Empower Implementation Report

Years One and Two

Arizona Department of Health Services
Public Health Prevention
Research and Development

11/8/2016

TABLE OF CONTENTS

Overview ... 1

Standard 1: Physical Activity (Ten components) ... 3

Standard 2: Sun Safety (Six components) ... 5

Standard 3: Breastfeeding (Four components) ... 7

Standard 4: Child And Adult Care Food Program (One component) ... 9

Standard 5: Fruit Juice (Seven components) ... 10

Standard 6: Family-style meals (Six components) ... 12

Standard 7: Oral health (Nine components) ... 14

Standard 8: Staff Training (One component) ... 16

Standard 9: ASHLine ... 17

Standard 10: Smoke-Free Campus (Four components) ... 18

Overview

The Arizona Department of Health Services developed the Empower Program to promote healthy environments and behaviors for children in Arizona's licensed childcare facilities.[1] It was first implemented in January 2010, offering discounted annual licensing fees to facilities agreeing to implement ten standards focusing on physical activity, sun safety, breastfeeding-friendly environments, Child and Adult Care Food Program, fruit juice, family-style meals, oral health, staff training, smokers' helpline, and smoke-free campuses:

1. Provide at least 60 minutes of daily physical activity (teacher-led and free play) and do not allow more than 60 minutes of sedentary activity at a time, or more than three hours of screen time per week.
2. Practice "sun safety."
3. Provide a breastfeeding-friendly environment.
4. Determine whether site is eligible for the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP), and participate if eligible.
5. Limit serving fruit juice to no more than two times per week.
6. Serve meals family style and do not use food as a reward.
7. Provide monthly oral healthcare education or implement a tooth brushing program.
8. Ensure that staff members receive three hours of training annually on Empower topics.
9. Make Arizona Smokers' Helpline (ASHLine) education materials available at all times.
10. Maintain a smoke-free campus.

An initial study of the program, which focused on 112 centers, indicated that the program held promise, but that the instrument used to assess practices needed to be improved. The early tool used a rating of whether the facility was in or out of compliance with each standard, and provided no further detail. On December 1, 2011, the survey process was reviewed at a quarterly licensing surveyors meeting and it was determined that more detailed measures were needed to evaluate the thoroughness and levels of implementation. On July 1, 2013, updated Administrative Rules went into effect, which required that updated standards be reflected in written policies. This provided a point in time when a new assessment methodology could be implemented that would provide more information on implementation progress, as well as barriers and opportunities for technical assistance and education.

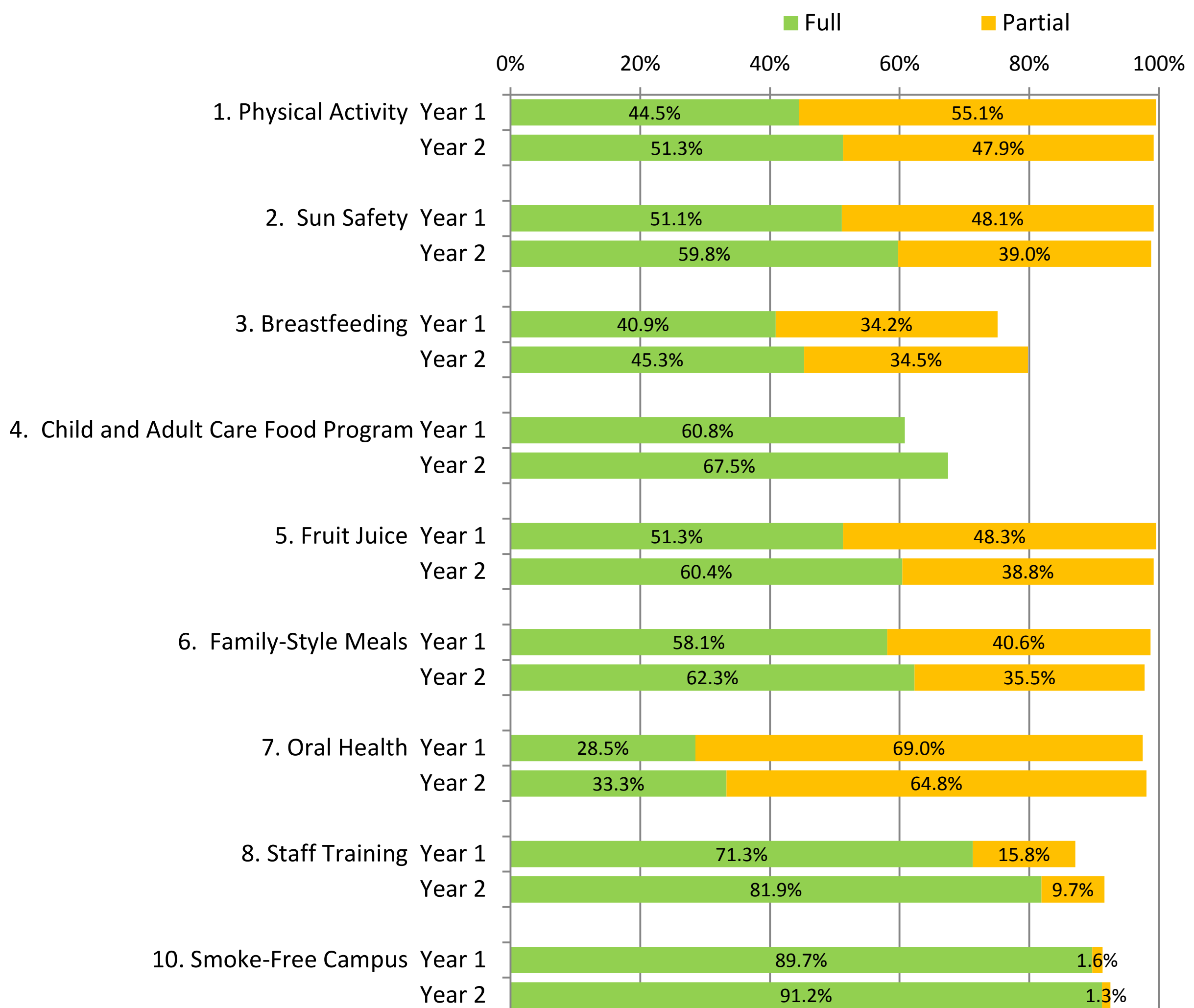
A new survey tool was developed that isolated key components of each standard, including an explicit requirement to provide family education for most standards. Components were clarified and operationalized, replacing words like "encourage" or "promote" with words like "provide" or "schedule." Key components of each standard were further developed to allow an assessment of written policies and self-reports of progress implementing the component (i.e., full, partial, or none). The tool also has a place to provide comments from child care facility and licensing staff. Licensing staff incorporated the new monitoring tool into their regular site reviews concurrently with the date of the new rules change. This report summarizes results from the first two years (July 1, 2013, to June 30, 2014, and July 1, 2014, to June 30, 2015) of data using the new methodology and survey tool. For

[1] To learn more about the program, please see the Empower Guidebook, Third Edition: Ten Ways to Empower Children to Live Healthy Lives, Standards for Empower Child Care Facilities in Arizona.

facilities reviewed more than once, only the first evaluation is included each year. Data from a total of 1,527 site reviews are included for year one and 1,108 site reviews from year two. Ultimately, this and future evaluation efforts should lead to a better understanding of how to support sites in their implemention of the Empower Program and identification of best practices and barriers to implementation.

The Empower Program is still in a capacity-building phase, and this evaluation is focused on self-reported implementation, which increased between year one and year two for all standards (see Figure 1). A standard is rated as fully implemented when a facility reports that they have fully implemented each of the components of the standard. The standard is rated as partially implemented when a facility reports implementing some of the components at least partially.

Figure 1. Implementation of Empower Standards Overall



Details on each component of each standard are presented in the remainder of this document.

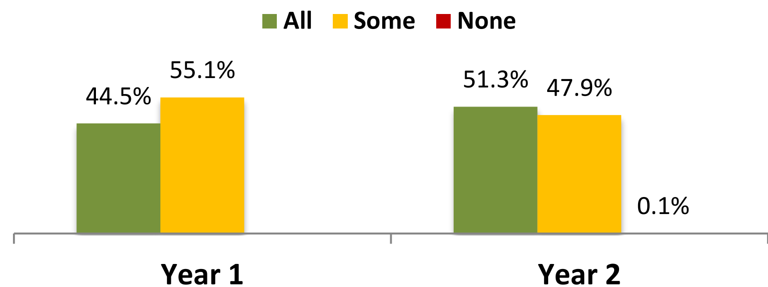
STANDARD 1: PHYSICAL ACTIVITY (TEN COMPONENTS)

The physical activity standard requires planned daily physical activity in curricula for children one year and older with the following ten components:

1. Include at least 60 minutes per day for children one year and older.
2. Include teacher-led activities.
3. Include free play opportunities.
4. Include opportunity to participate in outdoor physical activity.
5. Include moderate levels of physical activity.
6. Include vigorous levels of physical activity.
7. Limit sedentary time to less than 60 minutes at a time, except when sleeping.
8. Limit screen time to three hours or less per week.
9. Prohibit using or withholding physical activity as punishment.
10. Make information on screen time available (in English and Spanish) to families at least once per year.

Approximately 45 percent of facilities in year one and 51 percent of facilities in year two reported full implementation of all ten physical activity components, as shown in Figure 2. By year two, approximately nine in ten facilities reported fully implementing eight of the ten components; however, lower levels of implementation were reported for including vigorous physical activity and providing information on screen time. (See Figure 3.)

Figure 2. Percent of facilities implementing all, some, or none of the physical activity components



Some themes emerged from child care facility staff comments, including questions about the meaning of vigorous activity, the differences between moderate and vigorous activity, as well as asking for further clarification of screen time. Some said that they have a limited hour program, such as half day or after-school program. A few said they do not have a playground for outdoor play. Several said they do not allow screen time at all.

Licensing staff feedback affirmed respondents' comments regarding facility confusion related to the definitions of moderate and vigorous activity. Additionally, they noted that some facility staff did not know the meaning of the word "sedentary." Licensing staff also reported that the use of the word "prohibits" is very confusing for facility staff and they frequently have to provide guidance to those completing the assessment. Licensing staff recommended using language from the licensing rules that is more familiar to providers in future evaluations.

Figure 3. Physical Activity Components Level of Implementation

STANDARD 2: SUN SAFETY (SIX COMPONENTS)

The sun safety standard has six components, which require protecting all children from overexposure to the sun during any outdoor session:

1. Follow the age-specific sun recommendations listed in the Empower Guidebook.
2. Check the intensity of the sun's rays and use the UV index when planning outdoor activities.
3. Limit exposure during peak UV hours from 10 a.m. to 4 p.m.
4. Protect staff's and children's skin when outdoors.
5. Obtain permission from the child's family before applying sunscreen.
6. Encourage the child's family to apply sunscreen to children before they arrive at your site.

Approximately 51 percent of facilities reported full implementation of all six sun safety components in year one, and 60 percent in year two (see Figure 4). Approximately 90 percent of centers reported fully implementing components related to limiting sun exposure to age-specific recommendations, limiting exposure during peak hours, and encouraging families to apply sunscreen to their children. Figure 5 shows the percent of facilities reporting full, partial, or no implementation of each component of this standard.

Figure 4. Percent of facilities implementing all, some, or none of the sun safety components

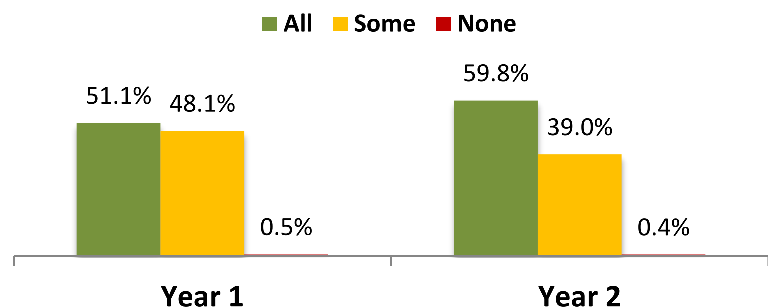
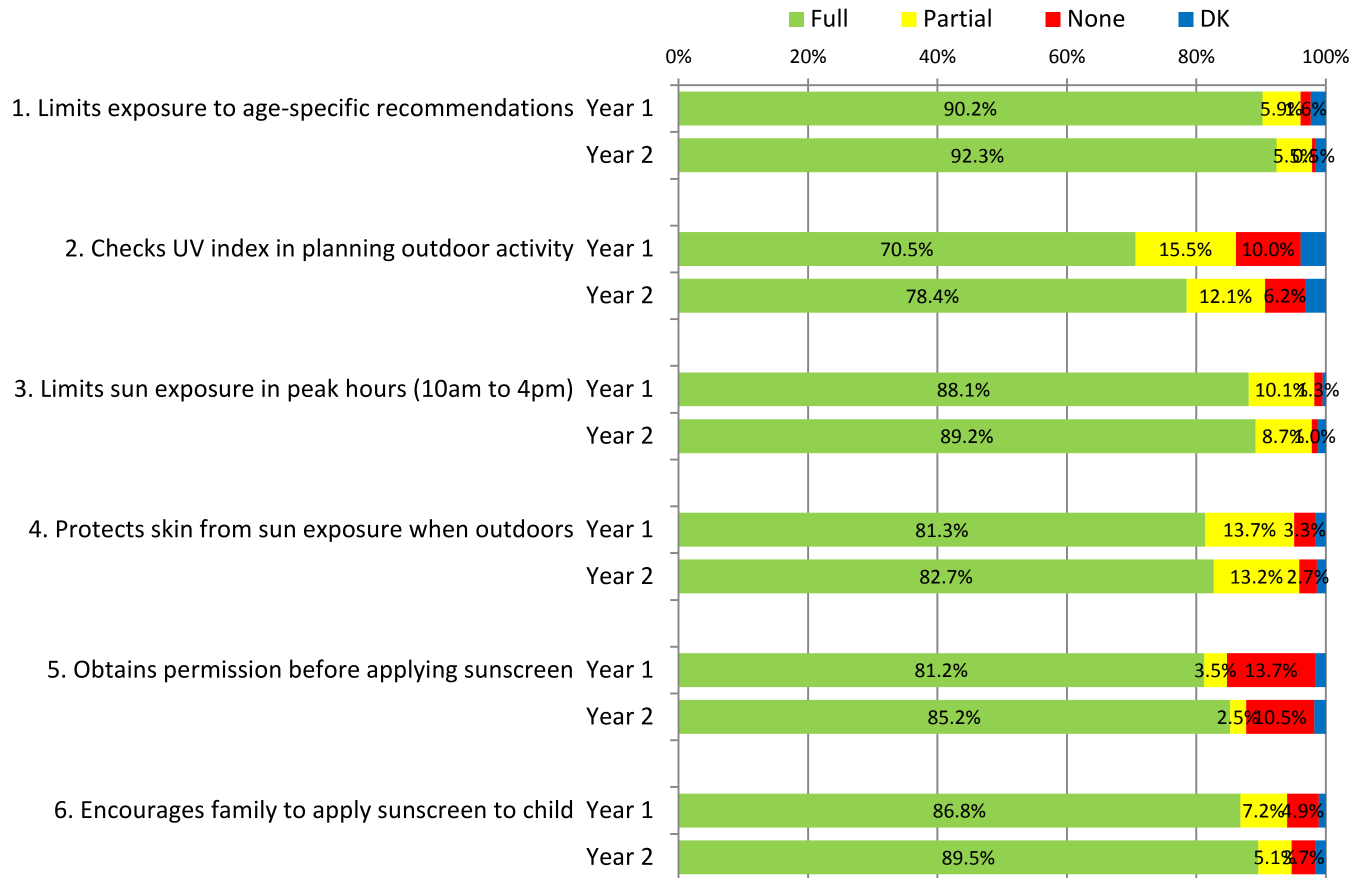


Figure 5. Sun Safety Components Level of Implementation



Child care facility staff made comments about shaded outdoor playgrounds, indoor-only play areas, and interest in the UV index. One comment said they were unaware of a UV index, another said they wanted to learn more, and a third said they would now add it to their policy. Several facilities said they were doing things such as limiting sun exposure in the summer or encouraging parents to dress kids appropriately to protect from the sun. A couple of facilities asked what was meant by the age-specific recommendations, and many stated their facility does not apply sunscreen to children at all. Licensing staff reported that for the sun safety standard, it was unclear to providers what it meant to “check intensity” with regard to UV index, and recommended using language from the licensing rules that is familiar to providers.

STANDARD 3: BREASTFEEDING (FOUR COMPONENTS)

The breastfeeding standard requires provision of ongoing support to breastfeeding mothers with the following four components:

1. Breastfeeding mothers, including employees, shall be provided a private and sanitary place to breastfeed their babies or express milk. A bathroom is not acceptable.
2. Provide a refrigerator for storage of expressed breast milk.
3. Reassure nursing mothers that they are welcome by displaying breastfeeding promotion information.
4. Provide information on breastfeeding (in English and Spanish) to families at least once per year.

Approximately 41 percent of facilities reported full implementation of all four breastfeeding components in year one, and 45 percent in year two (see Figure 6). Nearly a quarter of facilities (22.5 percent) in year one and 15 percent in year two reported not implementing any of the four components. In addition, a substantial proportion of facilities say that they have not implemented each component at all, as shown in Figure 7.

Figure 6. Percent of facilities implementing all, some, or none of the breastfeeding components

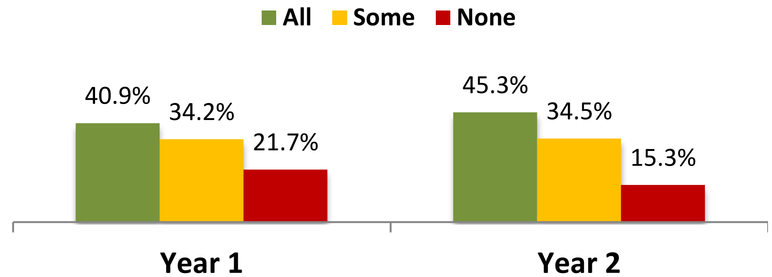
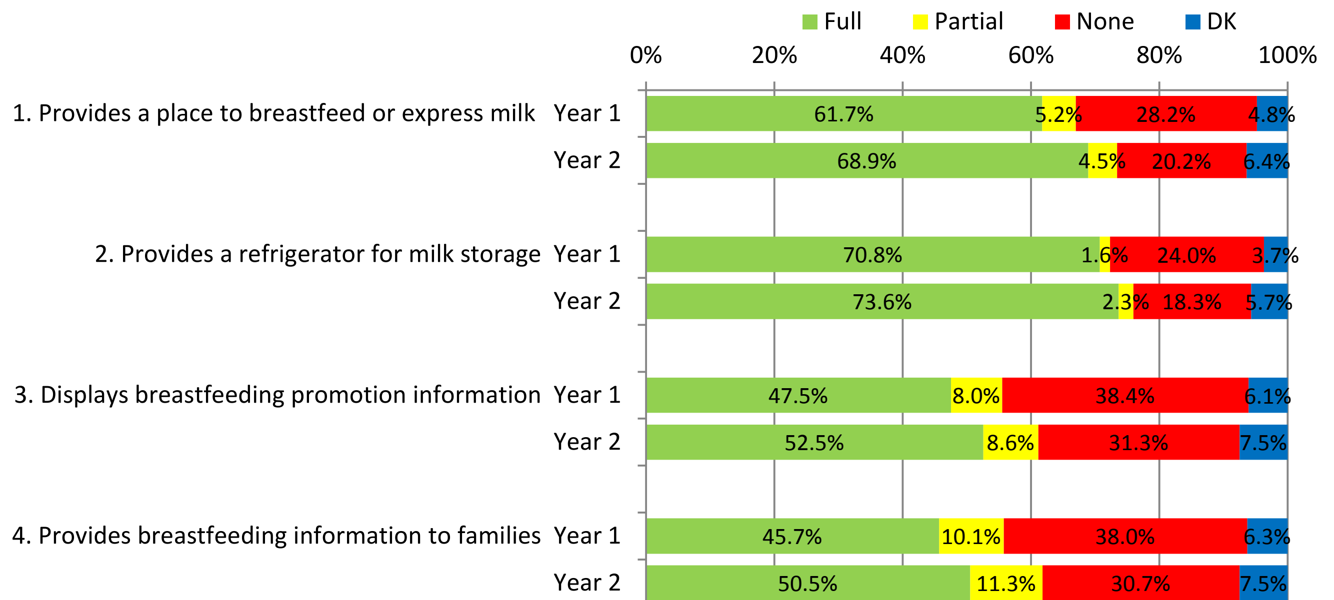


Figure 7. Breastfeeding Levels of Implementation



The main theme emerging from the comments from child care facility staff related to the perception that this standard did not apply to them. The majority of comments were reports of having no infants in their facility. Several facilities provided explanation regarding the ages of children their facility did serve, such as preschool aged kids or after-school programs for school-age children. A handful said they did not have infants in their facility but were able to accommodate breastfeeding mothers if necessary.

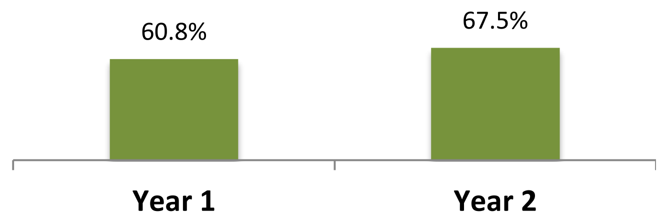
Licensing staff reaffirmed what was captured in the comments section of the assessment tool. They also reported that many of the facilities are public schools enrolling only school-age children, and in these cases families with infants rarely enter the facility. As a result, facility employees believed that this standard is not applicable to them. The licensing staff stressed how important education is for this standard, noting how often they must explain the standard to facility employees in order for them to fully understand the meaning of breastfeeding-friendly environment.

STANDARD 4: CHILD AND ADULT CARE FOOD PROGRAM (ONE COMPONENT)

The Child and Adult Care Food Program (CACFP) standard requires the development and implementation of a written policy that includes checking the eligibility of the children within a facility for CACFP. If eligible, those children would be enrolled in CACFP and facilities should document the eligibility and participation status of all children. This component is evaluated by whether or not the facility has a written policy.

In year one, 60.8 percent had a written policy on CSFP, and in year two this increased to 67.5 percent, as shown in Figure 8. Some themes emerged from comments on the CACFP standard. Several respondents reported not participating in the program and for some, it was because their families were ineligible. A few facilities stated that their children received free or reduced lunch.

Figure 8. Percent of facilities with written policies on CACFP



Feedback was also provided by licensing staff on the CACFP section of the assessment tool. Licensing staff reported that this standard is typically dealt with by program administrators. Classroom directors and their staff are rarely aware of these answers. Licensing staff noted that not all programs are eligible to participate in CACFP. Therefore, they do not recommend having CACFP as a stand-alone standard, but instead should be a component of another standard such as family-style meals. All licensed programs must comply with the licensing rule requirement of having a food chart and serving tables based on CACFP requirements within their facilities, even if they are not a CACFP-eligible facility.

STANDARD 5: FRUIT JUICE (SEVEN COMPONENTS)

The fruit juice standard requires a commitment to supporting children in establishing lifelong healthy eating and drinking habits with the following seven components:

1. Offer water throughout the day.
2. Offer water as the first choice for thirst.
3. Prohibit serving fruit juice more than two times per week to children one year or older.
4. Prohibit serving more than a half cup (or four ounces) of fruit juice at one time for children less than six years of age.
5. Serve 100 percent fruit juice with no added sugar or never serves juice.
6. Serve fruit juice only during meal or snack time.
7. Provide information on fruit juice (in English and Spanish) to families at least once per year.

Approximately 51 percent of facilities-reported full implementation of all seven fruit juice components in year one, and 60 percent in year two (see Figure 9). Nearly 100 percent of facilities report full implementation of the first two components of the standard, offering water throughout the day and offering water as the first choice for thirst. Most facilities reported fully implementing the component, serving 100 percent fruit juice or never serving fruit juice. See Figure 10 for the self-reported levels of implementation for each component.

Figure 9. Percent of facilities implementing all, some, or none of the fruit juice components

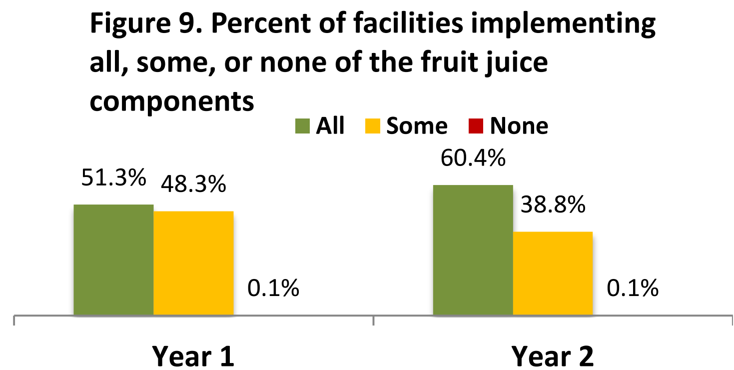
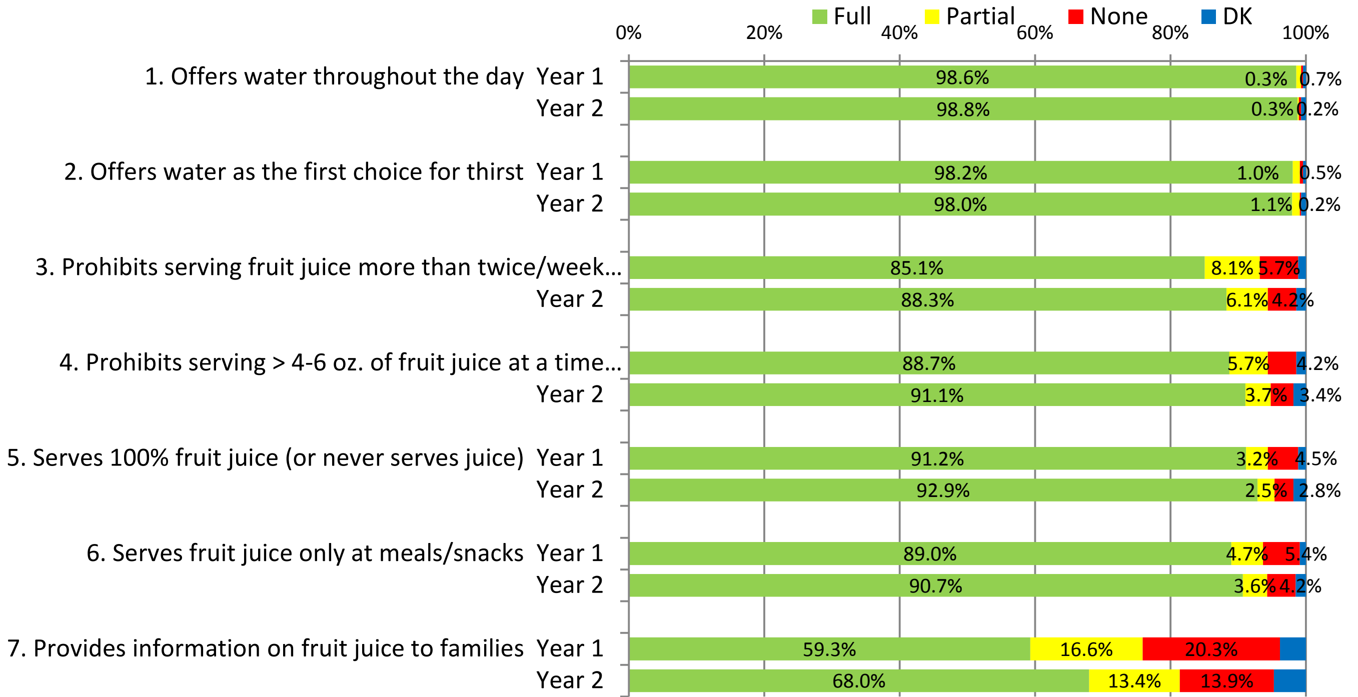


Figure 10. Fruit Juice Components Level of Implementation



The large majority of comments from child care facility staff stated that the facility does not serve juice at all, and many mentioned not serving juice because it was not allowed. Several noted that parents sometimes give the child juice for lunch or snack. A few respondents only provide milk or water at their facility. Licensing staff reported that providers do not recognize a difference between the term “offers” used on the assessment vs. the term “available” written in the licensing rules. They also reported that the use of the word “prohibits” is very confusing for providers. Licensing staff must frequently provide guidance to providers, with examples. They recommend using language from the licensing rules that is familiar to providers in future assessments.

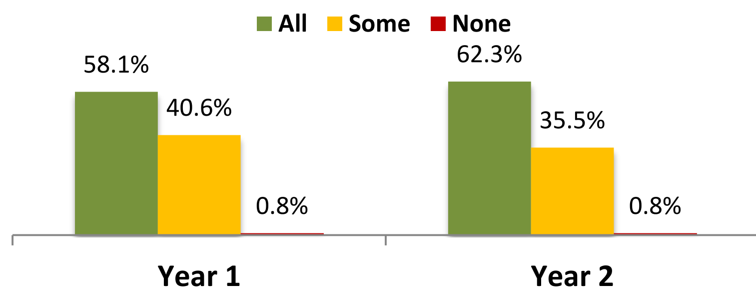
STANDARD 6: FAMILY-STYLE MEALS (SIX COMPONENTS)

The family-style meal standard requires a commitment to supporting children in establishing lifelong healthy eating and drinking habits with the following six components:

1. Serve meals family style whenever possible.
2. Utilize child-friendly serving utensils and containers.
3. Participate, sit, and interact with children at mealtime.
4. Allow children to serve themselves so they may choose what to put on their plates and how much to eat.
5. Prohibit using food as a reward or punishment.
6. Provide information on healthy eating (in English and Spanish) to families at least once per year.

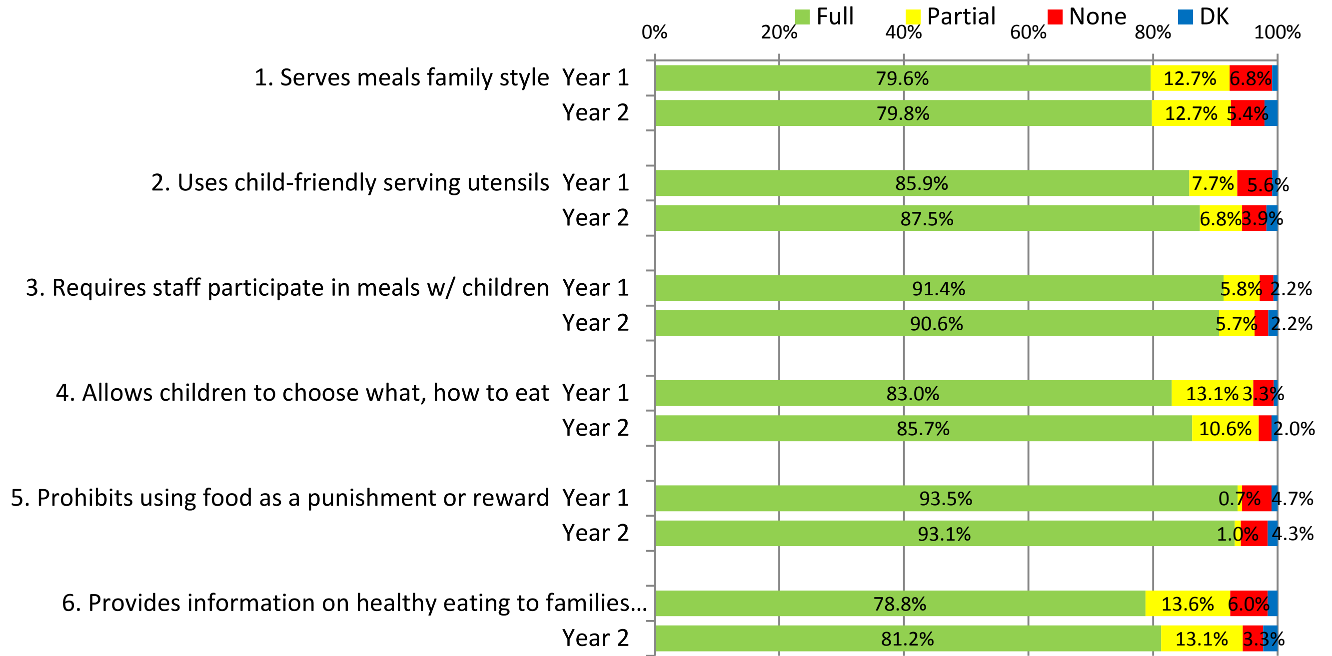
Approximately 58 percent of facilities reported full implementation of all six family-style meals components in year one, and 62 percent in year two, as shown in Figure 11. Ninety percent or more reported prohibiting the use of food as punishment or reward, and requiring staff participation in meals. See Figure 12 for the self-reported levels of implementation for each component.

Figure 11. Percent of facilities implementing all, some, or none of the family-style meals components



The large majority of comments from child care facility staff stated that their facility does not serve meals. Many mentioned that children bring their own lunch and snacks. Some discussed limitations regarding food allergies. A few mentioned the use of prepackaged foods and no need for utensils. Feedback was also provided by licensing staff on the family-style meals section of the assessment tool. Licensing staff suggests that the term "child-friendly" should have guidance or a definition on the actual assessment tool. Similar to other components of standards, the word "prohibit" is problematic and is confusing to respondents.

Figure 12: Family-Style Meals Components Level of Implementation



STANDARD 7: ORAL HEALTH (NINE COMPONENTS)

The oral health standard requires facilities to protect the health of their students and staff in regards to tooth decay by following these nine components:

1. Provide monthly oral health education.
2. Implement a tooth brushing program at facility.
3. Prohibit teachers/caregivers from sharing food or utensils with a child.
4. Prohibit licking a pacifier to “clean” it before giving it to a baby or toddler.
5. Prohibit putting children to sleep with a bottle.
6. Limit serving of snacks to scheduled time and provide healthy options.
7. Inform parents about cleaning teeth at home.
8. Educate parents on oral hygiene.
9. Provide information on tooth decay (in English and Spanish) to families at least once per year.

Approximately 29 percent of facilities reported full implementation of all nine oral health components in year 1, and 33 percent in year 2 (see Figure 13). The toothbrushing program had the least amount of facilities reporting full implementation. Figure 14 shows the self-reported levels of implementation for each component.

Figure 13. Percent of facilities implementing all, some, or none of the oral health components

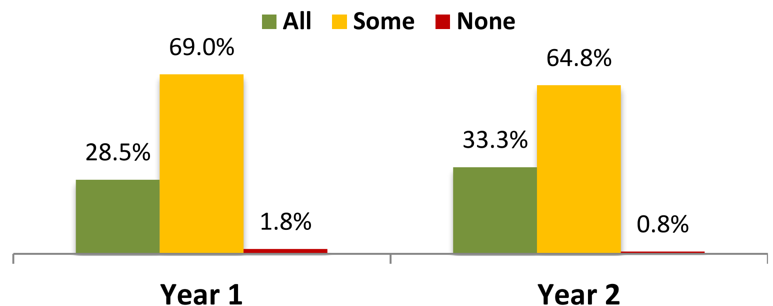
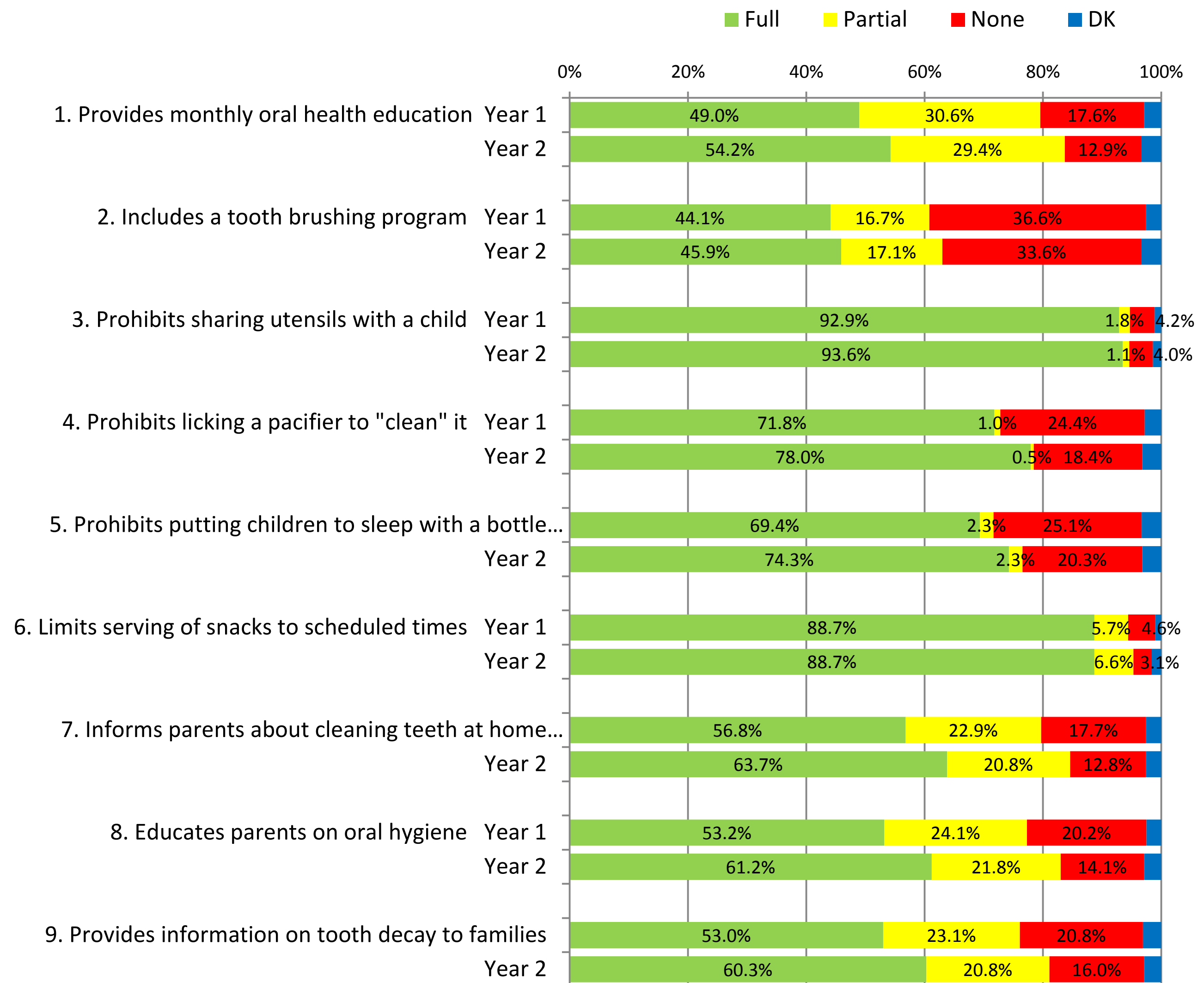


Figure 14. Oral Health Components Level of Implementation



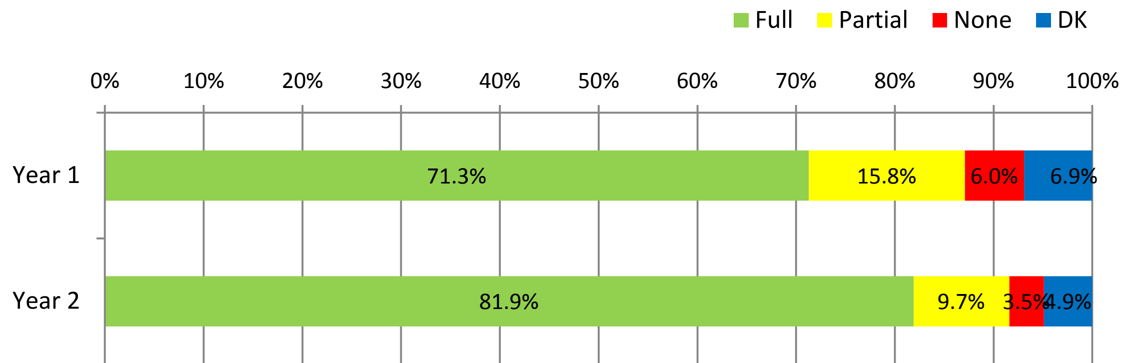
Many comments from child care facility staff said that their facility did not serve children that used pacifiers or bottles. Some mentioned that their facility does not have nap time. A few said that their center was only utilized as a before- or after-school program so they did not offer the components of the oral health standard.

Licensing staff reported confusion by respondents on the “sharing utensils” component. Facilities frequently need clarification about whether it means children do not share eating utensils with adults or with other children. Additionally, licensing staff indicated that providers are appalled, and often offended, by the “licking pacifier” component and they recommend the component be removed.

STANDARD 8: STAFF TRAINING (ONE COMPONENT)

The staff training standard requires facilities to commit to furthering staff education on the Empower Program and topics by ensuring that staff members receive three hours of training annually on Empower topics. This standard is evaluated in two ways: 1) whether the site has the component in a written policy and 2) self-reported level of implementation of the component. Approximately 71 percent of facilities reported full implementation of the staff training component in year one, and 82 percent in year two.

Figure 15. Require Three Hours of Staff Training Level of Implementation



STANDARD 9: ASHLINE

The ASHLine standard requires facilities to commit to Standard 9, which is to support the efforts of the Arizona Smoker's Helpline to help staff and families quit tobacco by providing information on the dangers of second- and third-hand smoke (in English and Spanish) at least once per year. The assessment included a few questions asking facilities whether they participate in the ASHLine Referral Training pilot program, which is not a requirement. Those that are participating in the program were asked if at least one staff member is trained in referring tobacco users to the program. Less than a fifth of facilities (17.3 percent) participated in the ASHLine Referral Training Pilot program in year one.

Several comments from child care facility staff said they did not know whether or not they participate in ASHLine. A few said they were not familiar with the program but were interested in participating. Others reported calling ADHS and receiving no response. These respondents tended to also mention that they needed more information about the program and the materials. Licensing staff mentioned that ASHLine is generally handled by program administrative staff and classroom staff are rarely aware of this standard. The Office of Research and Development is providing the Bureau of Tobacco and Chronic Disease with contact information of those facilities that have indicated interest in the program for follow-up.

STANDARD 10: SMOKE-FREE CAMPUS (FOUR COMPONENTS)

The smoke-free campus standard requires facilities to commit to provide a smoke-free environment for children and staff by following these four components:

1. Creates and displays the smoke-free policy.
2. Provides written guidelines about the smoke-free policy to families.
3. Provides written guidelines about the smoke-free policy to employees.
4. Posts the provided Smoke-Free Arizona Act sign at the entrance of the facility.

Approximately 69 percent of facilities reported full implementation of all four smoke-free campus components in year one, and 75 percent in year two, as shown in Figure 16.

The majority of facilities self-reported full implementation of the first component, displaying the smoke-free policy. About three quarters (76 percent) of facilities reported fully implementing the second component, which is to provide written guidelines about the smoke-free policy to parents. (Figure 17)

Figure 16. Percent of facilities implementing all, some, or none of the smoke-free campus components

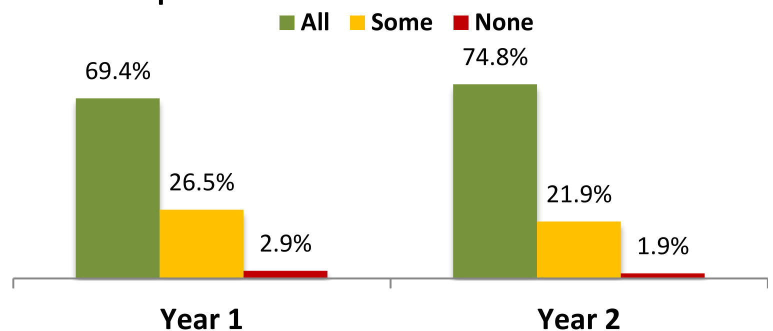
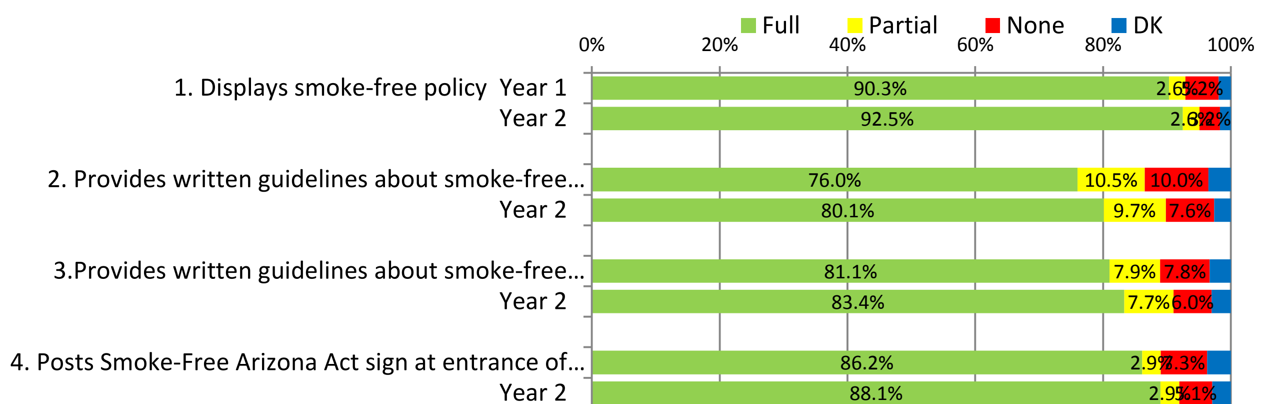


Figure 17. Smoke Free Components Level of Implementation



Although there were no comments on the smoke-free standard from child care center facility staff, licensing staff reported that some facilities chose not to enroll in Empower due to this standard, particularly in group homes, because staff members wanted to be able to smoke at the site.