Family Child Care Nutrition Standards Project: Phase I Development Process

Background

Early childhood is the single most critical period of human development. During these years, the foundation is laid for lifelong healthy habits, including nutritional habits and preferences.[1] Consequently, young children are especially vulnerable to the impacts of food insecurity, with poor nutrition affecting young children's ability to learn and grow.[2] Child care providers play an integral role in the nutritional status of our young children.[3]

California, like other states, has a variety of child care options for infants and young children, including licensed child care centers and licensed family child care homes (FCCHs). The majority of available licensed child care slots are in child care centers, but FCCHs serve a significant number of children throughout the state. In 2012, there were approximately 33,365 FCCHs in California with a collective 335,719 slots for children.[4]

Research shows that a large proportion of children spend a considerable amount of time (about 30 hours per week) in FCCHs – and the quality of nutrition they receive in that setting varies greatly.[5] Less than half of California FCCHs participate in the federal Child and Adult Care Food Program (CACFP), which offers meal reimbursements to providers who serve meals that meet federal nutrition standards.[6] [7] More than 20% of California's children live in poverty.[8] For these children and their families, healthy food may be prohibitively expensive or difficult to access, making the nutritional quality of the meals and snacks that they consume in child care especially critical to their health and development.

All California child care centers must follow the federal nutrition standards set by CACFP, regardless of whether they participate in the program. However, the only nutrition standard that currently applies to FCCHs in California is the state's Healthy Beverages in Child Care Law (AB 2084), which was enacted in 2010. In 2012, California Food Policy Advocates (CFPA) sponsored state legislation (AB 1872) that would have extended the CACFP nutrition standards to FCCHs. The bill was vetoed by Governor Brown. The veto message expressed support for providers receiving additional nutrition education and training – and stated the governor's reluctance to impose a "confusing mandate" about nutrition standards. In response to this veto, CFPA successfully sponsored AB 290 in 2013. The legislation amended child care licensing laws to add one hour to the preventive health and safety training on the importance of childhood nutrition and the resources provided by CACFP.

CFPA and the Nutrition Policy Institute (NPI) at the University of California's Division of Agriculture and Natural Resources envision a day when a clear, consistent nutrition policy is in place for all children in child care throughout California. To fully realize this vision, research is needed to develop science-based nutrition standards that can be pilot tested in California FCCHs. Pilot testing is essential to evaluate the effects of implementing nutrition standards.

CFPA and NPI received support from the David and Lucile Packard Foundation to advance this work by: (1) developing science-based standards in conjunction with nutrition researchers, (2) consulting with California FCCH experts, and (3) selecting FCCHs to pilot test the implementation. Through these efforts, we will be able to address Governor Brown's concerns about a "confusing mandate": this research will shape a clear, feasible,

effective policy on nutrition standards in FCCHs. This discussion paper outlines the process undertaken to develop science-based nutrition standards for FCCHs.

The process used to develop appropriate nutrition standards for pilot testing was collaborative, bringing together child care experts with varied experience and training. In 2015 and early 2016, we convened a series of meetings with nutrition researchers, CACFP sponsors (including Child Care Food Program Roundtable leaders), provider representatives (e.g., unions, resource and referral networks), and other relevant stakeholders. The goal of these convenings was to determine the key elements of a nutrition standards policy that could be pilot tested in FCCHs. A successful nutrition standards policy will improve the health and well-being of infants and young children and elevate the quality of care in FCCHs without negatively impacting the viability of workforce.

Policy Scan: Nutrition in Family Child Care Homes

In order to establish an understanding of state-level nutrition policies, CFPA cataloged current state statutes and regulations governing FCCHs and reviewed policy recommendations for regulatory standards in FCCHs.

STATE POLICIES ON NUTRITION IN FAMILY CHILD CARE HOMES

Utilizing the Public Health Law Center's Healthy Child Care 50-State Review, CFPA created a simplified matrix that provides a snapshot of current information on state-level policies that regulate nutrition in FCCHs.[9] This matrix assesses the quality and extent of nutrition standards policies, and served as a resource in the development of nutrition standards for pilot testing.

Highlights of the review of state policies include:

- 31 states already require FCCHs to follow the CACFP meal pattern.
- 6 states specify food groups or meal patterns that must be met, which are similar to but less specific than CACFP.
- 5 states require FCCHs to supplement food brought from home if the food brought from home does not meet the CACFP meal pattern.
- Mississippi has the strongest policy in the nation, requiring all licensed child care facilities – including FCCHs – to go above and beyond the CACFP meal pattern by meeting additional nutrition standards and healthy feeding practices. For example, state regulations exceed CACFP standards by requiring whole grains; limiting fat, sugar and sodium; and restricting processed meats and cheeses. These policies were enacted in May 2013.
- Only 13 states (including California) lack state-level nutrition policies for meals and snacks in FCCHs.

The CFPA Family Child Care Nutrition Standards Policy Matrix can be accessed at: https://goo.gl/spDKwh

POLICY RECOMMENDATIONS

Several national organizations have released evidence-based nutrition recommendations for all child care environments.

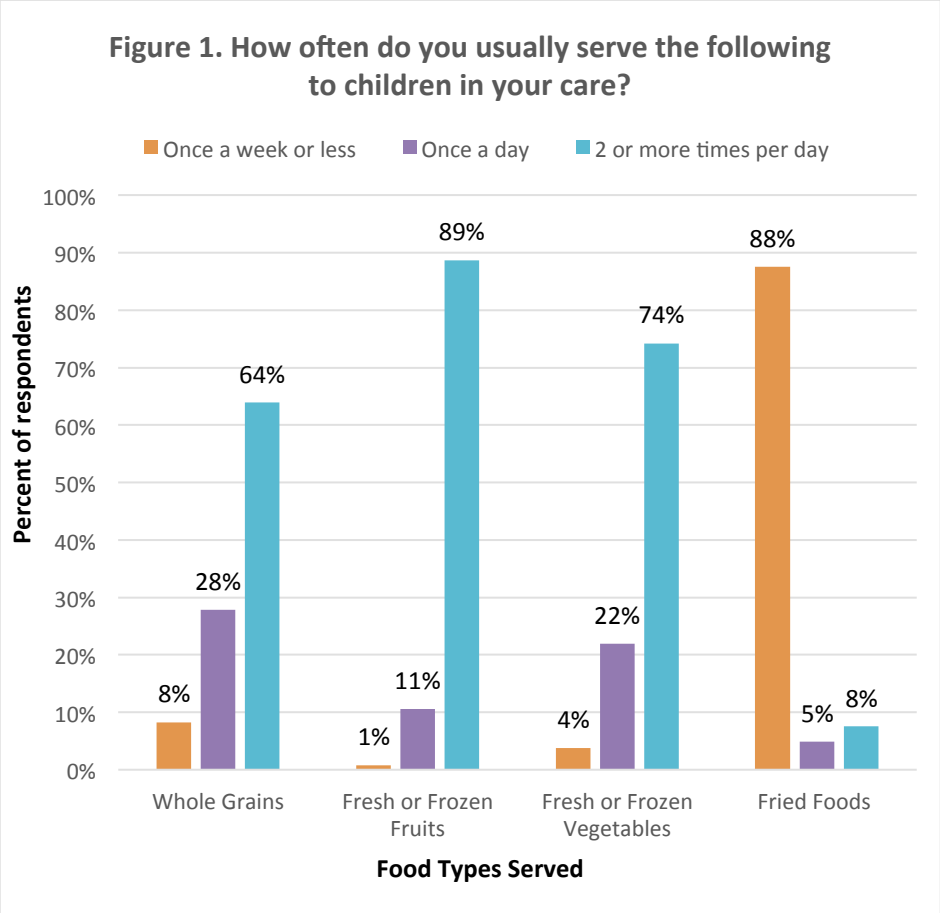
- **The Institute of Medicine** recommends the inclusion of specific requirements related to physical activity, sedentary activity, and child feeding in child care regulations.[10]

- **The National Center for Chronic Disease Prevention and Health Promotion** reports that states should ensure regulations, policies, and legislation at all levels promote healthier foods in child care settings.[11]
- **The National Resource Center for Health and Safety in Child Care and Early Education, the American Academy of Pediatrics, and the American Public Health Association** published a set of national standards describing evidence-based best practices in nutrition, physical activity, and screen time for early care and education programs for all types of early care and education settings.[12]
- **The California Department of Education** provides goals and recommendations for state and federal policy and practices to improve nutrition and physical activity in child care.[13]
- **The American Heart Association** states that child care providers should meet minimum, uniform standards in nutrition, physical activity, screen time limitations, breastfeeding, and professional development.[14]

Southern California Family Child Care Survey

CFPA received support from Kaiser Permanente Southern California to survey FCCH providers in Kern, Los Angeles, San Diego, San Bernardino and Riverside counties about nutrition and current food service practices. These survey results can serve as a baseline of the current state of nutrition practices in many FCCHs.

From July to September 2015, CFPA promoted the online survey through the county Resource & Referral Networks. The survey was available in English and Spanish. The Resource & Referral Networks sent out 4,154 surveys to providers; CFPA received 268 complete responses (16% response rate). Respondents operate a mix of small (57%) and large (43%) licensed FCCHs.* The majority of respondents have a good deal of



* A licensed Small FCCH may provide care for either: (1) Four infants, or six children, no more than three of whom may be infants; or (2) Six children, or up to eight children when one child is at least six years of age and one child is attending kindergarten or elementary school and no more than two infants are in care. A licensed Large FCCH must include an assistant provider in the home and may provide care for either (1) Twelve children, no more than four of whom may be infants; or (2) Up to fourteen children when one child is at least six years of age and one child is attending kindergarten or elementary school, and no more than three infants are in care.

experience; 69% of respondents have 7 or more years of experience. Sixty percent of respondents participate in CACFP. Almost 70% report that they or someone on staff attends training on nutrition (not including food safety) at least once per year and most (67%) also report providing nutrition education to children through curriculum or activities. An encouraging percentage (64%) state that their FCCH has a written policy on nutrition related to food and beverages.

Only 50% report being very familiar with the recommendations in the 2010 Dietary Guidelines for Americans (DGA), though 90% said they follow the DGA when serving meals and snacks to children. From this finding, it seems that most providers are motivated to serve healthy foods to children. However, the 40% of providers who are not participating in CACFP may lack sufficient guidance on what types of food to serve and recommended meal patterns.

FCCH providers appear to have control over the food served in their care – 88% report that menus are planned by the licensee themselves and 93% cook the meals. Procurement of foods for FCCHs varied with most providers shopping weekly at local wholesale stores (47%) and national retail grocery stores (41%). Seven percent rely on small grocers or convenience stores, which may limit the types of healthy foods available.

As seen in **Figure 1,** many of the providers already adhere to some of standards that the Family Child Care Advisory Committee thought would be challenging, such as serving whole grains at least twice a day.

Most providers (80%) express a great deal of confidence in their ability to serve healthy meals and snacks in their respective FCCH. Eighty-seven percent report reading nutrition labels when buying food and 76% report that they have cost-effective strategies for serving nutritious options to the children in their care.

Science Advisors

In order to guide the development of science-based nutrition standards for FCCHs, NPI organized a group of national science advisors.

NPI selected Advisors based on their expertise in nutrition and obesity prevention with respect to young children and child care. NPI tasked the Advisors with developing a comprehensive set of infant (0-2 years of age) and child (>2 years of age) recommendations that define nutritionally ideal standards for these age groups. The nutrition science advisors are listed in **Table 1**.

Current nutrition standards and guidelines for child care settings were selected from authoritative bodies including the United States Department of Agriculture[15, 16]; NapSACC (Nutrition and Physical Activity Self-Assessment for Child Care)[17]; Institute of Medicine[18]; the Dietary Guidelines Advisory Committee[19]; the American Academy of Pediatrics, the American Public Health Association and National Resource Center for Health and Safety in Child Care and Early Education[20]; the Academy of Nutrition & Dietetics[21]; and Nemours[22].

Once the guidelines were tabulated by NPI, the Science Advisors analyzed the current child care standards, recommendations, and guidelines from the above-identified scientific bodies to develop the *Nutritionally Ideal Infant and Child Practices for Family Child Care.* They also ranked each nutrition standard according to impact (high, medium or low) on child nutrition, obesity, and health. Two sets of "nutritionally ideal" standards were created, one for infants up to 12 months of age (**Table 2**) and another for children 1-18 years old (**Table 3**). While 80% of child care requests in California are for infants and preschoolers, nutrition standards were developed for children up to 18 years of age to be consistent with the ages included in the proposed CACFP standards.[23]

Family Child Care Advisors

In order to determine the most appropriate nutrition standards policy to pilot test, CFPA convened a Family Child Care Advisory Committee that included advocates, CACFP sponsors (including the Child Care Food Program Roundtable leaders), FCCH provider representatives (e.g., unions, resource and referral networks), and other relevant stakeholders. The Family Child Care Advisors are listed in **Table 4**.

The Advisors guided the development of a feasible and achievable set of nutrition standards to be pilot tested in FCCHs. The goal of convening this group was to decide upon policy recommendations that will improve the lives of children and elevate the quality of care without negatively impacting the viability of the FCCH workforce.

FAMILY CHILD CARE ADVISORY COMMITTEE MEETINGS

The first meeting with this Advisory Committee was held on September 14, 2015 in San Diego, CA. The objectives of this meeting were to: (1) come to an agreement about the role of nutrition in child care; (2) discuss the value of nutrition standards in FCCHs; (3) understand science-based nutrition practices; (4) explore practical considerations for pilot implementation; and (5) establish next steps for the Family Child Care Advisory Committee.

The Advisory Committee reviewed the nutritionally ideal standards developed by the Science Advisors. Small groups convened to review the nutritionally ideal standards and determine which standards would be the easiest for providers to implement, which would be moderately difficult, and which would be the most difficult. The Advisory Committee was also surveyed after the meeting to ensure that their reactions to each element of the standards were recorded. **Tables 5 and 6** show the Family Child Care Advisory Committee's assessment of each of the nutritionally ideal standards. This assessment reflects expected feasibility of implementation by FCCH providers.

The Advisory Committee also discussed the types of support and systems that would make the moderately-difficult-to-implement and difficult-to-implement standards more achievable. As this work continues, the Advisory Committee's recommendations will be further prioritized to advise the implementation of the standards. Recommendations included:

- Support systems for communication, training, and peer learning;
- Integration with existing policies and programs in FCCHs;
- Alignment with Quality Rating and Improvement Systems (QRIS) initiatives and other quality improvement strategies;
- Procurement practices or cooperative purchasing to make healthy foods more affordable; and
- Better linkages to farm to preschool.

Advisors also identified other factors, beyond nutritional impact, that are important to consider when developing a nutrition standard to pilot test, such as:

- Choosing the most convenient reporting methods;
- Upcoming CACFP meal pattern and regulation changes;
- Securing buy-in from providers and engagement with quality improvement efforts;
- Children's social-emotional development of healthy relationships with food;
- Providers' capacity to meet requirements;
- Anticipating the impact of changes on providers and the children in their care;
- Professional development;

- Engagement practices of providers and families; and
- Understanding family dynamics and home nutrition environments that shape children's preferences.

Following the first Advisory Committee meeting, a draft Discussion Paper was shared with the advisors who participated in the first convening. Participants were asked to review the paper and ensure it accurately reflected their contributions to development of the nutrition standards. This provided an additional point at which the advisors could comment on tiering of the nutrition standards.

The second meeting with the Advisory Committee was held on April 18, 2016 in Berkeley, CA. The objectives of this meeting were to: (1) review the final draft of the nutrition standards; (2) discuss how to operationalize the standards into an effective pilot intervention; (3) provide input on the intervention design and evaluation plan to work towards a final, testable nutrition standard for the pilot; and (4) discuss policy considerations for the pilot.

The meeting began with a review of the importance of early childhood nutrition and the accomplished work of the Committees, including the development and scoring of the nutrition standards. Advisors were asked to discuss the scored and tiered standards. The following topics were addressed.

1. Major events that happened in the previous seven months that could have impacted the nutrition standards to be tested:
    - The convening of a federal workgroup that is in the process of developing recommendations on how to incorporate children, 0-2 year olds in the 2020 Dietary Guidelines for Americans.
    - Enforcement and implementation of California Assembly Bill 290, *Foundations for Healthy Nutrition in Child Care*, which amended California child care licensing laws to add one hour to the Preventive Health and Safety Graining in order to educate prospective child care providers about the importance of childhood nutrition and the Child Adult Care Food Program (CACFP).
    - Water safety issues related to lead and other contaminants that could impact the health and well-being of children in care.
    - The release of the new CACFP meal pattern for infants and children 1-18 years old.

2. The tiering of the nutrition standards and their appropriateness for a FCCH pilot:
    - In theory, Tier 1 should be what's already happening in FCCH settings, although there was no consensus about the baseline of foods served and healthy practices occurring.
    - Sodium standards were highlighted as a standard that seemed extremely difficult for FCCH providers to meet.
    - It was flagged that the total number of standards may impact the feasibility of any one standard.
    - The importance of testing standards that can be monitored was raised; licensing analysts can only be expected to have a monitoring skillset, not a capacity to provider technical assistance.
    - FCCHs vary greatly – some providers care for children alone, while others have additional staff to help.

While there was agreement among Advisors that some standards should be easily met, such as offering fruits and vegetables, there were many standards for which the Advisors did not find complete consensus. It was clear that pilot testing will be an essential step in understanding which nutrition standards are already being met in FCCHs, which nutrition standards can be met without much additional support, and which standards will require extensive support to implement.

Dr. Abbey Alkon with the University of California, San Francisco collected feedback from Advisors using an intervention design tool, which examined the following components: the number of providers participating in the pilot study; intensity of the intervention; how educational components of the intervention are administered; length of intervention time; and other cultural and literacy considerations to think through in the intervention design planning. **Table 10** summarizes the feedback collected from the Advisory Committee.

Some additional ideas generated by the Advisory Committee included:

- The train-the-trainer model may be successful if provided by a "trusted messenger," such as a peer or other family child care provider.
- The intervention could be offered with different levels of intensity.
- The intervention should include nutrition policies, attitudes, beliefs, and practices.
- Include materials to share with parents to ensure a consistent message between the family child care home and child's home.
- Providers can share resources and tips, including topics of food prep, cooking activities with children, farm-to-school curriculum, shopping strategies, and recipes – these may be neighborhood specific.

Dr. Lorrene Ritchie with the University of California, Nutrition Policy Institute guided a discussion on the necessary elements for a rigorous, yet resource- and policy-relevant evaluation design.

The following were presented as possible pilot evaluation questions:

- Was the intervention implemented as planned?
- Were the standards implemented as intended?
- Which standards were hard to implement and why?
- What was the cost to providers (in terms of time and financial resources)?
- Should the standards be modified and if so, in what ways?

The Advisors were asked to consider the most important information to be learned from the evaluation. The following was discussed:

- Differential implementation of the standards by CACFP status
- Organizations and/or networks that provide nutrition resources with whom FCCHs partner
- The types of resources provided by these organizations and their relevance in implementing the standards
- Perceived benefits of the standards, including the impact on professional development
- Additional incentives needed for providers to implement the standards
- The role of peer-sharing/mentoring in implementing the standards
- The length of time it takes for providers to change their nutrition practices
- The impact the intervention will have on children

Additional recommendations emerged, including giving participants ample time (6-9 weeks) to plan ahead for any training and evaluation activities, and informing participants that other FCCH providers were involved in the development of the standards. Advisors considered Resource and Referral agencies the best positioned to help with recruitment. Other suggestions for recruitment strategies included: text messages, computer generated calls, personal calls, and postcards.

Screening and data collection protocols were discussed. Advisors considered the importance of selecting participants who were willing to share food purchase receipts, in order to capture the economic impact. Lastly, Advisors recommended the use of incentives after the first and final data collection.

The feedback generated during the final Advisory Committee meeting will help guide the development of the pilot and its evaluation, and help determine the extent to which nutrition standards can be successfully implemented and considered for statewide policy.

Nutrition Standards for Pilot Testing

As previously described, NPI convened an authoritative group of nutrition science experts to identify the ideal set of nutrition standards for young children. In order to refine this set of ideal standards for practical use and pilot testing in California FCCHs, NPI and CFPA further vetted these standards through the Family Child Care Advisory Committee. In addition, NPI distributed a questionnaire to the Science Advisors to document their assessments of the nutritional impact for each standard and CFPA distributed a questionnaire to each Family Child Care Advisor to document their beliefs about the feasibility of each standard. CFPA then scored each nutrition standard by comparing the Science Advisors' assessments and the Family Child Care Advisors' assessments. These comparisons allowed us to develop tiers of potential standards to pilot test. (**Table 7** shows the comparisons used to create the tiers.) These tiers were again vetted by the Family Child Care Advisors and further refined after the release of the updated CACFP meal patterns.[†] To our knowledge, this is the first time nutrition standards have been organized and presented in a format that prioritizes both workforce feasibility and nutritional impact. Depending on the final pilot design and available resources, some or all of the tiers will be tested.

Synthesizing the practical with the nutritionally ideal enables us to develop and test nutrition standards that are high-impact, based on the latest nutrition science, and achievable for FCCH providers. A pilot could test different tiers of standards in FCCHs – as well as new CACFP standards.

Table 8 summarizes the tiers of nutrition standards for infants. **Table 9** summarizes the tiers of nutrition standards for children.

Intervention Design and Evaluation Plan

Dr. Abbey Alkon and Dr. Lorrene Ritchie submitted reports to CFPA that outline the proposed designs for the intervention and evaluation. More details on these plans are available upon request.

Next Steps

PILOT SELECTION

CFPA will thoughtfully identify and recruit pilot communities in which to test the viability of the nutrition standards policy. We are working with the research consultants and a team of stakeholders to design a rigorous pilot intervention and evaluation. The work in this initial phase of the project will prepare us to enter into the next phases of the project – testing of the nutrition standards and assessment of policy implications.

[†] USDA released a proposed rule in January 2015 to update the CACFP meal patterns, the final rule was released in April 2016, and CACFP providers will be required to comply with the updated meal patterns by October 2017.

Pilot testing will most likely commence at the end of 2016. Additional funding is being sought after to expand the number of pilot communities that will test nutrition standards. Pilot consultants will continue to engage and collaborate with CFPA as the intervention design and evaluation plan is finalized. CFPA will reconvene the Advisory Committee in late 2017 as data and findings from the pilot become available.

THE POTENTIAL IMPACT OF A NUTRITION STANDARDS POLICY

The nutrition standards developed under this project could drive the adoption of a local or state policy on nutrition standards in FCCHs. Consequently, the nutrition standards developed through the process have the potential to impact the quarter of a million California children in licensed FCCHs.

While a statewide policy on nutrition standards tied to child care licensing (similar to the policy established for beverages in child care) could have the greatest reach, there are many other ways a nutrition standards policy could be adopted, for example, through state child care quality rating systems or through training and education protocols for providers. The work we are undertaking now could also inspire localities throughout the state or the country to develop similar standards – affecting countless more children.

The nutrition standards that emerge from this process could have an immediate impact even without testing or legislation. For instance, experience with beverage standards in child care suggests that some providers may adopt nutrition standards even without being required to do so. While such early adopters may represent the "low-hanging fruit" among providers, simply by publishing the science-based standards recommended by this project's Advisory Committees, we may inspire quality-focused child care leaders to incorporate the standards into their own efforts. The nutrition standards could also lay the foundation for multiple pilot projects beyond this project. A number of communities are focused on improving early childhood nutrition and may welcome the opportunity to pilot test various forms of the developed policy.

Thank You

CFPA and NPI would like to thank all the individuals who provided their expertise in the Advisory Committees. It is with their diverse knowledge that these standards are impactful, practical, and policy-relevant. In additional, we a grateful to Dr. Abbey Alkon, who opted to join this project mid-way to provide her child care training expertise and develop the pilot intervention design. Lastly, we are extremely appreciative of the funding from the David and Lucile Packard Foundation and the support from our Program Officer, Linda Shak.

Contact

For more information about this report or the Family Child Care Nutrition Standards project, please contact Elyse Homel Vitale at elyse@cfpa.net or 510.433.1122 ext. 206.

Appendix

Table 1. List of Science Advisors		
Name	**Affiliation**	**Expertise**
Karen Cullen, DrPH	Baylor	Federal nutrition assistance programs, family nutrition
Jane Heinig, PhD	UC Davis	Breastfeeding and early childhood feeding
Kathryn Henderson, PhD	Independent Consultant (formerly Yale)	Child development and nutrition policy
Donna Johnson, PhD	University of Washington	Public health nutrition, nutrition interventions
Susie Nanney, PhD, MPH, RD	University of Minneapolis	Obesity prevention in community settings and childcare
Sara Neelon, PhD	John Hopkins	Childcare policy and nutrition in young children
Angela Odoms-Young, PhD	University of Illinois at Chicago	Child nutrition and obesity prevention, health equity
Dianne Stanton Ward, EdD	University of North Carolina at Chapel Hill	Child obesity prevention, childcare policy and practices
Mary Story, PhD, RD	Duke	Child nutrition and obesity, nutrition policy
Elsie Taveras, MD	Harvard	Child obesity prevention and treatment, infant and toddler feeding practices
Shannon Whaley, PhD	Public Health Foundation Enterprises -WIC	Special Supplemental Nutrition Program for Women, Infants and Children (WIC), child development

Table 2. NUTRITIONALLY IDEAL PRACTICES FOR FAMILY CHILD CARE: INFANTS		
Scientific Advisory Nutrition Recommendations for 0- up to 12-Month-Olds		**Impact**
Fruits	• Offer unsweetened whole, mashed, or pureed fruit to infants 6-12 months old	MEDIUM
	• Offer fruit that is fresh, frozen, or canned (all with no added sugars)	MEDIUM
	• No 100% juice, juice drinks, or other juice beverages are served	HIGH
Vegetables	• Offer whole, mashed, or pureed vegetables for infants 6-12 months old	HIGH
	• Offer vegetables that are fresh, frozen, or canned (all with no added salt, fat, or sugar)	MEDIUM
Protein Foods	• Serve proteins such as egg yolks, beans, meat, poultry, fish without bones to infants 6-12 months old	HIGH
	• Protein foods are served with no added salt	MEDIUM
Dairy	• Offer only breastmilk and/or infant formula for infants 0-12 months old	MEDIUM
	• Offer no cow's milk, unless doctor's note	MEDIUM
Grains	• Grains are served with no added salt, fat, or sugar	MEDIUM
Water	• Breastmilk and formula are the best sources of water	MEDIUM
	• Infants 6-9 months old begin using a cup for drinking water	MEDIUM
Introduction of Solids	• At 6 months old, introduce developmentally appropriate solid foods in age-appropriate portion sizes	HIGH
	• At 9 months old, begin self-feeding with finger foods and transition to foods served at the table as developmentally appropriate	HIGH
Breastfeeding Promotion	• Breastfeeding is supported and encouraged	MEDIUM
	• Ensure access to a private area (not a bathroom) with a chair and an electrical outlet for breastfeeding or pumping	MEDIUM
	• Adequate refrigerator/storage space available for breastmilk	HIGH
Healthy Feeding Practices	• Infants held in one's arms or sitting up on one's lap while bottle feeding	MEDIUM
	• Bottles never propped; infants not allowed to carry, sleep, or rest with bottle	MEDIUM
	• No solid food and no beverages other than breastmilk or infant formula in bottle	HIGH
	• Younger infants are breast or bottle fed on demand by provider recognizing feeding cues (e.g., rooting, sucking)	HIGH
	• Infants are guided by own feelings of hunger and satiety; not pressured to eat all that is offered	HIGH
	• Solid foods offered at regular meal and snack times	MEDIUM
	• Snack foods are nutritionally equivalent to meal foods	MEDIUM
	• Older infants are included in family-style meals where provider and infant eat together	MEDIUM
	• Older infants self-feed with their fingers and drink from a cup with assistance	HIGH
	• Avoid choking hazards (e.g., cutting grapes into smaller pieces)	HIGH
	• Distractions are minimized at mealtime (e.g., TV, toys, phones, video games)	MEDIUM

Table 3. NUTRITIONALLY IDEAL PRACTICES FOR FAMILY CHILD CARE: CHILDREN		
Scientific Advisory Nutrition Recommendations for 1- to 18-Year-Olds		**Impact**
100% Fruit Juice	• Rarely or never offered • When offered, no more than one age-appropriate serving 1 time per day	MEDIUM HIGH
Other Fruit	• Offer ≥2 times per day • Offer only fruit that is fresh, frozen, or canned in water (all with no added sugars)	HIGH MEDIUM
Vegetables	• Offer ≥2 times per day • Dark green, orange, red, or deep yellow veggies offered ≥1 time per day • Offer no deep fried or pre-fried baked vegetables	HIGH MEDIUM HIGH
100% Whole Grains	• Offer ≥2 times per day • No white (non-whole) grains or grain-based desserts (e.g., cake, cookies, pie, pastries, donuts) • Offer only cereals that are WIC approved (≤6 g sugar per dry ounce and ≥28 mg iron per 100 mg)	MEDIUM MEDIUM MEDIUM
Protein Foods	• Offer ≥2 times per day • Offer lean proteins, such as seafood, fish, lean meat, poultry, eggs, beans, peas, soy products, tofu, unsalted nuts/seeds • Offer no processed meats and no deep-fried or pre-fried meats or fish	MEDIUM MEDIUM HIGH
Dairy	• For children 12-24 months old, offer unflavored whole milk ≥2 times per day • For children >24 months old, offer unflavored fat-free or 1% milk ≥2 times per day • Offer only non-dairy milk substitutions (e.g. soy milk) that are nutritionally equivalent to milk • Yogurt offered ≤1 time per day, must have <20 gram sugar per cup • Natural cheese offered no more than 1-2 times per day	MEDIUM MEDIUM MEDIUM MEDIUM MEDIUM
Fats	• Use only liquid, non-tropical vegetable oils instead of solid fats	MEDIUM
Water	• Water is easily available for self-serve indoors and outdoors and actively offered with meals and snacks and at other times as appropriate	HIGH
Added Sugars	• No foods with sugar or sugar equivalents (e.g., high fructose corn syrup, fructose, corn syrup, can sugar, evaporated cane juice, sucrose) listed as the first or second ingredients. No foods having a combination of 3 or more sugar/sugar equivalents. • No low-calorie sweeteners or items containing low-calorie sweeteners (e.g., diet foods, diet beverages) • No sugar-sweetened beverages	HIGH MEDIUM HIGH
Sodium	• No high-salt foods (>200 mg sodium per snack item or >480 mg sodium per entrée) • No salt added at table	HIGH MEDIUM
Meal and Snack Patterns	• ≥1 meal and 1 snack for care <8 hours • ≥2 meals and 2 snacks for care ≥8 hours • Meals and snacks offered every 2-3 hours at regularly scheduled times • No eating between scheduled meals and snacks, except for water • A variety of culturally relevant items are offered	MEDIUM MEDIUM MEDIUM LOW MEDIUM

Table 3. NUTRITIONALLY IDEAL PRACTICES FOR FAMILY CHILD CARE: CHILDREN		
Scientific Advisory Nutrition Recommendations for 1- to 18-Year-Olds		**Impact**
	• Offer only snack foods that are nutritionally equivalent to meal foods	MEDIUM
Healthy Feeding Practices	• Meals and snacks are served family style; providers teach children to serve themselves age-appropriate portion sizes with assistance as needed	MEDIUM
	• Use dishware and utensil that are sized age appropriately	MEDIUM
	• At least one childcare provider sits with children at table and eats same meals and snacks	MEDIUM
	• Provider models healthy eating and doesn't consume other items in front of children	MEDIUM
	• Allow enough time to eat	MEDIUM
	• Distractions are minimized while eating (e.g., TV, toys, phones, video games)	MEDIUM
	• Foods and beverages are not used as reward or punishment	MEDIUM
	• No pressure to eat or to clean plate; mealtime conversation does not focus on the amount of food that is or isn't eaten	MEDIUM
	• Children are asked if they are full before removing plates and asked if they are hungry before serving seconds	MEDIUM
	• Young children expected to: eat a lot some meals and very little at others; not eat everything that's offered; change likes/dislikes; be messy; take months or years to accept new foods	MEDIUM
	• Snack foods are nutritionally equivalent to meal foods	MEDIUM
Foods Outside of Meals or Snacks	• Offer non-food items at celebrations and fundraisers	MEDIUM
	• When food is provided at celebrations or fundraisers, serve only healthy items, such as fruit, vegetables, and water	MEDIUM

Table 4. List of California Family Child Care Advisors		
Name	**Organization**	**Position**
Kula Koenig	American Heart Association	Government Relations
Barbara Terrell	California Association for Family Child Care; Family Child Care Provider	President; Family Child Care Provider
Domenica Benitez	California Child Care Resource and Referral Network	Provider Services Manager
Nina Buthee	California Child Development Administrators Association	Executive Director
Kelley Knapp	California Department of Education, Nutrition Services Division	Nutrition Education Consultant
Aaron Ross	California Department of Social Services, Child Care Licensing Program	Child Care Program Licensing
Natalie Dunaway	California Department of Social Services, Child Care Licensing Program	Child Care Advocate – Northern CA
Shanice Boyette	California Department of Social Services, Child Care Licensing Program	Child Care Program Licensing
Debbie Zaragoza	Child Development Associates, Inc. / Child Care Food Program Roundtable	Nutrition Program Manager
Kate Miller	Children Now	Senior Associate, Early Childhood Policy
Paula James	Contra Costa Child Care Council, Child Health and Nutrition Program	Director
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Jacqueline Deader	FRAMAX / Child Care Food Program Roundtable	Administrative Director
Doris Fredericks	Healthy Living: Nutrition, Fitness, and Mindful Eating	Consultant
Nanette Rincon-Ksido	Service Employees International Union (SEIU)	External Organizing Director, SEIU Local 99
Bobbie Rose	UCSF School of Nursing	BSN, Child Care Consultant
Veronica Klinger	YMCA San Diego	Field Services

Table 5. POTENTIAL NUTRITION STANDARDS: INFANTS 0-12 MONTHS OLD		
Potential Standards Rated By Degree Of Difficulty For Family Child Care Providers		**Rating**
Fruits	• Offer unsweetened soft, mashed, or pureed fruits to infants 6-12 months old	EASY
	• Fruit may be fresh, frozen, or canned in water with no added sugars	EASY
	• No 100% juice, juice drinks or other beverages are served	MEDIUM
Vegetables	• Offer soft, mashed or pureed vegetables to infants 6-12 months old	EASY
	• Vegetables may be fresh, frozen or canned, with no added sugars, salt or fat	EASY
Protein Foods	• 6-12 month old infants may be served protein foods, such as soft cooked egg yolks, beans, meat, poultry, and fish without bones	EASY
	• Salt is not added to any protein foods	MEDIUM
Breastmilk, Formula, and Water	• Breastfeeding is supported and encouraged	EASY
	• Infants must be given only breastmilk and/or iron-fortified infant formula	EASY
	• No cow's milk offered under one year, unless ordered by a physician	EASY
	• Breastmilk and formula are the best sources of water for at least the first six months	MEDIUM
	• At 6-9 months, infants begin using a cup for drinking water	MEDIUM
Introduction of Solids	• At 6 months, introduce developmentally appropriate solid foods in age-appropriate portion sizes	MEDIUM
	• At 9 months, children begin self-feeding with finger foods and transition to table foods as developmentally appropriate	MEDIUM
Breastfeeding Promotion	• A private area (not a bathroom) with a chair and an electrical outlet for breastfeeding or pumping is made available	DIFFICULT
	• Adequate refrigerator/storage space is provided for breastmilk	MEDIUM
Healthy Feeding Practices	• Infants held in one's arms or sitting up on one's lap while bottle feeding	MEDIUM
	• Bottles are never propped; infants are not allowed to carry, sleep, or rest with a bottle	MEDIUM
	• No solid food and no beverages other than breastmilk or infant formula in bottles	EASY
	• Younger infants are breast or bottle fed on demand by provider recognizing feeding cues (e.g., rooting, sucking)	MEDIUM
	• Infants are guided by own feelings of hunger and satiety; not pressured to eat all that is offered	MEDIUM
	• Solid foods are offered at regular meal and snack times	MEDIUM
	• Older infants included in family style meals, as developmentally appropriate,, where provider and infant eat together	MEDIUM
	• Older infants self-feed with their fingers and drink from a cup with assistance	EASY
	• Foods are safe to eat (e.g., avoid choking by cutting grapes into smaller pieces)	EASY
	• Minimize distractions at mealtime (TV, toys, phones, video games, etc.)	MEDIUM

Table 6. POTENTIAL NUTRITION STANDARDS: CHILDREN 1-18 YEARS OLD		
Potential Standards Rated By Degree Of Difficulty For Family Child Care Providers		**Rating**
Fruit Juice and Water	• Water is easily available for self-serve indoors and outdoors, including at meals and snacks	EASY
	• 100% fruit juice is rarely or never offered	EASY
	• Offer no more than one age-appropriate serving of 100% juice per day	MEDIUM
Fruit	• Fruit is offered ≥2 times per day	EASY
	• Fruit may be fresh, frozen, or canned in water with no added sugars	EASY
Vegetables	• Vegetables are offered ≥2 times per day	MEDIUM
	• Dark green, orange, red, or deep yellow veggies are served > 1 time per day	MEDIUM
	• Offer no deep fried or pre-fried baked vegetables	MEDIUM
Grains	• 100% whole grains are offered ≥2 times per day	DIFFICULT
	• Offer no white (non-whole) grains or grain-based desserts (e.g., cake, cookies, pie, pastries)	MEDIUM
	• Only offer breakfast cereals that are WIC approved (≤6 g sugar per oz, ≥28 mg iron per 100 mg)	DIFFICULT
Protein Foods	• Offer two age-appropriate servings of protein per day (seafood, fish, lean meat, poultry, eggs, beans, peas, soy products, tofu, unsalted nuts/seeds)	EASY
	• Offer no processed meats and no deep-fried or pre-fried meats or fish	MEDIUM
Dairy	• For 12-24 months old children, offer 1 cup per day of unflavored whole milk	MEDIUM
	• For children >24 months old, offer 2 cups per day of unflavored fat-free or 1% milk	MEDIUM
	• Non-dairy milk substitutions (e.g. soy milk) must be nutritionally equivalent to milk	MEDIUM
	• Sugar in yogurt is limited to <20 gram/cup	MEDIUM
Fats, Sweeteners, and Sodium	• Use liquid, non-tropical vegetable oils instead of solid fats	MEDIUM
	• Offer foods high in added sugar (sugar listed as the first or second ingredient)	MEDIUM
	• Offer no low-calorie sweeteners (e.g., diet foods or beverages)	MEDIUM
	• Serve no sugar-sweetened beverages	MEDIUM
	• Do not serve high-salt foods (>200 mg sodium per snack item or >480 mg sodium per entrée)	MEDIUM
	• No salt added at table	MEDIUM
Healthy Feeding Practices	• Children are offered ≥1 meal and 1 snack for care <8 hours	MEDIUM
	• Children are offered ≥2 meals and 2 snacks for care ≥8 hours	MEDIUM
	• Meals and snacks are offered every 2-3 hours at regularly scheduled times	MEDIUM
	• No eating between scheduled meals and snacks, except for water	DIFFICULT
	• A variety of culturally relevant items are offered	MEDIUM
	• Meals and snacks are served family style; providers teach children to serve themselves age-appropriate portion sizes with assistance as needed	MEDIUM
	• Use dishware and utensils in age-appropriate sizes	EASY
	• At least one childcare provider sits with children at table and eats same food	MEDIUM
	• Provider models healthy eating and doesn't consume other items in front of	MEDIUM

Table 6. POTENTIAL NUTRITION STANDARDS: CHILDREN 1-18 YEARS OLD		
Potential Standards Rated By Degree Of Difficulty For Family Child Care Providers		**Rating**
	children	
	• Allows enough time to eat	EASY
	• Minimize distractions while eating (TV, toys, phones, etc.)	MEDIUM
	• Foods and beverages are not used as reward or punishment	EASY
	• No pressure to eat or clean plate; mealtime conversation is not focused on what or how much is eaten	EASY
	• Children are asked if they are full before removing plates and asked if they are hungry before serving seconds	EASY
	• Acknowledge that young children eat a lot some meals and little at others; do not eat everything offered; change likes/dislikes; are messy; and take time to accept new foods	MEDIUM
	• Offer non-food items at celebrations and fundraisers	DIFFICULT
	• When food is provided at celebrations, only offer healthy items, such as fruit, vegetables, and water	MEDIUM

Table 7. Nutrition Standards Pilot Testing Tiers		
Difficulty of Implementation	**Nutritional Impact**	**Tier**
Easy	High	1
Easy	Medium	1
Medium	High	1
Medium	Medium	2
Difficult	High	2
Easy	Low	3
Medium	Low	3
Difficult	Medium	3
Difficult	Low	4

TABLE 1: Infants 1-12 Months
Nutrition Standards to Pilot Test

Nutrition standard tiers based on both nutritional impact and feasibility of implementation:
Tier 1: [high or medium nutritional impact] & [easy or medium difficulty of implementation]
Tier 2: [high or medium nutritional impact] & [medium difficulty of implementation]
Tier 3: [low or medium nutritional impact)] & [difficult implementation]

	TIER 1	TIER 2	TIER 3
VEGETABLES	• Offer pureed, mashed or whole vegetables for infants 6 through 11 months.[2] • Vegetables can be fresh, frozen or canned (all with no added salt,[2] fat, or sugar) for infants 6 through 11 months.		
FRUIT	• Offer unsweetened whole, mashed, or pureed fruits to infants 6 through 11 months.[3] • Fruit can be fresh, frozen, or canned (all with no added sugars) for infants 6 through 11 months.		
PROTEIN	• Offer proteins such as soft cooked egg, beans, meat, poultry, and fish without bones for infants 6 through 11 months.[2,3,13]	For infants 6 through 11 months: • Serve protein foods with no added salt.[2] • Offer natural cheese[5] no more than 1-2 times per day; choose low-fat or reduced-fat cheeses; do not serve cheese food/spread.[13] • Offer yogurt ≤ 1 time per day, must have <23 grams sugar per 6 oz.[13]	
GRAINS	• Offer iron-fortified infant cereals for infants 6 through 11 months.[6]		
BREAST-FEEDING AND OTHER BEVERAGES	• Offer only breast milk and/or iron-fortified infant formula for infants 0 through 11 months.[5] • No cow's milk, unless a doctor's note.[2] • Do not serve 100% juice, juice drinks or other beverages.[1,3] • Support and encourage breastfeeding.[1-4]	• While breast milk and formula are the best sources of water, at 6-9 months begin using a cup for additional drinking water.[8]	• Ensure access to a private area (not a bathroom) with a chair and an electrical outlet available for breastfeeding or pumping.[2,4]
INTRODUCING SOLID FOODS	• At about 6 months, introduce developmentally appropriate solid foods in age-approproate portion sizes.[3,5] • Start with iron-fortified infant cereal or pureed meats, and then pureed vegetables and fruits, and then other protein-rich foods.[6,12] • Introduce foods gradually, one at a time, and wait for at least 3 to 5 days, watch for allergic reactions such as diarrhea, rash or vomiting.[6,12] • At 9 months, begin self-feeding with finger foods then transition to foods served at the table as developmentally appropriate.[6] • Encourage older infants to self-feed with their fingers and drink from a cup with assistance.	• Offer solid foods at regular meal and snack times for infants 6 through 11 months.	

*NOTE: These standards are NOT REQUIRED for licensed family child care providers and are NOT the new CACFP nutrition standards. These standards will be pilot tested prior to October 1, 2017 when CACFP providers are required to comply with the new CACFP nutrition standards.

TABLE 2: Children 1 Nutrition Standards to Pilot Test

Nutrition standard tiers based on both nutritional impact and feasibility of implementation:
Tier 1: [high or medium nutritional impact] & [easy or medium difficulty of implementation]
Tier 2: [high or medium nutritional impact] & [medium difficulty of implementation]
Tier 3: [low or medium nutritional impact)] & [difficult implementation]

	TIER 1	TIER 2	TIER 3
VEGETABLES	• Offer vegetables ≥ 2 times per day.[4] • Do not serve deep fried or pre-fried baked vegetables.	• Offer dark green, orange, red, or deep yellow vegetables served ≥ 1 time per day.[4]	
FRUIT	• Offer fruit ≥ 2 times per day.[4] • Offer only fruit that is fresh, frozen, or canned fruit in water (all with no added sugars).[4,9,10]		
PROTEIN	• Do not serve processed meats or deep-fried or pre-fried meats or fish.[3,4] • Offer lean protein ≥ 2 times per day, such as seafood, fish, lean meat, poultry, eggs, beans, peas, soy products, tofu, unsalted nuts/seeds.	• Offer yogurt ≤ 1 time per day, must have <23 grams sugar per 6oz.[5,13] • Offer natural cheese[5] no more than 1-2 times per day; choose low-fat or reduced-fat cheeses; do not serve cheese food/spread.[13]	
GRAINS		• Do not serve white (non-whole) grains or grain-based desserts (e.g. cake, cookies, pie, pastries, donuts).[1]	• Offer only cereals that are WIC approved breakfast cereals (≤6 g sugar per dry ounce and ≥28 mg iron per 100 mg).[5] • Offer 100% whole grains ≥ 2 times per day.[1]
BEVERAGES	• Do not serve sugar-sweetened beverages.[5,6] • Rarely or never offer 100% fruit juice.[3] • When offered, give no more than one age-appropriate serving of 100% fruit juice per day.[2] • Ensure that water is easily available for self-serve indoors and outdoors and actively offered with meals and snacks and at other times as appropriate.[2-4,9]	• For children 12-24 months old offer unflavored whole milk ≥ 2 times per day.[11,13] • For children >24 months old offer unflavored fat-free or 1% milk ≥ 2 times per day.[3,10] • Offer only non-dairy milk substitutions (e.g. soy milk) that are nutritionally equivalent to milk.[5]	
SUGAR AND SODIUM	• Do not serve foods with added sugar or sugar equivalents (e.g. high fructose corn syrup, fructose, corn syrup, cane sugar, evaporated cane juice, sucrose, etc.) listed as the first or second ingredients or having a combination of 3 or more kinds of sugar/sugar equivalents.	• Do not serve low calorie sweeteners or items containing low-calorie sweeteners (e.g., diet foods or diet beverages).[6] • Do not serve high salt foods (>200 mg sodium per snack item or >480 mg sodium per entrée). • Do not add salt at the table.	

*NOTE: These standards are NOT REQUIRED for licensed family child care providers and are NOT the new CACFP nutrition standards. These standards will be pilot tested prior to October 1, 2017 when CACFP providers are required to comply with the new CACFP nutrition standards.

TABLE 3: Healthy Practices Nutrition Standards to Pilot Test

Nutrition standard tiers based on both nutritional impact and feasibility of implementation:
Tier 1: [high or medium nutritional impact] & [easy or medium difficulty of implementation]
Tier 2: [high or medium nutritional impact] & [medium difficulty of implementation]
Tier 3: [low or medium nutritional impact)] & [difficult implementation]

	TIER 1	TIER 2	TIER 3
INFANTS 0 THROUGH 11 MONTHS	• Avoid choking hazards (e.g., by cutting grapes into smaller pieces).[6] • Ensure that infants are guided by own feelings of hunger and satiety and are not pressured to eat all that is offered.[6] • Feed younger infants on demand by recognizing feeding cues (e.g., rooting, sucking).[7] • Provide adequate refrigerator/storage space for breastmilk.[2] • Do not serve solid food and no beverages other than breast milk or iron-fortified infant formula in bottle.[6]	• Include older infants at family style meals where provider and children eat together. • Minimize distractions at mealtime (e.g., no TV, toys, phones, video games).[4] • Hold infant in one's arms or sitting up in one one's lap while bottle feeding.[3] • Never prop bottles; do not allow infants to carry, sleep, or rest with bottle.[3]	
CHILDREN 1 YEAR AND OLDER	• Use dishware and utensils that are sized appropriately.[3] • Allow enough time to eat.[2] • Do not use foods or beverages as reward or punishment.[4] • Do not pressure to eat or clean plate; mealtime conversation should not focus on the amount of food that is or isn't eaten.[4]	• Ask children if they are full before removing plates and ask if they are hungry before serving seconds.[4] • Use only liquid non-tropical vegetable oils instead of solid fats.[3,9] • Offer ≥ 1 meal and 1 snack for care < 8 hours.[10] • Offer ≥ 2 meals and 2 snacks for care ≥ 8 hours.[10] • Provide meals and snacks every 2-3 hours at regularly scheduled times.[10] • Offer a variety of culturally-relevant items. • Serve meals and snacks family style; providers teach children to serve themselves age-appropriate portion sizes with assistance as needed.[4] • At least one child care provider sits with children at table and eats same meals and snacks.[2,4] • Provider models healthy eating and doesn't consume other items in front of children.[4,10] • Minimize distractions while eating (e.g., no TV, toys, phones, video games).[4] • Expect young children to: eat a lot some meals and very little at others; expect children to not eat everything offered; change likes/dislikes; be messy; take months or years to accept new foods.[2,4] • When food is provided at celebrations or fundraisers offer only healthy items, such as fruit, vegetables and water.[2,4]	• Offer non-foods at celebrations and fundraisers.[2,4]

*NOTE: These standards are NOT REQUIRED for licensed family child care providers and are NOT the new CACFP nutrition standards. These standards will be pilot tested prior to October 1, 2017 when CACFP providers are required to comply with the new CACFP nutrition standards.

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Table 10. Intervention Design Proposal Feedback	
Study Design	Experimental study with a pre-post design with no randomization or control group.
Target Population	Licensed FCCH provider
Setting	Licensed FCCH in CA, FCCHs that include children with CACFP and non- CACFP subsidies. Workshops can be provided at local Resource and Referral Agency
Sample size	A minimum of 30 FCCH providers will participate in the pilot study
Intervention	There are several possible designs for the intervention: (1) train the trainer model (2) train the FCCH provider in a group or individual setting (3) Educational workshop with follow-up technical assistance on-site with goal setting, action plan, monitor progress, and self-evaluation.
Mode of administration	(1) in-person workshops, (2) on-line training with or without videos or interactive components, (3) additional materials provided online, in-person, video for parents and children
Length of intervention	The educational component of the intervention is provided once and the follow-up can be immediately after the workshop (pre- and post) along with a longer follow-up 3-6 months after the workshop
Intensity	The educational component will be 1-2 hours. The TA onsite visits would be 15-20 minutes and other follow-up by email or phone would be 5 minutes/ per encounter
Literacy Level	Check all written materials with Flesh-Kincaid to be at the 5th-6th grade level (per WIC).
Cultural Considerations	The educational materials should address food preferences that differ based on culture, religion, medical condition and individual needs.

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