Nevada Early Childhood Obesity Prevention State Plan 2021-2026

INTRODUCTION

Childhood Obesity

Childhood obesity is one of the most pressing health threats facing the United States and it affects all communities and all categories of race, ethnicity, and family income (Partnership for a Healthier America [PHA], 2021). According to the Center for Disease Control (CDC), overweight is defined as a body mass index (BMI) at or above the 85th percentile and below the 95th percentile for children and teens of the same sex and age. Obesity is defined as BMI at or above the 95th percentile for children and teens of the same sex and age. Approximately, 17.0% of U.S. youth have obesity and an alarming estimate of 9.4% of those children are between the ages of 2 and 5 (National Health and Nutrition Examination Survey [NHANES], 2018). Similarly, rates of obesity for U.S. children ages 6 to 11 have more than quadrupled in the past 40 years from – 4.2% to 17.4% (NHANES, 2018).

Health Effects

Childhood obesity is associated with a higher chance of premature death and disability in adulthood (World Health Organization [WHO], n.d.). Obesity can harm nearly every system in a child's body; heart, lungs, muscles, bones, kidneys, digestive tract, hormones that control blood sugar and puberty, as well as take a heavy social and emotional toll (Ebbeling et al., 2002). Obese children and adolescents suffer from short-term and long-term health consequences such as: asthma, high blood pressure, obstructive sleep apnea, and metabolic syndrome (UCSF Health, 2021). The most significant health consequences of childhood overweight and obesity, that often do not become apparent until adulthood include: cardiovascular disease, diabetes, musculoskeletal disorders, especially osteoarthritis, and certain types of cancer such as, endometrial, breast, and colon cancer (WHO, n.d.). Obesity's mental health impact is also critical. Obesity has shown to increase children's susceptibility to bullying and teasing which can lead to anxiety, stress, low self-esteem, and depression (Trevino, 2017; Childhood Obesity Foundation, 2019). In addition, for some children already experiencing mental health challenges, the development of unhealthy eating habits can be used as a coping mechanism which can lead to obesity in childhood and later in life.

Economic Costs

Childhood obesity not only increases the risk of developing a noncommunicable disease at a younger age but also proliferates the economic burden on the U.S. health system. Study's continue to show obese children are more likely to become and remain obese well into adulthood—extending their dependency on the health care system and other health related supports (WHO, n.d.). In 2016, diseases driven by the risk factor of obesity and overweight accounted for $480.7 billion in direct health care costs in the United States, with an additional $1.24 trillion in indirect costs due to lost economic productivity (Milken Institute, 2020).

Public Health Professionals Gateway. (n.d.). Social Determinants of Health. *Center for Disease Control and Prevention.* https://www.cdc.gov/publichealthgateway/sdoh/index.html

Social Disparities

Most childhood unhealthy weights are caused by children over eating much of the wrong foods and, to some extent, having inadequate levels of physical activity (Childhood Obesity Foundation, 2019). These can often be caused by complex systems and intersecting factors and social determinants of health that contribute to the increasing rates of overweight and obesity such as: physiology, socioeconomic status (SES), education level, race/ethnicity, environmental, and social and cultural influences (Childhood Obesity Foundation, 2019; Office of Disease Prevention and Health Promotion [ODPHP], n.d.). Social determinates of health (SDOH) have a major impact on people's health, well-being, and quality of life (ODPHP, n.d.). They contribute to a wide variety of health disparities and inequities such as, not having access to safe housing and neighborhoods which may discourage outdoor physical activity, limited job opportunities, limited access to healthy foods, and limited access to healthcare (ODPHP, n.d.). Individuals who do not have access to healthy food options and space for movement are less likely to have good nutrition; consequently, raising their risk of health conditions like, heart disease, diabetes, and obesity (ODPHP, n.d.).

Impacts of COVID-19

Moreover, in 2019 a global pandemic (COVID-19) exacerbated preexisting barriers for underserved children and families. The effects of COVID-19 caused economic hardship, school closures, limited physical activities, and increased food insecurity for many families (Jenssen et al., 2021). A study conducted by the American Academy of Pediatrics (2021), explain the efforts to reduce COVID-19 transmission have likely contributed to worsening pediatric obesity. Disadvantaged families have faced the difficulties of disrupted family routines, sleep dysregulation, reduced physical activity, increased screen time, increased access to unhealthy snacks, and less consistent access to appropriately proportioned meals through schools—all risk factors that have shown to promote weight gain, similarly, during the summer months (Jenssen et al., 2021).

Children's Health in Nevada

Weight Status	2018-2019	2019-2020	% Change
Underweight	17.2%	17.3%	0.58%
Healthy	51.2%	50.3%	-1.76%
Overweight/Obese	31.6%	32.4%	2.53%

Source: NICRP, 2020 Kindergarten Health Survey

Several different measures of childhood obesity in Nevada demonstrate the need for more prevention and intervention strategies. According to the State of Childhood Obesity (n.d.), in Nevada, 12.9% of youth ages 10 to 17 are obese—ranking Nevada 36th in nation including the District of Columbia. In addition, within 2 to 4-year-old WIC participants in Nevada, 11.6% are considered obese (State of Childhood Obesity, 2016). Furthermore, the annual Nevada Kindergarten Health Survey (KHS) reported, 32.4% of children entering kindergarten in 2019 were considered overweight or obese—a 2.53% increase from the year prior (NICRP, 2020). The KHS (2020) also shows the percentage of obese youth in Nevada has been steadily climbing among some of its most vulnerable populations (e.g. 30.6% of African American/Black, 29.9% of Hispanic, and 22.0%

of Asian/Pacific Islander kindergarten students were obese in 2019-2020). Finally, according to the Nevada Child Height and Weight Annual Report (2018), 43.1% of Nevada children within grades 4, 7, and 10 were considered overweight or obese based on their BMI.

Determinants of pediatric obesity act at many levels and different stages of childhood (Campbell, 2015). Within Nevada, health disparities such as access to primary care, affordable health insurance, and safe built environments are not only factors that contribute to childhood obesity but also disproportionately affect its most vulnerable populations (CAA, 2019; DHHS, 2019; NICRP, 2019, 2020). The median household income in Nevada for 2019 was $63,276 with approximately 38.9% of its households earning less than $50,000 annually; specifically, it's African American/Black and Hispanic households (U.S. Census Bureau, 2020). Study's continue to show a family's economic well-being is a contributing factor for pediatric obesity as it may limit access to safe outdoor spaces, healthy foods, and food security (Campbell, 2015; CAA, 2019). Moreover, 11.4% of Nevada's total population was uninsured in 2019—8% of that total included children ages 0 to 18 (U.S. Census, 2020; National Kids Count, 2020). Affordable and accessible health care is essential for all children as it provides them with routine primary care services such as, measuring BMI, monitoring eating habits, and levels of physical activity which are critical to obesity prevention (Harvard T.H. Chan, 2016; NICRP, 2020).

For Nevada to reduce these health disparities in childhood obesity it must provide equal access to services that promote optimal health by meeting individuals and families where they are physically, emotionally, and economically (Nevada Minority Health and Equity Coalition, 2021). The estimated cost for treating overweight and obesity related conditions in Nevada totals $337 million annually according to estimates from the CDC (Nevada State Health Division Bureau of Community Health, 2006). These costs are expected to increase over time.

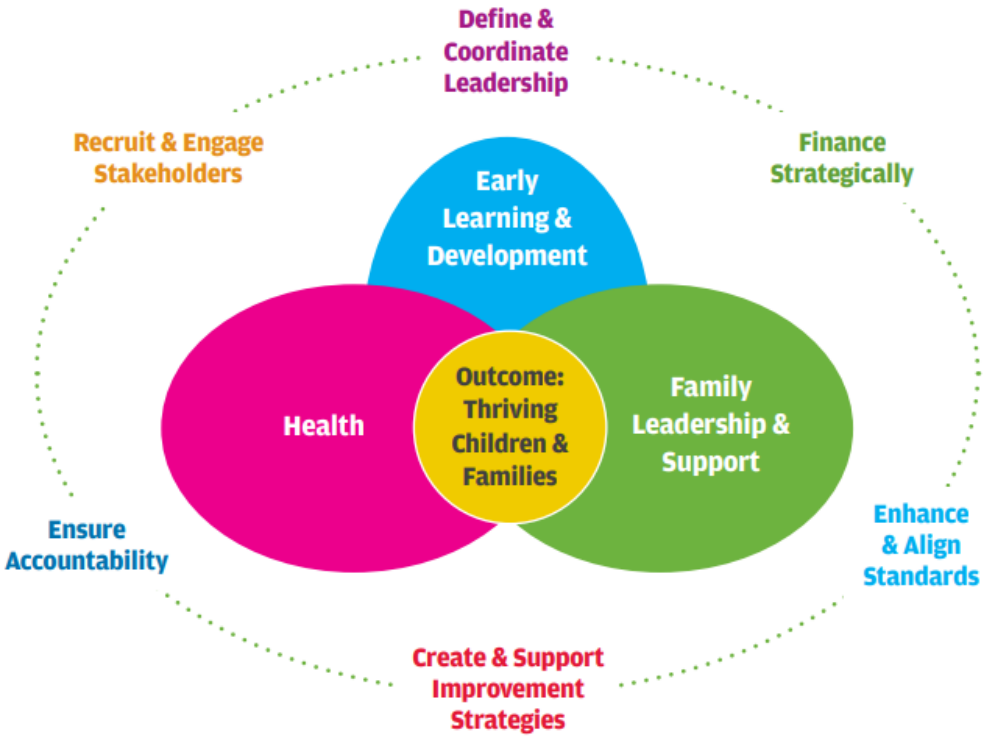
THE NEVADA EARLY CHILDHOOD OBESITY PREVENTION PLAN

Reducing and preventing childhood obesity in Nevada is achievable through consistent efforts introduced and supported by children's parents, guardians, caregivers, coaches, teachers, Early Care and Education (ECE) providers, health care providers, and community members. The Nevada Early Childhood Obesity Prevention Plan provides a valuable framework offering support for community leaders in promoting healthy behaviors and helping to build stronger communities.

Nevada's Early Childhood Obesity Prevention Plan focuses on community strategies to help support a healthy start for children. The plan targets children from birth to eight years of age and promotes obesity preventive behaviors including: healthy eating; increasing physical activity; limiting sedentary time (especially screen/media); gaining adequate sleep; and providing breastfeeding support. Establishing healthy habits within the first five years of life is critical for a child's lifelong health and development.

Early Childhood Systems Framework

A child and families do not develop in isolation and issues that lead to obesity are interconnected embedded within various social systems. Therefore prevention cannot be successful unless approached using a systems framework. To align with previous work conducted in the field of early childhood in Nevada, the Early Childhood Systems Framework (ECSWG, 2013) will be used to ensure that strategies and objectives for both prevention and intervention work comprehensively across the sectors of 1) Health, 2) Early Learning and Development, and 3) Family Support and Leadership in order to achieve agreed-upon goals for thriving children and families.



The Nevada Early Childhood Obesity Prevention Plan will follow these fundamental values from the Nevada Early Childhood Advisory Council (NECAC, 2019):

- "All" means all. Opportunities and access are needed for children regardless of race, ethnicity, language, ability, or socio-economics; also includes children in all environments including those with disabilities.
- Accountability is important. Programs supported by public dollars must be responsive to those they serve and accountable for delivering high quality services.
- Allow for local solutions. Nevada's local communities and businesses share many of the same goals and have specialized and innovative ways to deliver. A focus on results, not process, allows for innovation and strategy toward a shared outcome.

Target Setting: Children 0-8yo within the community, excluding K-12 public/private education.

Timeline: Fiscal year 2021-2026. Action plans will be updated on an annual basis.

Target Populations:

Strategies and objectives within this state plan will focus on the following target populations in order to maximize efforts to reduce childhood obesity.

Pregnant persons

Behaviors during pregnancy have a long-term impact on the child and mother's health after birth. Encouraging pregnant persons to breastfeed when possible and encouraging persons to make healthy choices while pregnant and after can influence the trajectory of the pregnant person's and child's life.

Parents and primary caregivers with children ages 0-8

Parents and primary caregivers are an important influence on a child's health and behaviors. Parent and caregiver choices directly impact the way children live and ultimately the behaviors that they learn and develop on their own. A child's behaviors cannot be changed without changing parents' behaviors as well. Parents are called to model healthy behaviors, promote alternate activities other than screen time, and promote physical activity.

Vulnerable or Underserved Families

Given that resources are limited some families may be more vulnerable and/or underserved and should be prioritized. The following indicators align with the Nevada Early Childhood Advisory Council's Strategic Plan.

- Have household incomes at or below 200% of the Federal Poverty Level,
- Reside in rural areas,
- Reside in tribal areas or are members of a tribe,
- Speak a language other than English,
- Have a child with a disability,
- Have a child under 3 years of age,
- Experiencing Homelessness,
- Involved with Child Protective Services,
- Have children who experience 4 or more adverse childhood experiences (ACES) as identified by the Centers for Disease Control and Prevention (2016):
    - o emotional abuse
    - o physical abuse
    - o sexual abuse
    - o mother treated violently
    - o substance abuse in the household
    - o mental illness in the household
    - o parental separation or divorce
    - o incarcerated household member
    - o emotional neglect
    - o physical neglect
    - o experiencing racism (The Health Federation of Philadelphia, 2016)
    - o witnessing violence(The Health Federation of Philadelphia, 2016)
    - o living in an unsafe neighborhood (The Health Federation of Philadelphia, 2016)
    - o living in foster care (The Health Federation of Philadelphia, 2016)
    - o experiencing bullying (The Health Federation of Philadelphia, 2016

Early care and education professionals

Outside of parents and caregivers, children learn their behaviors in the environments where they spend their time, one of those being childcare and education settings. The policies, behaviors, and activities presented in childcare and education settings directly impact the behaviors that children partake in and pick up. Early care and education professionals are called to model healthy behavior, implement physical activity policies, and provide education to parents and children on the importance of healthy eating, physical activity, and nutrition.

Community-based child and family service providers and agencies

Providers and agencies within the community are an important group to target because their policies and services affect families and children's lives. By addressing these policies and services to ensure, they are inclusive of health-promoting behaviors, we can influence parents' and children's dietary and physical activity behaviors. These providers and agencies are called to consider their practices and ensure they are inclusive of health-promoting language and behaviors.

Health care providers

Resources and education provided to a pregnant woman or parents with young children also shape behaviors and attitudes. Health care providers are typically at the forefront of this with prenatal check-ups, newborn visits, well-child visits, etc. Health care providers are called to provide education and resources on breastfeeding, physical activity, and nutrition. As well as advocate for the reimbursement of obesity prevention practices. Lastly, health care providers are called to model healthy eating and physical activity in their individual lives as well.

Policy Makers

Advocating for policy change and implementation is an important part of behavior change. While behaviors, diets, and activities contribute to an individual's susceptibility to being overweight or obese, the political decisions and policies put in place do play a role in that. Ultimately lobbying policymakers and informing them is the best way to address every facet influencing an individual's lifestyle.

Overarching Goals of the
Nevada Early Childhood Obesity State Plan

EARLY CARE AND EDUCATION FACILITIES

Overarching Goal 1: Promote for healthy nutrition and physical activity for young children (0-8) in **Early Care and Education facilities** and support implementation of best practices/standards.

AWARENESS AND EDUCATION

Overarching Goal 2: Increase awareness on the importance of preventing early childhood obesity among **parents of children ages 0-8**.

Overarching Goal 3: Increase awareness among **non-early early care and education providers and community partners** that work with or have contact with children ages 0-8.

Overarching Goal 4: Increase education and implementation of **best practice and current research** regarding Early Childhood Obesity prevention strategies.

INFRASTRUCTURE

Overarching Goal 5: Establish **data collection systems** to enhance knowledge of efforts.

Overarching Goal 6: Increase standards **for Early Care and Education facilities**.

Overarching Goal 7: Increase **sustainable funding** to support Nevada Early Childhood obesity prevention efforts.

EARLY CARE AND EDUCATION FACILITIES

OVERARCHING GOAL 1: Promote for healthy nutrition and physical activity for young children (0-8) in **Early Care and Education facilities** and support implementation of best practices/standards.

Strategy 1.1: Increase implementation and knowledge of PAN Curriculum and Standards.

Objective 1.1.1. Provide technical assistance with the development of early childhood wellness plan.

Objective 1.1.2. Provide Nevada Registry trainings on strategies for implementing PAN standards.

Objective 1.1.3. Increase outreach and utilization of UNR-Extension website, *Healthy Kids Resource Center,* by EC providers.

Strategy 1.2: Increase access to healthy foods in Early Care and Education settings.

Objective 1.2.1. Establish community gardens in Early Care and Education settings.

Objective 1.2.2. Improve access to community garden curriculum.

Objective 1.2.3. Increase Early Care and Education facility participation in CACFP.

Strategy 1.3: Address local and state policies to increase the ability of providers to offer healthy food in Early Care settings.

Objective 1.3.1. Align local and state food-related policies and regulations in Early Care settings.

Objective 1.3.2. Ensure Early Care settings have policies and procedures in place to promote breastfeeding within the facility.

AWARENESS AND EDUCATION

OVERARCHING GOAL 2: Increase awareness on the importance of preventing early childhood obesity among **parents of children ages 0-8**.

Strategy 2.1: Increase awareness of childhood obesity issues and resources available.

Objective 2.1.1. Early Childhood Obesity Steering Committee members will attend community events to share information and resources for the prevention of early childhood obesity.

Objective 2.1.2. Execute coordinated media campaigns to unify messaging around Early Childhood Obesity Prevention.

Objective 2.1.3 Increase awareness and utilization of UNR-Extension website for resources available to parents

Strategy 2.2: Create, expand, or improve community environments where children can be physically active.

Objective 2.2.1. Participate in and support engagement by the community in state, local and regional efforts to identify barriers to walkability. Gather and share data about barriers to walking, biking, etc., in neighborhoods.

Objective 2.2.2. Enhance the use of public spaces for physical activity.

Strategy 2.3: Support initial and ongoing breastfeeding.

Objective 2.3.1. Increase awareness of breastfeeding support through media campaigns for parents.

Objective 2.3.2. Support OBGYNs and pediatricians to discuss breastfeeding with parents and families.

Objective 2.3.3. Support hospitals with labor and delivery units to promote successful initiation of breastfeeding.

Objective 2.3.4. Support lay professionals that support breastfeeding especially in communities of color.

OVERARCHING GOAL 3: Increase awareness among **non-early care and education providers and community partners** that work with or have contact with children ages 0-8.

Strategy 3.1: Increase awareness of issues and resources available among Non-Early Care Education providers and community partners who work with or have contact with children ages 0-8.

Objective 3.1.1 Encourage the training of healthcare providers to understand and interpret universal screening and charting of the child's weight at regular office visits and communication with parents' in-between visits.

Objective 3.1.2 Train healthcare staff for developmental/sensitive culturally appropriate discussions with families about the impact of nutrition, physical activity, weight, and family environment on the whole child, to inform prevention and/or treatment and best practices

Objective 3.1.3. Share best practices with other providers (e.g. Community Health Workers CHWs) that work directly with children 0-8.

Strategy 3.2: Increase number of providers/community partners who are trained in EC PAN standards.

Objective 3.2.1. Increase training opportunities and integration of PAN information into trainings for non-ECE providers and community partners.

Objective 3.2.2. Integrate Early Childhood Obesity prevention training into existing state/local conferences and summits.

Strategy 3.3: Increase stigma-reducing language in community environments as it relates to childhood obesity.

Objective 3.3.1. Create communitywide opportunities for health lifestyle programs and inclusive physical activity programs.

Objective 3.3.2. Seek participation of community leaders of diverse race, ethnicity, culture and ability to promote inclusive language.

Objective 3.3.3. Ensure brochures and other educational and informative materials released from the steering committee include inclusive and stigma-reducing language as a model for other agencies.

Strategy 3.4: Increase the availability of healthy food and beverages in the emergency and/or government food system.

Objective 3.4.1 Ensure that food and beverages made available through government-funded food assistance programs meet the Dietary Guidelines for Americans (SNAP ED)

Objective 3.4.2. Increasing access for those receiving SNAP or other assistance to take advantage of farmers' markets, produce carts, and other healthy food retail.

INFRASTRUCTURE

OVERARCHING GOAL 4: Establish **data collection systems** to enhance knowledge of existing efforts.

Strategy 4.1: State of Nevada BMI Data Report

Objective 4.1.1. Sustain BMI Data Surveillance and utilize BMI data in order to identify trends to improve student health.

Objective 4.1.2. Release an update of available data on an annual basis.

Strategy 4.2: Develop system to track EC obesity prevention programs, efforts and resources statewide.

Objective 4.2.1. Develop a comprehensive list of programs, resources and strategies.

Objective 4.2.2. Create a system to track program use and to regularly disseminate information.

OVERARCHING GOAL 5: Increase knowledge of **best practice and current research** regarding Early Childhood Obesity prevention strategies.

Strategy 5.1: Disseminate evidence-based practice and current EC Obesity research to all Steering Committee members.

Objective 5.1.1. Attend national conferences/participate in webinars.

Objective 5.1.2. Share information on new early childhood obesity information and strategies for best practices.

Strategy 5.2: Education and inform community, policy makers, and health care professionals on best practices and current research.

Objective 5.2.1. Distribute information to professionals as appropriate based on area and most effective means.

OVERARCHING GOAL 6: Increase the number of standards being met in Early Care and Education Programs

Strategy 6.1: Ensure Nevada Early Care and Education settings are using best practices for nutrition, physical activity, breastfeeding and screen time.

Objective 6.1.1. Create strategies to address any gaps identified between NV EC policies regarding PAN and CFOC standards.

Objective 6.1.2. Create strategies to address any gaps identified between QRIS indicators to crosswalk with CFOC standards.

OVERARCHING GOAL 7: Increase **sustainable funding** to support Nevada Early Childhood obesity prevention efforts.

Strategy 7.1: Identify, develop, and secure sustainable funding and resources to support Early Childhood Obesity prevention efforts.

Objective 7.1.1. Increase Nevada's capacity to become competitive for federal and/or national grant programs that would provide Early Childhood Obesity Prevention programs.

Objective 7.1.2. Increase evaluation resources to determine effectiveness of evidence-based programs and intervention to be included in RFA/RFP applications (10-15% allocated to evaluation in each RFA/RFP application)

Objective 7.1.3. Identify public and private funding, grants, and support to further Early Childhood obesity prevention.