their center or family home, some providers suggested turning off the television indefinitely, or for a week, to allow them and the children to explore ways that they can have fun through physical activities. Some providers have eliminated televisions from their center or home altogether. One center provider said:

  “I think I’m just going to take all the TVs out by the end of the year. Nobody is going to have a TV, because that’s time that you could be doing other activities with the kids.”

- **Implementing Center-Level Screen Time Policies**

  To cut down on television usage, many centers have their own center-level policies requiring that television or video viewing be for educational purposes only (e.g., phonics videos, books read on video). These policies require that if there is television or video viewing planned, it be incorporated into the teacher’s lesson plan with prior approval. As one child care center provider explained:

  “Well, we only have one TV in the whole center, and in order to use it, it has to be part of your curriculum. It has to be written into your lesson plan, and it has to be approved.”

- **Enforcing Time Limits on Computer Exposure**

  A couple of providers reported using timers to limit exposure to computers and to help all children have access to the one or two computers available at the center. One provider sets a timer for 20 minutes, allowing each child only 20 minutes of exposure. Some center directors also noted that they are now monitoring the classrooms to ensure that computer time limitations are enforced by staff.

Increasing Opportunities for Indoor and Outdoor Physical Activity

Delaware’s child care licensing rules, outlined in Chapter 1, set the following minimum requirements for physical activity in child care centers and homes:

- Each child, according to his or her ability, must be provided the opportunity for a minimum of 20 minutes of moderate to vigorous physical activity indoors or outdoors for every 3 hours the child is in attendance (equal to 60 minutes daily for a full 8- to 9-hour day).

While parents generally endorsed the need for physical activity beginning at an early age and the role of child care providers in ensuring that physical activity is part of their daily routine, they provided little input on this topic during the focus groups. Thus, the findings in this section are solely from the discussions with providers. Provider input is presented in three sections:

- Challenges that providers face in implementing the requirement,
Challenges to Implementation

While supporting the physical activity regulation, many center and home providers noted challenges that they face in implementing this rule. These challenges included limited available outdoor space, issues related to fixed and portable play equipment, and limited staff knowledge or motivation to incorporate teacher-led physical activity into daily lesson plans.

Limited Outdoor Play Space

The availability of outdoor playground space varied widely across locations and providers. Some centers and homes had no outdoor space on site for active play. Others had as many as three playgrounds at their facility. Those with limited space described constraints on the children’s ability to run and play, and their efforts to seek out additional external space. One center provider explained:

“We have to take them over to different park areas that have playground equipment…. They need space to run, not a small, fenced-in area.”

Cost of Purchasing Equipment

Several providers, particularly child care home providers, noted that they lacked equipment to support active play. The barrier most often cited for this lack of equipment was cost. It is important to note that inexpensive portable equipment, such as balls and hula hoops, may promote moderate to vigorous physical activity as much as or more than expensive fixed playground equipment. The costs of some of this equipment may be prohibitive for some providers with fewer resources, as suggested in some of their recommendations below.

Limited Staff Knowledge or Motivation

As the individuals who will be primarily implementing the physical activity standards, teachers and staff were cited by center directors as key individuals from whom to obtain buy-in. Their embracement of the policy changes was also seen as being a key motivator for children to be active.

Several center directors noted that they have faced challenges in engaging staff in physical activities with the children. Center directors report that teachers are not engaging the children in indoor or outdoor activities for a number of reasons. These include lack of desire or motivation, lack of understanding of the need for structured activities, lack of knowledge about how to incorporate simple activities into the daily child care routine, and physical inability to be active (due apparently to being overweight).

With regard to staff engagement with outdoor physical activity, several center directors reported that staff would rather use outdoor activity time as their break or “social hour.” Many providers said that they are very grateful to now have a policy to help enforce increased staff interaction with children on the playground, but they are finding that many teachers are still reluctant to participate in moderate or vigorous physical activities with the children.

Parents from the focus groups have also observed the low level of staff engagement of children on the playground. As one parent expressed,

“One of my pet peeves is kids being out on the playground and staff not interacting and engaging and more or less just standing by the sidelines, not getting those kids to be more active and moving.”

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A few center directors said the lack of staff engagement in encouraging outdoor physical activity was due to teachers’ misperceptions of their role in the child care setting. Specifically, these directors thought that some teachers might believe that their engagement and education of children does not extend beyond the classroom walls. Providers expressed a need to educate staff about the importance of being a teacher on the playground as well as in the classroom.

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Parents’ Concerns About Overemphasis on Structured Activity

When asked their thoughts on the physical activity guidelines, most parents said that physical activity is very important and spoke positively about the guidelines. At the same time, many parents also expressed a view that too much emphasis on structured activities would inhibit their child’s natural exploration, socialization, learning process, and creativity. Some parents and several family daycare home providers voiced the opinion that children in this young age group get enough physical activity from unstructured free play, particularly outdoors, and should not be forced into more structured activities. As one parent expressed:

“I think maybe the structured is more important as they get older. When I see them, even if they are playing dress-up, they’re running around chasing each other, so at least they’re moving.”

Strategies for Overcoming the Challenges

Several providers highlighted innovative strategies that they have already been using to enhance staff engagement and physical activity opportunities for children in their care. These promising strategies are summarized below.

- Maximizing Use of Public Playgrounds and Limited Indoor Space

Some center and home providers are incorporating regular trips to nearby parks and playgrounds to overcome the barrier of limited outdoor play space. A few home providers mentioned that they coordinate their outdoor play time with other providers who live in their area and share yards. This strategy offers multiple benefits, enabling the providers to use more space than is otherwise available to them, offering additional adult supervision, and exposing children to different environments and playmates.

Providers have also been creative in developing structured indoor physical activities for the children. Some common indoor games and activities used by providers include musical chairs, dancing, Simon Says, and yoga.

- Finding Low- and No-Cost Activities and Equipment

Providers have come up with a number of simple low- and no-cost ways of getting children moving. Some have purchased inexpensive equipment such as balls, jump ropes, hula hoops, and streamers. One of the free strategies frequently used to engage children is playing music. Many providers noted how much their children love to dance and how easy it is to get children up and moving wherever they are once music is played. One provider has found that blowing bubbles is a simple and effective method for encouraging kids to run and jump. Others have found that no-cost, large cardboard boxes can be used as a great substitute for more expensive crawling tubes or tunnels.

Providers have also sought the help of outside organizations to obtain needed equipment at low-cost or on loan, citing the practicality of periodically borrowing higher-cost items that are difficult to store, such as parachutes and tunnels. At one center, they address cost issues by requesting that parents pay for external activities, like taking the children swimming or on field trips.
Incorporating Physical Activity Into Transition Times

Several providers also reported incorporating more physical activity time into the children’s schedule during transition periods between learning exercises. Involving the children in small bouts of physical activity throughout the day builds towards the required 20 minutes every 3 hours and keeps the children from sitting for long periods.

One center director explained how her teachers now incorporate physical activity into transition times:

“You have circle time, and then you have physical activity. We use it as transition time. So you may only have 5 or 10 minutes, but if you’re doing that three and four times throughout the course of the morning, you’ve got your 20 minutes.”

Some center directors talked about allowing some of these transition times to be focused on activities with creative self-expression rather than very structured activities.

Implementing Center-Level Policies and Lesson Plan Requirements

In order to most effectively implement the new physical activity standards into their centers, many directors report requiring teachers to incorporate structured activities into their lesson plans. In many cases, teachers are required not only to schedule this time into the child’s day but to be specific about the types of activity in which the child will be engaged.

Some centers are also requiring that physical activity be incorporated into the lesson plan at multiple times during the day (e.g., once in the morning and once in the afternoon or during transition time) and in multiple settings (e.g., outdoors and indoors). One director explained:

“And they can’t just say on their lesson plan ‘outdoor time.’ It needs to say ‘bubbles and balloons’ or whatever they are doing, and it needs to be a structured activity.”

Center directors have found that requiring teachers to include structured activities in their lesson plans has changed the teachers’ attitudes toward outdoor activity time, enabling them to see that this time is an opportunity for important child education. As a result, they have noticed improved staff engagement with the children on the playground.

“…Now [the teachers] have to have lesson plans and activities that they are going to do outside to keep the children engaged…, It has caused a change in the teachers’ thinking. Outside time is not sit-down-and take-a-break time; it’s still interact-and-work-with-the-children time.”

—child care center provider
Increasing Staff Monitoring

Despite the inclusion of physical activity in many of the centers’ lesson plans, providers still have concerns of whether lessons plans are being executed and the physical activity standards are being met. To address these concerns, directors report increasing their level of staff monitoring for lesson plan compliance, especially during outdoor activity time. When directors encounter staff members who may not be compliant in implementing the physical activity guidelines, they have also found it effective to reiterate the importance of leading by example in being active right along with the children. Providers recognize that low staff participation in child activities negatively impacts the positive messages they may be teaching them about physical activity. To further clarify the expectations of staff, one New Castle County center provider has gone as far as rewriting job descriptions to include language that states that teachers are required to be “actively involved with children outside.”

Creating Opportunities to Share Ideas and Resources

Several center directors reported working more closely with their teachers to determine what they would like to do in the classroom and what equipment is necessary. To assist teachers, several directors reported that they purchased the necessary equipment and materials based on their teachers’ ideas for activities. A couple of center directors noted that they have also compiled activity ideas and materials for their staff in binders or boxes kept outside for teachers to easily pull out ideas. The equipment that they have purchased or received free through trainings includes scarves, hockey sticks, baseballs, jump ropes, hula hoops, and parachutes.

In order to assist and encourage staff in developing ideas for activities and their lesson plans, centers and child care-sponsoring agencies have provided more staff opportunities for collaboration through internal meetings and trainings. During these events, staff share their ideas for structured activities and even practice learning various activities.
Recommendations to State Agencies

In addition to encouraging the promising practices noted above, many providers expressed a need for more supports from state agencies in the form of equipment, resources, and information that could help them incorporate more teacher-led physical activity into provider practices.

- **Provide Sample Lesson Plans and Guidance for Increasing Children’s Physical Activity**

As noted above, finding developmentally appropriate activity ideas for young children has been a challenge for providers. Both center and family home providers expressed a need for simple, easy-to-use lesson plans and activity ideas to effectively increase children’s physical activity levels. Suggested ideas for materials that would be helpful included examples of structured teacher-led activities (for indoors and outdoors). They are specifically looking for ways in which teachers can encourage children to be more active as part of many of their activities, for example, during circle time or at center time for preschoolers.

- **Offer Providers a Mechanism for Sharing Play Equipment**

One of the primary recommendations that providers offered for increasing the availability of equipment at facilities was to create a resource distribution center (or lending library) for borrowing and sharing equipment. Such a center could minimize the impact on family home and center providers’ limited budgets. A lending library would also alleviate some of the storage issues faced by centers and homes with limited space to house equipment that may not be used on a regular basis. Family home providers in Kent and Sussex Counties described a helpful resource center where they used to be able to borrow equipment and resources before it closed down:

“We used to have a child care connection center, which was basically a lending library. We had a lot of stuff in there that we could borrow for 3 weeks…things you would not normally be able to buy, different things, expensive things.”

A few providers also suggested that the state find a mechanism for purchasing or donating play equipment to homes and centers most in need. To assist them in using the equipment regularly, family home providers would also like the help of a volunteer or extra staff person who could teach the children various activities while the providers are tending to meal preparation or other responsibilities.

“Just the chance for (staff) to sit around and say, ‘Oh, do you remember this game we used to play?’ or just to take some of these ideas...that you can adapt and change...it’s just a matter of teachers getting together and brainstorming.”

—child care center provider
8. Nutrition and Physical Activity Training

In Delaware, as in all states, initial and ongoing training is a requirement both for state child care licensure and for participation in the Delaware CACFP. Under OCCL rules, when child care providers seek licensure they must attend a class where they are introduced to all of the state’s child care licensing requirements. To maintain their licensure, staff members in centers and homes must complete 18 and 12 hours of professional development training per year, respectively. They may choose which authorized training classes to attend to obtain their CE credits. As defined by OCCL, this training must include topics such as child development, child education, and nutrition. However, Altarum’s discussions with OCCL staff revealed that while there is much being planned, there are currently few trainings available to assist providers in complying with the state’s new enhanced CACFP healthy eating guidelines.

Pursuant to FNS regulations, CACFP must offer training on its program rules to all CACFP participating child care facilities (CFR 226.6(a) and CFR 226.16(d)(2) and (3)). The content and format of this training are not mandated by federal regulations, but state CACFP agencies must provide training. These trainings occur first when an organization initially joins the program. Ongoing technical assistance to monitor providers and help them comply with the program rules is also provided. In addition, CACFP-sponsoring agencies (agencies that sponsor many child care homes and centers for CACFP participation, which in Delaware include Catholic Charities, Children and Families First, the Delaware Parents Association Inc., and Dover Air Force Base) must provide their own training at least once a year and offer technical assistance to the homes and centers that they sponsor. In Delaware, the annual state training was held in Wilmington and Dover in fall 2009, and the sponsoring agencies’ trainings have been held at various locations based on the location of the organizations that they sponsor.

Collaborating with state agencies, Nemours has provided additional trainings on healthy eating and physical activity since 2006. These trainings are offered to schools, child care agencies, medical providers, and the public. As part of these educational efforts, they have adopted and disseminated a simple message to promote healthy lifestyles: 5-2-1-Almost None. This message encourages children to do the following each day:

5—Eat at least 5 servings of fruits and vegetables
2—Spend no more than 2 hours a day in front of a television or computer screens
1—Participate in at least 1 hour of physical activity
Almost None—Drink almost no sugar-sweetened beverages

In 2007, Delaware CACFP and Nemours produced an educational booklet on healthy eating for young children titled *Best Practices for Healthy Eating: A Guide to Help Children Grow Up Healthy*. This resource outlined preliminary healthy food recommendations aligned with the recommendations of the 2005 Dietary Guidelines for Americans, explained the rationale for these recommendations, described age-appropriate portion sizes for foods in each of the CACFP food groups, and included sample written policies that providers could put in place in their own programs and use to communicate with families. This resource guide was disseminated and formed the basis of 12 two-part workshops provided by Nemours for CACFP sponsors in 2007 and early 2008. During this period, before CACFP put the new CACFP nutrition guidelines in place, CACFP and Nemours also provided train-the-trainer sessions for umbrella agencies to help them implement enhanced nutrition classes for the many centers and homes they oversee for the State CACFP.²⁷

As a result of these early training efforts, many CACFP-sponsoring agencies created their own training materials and agendas to serve the homes and centers they administer. These materials included food demonstrations, recipe sharing, periodic newsletters offering recipes, shopping lists for specific recipes, and menus to help providers comply with the new nutrition guidelines. These strategies and resources were mentioned by several of the child care home providers in the focus groups.

In addition to these training events, Nemours staff designed and conducted two more intensive, multisession trainings for small groups of providers. First, from 2006 to 2008, Nemours conducted a pilot effort with four child care centers, using mainly onsite training and technical assistance. Building on the lessons learned from the pilot training sites, Nemours implemented a 15-month training and peer support effort in 2008–2009 called *Taking Steps to Healthy Success: A Child Care Learning Collaborative to Promote Healthy Eating and Physical Activity*. The 28 centers who volunteered to participate in this Child Care Learning Collaborative project were asked to send a “leadership team” to five group training sessions. These sessions were supplemented with onsite technical assistance and mentoring by staff from centers who had previously received training from Nemours. Participating centers also received free educational materials, including videos that they could use to train their staff. They also were given small grants to purchase equipment or conduct an activity that would enhance either the nutrition or physical activity they provide at the center.

²⁷ Information on CACFP Nemours 2006–2009 trainings obtained from Nemours Health and Prevention Services staff.
The focus group findings that follow discuss providers input regarding the following:

- Past training and current training needs and
- Recommendations for future trainings.

### Provider Input on Past Training and Current Training Needs

Many CACFP participating centers and child care home operators spoke positively about the formal CACFP class trainings that they had already attended. Home providers offered particularly high praise for the content and format of their sponsor agencies’ trainings. They emphasized how useful the practical information was that they received from their sponsoring agency. Specifically, they mentioned their appreciation of the training on label reading and the sharing of specific practical recipes to meet the new guidelines. Two child care home providers, for example, spoke very positively about the different kinds of trainings that they had attended with their sponsoring agencies:

“I went to the last label reading training. It was a while ago, but it was helpful, because there are some many different products on the market that don’t fit the CACFP guidelines.”

“We took a class at the library and they had all the providers bring in a dish prepared with the recipe that the kids would eat and we exchanged recipes. We got a lot out of it, because, of course, you’re going to bring something you know the kids are going to eat. And we actually got a lot of good meals out of that. And they need to do more of that: classes exchanging so that people can get a taste of things.”

Those who attended Nemours’ more intensive, yearlong trainings for child care center directors and staff together also gave positive feedback, and applauded these sessions as models of peer-to-peer training. They were appreciative that Nemours provided the resources necessary to send both directors and staff to training. In the words of one center director,

“I think the Nemours Childcare Learning Collaborative model, where we could bring staff to be trained, was excellent, and this should be offered to centers in the whole state.”

### Provider Recommendations for Improving Future Training

Providers in all seven groups uniformly highlighted the need for training, technical assistance, and accompanying resources with simple and short take-home messages. They said that this approach would offer them practical information and simple tools that they can use to overcome challenges they face in implementing the new policies. They also stressed the need to maintain a focus on positive messages about the nutrition policies and their impact on children. They recommended avoiding a focus on what foods are no longer allowed or limited.

Some child care center directors in the groups also offered recommendations with regard to the content of training on physical activity. For example, a few directors suggested that their staff need more ideas for planning structured activities. The directors felt this would make their staff more likely to engage the children and include structured physical activity as part of their daily lesson plans. A couple of providers noted that trainings would be more beneficial to them if they included activity ideas directly tied to developing various motor skills. Several mentioned that they also like more ideas for physical activity suitable to children under age 3.
Focus group participants from many centers, and from a large majority of the home providers, asked for more training opportunities. They wanted both group and individualized trainings and technical assistance and emphasized that expanded training in these two forms would help them address the challenges of implementing the new policies.

Providers suggested various ways to improve future trainings when they are offered. They recommended new methods for providing training and information, changes to the format and type of group trainings, strategies for improving participation in group trainings that are offered, and new areas of focus for the content on which they would like training and technical assistance.

### Provide Training Using a Participatory Format

When asked how they would like to receive future group trainings from CACFP and OCCL on the nutrition and physical activity standards, providers offered similar ideas. Providers from both child care centers and child care homes stressed that training would be most effective if participants are actively engaged in discussion that relates to their own experiences:

“I think an open forum discussion is good, too, because we learn from each other.”

Focus group participants specifically noted the value of a hands-on training approach to help them apply the standards for physical activity. They said that giving staff interactive opportunities to learn exactly how to do structured activities would best motivate them by demonstrating that such activities are enjoyable.

### Limit and Tailor Use of Online Training

When specifically probed for their views about the Internet as a vehicle for providing training, a majority of providers said that they think in-person trainings are more effective for themselves and their staff.
On the one hand, several center operators expressed concern that staff would not make the time to participate in a Web-based training and that continuing education credits would be hard to justify unless there were a method for testing and following up to ensure that the staff had actually completed the training. On the other hand, a few providers suggested Web-based classes could be useful if combined with in-person classes or meetings to ask questions and practice new skills. Overall, providers’ comments indicate the need to offer various options in the format of training as peoples’ learning styles vary.

However, even providers who felt strongly that training should be in-person said that the Internet is an effective way to share resources and communicate with providers on an ongoing basis. For example, several center and home providers suggested that a more active Web site with updated information could help them become actively engaged in ongoing education. Home providers and participants from smaller centers suggested that this kind of site should offer timely information on where to find free or low-cost food products, lists of allowable foods, sample menus and child-friendly recipes, and how to obtain materials to use as teaching tools with the children or parents.

Expand Trainings to Include Child Care Center Teachers

Center directors overwhelmingly agreed that they want more education and training opportunities for teams of staff rather than just the administrator. This was the format for the Nemours Child Care Learning Collaborative trainings. However, these center directors did not necessarily see the need for yearlong trainings as provided under the Nemours collaborative training model. They noted that even effective one-time trainings that included staff would better enable them to gain support within their centers and to meet the goals of the nutrition and physical activity guidelines. A few administrators from larger centers had conducted this kind of in-service training for staff after attending trainings by Nemours. As noted in the chapter above on staff engagement, many center providers said that they do not feel comfortable providing adequate training to staff or need help in this area. Some feel that they lack the skills to help motivate positive staff involvement in the areas of nutrition and physical activity.

Improve Training Accessibility

Many providers from urban and rural areas of the state emphasized that all group trainings on the nutrition and physical activity standards need to be more widely available. They recommended that they be offered at different locations than in the past. They also recommended that trainings be offered at various times of the day to accommodate staff who can come to classes only in the afternoon, in the evening, or on weekends.

Home providers and center directors from all three counties noted that they and their staff would be more likely to participate in classes outside of their centers if the sites were close by or accessible by public transportation. In Wilmington, several providers said that there is a lack of public transportation to areas outside of downtown or in the evenings. In Sussex County, many providers said that it was hard for many of them to get to training in Dover or Wilmington and suggested either (a) locating CACFP and other trainings closer to the more rural areas in this county or (b) working through the current local child care provider association.
Promote Attendance

Home and center providers indicated their support for making group trainings more accessible, providing incentives to participants (such as a book or play equipment), and offering CE professional development credits for successful completion. A couple of center directors suggested that if more trainings on the new standards become available at various locations around the state, OCCL should mandate providers to participate in these as part of their required CE credits.

Consider Local Trainings That Involve Children or Parents

Several providers recommended involving staff and children together in local trainings as a more effective way of engaging staff that would give them immediate hands-on practice. They suggested that this type of training be conducted at a location that can accommodate staff and children from multiple centers. In the words of one center director:

“[Having staff and kids participate together] would bring about a lot more change…if they could pick maybe a group of five [children] to come along with the teachers so that [the teachers are] able to work with those students and teach them those different things.”

Another provider suggested inviting parents to the formal trainings on the nutrition and physical activity guidelines so that parents could see these policies as something that they can work on with providers and support at home.

Arrange Forums for Providers to Share Information

In addition to trainings offered by the state or sponsoring agencies, providers overwhelmingly expressed a strong desire to have more opportunities to interact with and learn from their fellow child care providers. They felt that more forums of this sort (both in person and online) would enable them to share physical activity ideas and learn how to best adapt to the policy changes. They placed a high value on learning from the experiences of their peers.

A couple of providers suggested the creation of an online forum that connected them to tools and curriculum with activity ideas, information about obtaining needed equipment and resources from other centers or sources, and the times and locations of available trainings.
9. Conclusion and Recommendations

The purpose of this focus group research has been twofold. The primary purpose was to assess how child care providers and parents in Delaware are responding to the state’s enhanced nutrition and physical activity standards for child care facilities. The secondary purpose was to determine what providers needed in order to help them implement these health promoting standards.

This study was conducted in partnership with three organizations in Delaware, Nemours, the CACFP, and the OCCL. Therefore, a priority has been placed on developing recommendations relevant to representatives from these agencies to assist them in their ongoing efforts to help child care providers and parents comply with the nutrition and physical activity standards implemented in Delaware. These findings and recommendations may also be applicable to stakeholders in states and communities across the nation that are developing or implementing obesity prevention policies for child care settings.

The focus group findings clearly indicate that both child care providers and parents in Delaware have responded positively to the goals of the state’s nutrition and physical activity standards for child care. They have also welcomed most of the content of these policies. The lengths to which child care center and child care home providers are going in order to come into compliance with the new policies are highly encouraging. These efforts demonstrate the innovative “children come first” approach taken by providers. The fact that providers and parents have embraced the overall goal of Delaware’s healthy eating and physical activity guidelines is obviously critical for successful implementation of these health promoting policies. As partners across Delaware work together to develop and implement plans to improve the nutritional quality of meals and increase physical activity opportunities in child care, the continued acceptance of providers and parents of these policies needs to be reinforced and should not be taken for granted.

In addition to supporting the intent of the policies, most providers and parents in the focus groups appeared to understand the rationale for the majority of the standards in Delaware. However, many providers and parents still reportedly do not understand enough about the need for some of the state’s nutrition guidelines, especially the mandate that children over age 2 be served only 1% or fat-free milk. As future training tools are developed in Delaware and other states, it will continue to be critically important to communicate the rationale for helping children develop healthy eating and physical activity habits early in their lives.

The previous efforts to provide training to the child care community were greatly appreciated, but additional supports, including improved and expanded trainings, are needed. Providers also stressed a need for more tools, guidance, and technical assistance to address the challenges that they have in changing their practices and thus enable them to fully comply with the standards.

Focus group participants talked about a number of challenges that they are facing or anticipate facing as they work to comply with the new nutrition and physical activity standards. Many emphasized the additional time required to cook healthy meals and
change the way that they shop for food. Others were concerned about the financial costs and challenges of limited access to healthful foods. Overall, center and home providers stressed the need for not only more training and resources, but also policy and system supports that would make it easier for providers to successfully comply with the requirements and to make the right choices in their daily practices.

Findings from the focus groups have led to a set of recommendations that are intended for agencies committed to supporting child care providers in their implementation of enhanced nutrition standards and physical activity licensure policies. Helping child care providers fully implement improved meal quality and physical activity standards hinges on expanded trainings; technical assistance; and the development of new, easily accessible tools and resources. Equally important is recognizing that providers need to gain the support of staff and parents as they make these changes. Finally, the consideration of longer-term system supports can provide the financial assistance and incentives that will make it easier for providers to make the right choices in their daily practices. These findings form the basis of seven broad recommendations detailed below. Certainly not all of the recommendations in this report are immediately achievable, but they are important to consider as a comprehensive strategy is crafted in Delaware. They might also be useful in other states and communities or at the federal level to help providers successfully implement improved childhood obesity prevention standards for child care.
Recommendations

- Clearly and consistently communicate the rationale for nutrition and physical activity standards in child care.
- Offer supports to help providers address the challenges of meal planning, food preparation, and food purchasing.
- Develop new resources and expand on existing ones to help providers educate and engage preschool children in healthy eating habits and increased physical activity.
- Help providers implement strategies to successfully engage staff and parents.
- Expand and improve training and technical assistance for child care directors and staff.
- Develop and implement mechanisms for improved peer-to-peer information sharing.
- Align state child care Quality Rating and Improvement Systems (QRIS) with enhanced nutrition and physical activity standards.

**Clearly and consistently communicate the rationale for nutrition and physical activity standards in child care**

Child care providers and parents need to fully understand the rationale behind enhanced nutrition and physical activity standards. Armed with the right information, providers and parents can be even more effective supporters of the policies that are being implemented. They will be more likely to fully support changes in the foods that they prepare and serve to children, as well as better equipped to communicate effective messages to their colleagues, the children, and the children’s parents.

**Offer supports to help providers address the challenges of meal planning, food preparation, and food purchasing**

Providers’ most frequently cited challenges in implementing the nutrition standards were related to the time and financial costs associated with menu planning, food preparation, and food purchasing. The time needed to find allowable foods and to shop at multiple food suppliers and the rising costs of their food budgets were major concerns. Limited access to healthful foods was also reported as a challenge. In general, providers asked for informational tools and for assistance from suppliers and the state to improve their access to the foods that they need to meet the guidelines and at lower costs. The following suggested actions build on the promising strategies providers reported during the focus groups and their recommendations for state action:

- **Develop sample menus with recipes** that are child friendly, are tested with providers, and can be scaled up for large child care facilities.
- **Provide lists of commonly used allowable foods**, such as cereals that contain less than 6 grams of sugar; and alternatives to popular, unallowable foods, such as frozen chicken nuggets and tater tots.
- **Create a cookbook** with recipes and hints from local providers and parents.
- **Build partnerships with food retailers and institutional food suppliers:**
  - Encourage suppliers to develop relationships with providers by offering one-on-one shopping assistance for providers.
  - Educate suppliers and providers about the collective buying power represented by child care operators.
  - Encourage suppliers to develop educational tools such as child-friendly, low-cost recipes tied to shopping lists.
• Work with suppliers to create food labels that indicate which foods meet the enhanced nutrition guidelines, similar to labels food suppliers use for foods that meet the guidelines of school meal programs.

- **Consider meal subsidies for providers.** The Federal Government, states, and communities should consider higher meal subsidies where the costs for compliance with the child care nutrition standards are excessive due to local food costs or other conditions.

- **Offer subsidies or other incentives to local growers.** These financial incentives can help growers bring fresh produce to child care providers and potentially at lower cost. A model of a similar effort is the USDA’s Fresh Fruits and Vegetable Program, which brings fresh products from local farms to school meal programs in selected schools in all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

- **Work with food banks and pantries** to help interested child care providers obtain timely information about available food donations that meet the state’s nutrition guidelines.

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*Develop new and expand on existing resources to help providers educate and engage preschool children in healthy eating habits and increased physical activity*

Some parents and providers described educational activities in which their children are engaged to learn about healthy foods and to increase their opportunities for moderate to vigorous physical activity. These practices were reported at only a few centers represented in the focus groups. The need for specific practical materials, lesson plans, and other supports to help providers in this area was clearly evident from the focus group discussions. Recommended types of materials include

- **Educational displays** targeted to children such as bulletin boards and posters;

- **Games, songs, and rhymes** (in hardcopy and online) that staff can use to reinforce the nutrition and physical activity standards (e.g., those incorporating messages about healthy snacks or fruits and vegetables);

- **Step by step guides for activities** to engage the children in trying new foods;
- **Sample daily lesson plans** that integrate indoor and outdoor physical activity opportunities throughout the child care day;
- **Sample staff-led physical activity lessons** that require limited or no equipment and can be integrated into the daily child care routine;
- **Information on sources of play equipment** for preschoolers which are available at no or low cost; and
- **Lending libraries** where providers can borrow equipment to promote physical activity among young children, such as jungle gyms, slides, crawl tunnels, and activity CDs.

### Help providers implement strategies to successfully engage staff and parents

Providers in the focus groups emphasized the need for effective strategies to help them gain the enthusiastic support of both staff and parents. Some center operators that attended the more intensive trainings by Nemours have already implemented promising strategies for engaging staff and parents at their centers. Yet most providers, including some who had attended Nemours trainings, felt that gaining staff and parental engagement are still among their greatest challenges in implementing the new nutrition and physical activity standards.

Parent participants who strongly supported the standards emphasized that in addition to engaging parents, child care providers should offer them the information and skills that they need to reinforce the health-promoting messages and behaviors at home. State agencies and their partners, such as Nemours, should consider developing some of the following materials and tools:

- **A step-by-step guide for organizing meetings and events for families** to learn about the goals of the standards and participate in activities reinforcing the standards.

- **Informational materials directed to parents and guardians** in culturally and linguistically appropriate formats to reach adults with limited literacy, people who do not speak or read English, and people of a variety of cultures.

- **Sample policies that centers can incorporate into parent handbooks** describing the nutrition and physical activity policies and their rationale. This will help inform parents on how the center is implementing these policies—for example, by distributing weekly menus, recipes, and information and resources on how to help children reduce screen time and be more physically active.

- **Written materials and other resources for staff training** that child care directors can use to engage and train their cooks and teachers.

### Expand and improve training and technical assistance for child care directors and staff

Based on their past experience, Delaware providers had many suggestions for training providers like themselves on these standards. They stressed the need for trainings that addressed the rationale of the guidelines and have a how-to focus. Training could reportedly be most effective if it included hands-on guidance in group settings; opportunities for information sharing among peer providers; exchange of promising practices; and, in some cases, follow-up, one-on-one technical assistance. They also suggested ways to improve the availability and accessibility of these trainings so that more providers and child care facility staff can attend.

Recommendations for expanding training opportunities are presented below and address three areas: the format of trainings, expanding access to trainings and providing incentives for participation, and changing the child care training infrastructure.
Offer participatory group trainings with hands-on instruction and practice (e.g., tasting new foods, menu preparation, label reading, practicing structured physical activities). While providers clearly have very different learning styles and preferences, Web training may not be the best primary training option for most providers.

Encourage team participation at trainings. Offer trainings for centers that involve center operators, teachers, and cooks as part of learning teams, similar to the Nemours Child Care Learning Collaborative model.

Establish a mechanism to support peer-to-peer support and direct one-on-one technical assistance to aid providers who need continued instruction in implementing the standards.

Improve accessibility of trainings by conducting them in various locations across the state, at sites accessible by public transportation, and on different days of the week to minimize travel costs and accommodate directors’ and staff’s work schedules.

Offer incentives for attendance such as continuing education credits and provider resources (e.g., age-appropriate picture books, music CDs, or portable play equipment to reinforce the nutrition and physical activity messages of the child care standards).

Require nutrition and physical activity instruction for new providers receiving licensure and for basic child care certification programs.

Allow participation in CACFP-sponsored trainings to count as continuing education credits for child care providers.

Expand nutrition and physical activity trainings available for licensing and certification education credits by working with organizations who offer these trainings.
Develop and implement mechanisms for improved peer-to-peer information sharing

In addition to enhanced trainings, child care providers overwhelmingly expressed a need to share information and to learn from one another as they overcome obstacles in implementing the new standards. Recommended mechanisms to facilitate peer-to-peer exchange follow:

- Newsletters disseminated by CACFP and child care licensing organizations that provide training and technical assistance. These could regularly highlight current information, sample menus or recipes, parent engagement tips, and promising approaches providers are using to successfully comply with the standards.

- A well-publicized Web site to allow providers to link to free informational materials; learn about no- or low-cost resources that help providers comply with the standards; find up-to-date schedules for nutrition and physical activity trainings; and share recipes, shopping tips, reviews of store selections and pricing, lessons, and other strategies being used in implementing the standards.

Align state child care QRIS with enhanced nutrition and physical activity standards

A few center providers noted that their training priorities and center-level policies are driven in part by Delaware Stars for Early Success, the state’s QRIS. Providers in several focus groups suggested that if the Stars rating of child care facilities were more closely tied to the state’s child care licensing standards, providers would be more likely to focus their training to meet these standards. Building on suggestions from Delaware’s child care providers and research into other states’ proposed QRIS efforts,28 specific recommendations follow:

- Incorporate specified amounts of nutrition and physical activity training as part of QRIS ratings. State child care QRIS standards could include a requirement for child care administrators and kitchen staff to participate in a minimum number of hours of training in nutrition and in developmentally appropriate physical activity for young children.

- Include documentation of physical activity in child care providers’ lesson plans. State child care QRIS standards for centers could include a requirement to document teacher-led physical activity in the daily schedules and program lesson or activity plans.

These recommendations are likely to be applicable in many states other than Delaware. Even in states without regulations such as those governing Delaware’s CACFP and child care licensing, QRIS is often tied to child care subsidy levels and might provide the financial incentive needed to help providers prioritize improving their nutrition and physical activity policies and practices.
