2025 ANNUAL REPORT

Achieving a State of Healthy Weight

University of Colorado Anschutz

College of Nursing

2025 Annual Report:
Achieving a State of Healthy Weight

University of Colorado Anschutz Medical Campus
College of Nursing

Program Director
Alison M. Pilsner, MPH, BSN, RN, CPH, IBCLC

Assessment Team
Alexandra Lichota, MA

Advisors
Kelly Dahl, MPH
Margaret West, MPA
Division of Nutrition, Physical Activity, and Obesity
U.S. Centers for Disease Control and Prevention

Suggested citation: University of Colorado College of Nursing. *2025 Annual Report: Achieving a State of Healthy Weight.* University of Colorado Anschutz Medical Campus; 2026. https://nursing.cuanschutz.edu/research/healthy-weight

This assessment is supported by the U.S. Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity, in the National Center for Chronic Disease Prevention and Health Promotion (subcontract #UCDCN-02-4574, awarded by prime contract McKing Consulting Corporation).

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Executive Summary

What is the Achieving a State of Healthy Weight (ASHW) Report?

The ASHW Report is a nationally recognized resource that tracks how states support healthy eating, active play, and obesity prevention in early childhood through licensing regulations. Led by the University of Colorado College of Nursing in partnership with the Centers for Disease Control and Prevention (CDC)'s Division of Nutrition, Physical Activity, and Obesity, ASHW annually evaluates licensing regulations across all 50 states and the District of Columbia. Now in its 16th year, the 2025 ASHW Report, along with three updated state supplements,[1-3] provides the nation's most current assessment of how early care and education (ECE) licensing regulations align with 47 High-Impact Obesity Prevention Standards (HIOPS) derived from *Caring for Our Children: Preventing Childhood Obesity*,[5] which served as the national benchmark for the 2025 review.

What Do We Know?

Childhood overweight and obesity often begin early and can lead to serious, long-term health consequences.[6] ECE programs, which serve millions of children each week, can play a vital role in shaping lifelong healthy behaviors. Licensing regulations can support these efforts through promoting breastfeeding support, nutritious meals, daily physical activity, and reduced screen time for young children in child care.

WHAT'S NEW IN 2025

6 STATES
had regulatory changes

Maryland showed the greatest improvement in 2025, particularly in family child care homes, while Oregon also strengthened regulations related to the HIOPS. New Hampshire removed CACFP-aligned regulatory language, resulting in lower ratings across several infant feeding and nutrition standards. Utah, Arizona, and Montana also had lower ratings. These changes demonstrate the importance of maintaining and strengthening evidence-based obesity prevention standards as states revise child care licensing regulations.

How Can This Report Be Used?

1. **Assess** how state regulations support obesity prevention.
2. **Highlight** state policy successes and monitor changes over time.
3. **Identify** opportunities to strengthen licensing regulations.
4. **Inform** research, policy, and quality improvement efforts.

Early Care and Education Matters

Statewide, evidence-based policies and practices strengthen ECE environments, support healthy eating and physical activity, and lay a strong foundation for lifelong healthy behaviors.

Introduction

Childhood obesity remains a significant public health challenge in the United States, affecting 1 in 5 children and adolescents.[7] Rates are even higher among children from low-income households and those who identify as Black, Hispanic, or Native American. Between 2017 and 2020, approximately 13% of children aged 2–5 experienced obesity.[8] These patterns often persist into adolescence[9-10] and adulthood,[11] increasing the risk of chronic disease, premature death,[12-13] and substantial healthcare costs—estimated at $1.3 billion for U.S. children in 2019.[7] Early childhood offers a critical window for establishing lifelong healthy behaviors. Early care and education (ECE) programs play an important role by providing nutritious meals, promoting physical activity, and creating environments that support healthy growth and development.[14-18]

Why ECE? Each week, about 12.5 million children—nearly 60% of all U.S. children under age five—attend ECE programs.[19] These programs serve families across all income levels, with many children receiving federally subsidized care. Licensed ECE programs play a vital role in promoting health by encouraging active play, supporting healthy mealtime routines, and providing nutritious meals and snacks.[14,20-26]

Why ECE Licensing? State licensing regulations establish the foundation for safe, high-quality early care. Programs must comply with these state-specific requirements to obtain and maintain licensure, helping ensure developmentally appropriate environments for young children. Licensing is a powerful policy lever that impact ECE environments, giving states a key opportunity to support the health of large numbers of children.

High-Impact Obesity Prevention Standards (HIOPS): In 2010, a National Advisory Committee reviewed the evidence and identified 47 licensing standards with the greatest potential to prevent childhood obesity—now known as the HIOPS.[4] These science-based standards were derived from *Caring for Our Children: Preventing Childhood Obesity*[5] and have served as the benchmark for ASHW assessments across four domains: infant feeding, nutrition, physical activity, and screen time. Public health professionals, licensing officials, and child care providers can use the HIOPS to strengthen ECE policies and practices that promote healthy growth and development. By incorporating the HIOPS into licensing regulations, states can support healthy behaviors during the critical early years of life.

History of ASHW: *The* 2025 *Achieving a State of Healthy Weight* (ASHW) Annual Report marks the 16th year of the initiative,[27] which began in 2010 with *Achieving a Healthy Weight: A National Assessment of Obesity Prevention Terminology in Child Care Regulations*.[28] Since then, the ASHW team has released annual state-by-state assessments and tracked national trends in how child care licensing regulations support obesity prevention. ASHW findings also inform several CDC resources (see *Roadmap to Success* section), highlighting both progress and ongoing opportunities for improvement across child care centers, large family homes, and small family homes. Today, ASHW provides the nation's most current annual assessment of how state child care licensing regulations align with the HIOPS across all 50 states and the District of Columbia.

ASSESSMENT YEARS

Table 1. State Assessment Years: 2010 to 2025

This table shows the years each state was assessed or reassessed. An "X" indicates that a state was assessed because of HIOPS-related regulatory changes or updates to reflect the current rating methods. In 2025, more than 40 regulatory documents across 20 states were reviewed, but not all reviews led to a reassessment. See Appendix B for the documents reviewed in 2025.

	Years Rated															
State	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Alabama	X		X						X	X		X		X		
Alaska	X		X					X							X	
Arizona	X	X								X	X					X
Arkansas	X	X				X		X			X					
California	X		X					X						X		
Colorado	X		X			X	X	X				X			X	
Connecticut	X		X					X				X		X	X	
Delaware	X		X			X		X		X	X	X				
D.C.	X						X	X								
Florida	X		X	X				X		X						
Georgia	X		X		X			X			X		X	X		
Hawaii	X		X					X						X	X	
Idaho	X												X	X		
Illinois	X				X									X		
Indiana	X												X			
Iowa	X		X					X							X	
Kansas	X		X	X											X	
Kentucky	X			X					X			X				
Louisiana	X		X			X		X				X		X		
Maine	X		X					X				X				
Maryland	X		X			X		X						X		X
Massachusetts	X														X	
Michigan	X		X		X			X		X					X	
Minnesota	X		X					X							X	
Mississippi	X		X	X							X					
Missouri	X						X							X		

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

State assessed due to new or revised licensing regulations

State reassessed due to national CACFP updates

Table 1 (continued): State Assessment Years: 2010 to 2025

	Years Rated															
State	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Montana	X		X					X				X			X	X
Nebraska	X		X	X				X							X	
Nevada	X		X						X						X	
New Hampshire	X							X					X			X
New Jersey	X			X				X								
New Mexico	X		X		X			X							X	
New York	X			X	X	X		X								
North Carolina	X		X	X				X	X					X		
North Dakota	X	X									X			X		
Ohio	X		X				X					X				
Oklahoma	X						X	X					X			
Oregon	X		X					X				X			X	X
Pennsylvania	X										X			X		
Rhode Island	X		X	X				X				X		X	X	
South Carolina	X		X					X							X	
South Dakota	X													X		
Tennessee	X								X				X			
Texas	X		X		X							X		X	X	
Utah	X		X					X								X
Vermont	X						X	X								
Virginia	X		X					X							X	
Washington	X		X					X		X					X	
West Virginia	X		X		X									X		
Wisconsin	X		X							X						
Wyoming	X		X	X									X			

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

State assessed due to new or revised licensing regulations

State assessed due to national CACFP updates

Status of High-Impact Obesity Prevention Standards (HIOPS) Inclusion: 2025

This report outlines how all 50 states and D.C. have incorporated the 47 evidence-based HIOPS into licensing regulations for child care centers and family child care homes.

In 2025, the ASHW assessment team reviewed more than 40 regulatory documents across 20 states. Six states introduced HIOPS-related regulatory changes (see Table 1). Most improvements occurred in family child care homes. Lower ratings were also observed and were most often associated with regulatory revisions that removed or weakened previously aligned language. This report details those updates and evaluates how they affected each state's alignment with the HIOPS. The remaining states either did not introduce new HIOPS-related licensing changes or had updates pending that were not yet in effect during the assessment period.

Nationally, HIOPS are fully supported in:

- 33% of Child Care Centers licensing regulations
- 28% of Large Family Care Homes licensing regulations
- 26% of Small Family Care Homes licensing regulations

Most supported HIOPS in 2025 across all three care types continue to be:

- Provide children with space for play (PA1)
- Make water available inside and outside (ND1)
- Serve small-sized, age-appropriate portions (NF1)

Least supported HIOPS in 2025 across all three care types continue to be:

- Limit oils and avoid fried foods (NA1)
- Limit salt by avoiding salty foods (NG1)
- Provide staff orientation training opportunities for physical activity (PA2)

2025 Highlights by Obesity Prevention Domain

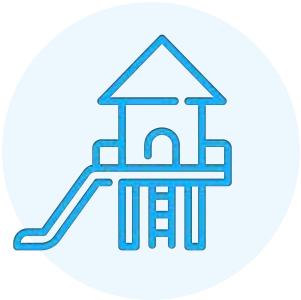
In 2025, regulatory changes in six states affected alignment with the 47 HIOPS. Most gains occurred in family child care homes; however, changes were observed across all four obesity prevention domains, reflecting both progress and opportunities to preserve or strengthen existing standards.

Breastfeeding
States continued to support breastfeeding through existing licensing regulations, with no major HIOPS-related changes identified in 2025.

Infant Feeding
Oregon clarified infant feeding requirements, strengthening guidance related to safe bottle feeding and developmentally appropriate feeding practices.

Nutrition
New Hampshire removed CACFP-aligned language, while Arizona, Maryland, Montana, Oregon, and Utah maintained or strengthened nutrition requirements.

Healthy Mealtime Practices
Arizona, Oregon, and Utah strengthened requirements that prohibit using food, rest, or physical activity as punishment, supporting healthier mealtime and caregiving practices.



Physical Activity
Maryland strengthened requirements for infant tummy time. In contrast, Arizona and Montana weakened some requirements for active play and outdoor time, while Utah weakened requirements for drinking water access and outdoor play space.

Screen Time Limits
Maryland and Montana strengthened screen time regulations by introducing or expanding limits on passive technology use in child care settings.

Additional 2025 Highlights

Tennessee continues to lead the nation in overall HIOPS support across licensed care types, followed by Texas, Washington, and Rhode Island.

National Progress Since 2010

Long-Term Leaders: Since 2010, the District of Columbia, Tennessee, Florida, Rhode Island, Nevada, and Texas have consistently maintained or strengthened licensing regulations across all child care types.

Opportunities for Continued Progress: Idaho, South Dakota, Nebraska, Wyoming, Indiana, and Massachusetts have the greatest opportunity to strengthen HIOPS alignment.

HIOPS Showing the Greatest Gains: The largest gains since 2010 were in nutrition and infant-feeding standards, particularly those addressing juice, milk, whole fruit, and sugary foods for young children.

Nutrition and infant feeding standards showed the strongest gains over time. The five HIOPS below had the greatest increases in state regulatory support since 2010. Four of the five were related to the 2017 CACFP regulatory updates; only NA5 was unrelated to CACFP changes.

- Serve no juice to children younger than 12 months of age (ID3)
- Serve skim or 1% milk to children two years of age and older (NA5)
- Offer juice (100%) only during meal times (NC2)
- Serve fruits, mashed or pureed, for infants 6 months up to 1 year of age (ID2)
- Avoid sugar, including concentrated sweets and sweetened drinks (NG2)

Figure 1. National Changes in State Support for the HIOPS, 2010 vs. 2025

Across all licensed child care types, full support for the HIOPS increased substantially between 2010 and 2025, while the proportion of standards that failed to address the HIOPS declined.

**In 2025, less than 0.5% of the ratings contradicted the HIOPS nationally.*

^The 2025 assessment includes fewer ratings (6,909 vs. 7,003) due to some states consolidating regulated child care types.

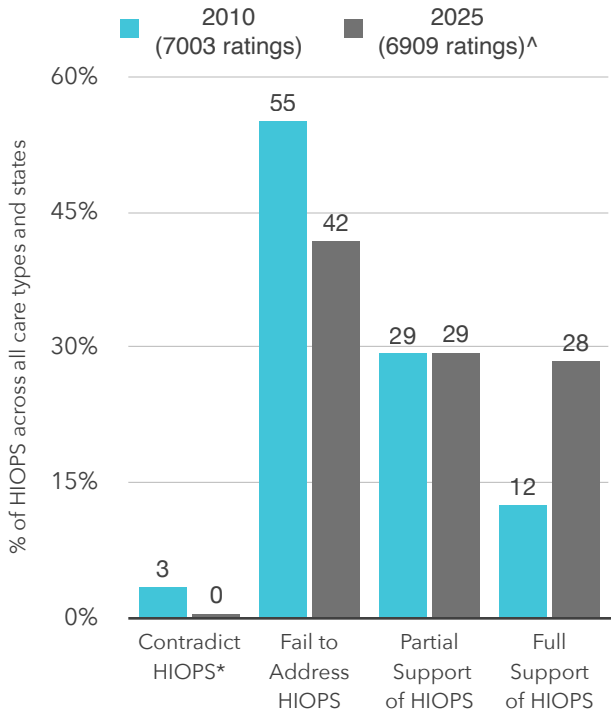


Figure 2. Differences in Support for the HIOPS by Licensed Child Care Type, 2025

This figure shows the extent to which licensing regulations differ by child care type in their support of High-Impact Obesity Prevention Standards (HIOPS) nationally.

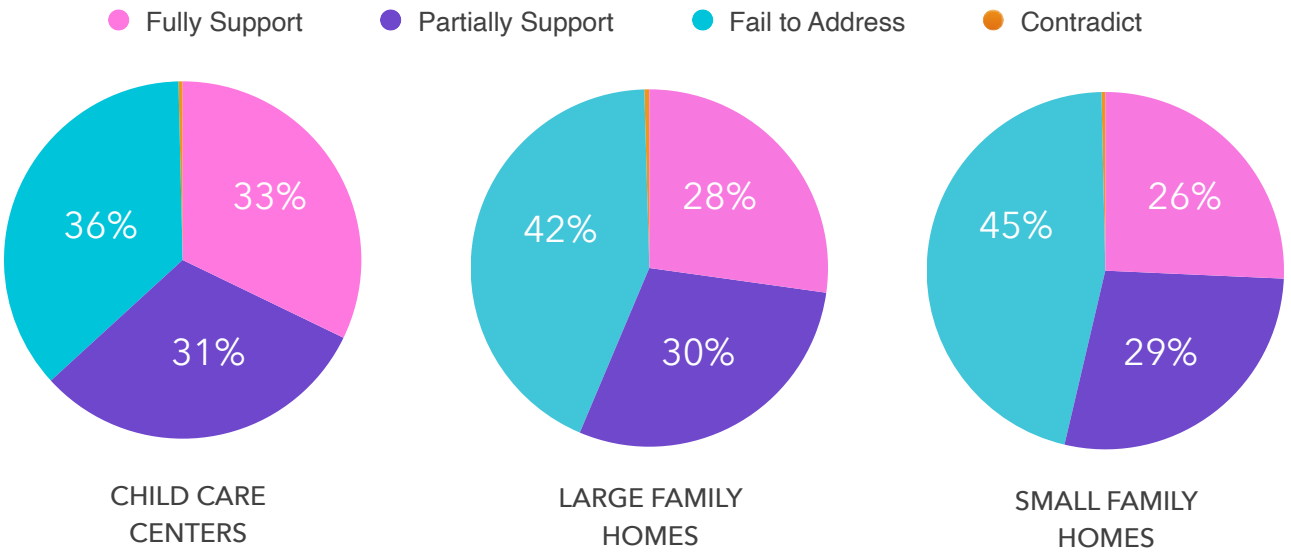


Figure 3. States Requiring CACFP Meal Patterns

This figure shows the 33 states that explicitly require programs to follow the USDA Child and Adult Care Food Program (CACFP) meal patterns (CFR 226.20) in their licensing regulations for at least one child care type, regardless of whether the program formally participates in CACFP.

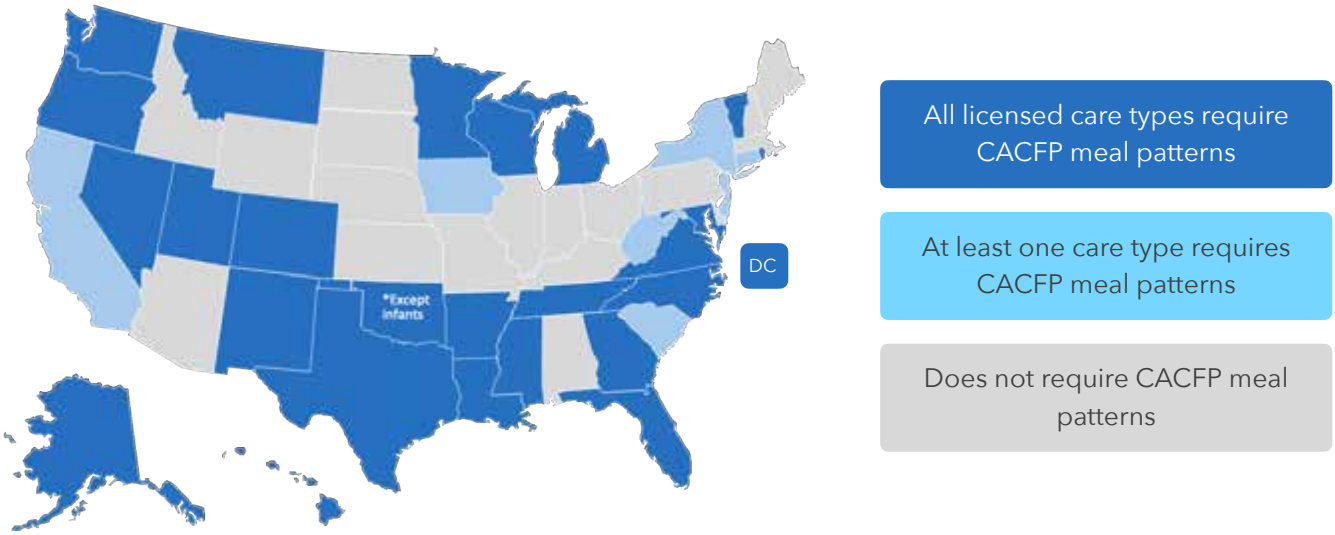


Figure 4. The 2025 State Ranking by Obesity Prevention Summary Score: ALL CHILD CARE TYPES

This figure illustrates the 2025 national rankings of state Obesity Prevention Summary Scores (OPSS) across all child care types (i.e., child care centers, large family child care homes, and small family child care homes). *Note: See **ASHW Methodology**[29] for details on score calculation.*

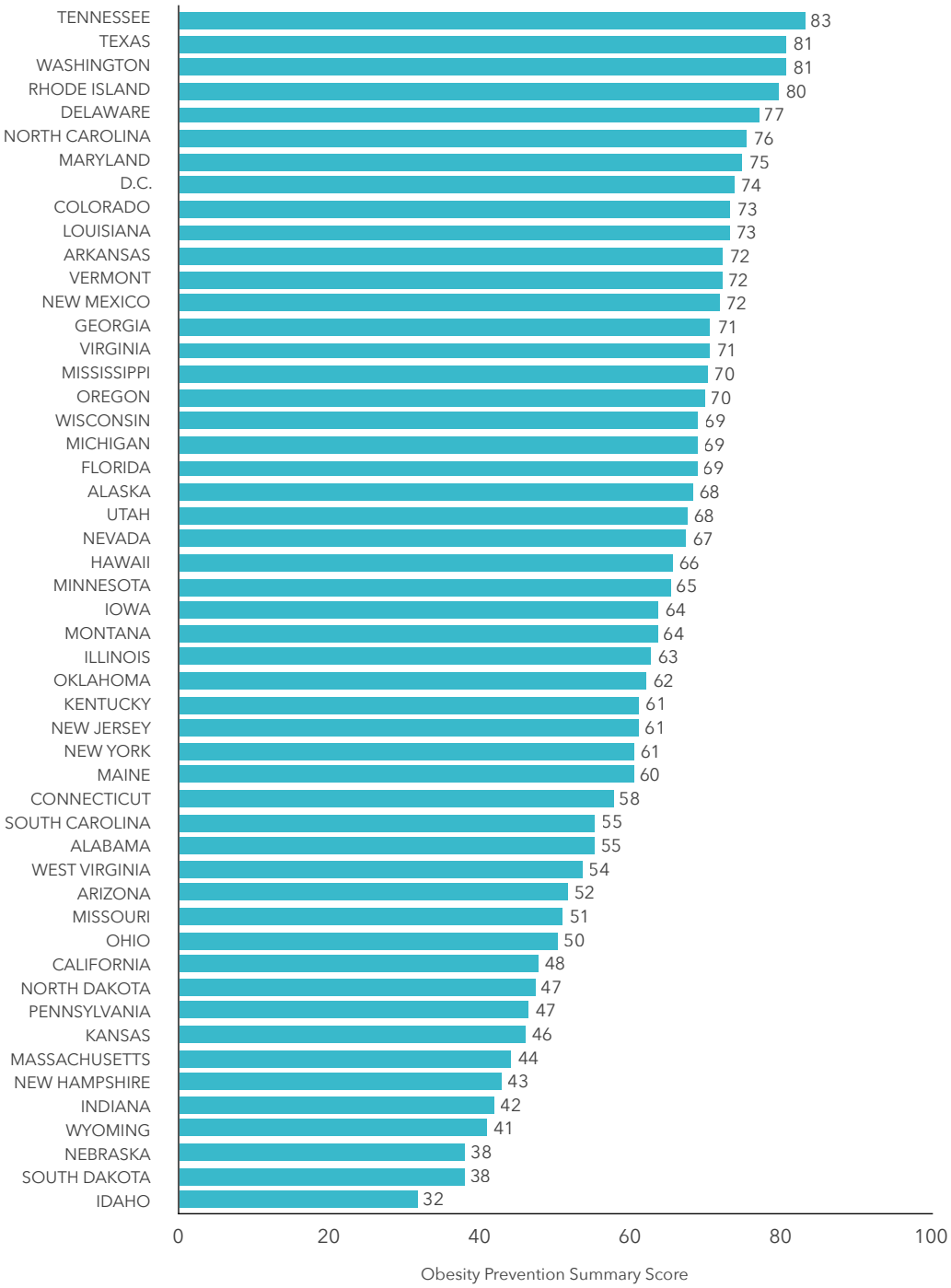
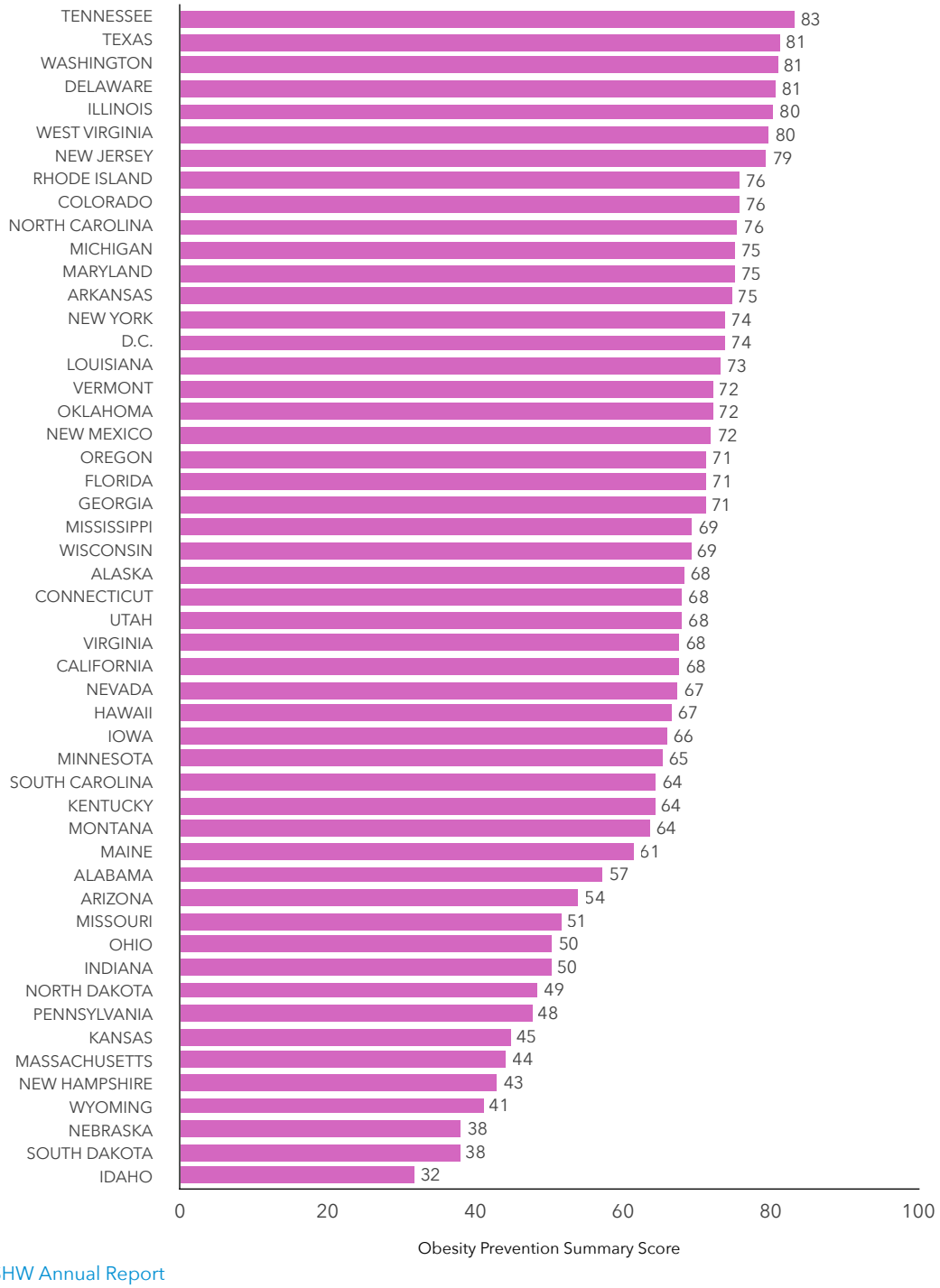


Figure 5. The 2025 State Ranking by Obesity Prevention Summary Score: CHILD CARE CENTERS

This figure illustrates the 2025 national rankings of state Obesity Prevention Summary Scores (OPSS) specifically for child care centers. *Note: See ASHW Methodology[29] for details on score calculation.*



Support of Individual High-Impact Obesity Prevention Standards (HIOPS) in 2025

The figures below provide a rank order of HIOPS from those standards supported the most to those standards supported the least across all child care types for each of the four domains
Note: See ASHW Methodology[29] for details on score calculation.

Figure 6. Breastfeeding & Infant Feeding Practices (11 HIOPS):

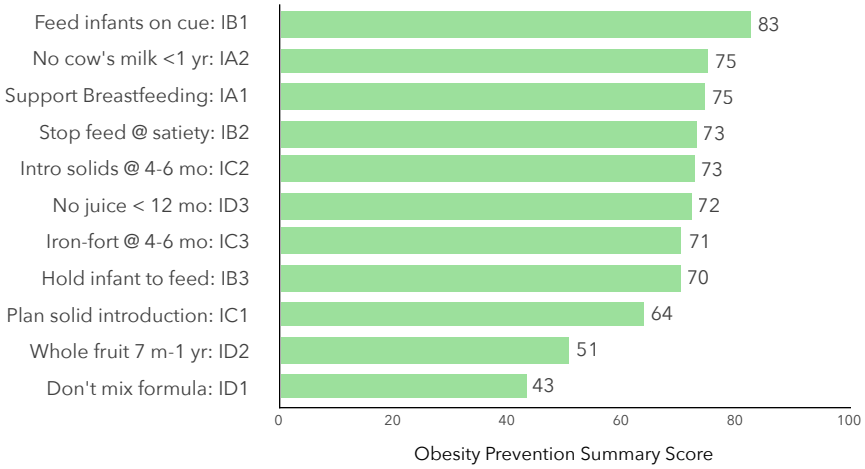
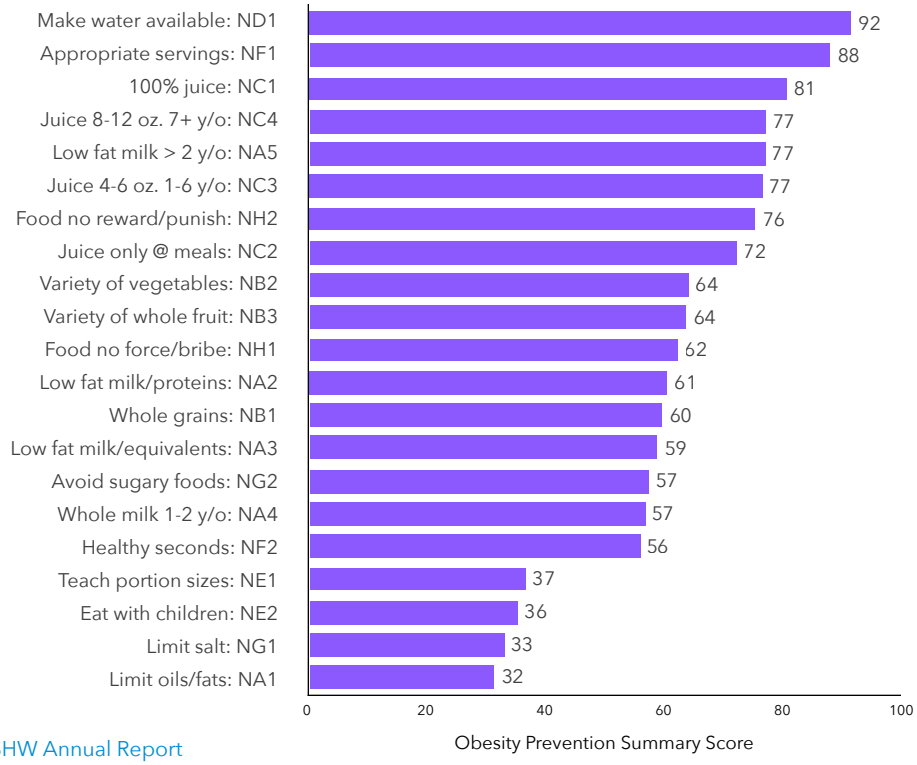


Figure 7. Nutrition Standards & Healthy Mealtime Practices (21 HIOPS):



Support of Individual High-Impact Obesity Prevention Standards (HIOPS) in 2025 (continued)

Figure 8. Physical Activity (11 HIOPS):

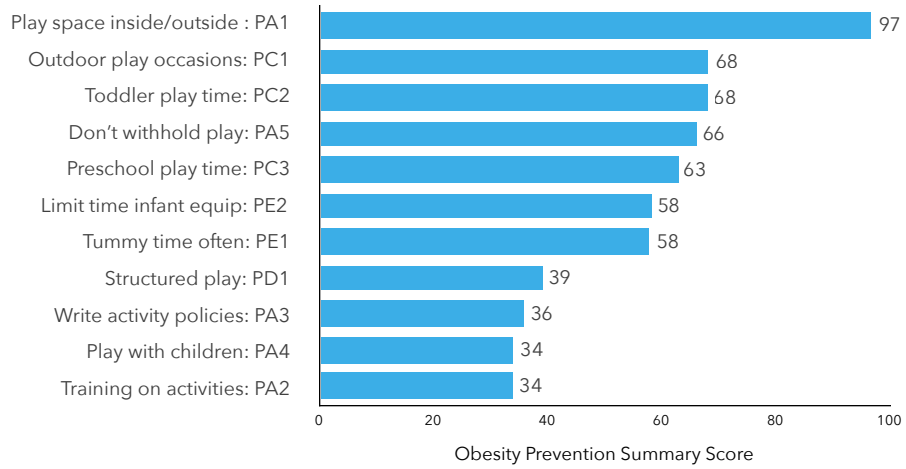


Figure 9. Screen Time Limits (4 HIOPS):

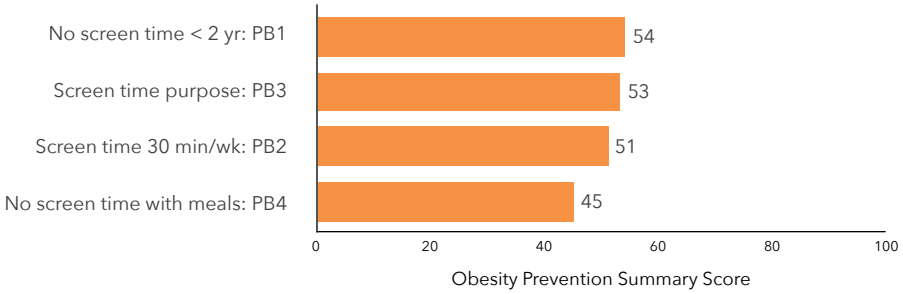
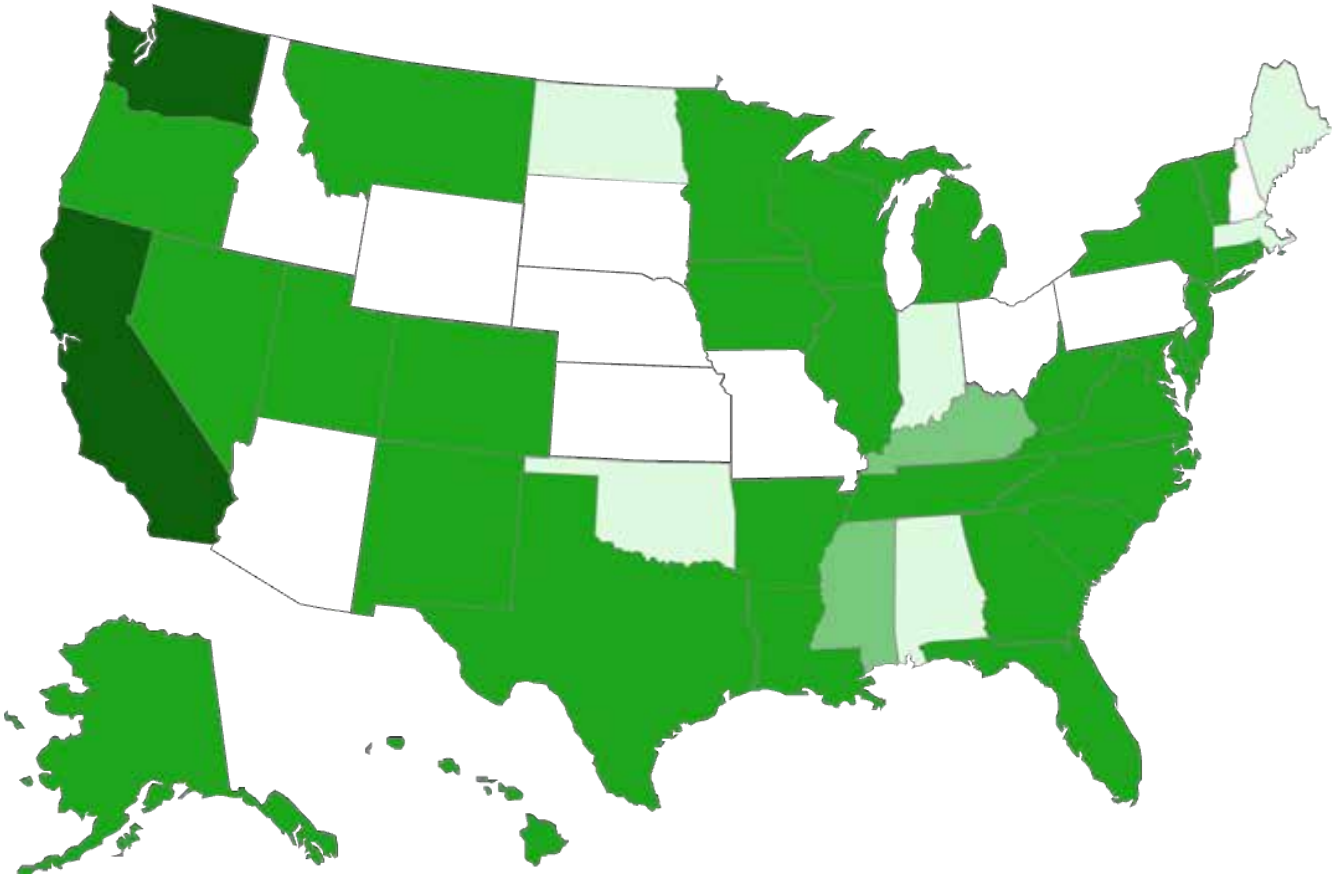


Figure 10. 2025 States Fully Meeting Infant Feeding High-Impact Obesity Prevention Standards (HIOPS)

The map illustrates how well each state meets the 11 infant feeding (IF) HIOPS for child care centers in 2025. For a detailed assessment of each state's ratings, refer to the 2025 State Profiles: Child Care Centers.[1]



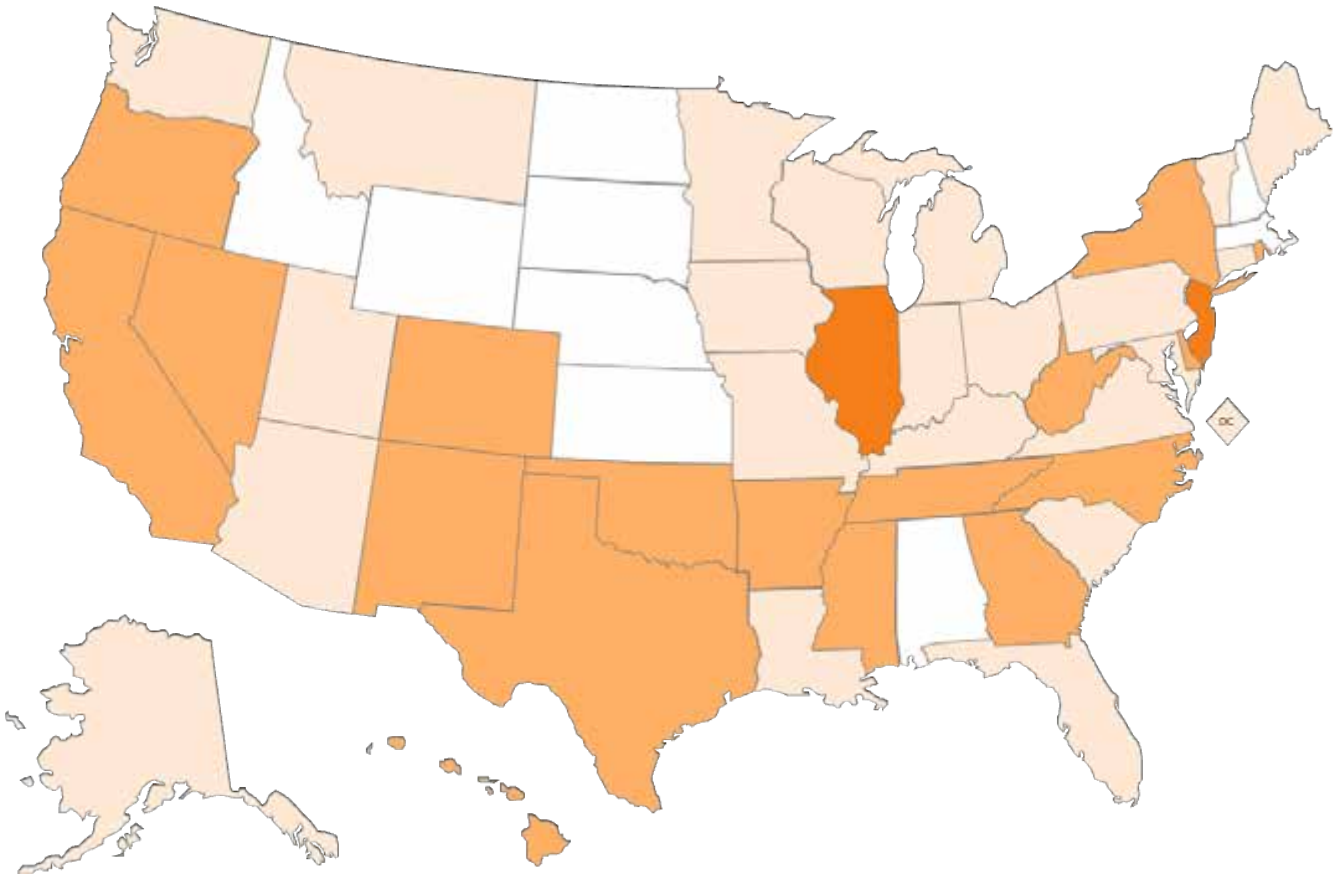
2025 Takeaway: California and Washington were the only states to fully meet 9-11 HIOPS.

Most states fully met 6–8 of the 11 Infant Feeding HIOPS for child care centers.

- Fully meets 9 to 11 IF HIOPS
- Fully meets 6 to 8 IF HIOPS
- Fully meets 4 to 5 IF HIOPS
- Fully meets 2 to 3 IF HIOPS
- Fully meets 0 to 1 IF HIOPS

Figure 11. 2025 States Fully Meeting Nutrition High-Impact Obesity Prevention Standards (HIOPS)

The map illustrates how well each state meets the 21 nutrition (NU) HIOPS for child care centers in 2025. For a detailed assessment of each state's ratings, refer to the 2025 State Profiles: Child Care Centers.[1]



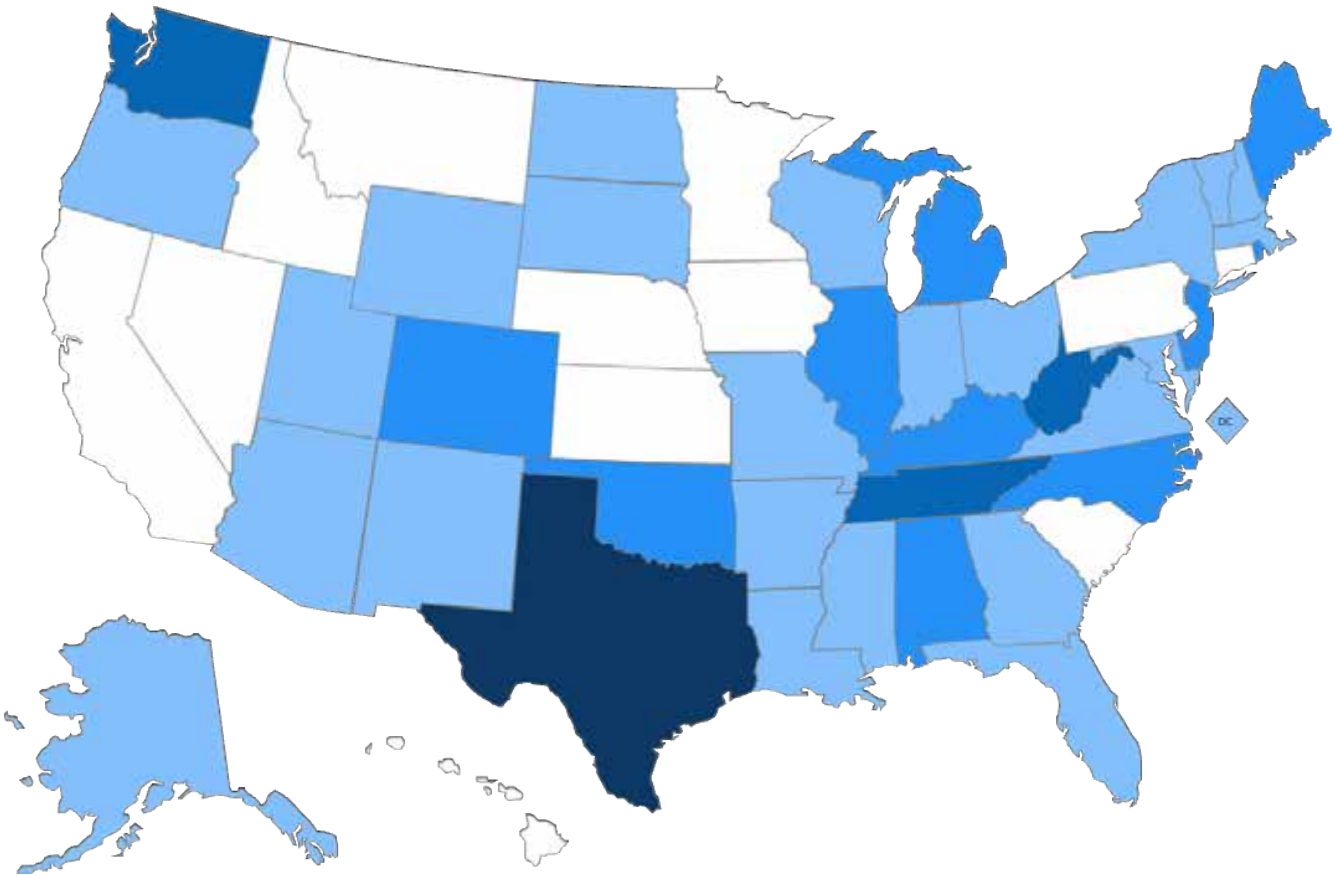
2025 Takeaway: Illinois and New Jersey were the only states to fully meet 12–16 HIOPS, and no state fully met 17 or more.

Most states fully met between 4 and 11 of the 21 Nutrition HIOPS for child care centers.

- Fully meets 17 to 21 NU HIOPS
- Fully meets 12 to 16 NU HIOPS
- Fully meets 8 to 11 NU HIOPS
- Fully meets 4 to 7 NU HIOPS
- Fully meets 0 to 3 NU HIOPS

Figure 12. 2025 States Fully Meeting Physical Activity High-Impact Obesity Prevention Standards (HIOPS)

The map illustrates how well each state meets the 11 physical activity (PA) HIOPS for child care centers in 2025. For a detailed assessment of each state's ratings, refer to the 2025 State Profiles: Child Care Centers.[1]



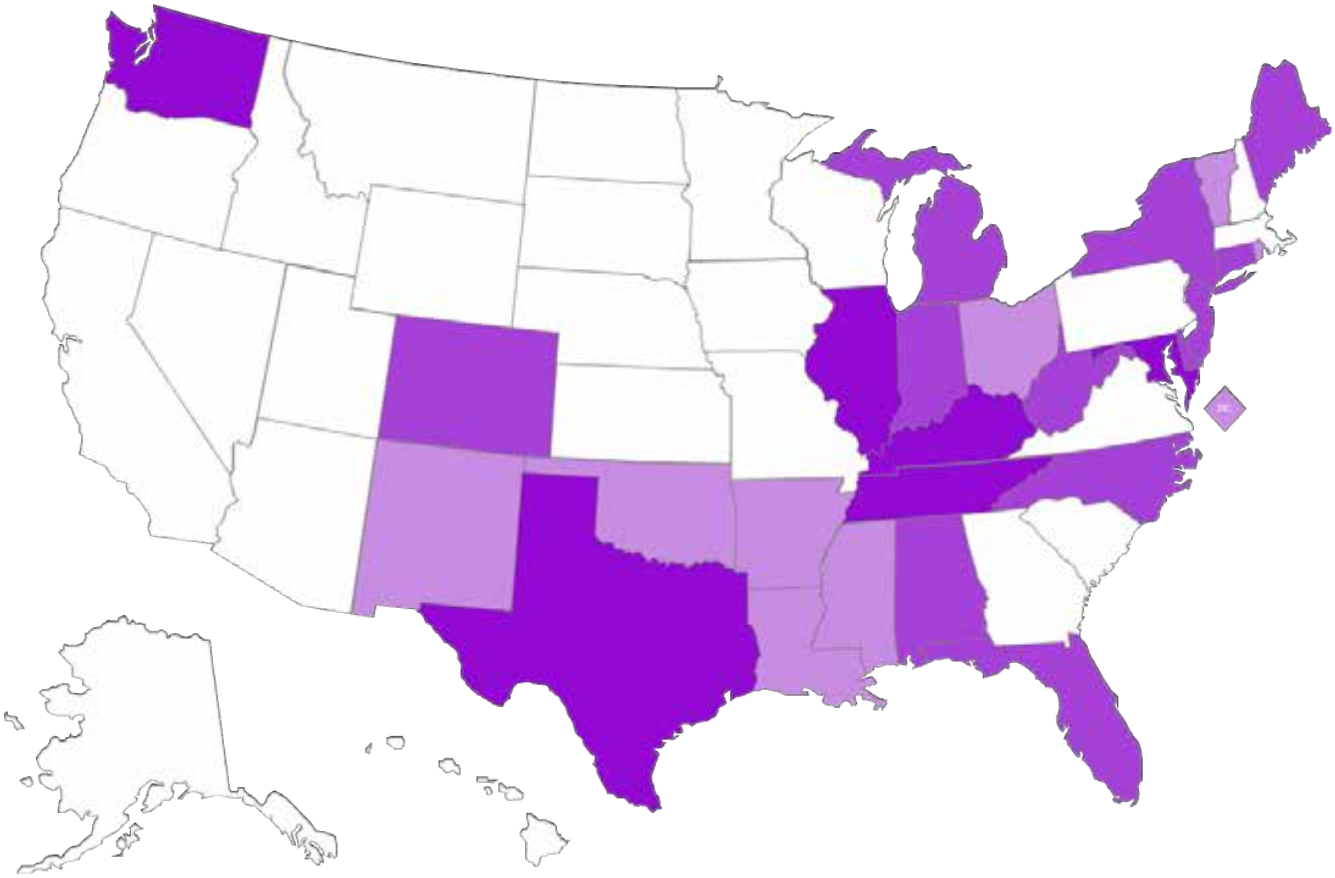
2025 Takeaway: Texas fully met 9 HIOPS, the highest level of alignment nationally.

Most states fully met 2–3 of the 11 Physical Activity HIOPS for child care centers.

- Fully meets 9 to 11 PA HIOPS
- Fully meets 6 to 8 PA HIOPS
- Fully meets 4 to 5 PA HIOPS
- Fully meets 2 to 3 PA HIOPS
- Fully meets 0 to 1 PA HIOPS

Figure 13. 2025 States Fully Meeting Screen Time High-Impact Obesity Prevention Standards (HIOPS)

The map illustrates how well each state meets the 4 screen time (ST) HIOPS for child care centers in 2025. For a detailed assessment of each state's ratings, refer to the 2025 State Profiles: Child Care Centers.[1]



2025 Takeaway: Only five states fully met 3 of the 4 Screen Time standards.

Nearly half of the states had no Screen Time standards fully met in child care centers.

No state fully met all four standards.

- Sixty-five percent of states (32 states and the District of Columbia) aligned infant feeding or nutrition standards with USDA CACFP meal patterns for at least one care type.
- In 2025, states focused on limiting screen time and strengthening rules to ensure that food, rest, and physical activity are not withheld or used as punishment.

Discussion

In 2025, the *Achieving a State of Healthy Weight (*ASHW) initiative assessed regulatory changes in six states (AZ, MD, MT, NH, OR, UT). These changes demonstrate that revisions to early childhood licensing regulations can both strengthen and weaken alignment with the HIOPS. While child care centers continue to maintain stronger standards overall, the greatest gains in 2025 occurred in family child care homes—an important area of progress given the critical role these settings play in caring for infants and toddlers.

Eight states (AZ, IL, IN, KS, KY, MS, UT, WV) have at least one regulation that contradicts a HIOPS standard, up from seven in 2024 (see state supplements for HIOPS rated "1"). In 2025, weakening or removal of previously supportive standards outpaced improvements among states with regulatory changes, showing that progress is not always linear.

Overall, state actions in 2025 demonstrate continued attention to obesity prevention through early care and education, while also showing the importance of preserving strong HIOPS language when licensing regulations are revised. Ongoing monitoring can identify both gains and declines in alignment and support states in strengthening standards across child care settings. Consistent licensing requirements can help support healthy eating, active play, and responsive care during the critical early years of life.

Key Areas of Focus in 2025

States prioritized regulatory changes that:

- Limited screen time, including restrictions on passive technology use
- Prohibited using food, rest, or physical activity as punishment
- Clarified infant feeding practices, including safe bottle feeding
- Supported developmentally appropriate infant care, such as supervised tummy time

Spotlight on 2025 State-Level Changes:

- **Maryland and Montana strengthened screen time requirements.**
  - Maryland introduced a 30-minutes weekly limit per on age-appropriate, educational screen time for children ages 2 and older.
  - Montana added new limits on screen time in child care settings.
- **Arizona, Oregon, and Utah strengthened requirements related to responsive caregiving practices.**
  - Arizona expanded prohibitions on using food, rest, toileting, or withholding outdoor play as punishment.
  - Oregon prohibited withholding or forcing food, rest, or toileting, including forcing a child to eat or placing foreign substances in a child's mouth.
  - Utah strengthened prohibitions on withholding food, rest, or toileting.
- **Oregon and Maryland strengthened developmentally appropriate infant practices.**
  - Oregon clarified that infant bottles contain only formula or human milk unless medically indicated.
  - Maryland strengthened infant physical activity requirements, including supervised tummy time.
- **New Hampshire experienced reduced alignment with infant feeding and nutrition standards.**
  - New Hampshire removed language requiring alignment with USDA CACFP meal patterns, decreasing alignment across 7 Infant Feeding and 16 Nutrition HIOPS ratings.
- **Montana experienced a trade-off in physical activity standards.**
  - Montana strengthened screen time requirements, it removed specific time requirements for vigorous physical activity for toddlers and preschoolers, resulting in reduced alignment with Physical Activity HIOPS.

Lessons Learned

Over 16 years, the ASHW team has identified several state actions that consistently strengthen the HIOPS in early care and education regulations. States aiming to improve child care regulations can take the following steps:

Apply regulatory changes consistently across all licensed child care types. In 2025, gaps remain in the strength of obesity prevention standards between centers and family child care homes.

Explicitly align infant feeding and nutrition requirements and meal patterns with current USDA Child and Adult Care Food Program (CACFP) meal patterns (CFR 226.20), even if providers do not formally participate in CACFP.

Preserve HIOPS language during licensing revisions. In 2025, several declines occurred when previously aligned regulatory language was removed or weakened. Maintaining strong infant feeding, nutrition, physical activity, and screen time requirements helps sustain progress over time.

Continue progress toward stronger Obesity Prevention Summary Scores (OPSS). No state has yet reached the maximum score across all care types, demonstrating continued opportunities to strengthen licensing standards while building on substantial progress since 2010.

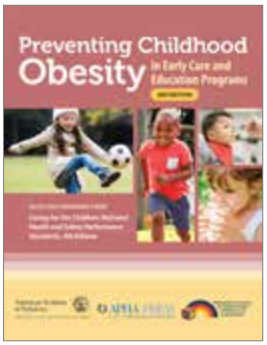
Roadmap to Success: Ensuring Safe and Healthy Environments Where All Children Thrive

ASHW reports spotlight clear opportunities for states to strengthen obesity prevention efforts in ECE programs. The resources below provide a data-driven view on how states can align their licensing regulations with the HIOPS and progress since 2010.

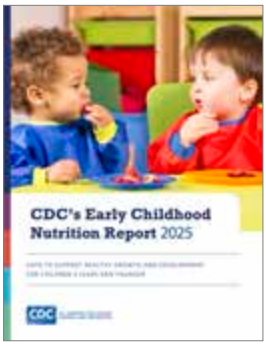
These tools offer a practical roadmap that helps policymakers, licensing staff, and public health leaders recognize key successes and target areas for continued improvement. By implementing strong, evidence-based regulations, states actively shape safer and healthier environments where all children can grow and thrive. Explore the tools below to move your state's child care licensing regulations forward.

ASHW 2025 State Supplements. The ASHW Supplements[1-3] for child care centers, large family child care homes, and small family child care homes provide a comprehensive view of each state's strengths and areas for improvement across the 47 HIOPS.[4] State profile pages display ratings from 2010 compared to updated 2025 ratings.

CDC's State Licensing Scorecards on Obesity Prevention in Child Care Centers: The CDC's State Licensing Scorecards[30] assess how well state ECE licensing regulations support the 47 HIOPS. State scores are determined using a point-based algorithm and include four obesity prevention domains: healthy infant feeding, nutrition, physical activity, and limits on screen time. States can use these scorecards alongside ASHW resources to identify regulatory gaps, monitor progress, and guide improvements in licensing standards.



Caring for Our Children (CFOC) updated special collection, *Preventing Childhood Obesity in Early Care and Education Programs (PCO).* PCO[5,31] presents expert, evidence-based best practices that informed the development of the HIOPS. These standards served as the national benchmark for the 2025 ASHW review and can help licensing professionals identify opportunities to strengthen state regulations.



2025 Early Childhood Nutrition Report.
This CDC report[32] presents national and state-level data on nutrition-related behaviors, practices, and policies that impact the health and development of children under age five. It highlights key indicators such as breastfeeding, support for infant feeding, timing of solid food introduction, healthy eating patterns, and food affordability.
This report serves as a valuable resource for guiding early childhood health and nutrition initiatives across the U.S.

The 2023 Early Care and Education State Indicator Report.
This report,[33] published by CDC's Division of Nutrition, Physical Activity, and Obesity, provides data on how states promote healthy growth and obesity prevention in ECE settings. States use these findings to strengthen ECE policies and practices, while communities use them to inform local action.

CDC's Spectrum of Opportunities Framework. This framework[34] helps states embed healthy growth and obesity prevention strategies into ECE systems. It outlines nine focus areas that guide policy development and support community-level planning. States can use these focus areas to strengthen ECE policies and practices, while communities can also consider the nine focus areas when planning their own work.

USDA CACFP Meal and Snack Patterns. CACFP meal and snack patterns[20] reflect science-based recommendations for nutrition in young children. States can improve infant feeding and nutrition standards by incorporating these patterns into child care licensing regulations.

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Source of ASHW High-Impact Obesity Prevention Standards (HIOPS) in PCO/CFOC Online Standards

The tables below list the ASHW High-Impact Obesity Prevention Standards (HIOPS) as outlined in the PCO/CFOC standards.

Multiple-sourced HIOPS: Some ASHW HIOPS draw from multiple PCO/CFOC standards where the same core concept appears in different contexts. For example, Infant Feeding HIOPS IB2—do not feed beyond satiety—appears in both Standard 4.3.1.2 (Feeding Infants on Cue by a Consistent Caregiver/Teacher, which notes "observing satiety cues can limit overfeeding") and Standard 4.3.1.8 (Techniques for Bottle Feeding, which advises "allow infant to stop the feeding"). As a result, some HIOPS are associated with more than one PCO/CFOC standard.

INFANT FEEDING		
HIOPS	**ASHW HIOPS Text**	**Source of HIOPS in PCO/CFOC Standards**
IA1	Encourage and support breastfeeding and feeding of breast milk by making arrangements for mothers to feed their children comfortably on-site.	4.3.1.1 - General Plan for Feeding Infants
IA2	Serve human milk or infant formula to at least age 12 months, not cow's milk, unless written exception is provided by primary care provider and parent/ guardian.	4.3.1.7 - Feeding Cow's Milk & 4.2.0.4 - Categories of Foods
IB1	Feed infants on cue.	4.3.1.2 - Feeding Infants on Cue by a Consistent Caregiver/Teacher & 4.3.1.8 - Techniques for Bottle Feeding
IB2	Do not feed infants beyond satiety; Allow infant to stop the feeding.	4.3.1.2 - Feeding Infants on Cue by a Consistent Caregiver/Teacher & 4.3.1.8 - Techniques for Bottle Feeding
IB3	Hold infants while bottle feeding; Position an infant for bottle feeding in the caregiver/teacher's arms or sitting up on the caregiver/teacher's lap.	4.3.1.8 - Techniques for Bottle Feeding
IC1	Develop a plan for introducing age-appropriate solid foods (complementary foods) in consultation with the child's parent/guardian and primary care provider.	4.3.1.11 - Introduction of Age-Appropriate Solid Foods to Infants
IC2	Introduce age-appropriate solid foods no sooner than 4 months of age, and preferably around 6 months of age.	4.3.1.11 - Introduction of Age-Appropriate Solid Foods to Infants
IC3	Introduce breastfed infants gradually to iron-fortified foods no sooner than four months of age, but preferably around six months to complement the human milk.	4.3.1.11 - Introduction of Age-Appropriate Solid Foods to Infants
ID1	Do not feed an infant formula mixed with cereal, fruit juice or other foods unless the primary care provider provides written instruction.	4.3.1.5 - Preparing, Feeding, and Storing Infant Formula
ID2	Serve whole fruits, mashed or pureed, for infants 6 months up to one year of age.	4.2.0.4 - Categories of Foods & 4.3.1.11 - Introduction of Age-Appropriate Solid Foods to Infants
ID3	Serve no fruit juice to children younger than 12 months of age.	4.2.0.4 - Categories of Foods & 4.2.0.7 - 100% Fruit Juice

NUTRITION		
HIOPS	**ASHW HIOPS Text**	**Source of HIOPS in PCO/CFOC Standards**
NA1	Limit oils by choosing monounsaturated and polyunsaturated fats (such as olive oil or safflower oil) and avoiding trans fats, saturated fats and fried foods.	4.2.0.4 - Categories of Foods
NA2	Serve meats and/or beans - chicken, fish, lean meat, and/or legumes (such as dried peas, beans), avoiding fried meats.	4.2.0.4 - Categories of Foods
NA3	Serve other milk equivalent products such as yogurt and cottage cheese, using low-fat varieties for children 2 years of age and older.	4.2.0.4 - Categories of Foods
NA4	Serve whole pasteurized milk to twelve to twenty-four month old children who are not on human milk or prescribed formula, or serve reduced fat (2%) pasteurized milk to those who are at risk for hypercholesterolemia or obesity	4.3.2.3 - Encouraging Self-Feeding by Older Infants and Toddlers
NA5	Serve skim or 1% pasteurized milk to children two years of age and older.	4.3.2.3 - Encouraging Self-Feeding by Older Infants and Toddlers
NB1	Serve whole grain breads, cereals, and pastas.	4.2.0.4 - Categories of Foods
NB2	Serve vegetables, specifically, dark green, orange, deep yellow vegetables; and root vegetables, such as potatoes and viandas.	4.2.0.4 - Categories of Foods
NB3	Serve fruits of several varieties, especially whole fruits.	4.2.0.4 - Categories of Foods
NC1	Use only 100% juice with no added sweeteners.	4.2.0.7 - 100% Fruit Juice
NC2	Offer juice only during meal times.	4.2.0.7 - 100% Fruit Juice
NC3	Serve no more than 4 to 6 oz juice/day for children 1-6 years of age.	4.2.0.4 - Categories of Foods & 4.2.0.7 - 100% Fruit Juice
NC4	Serve no more than 8 to 12 oz juice/day for children 7-12 years of age.	4.2.0.4 - Categories of Foods & 4.2.0.7 - 100% Fruit Juice
ND1	Make water available both inside and outside.	4.2.0.6 - Availability of Drinking Water
NE1	Teach children appropriate portion size by using plates, bowls and cups that are developmentally appropriate to their nutritional needs.	4.3.2.2 - Serving Size for Toddlers and Preschoolers & 4.7.0.1 - Nutrition Learning Experiences for Children
NE2	Require adults eating meals with children to eat items that meet nutrition standards.	4.5.0.4 - Socialization During Meals
NF1	Serve small-sized, age-appropriate portions.	4.3.2.2 - Serving Size for Toddlers and Preschoolers
NF2	Permit children to have one or more additional servings of the nutritious foods that are low in fat, sugar, and sodium as needed to meet the caloric needs of the individual child; Teach children who require limited portions about portion size and monitor their portions.	4.3.2.2 - Serving Size for Toddlers and Preschoolers & 4.5.0.4 - Socialization During Meals
NG1	Limit salt by avoiding salty foods such as chips and pretzels.	4.2.0.4 - Categories of Foods
NG2	Avoid sugar, including concentrated sweets such as candy, sodas, sweetened drinks, fruit nectars, and flavored milk.	4.2.0.4 - Categories of Foods
NH1	Do not force or bribe children to eat.	4.5.0.11 - Prohibited Uses of Food
NH2	Do not use food as a reward or punishment.	4.5.0.11 - Prohibited Uses of Food

PHYSICAL ACTIVITY/SCREEN TIME		
HIOPS	**ASHW HIOPS Text**	**Source of HIOPS in PCO/CFOC Standards**
PA1	Provide children with adequate space for both inside and outside play.	3.1.3.1 - Active Opportunities for Physical Activity
PA2	Provide orientation and annual training opportunities for caregivers/teachers to learn about age-appropriate gross motor activities and games that promote children's physical activity.	3.1.3.4 - Caregivers'/Teachers' Encouragement of Physical Activity
PA3	Develop written policies on the promotion of physical activity and the removal of potential barriers to physical activity participation.	9.2.3.1 - Policies and Practices that Promote Physical Activity
PA4	Require caregivers/teachers to promote children's active play, and participate in children's active games at times when they can safely do so.	3.1.3.4 - Caregivers'/Teachers' Encouragement of Physical Activity
PA5	Do not withhold active play from children who misbehave, although out-of-control behavior may require five minutes or less calming periods to help the child settle down before resuming cooperative play or activities.	3.1.3.1 - Active Opportunities for Physical Activity
PB1	Do not utilize media (television [TV], video, and DVD) viewing and computers with children younger than two years.	2.2.0.3 - Screen Time/Digital Media Use
PB2	Limit total media time for children two years and older to not more than 30 minutes once a week. Limit screen time (TV, DVD, computer time).	3.1.3.4 - Caregivers'/Teachers' Encouragement of Physical Activity" 2.2.0.3 - Screen Time/Digital Media Use
PB3	Use screen media with children age two years and older only for educational purposes or physical activity.	2.2.0.3 - Screen Time/Digital Media Use
PB4	Do not utilize TV, video, or DVD viewing during meal or snack time.	2.2.0.3 - Screen Time/Digital Media Use
PC1	Provide daily for all children, birth to six years, two to three occasions of active play outdoors, weather permitting.	3.1.3.1 - Active Opportunities for Physical Activity
PC2	Allow toddlers sixty to ninety minutes per eight-hour day for vigorous physical activity.	3.1.3.1 - Active Opportunities for Physical Activity
PC3	Allow preschoolers ninety to one-hundred and twenty minutes per eight-hour day for vigorous physical activity.	3.1.3.1 - Active Opportunities for Physical Activity
PD1	Provide daily for all children, birth to six years, two or more structured or caregiver/ teacher/ adult-led activities or games that promote movement over the course of the day—indoor or outdoor.	3.1.3.1 - Active Opportunities for Physical Activity & 3.1.3.4 - Caregivers'/Teachers' Encouragement of Physical Activity
PE1	Ensure that infants have supervised tummy time every day when they are awake.	3.1.3.1 - Active Opportunities for Physical Activity
PE2	Use infant equipment such as swings, stationary activity centers (ex. exersaucers), infant seats (ex. bouncers), molded seats, etc. only for short periods of time if at all.	3.1.3.1 - Active Opportunities for Physical Activity

State Documents Rated in 2025 for Achieving a State of Healthy Weight (ASHW)

The list below shows the documents rated in 2025 because they contained regulatory changes affecting one or more HIOPS. In total, the ASHW team reviewed more than 40 regulatory documents across 20 states in 2025; however, only documents with changes affecting HIOPS ratings were included in the assessment below. A full list of all documents rated since 2010 is available on the ASHW website.[36]

The ASHW assessment team actively identifies new and revised documents through website searches, email outreach, and direct communication with state licensing agencies. Occasionally, the team may miss regulations during the year they take effect. When that happens, the team screens and rates those documents for inclusion in the ASHW report for the year they are discovered. If state licensing personnel know of any missed documents, please contact the assessment team at healthyweight@cuanschutz.edu.

State	Regulation Document Title For links to states' documents, click here	Document Date	ASHW Year	Child Care Types		
				CTR	LRG	SML
AZ	**Arizona**					
	Arizona Administrative Code and Arizona Revised Statues for Child Care Facilities	8/3/2025	2025	X		
MD	**Maryland**					
	Title 13A State Board of Education Subtitle 16 Child Care Centers	10/9/2025	2025	X		
	Title 13A State Board of Education Subtitle 18 Large Family Child Care Homes	3/17/2025	2025		X	
	Title 13A State Board of Education Subtitle 15 Family Child Care	3/17/2025	2025			X
MT	**Montana**					
	Licensure of Day Care Facilities	5/1/2025	2025	X	X	X
NH	**New Hampshire**					
	Title 17, Chapter 892.2 Licensing of Group Child Care Centers and Group Child Care Homes	8/26/2025	2025	X	X	X
OR	**Oregon**					
	Rules for Registered Family Child Care Homes	7/1/2025	2025			X
UT	**Utah**					
	R381-100 Child Care Centers	5/21/2025	2025	X		
	R430-90. Licensed Family Child Care	7/28/2025	2025		X	
	R430-50 Residential Certificate Child Care	5/8/2025	2025			X

CTR=Child Care Centers, LRG=Large Family Child Care Homes, SML=Small Family Child Care Homes

Rating of the Child and Adult Care Food Program (CACFP)

The U.S. Department of Agriculture (USDA) Food and Nutrition Service (FNS) administers the Child and Adult Care Food Program (CACFP), also known as CFR 226.20. CACFP reimburses eligible child care and adult day care programs for providing nutritious meals and snacks to low-income families. Participating programs must follow age-specific CACFP Meal and Snack Patterns, which define required food types and serving sizes. Because CACFP offers guidance specific to early care and education (ECE), many states incorporate CACFP requirements into their child care licensing regulations—even for programs that do not formally participate.

Caring for Our Children (CFOC) Standard 4.2.0.3—Use of USDA Child and Adult Care Food Program Guidelines—encourages all child care programs to adopt CACFP guidance. In 2010, the ASHW external expert workgroup identified this standard as high-impact for obesity prevention. The ASHW assessment team used this determination to help develop the variables now referred to as High-Impact Obesity Prevention Standards (HIOPS).[1]

The ASHW assessment team includes CACFP in ratings for all Nutrition and Infant Feeding HIOPS, since states often use CACFP Meal and Snack Patterns to shape or strengthen nutrition regulations. The team designates a state as an "ASHW CACFP state" when regulations either reproduce CACFP requirements or require adherence to CFR 226.20. When a state meets this threshold, the team applies CACFP-aligned ratings to relevant HIOPS. If the regulations contain additional related language, the team reviews that content to determine whether it increases or decreases the CACFP rating.

Since 2010, two major CACFP updates have prompted ASHW to revise state ratings. In 2012, the team updated ratings for two HIOPS and applied those changes to all CACFP-aligned states. In 2017, CACFP issued updated Meal and Snack Patterns that became mandatory for participating programs. In response, the ASHW team improved ratings for four Infant Feeding and five Nutrition HIOPS. To apply these changes, the team reviewed each state's 2010 CACFP classification and assessed whether current regulations required adherence to updated CACFP guidelines (see ASHW 2017 Report, Appendix C: Methodology).

States differ in how they present CACFP requirements. Some cite CFR 226.20 directly or name CACFP explicitly. Others refer providers to the USDA FNS website or state CACFP contacts. Some reproduce meal patterns, with or without identifying them as CACFP content. Many use combinations of these approaches.[2]

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[1]National Resource Center for Health and Safety in Child Care and Early Education. Origin of Achieving a State of Healthy Weight high-impact obesity prevention standards. University of Colorado Anschutz Medical Campus College of Nursing; 2020. https://nursing.cuanschutz.edu/docs/librariesprovider2/research/ashw/hiopsorigin.pdf

[2]ASHW 2017 Report, Appendix C: ASHW 2017 Method Notes (p.33-34) available at: https://nursing.cuanschutz.edu/docs/librariesprovider2/research/ashw/ashw-2017-report.pdf

As a general rule, the ASHW assessment team awards improved CACFP ratings when a state references federal code, the CACFP program name, official meal patterns, or the CACFP website. When regulations include vague terms (e.g., "USDA Guidelines" only), the team contacts the state licensing agency for clarification. If the state does not respond, the team applies its best judgment. When a state newly adopts CACFP requirements, the team updates the state's ratings accordingly.

ASHW RATING SCALE

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

Table 1. Infant Feeding

This table summarizes Infant Feeding ratings assigned to state regulations that require licensed programs to follow CACFP. Ratings reflect the differences between the 2010 and 2017 CACFP updates. The last column notes applicable 2017 CACFP Best Practice ratings.

HIGH-IMPACT OBESITY PREVENTION STANDARDS (HIOPS)	ASHW CACFP Rating 2010/2017	ASHW CACFP Best Practice Rating
IA1. Encourage and support breastfeeding and feeding of breast milk by making arrangements for mothers to feed their children comfortably on-site.	3/3	4
IA2. Serve human milk or infant formula to at least age 12 months, not cow's milk, unless written exception is provided by primary care provider and parent/guardian.	4/4	-
IB1. Feed infants on cue.	4/4	-
IB2. Do not feed infants beyond satiety; Allow infant to stop the feeding.	4/4	-
IB3. Hold infants while bottle feeding; Position an infant for bottle feeding in the caregiver/teacher's arms or sitting up on the caregiver/teacher's lap.	2/2	-
IC1. Develop a plan for introducing age-appropriate solid foods (complementary foods) in consultation with the child's parent/guardian and primary care provider.	3/3	-
IC2. Introduce age-appropriate solid foods no sooner than 4 months of age, and preferably around 6 months of age.	3/4	-
IC3. Introduce breastfed infants gradually to iron-fortified foods no sooner than four months of age, but preferably around six months to complement the human milk.	3/4	-
ID1. Do not feed an infant formula mixed with cereal, fruit juice or other foods unless the primary care provider provides written instruction.	2/2	-
ID2. Serve whole fruits, mashed or pureed, for infants 6 months up to one year of age.	1/3	-
ID3. Serve no fruit juice to children younger than 12 months of age.	1/4	-

Table 2. Nutrition

This table summarizes how the ASHW team rated state nutrition regulations that require licensed programs to follow CACFP. The table displays ratings based on 2010 and 2017 updates (e.g., 3/4) and notes 2017 CACFP Best Practice ratings in the final column where applicable.

HIGH-IMPACT OBESITY PREVENTION STANDARDS (HIOPS)	ASHW CACFP Rating 2010/2017	ASHW CACFP Best Practice Rating
NA1. Limit oils by choosing monounsaturated and polyunsaturated fats (such as olive oil or safflower oil) and avoiding trans fats, saturated fats and fried foods.	2/2	3
NA2. Serve meats and/or beans - chicken, fish, lean meat, and/or legumes (such as dried peas, beans), avoiding fried meats.	3/3	-
NA3. Serve other milk equivalent products such as yogurt and cottage cheese, using low-fat varieties for children 2 years of age and older.	3/3	-
NA4. Serve whole pasteurized milk to 12-24 month old children who are not on human milk or prescribed formula, or serve reduced fat (2%) pasteurized milk to those who are at risk for hypercholesterolemia or obesity.	2/3	-
NA5. Serve skim or 1% pasteurized milk to children two years of age and older.	4*/4	-
NB1. Serve whole grain breads, cereals, and pastas.	3/3	4
NB2. Serve vegetables, specifically, dark green, orange, deep yellow vegetables; and root vegetables, such as potatoes and viandas.	3/3	4
NB3. Serve fruits of several varieties, especially whole fruits.	3/3	4
NC1. Use only 100% juice with no added sweeteners.	4/4	-
NC2. Offer juice only during meal times.	2/4	-
NC3. Serve no more than 4 to 6 oz juice/day for children 1-6 years of age.	3/4	-
NC4. Serve no more than 8 to 12 oz juice/day for children 7-12 years of age.	3/4	-
ND1. Make water available both inside and outside.	4*/4	-
NE1. Teach children appropriate portion size by using plates, bowls and cups that are developmentally appropriate to their nutritional needs	2/2	-
NE2. Require adults eating meals with children to eat items that meet nutrition standards.	2/2	-
NF1. Serve small-sized, age-appropriate portions.	4/4	-
NF2. Permit children to have one or more additional servings of the nutritious foods that are low in fat, sugar, and sodium as needed to meet the caloric needs of the individual child; Teach children who require limited portions about portion size and monitor their portions.	3/3	-
NG1. Limit salt by avoiding salty foods such as chips and pretzels. (Selected to complete the food groups)	2/2	-
NG2. Avoid sugar, including concentrated sweets such as candy, sodas, sweetened drinks, fruit nectars, and flavored milk.	1/3	-
NH1. Do not force or bribe children to eat.	2/2	-
NH2. Do not use food as a reward or punishment.	2/2	-

**NA5 and ND1 2010 values = 2. Starred rating values were effective in ASHW 2012 due to CACFP improvement.*

2025 State Support Across the HIOPS: Child Care Centers

This table shows the percentage of ratings for each state's center regulations, that a) contradict, b) fail to address, c) partially support, and d) fully support the 47 High-Impact Obesity Prevention Standards (HIOPS).

State	Contradicts	Fail To Address	Partially Supports	Fully Supports
ALABAMA	0%	51%	23%	26%
ALASKA	0%	30%	36%	34%
ARIZONA	2%	49%	32%	17%
ARKANSAS	0%	17%	45%	38%
CALIFORNIA	0%	36%	23%	40%
COLORADO	0%	19%	36%	45%
CONNECTICUT	0%	32%	32%	36%
DELAWARE	0%	9%	45%	47%
DISTRICT OF COLUMBIA	0%	19%	43%	38%
FLORIDA	0%	26%	36%	38%
GEORGIA	0%	28%	32%	40%
HAWAII	0%	34%	32%	34%
IDAHO	0%	96%	4%	0%
ILLINOIS	2%	15%	23%	60%
INDIANA	4%	60%	13%	23%
IOWA	0%	34%	34%	32%
KANSAS	2%	66%	23%	9%
KENTUCKY	2%	36%	28%	34%
LOUISIANA	0%	19%	45%	36%
MAINE	0%	40%	34%	26%
MARYLAND	0%	19%	38%	43%
MASSACHUSETTS	0%	72%	17%	11%
MICHIGAN	0%	19%	38%	43%
MINNESOTA	0%	34%	36%	30%
MISSISSIPPI	4%	21%	38%	36%
MISSOURI	0%	57%	28%	15%
MONTANA	0%	38%	32%	30%
NEBRASKA	0%	83%	13%	4%
NEVADA	0%	32%	34%	34%
NEW HAMPSHIRE	0%	72%	21%	6%
NEW JERSEY	0%	15%	34%	51%
NEW MEXICO	0%	26%	34%	40%
NEW YORK	0%	19%	43%	38%
NORTH CAROLINA	0%	21%	32%	47%
NORTH DAKOTA	0%	62%	28%	11%
OHIO	0%	62%	21%	17%
OKLAHOMA	0%	23%	38%	38%
OREGON	0%	26%	36%	38%
PENNSYLVANIA	0%	64%	26%	11%
RHODE ISLAND	0%	19%	36%	45%
SOUTH CAROLINA	0%	36%	34%	30%
SOUTH DAKOTA	0%	85%	9%	6%
TENNESSEE	0%	9%	36%	55%
TEXAS	0%	15%	28%	57%
UTAH	2%	23%	45%	30%
VERMONT	0%	23%	38%	38%
VIRGINIA	0%	30%	38%	32%
WASHINGTON	0%	13%	34%	53%
WEST VIRGINIA	0%	17%	28%	55%
WISCONSIN	0%	28%	38%	34%
WYOMING	0%	79%	13%	9%

2025 State Support Across the HIOPS: Large Family Homes

This table shows the percentage of ratings for each state's large family home regulations that a) contradict, b) fail to address, c) partially support, and d) fully support High-Impact Obesity Prevention Standards (HIOPS).

State	Contradicts	Fail To Address	Partially Supports	Fully Supports
ALABAMA	0%	55%	23%	21%
ALASKA	0%	30%	36%	34%
ARIZONA	2%	57%	28%	13%
ARKANSAS	0%	23%	40%	36%
CALIFORNIA	0%	85%	9%	6%
COLORADO	0%	23%	38%	38%
CONNECTICUT	0%	32%	32%	36%
DELAWARE	0%	19%	38%	43%
DISTRICT OF COLUMBIA	0%	19%	43%	38%
FLORIDA	0%	23%	43%	34%
GEORGIA	N/A - not regulated	N/A - not regulated	N/A - not regulated	N/A - not regulated
HAWAII	0%	36%	32%	32%
IDAHO	0%	96%	4%	0%
ILLINOIS	6%	45%	28%	21%
INDIANA	0%	85%	9%	6%
IOWA	0%	40%	30%	30%
KANSAS	2%	64%	21%	13%
KENTUCKY	2%	36%	28%	34%
LOUISIANA	N/A - not regulated	N/A - not regulated	N/A - not regulated	N/A - not regulated
MAINE	0%	45%	30%	26%
MARYLAND	0%	19%	34%	47%
MASSACHUSETTS	0%	72%	17%	11%
MICHIGAN	0%	34%	34%	32%
MINNESOTA	0%	34%	36%	30%
MISSISSIPPI	4%	19%	38%	38%
MISSOURI	0%	57%	30%	13%
MONTANA	0%	38%	32%	30%
NEBRASKA	0%	83%	13%	4%
NEVADA	0%	32%	34%	34%
NEW HAMPSHIRE	0%	72%	21%	6%
NEW JERSEY	N/A - not regulated	N/A - not regulated	N/A - not regulated	N/A - not regulated
NEW MEXICO	0%	26%	34%	40%
NEW YORK	0%	53%	30%	17%
NORTH CAROLINA	0%	21%	32%	47%
NORTH DAKOTA	0%	66%	23%	11%
OHIO	0%	62%	21%	17%
OKLAHOMA	0%	45%	38%	17%
OREGON	0%	26%	40%	34%
PENNSYLVANIA	0%	64%	26%	11%
RHODE ISLAND	0%	15%	26%	60%
SOUTH CAROLINA	0%	36%	34%	30%
SOUTH DAKOTA	0%	85%	9%	6%
TENNESSEE	0%	9%	36%	55%
TEXAS	0%	15%	30%	55%
UTAH	2%	23%	45%	30%
VERMONT	0%	23%	38%	38%
VIRGINIA	0%	23%	38%	38%
WASHINGTON	0%	13%	34%	53%
WEST VIRGINIA	2%	70%	23%	4%
WISCONSIN	N/A - not regulated	N/A - not regulated	N/A - not regulated	N/A - not regulated
WYOMING	0%	79%	13%	9%

2025 State Support Across the HIOPS: Small Family Homes

This table shows the percentage of ratings for each state's small family home regulations that a) contradict, b) fail to address, c) partially support, and d) fully support High-Impact Obesity Prevention Standards (HIOPS).

State	Contradicts	Fail To Address	Partially Supports	Fully Supports
ALABAMA	0%	55%	23%	21%
ALASKA	0%	30%	36%	34%
ARIZONA	N/A - not regulated	N/A - not regulated	N/A - not regulated	N/A - not regulated
ARKANSAS	0%	23%	43%	34%
CALIFORNIA	0%	85%	9%	6%
COLORADO	0%	23%	38%	38%
CONNECTICUT	0%	87%	6%	6%
DELAWARE	0%	19%	38%	43%
DISTRICT OF COLUMBIA	0%	19%	43%	38%
FLORIDA	0%	36%	34%	30%
GEORGIA	0%	28%	34%	38%
HAWAII	0%	36%	32%	32%
IDAHO	0%	96%	4%	0%
ILLINOIS	6%	45%	28%	21%
INDIANA	0%	85%	9%	6%
IOWA	0%	40%	30%	30%
KANSAS	2%	64%	21%	13%
KENTUCKY	2%	49%	28%	21%
LOUISIANA	N/A - not regulated	N/A - not regulated	N/A - not regulated	N/A - not regulated
MAINE	0%	45%	30%	26%
MARYLAND	0%	23%	34%	43%
MASSACHUSETTS	0%	72%	17%	11%
MICHIGAN	0%	34%	34%	32%
MINNESOTA	0%	34%	36%	30%
MISSISSIPPI	4%	19%	38%	38%
MISSOURI	0%	57%	30%	13%
MONTANA	0%	38%	32%	30%
NEBRASKA	0%	83%	13%	4%
NEVADA	0%	32%	34%	34%
NEW HAMPSHIRE	0%	72%	21%	6%
NEW JERSEY	0%	72%	21%	6%
NEW MEXICO	0%	26%	34%	40%
NEW YORK	0%	53%	30%	17%
NORTH CAROLINA	0%	21%	32%	47%
NORTH DAKOTA	0%	66%	23%	11%
OHIO	0%	62%	21%	17%
OKLAHOMA	0%	45%	38%	17%
OREGON	0%	30%	36%	34%
PENNSYLVANIA	0%	70%	21%	9%
RHODE ISLAND	0%	15%	26%	60%
SOUTH CAROLINA	0%	83%	15%	2%
SOUTH DAKOTA	0%	85%	9%	6%
TENNESSEE	0%	9%	36%	55%
TEXAS	0%	15%	30%	55%
UTAH	2%	26%	45%	28%
VERMONT	0%	23%	38%	38%
VIRGINIA	0%	23%	38%	38%
WASHINGTON	0%	13%	34%	53%
WEST VIRGINIA	0%	79%	17%	4%
WISCONSIN	0%	28%	38%	34%
WYOMING	0%	79%	13%	9%

For more information please contact
College of Nursing, ASHW Assessment Team
University of Colorado Anschutz Medical Campus
https://nursing.cuanschutz.edu/research/healthy-weight
healthyweight@cuanschutz.edu
Publication date: September 10, 2026

University of Colorado **Anschutz**

College of Nursing