

# Developing Evidence-Based and Actionable Nutrition Standards for Family Child Care Settings

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## Abstract

The purpose of this study was to develop nutritionally ideal standards for family child care settings, and refine those standards to be practicable for family child care providers. Science advisors developed a comprehensive set of ideal nutrition standards for infants (0-1 years) and children (>1 years). The nutrition standards were synthesized based on evidence-based impact by science advisors and feasible recommendations by practice-based advisors into a set of family child care nutrition standards that are realistic and impactful on nutritional health. Future research is needed to determine which nutrition standards are most important for obesity prevention in family child care.



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## Introduction

In the U.S. approximately one in every four children is obese or overweight before entering kindergarten,<sup>1</sup> a condition likely to carry into adolescence and adulthood. The consequences of this condition include increased risk of diabetes and heart disease, with severe ramifications for both the individual and for the state and federal budgets which collectively end up paying an estimated \$400 billion per year in healthcare and related costs.<sup>2</sup> The best public health intervention is the earliest intervention, while food habits and preferences are being established and while obesity may still be prevented.

Licensed child care is among the best settings for such an obesity-prevention intervention;<sup>3</sup> nearly seven million young children (out of a total population of more than 20 million) are in organized child care (as opposed to informal care with family, friends, and neighbors).<sup>4</sup> Many of these young children attend child care, where they consume much of their daily nutrition,<sup>4</sup> for a long day that matches their parents' employment. Licensed facilities can vary from small, family day care homes with a single provider and a few children, to large preschools with a director, multiple teachers, and several hundred children.

Approximately 3.3 million U.S. children go to qualifying child care facilities that participate in the Child and Adult Care Food Program (CACFP) where meals and snacks are regulated by federal nutrition standards, and site training is provided.<sup>5</sup> The United States Department of Agriculture (USDA) has released proposed regulations to better align the CACFP meal pattern with the *Dietary Guidelines for Americans*,<sup>6</sup> principally by increasing fruits, vegetables, and whole grains, and decreasing fat and sugar.<sup>7</sup> Once these proposed regulations are made final and implemented, they are likely to have the largest impact on the daily nutrition and weight status of young children of any single child care nutrition policy change since CACFP's introduction.<sup>8</sup> Of note, currently the *Dietary Guidelines for Americans* apply only to children 2 years and older; it is not until 2020 that the Guidelines are expected to address the nutritional needs of children 0 to 2 years old.<sup>9</sup>

The new meal pattern will not reach licensed child care homes in California that do not participate in CACFP – nor are there any other nutrition requirements or policies to which these homes are subject, except for California's Healthy Beverages in Child Care Law (AB 2084). California is one of 13 states that do not have state-level nutrition policies for family child care homes.<sup>10</sup> This is the population for which nutrition standards are needed – children in licensed homes not participating in CACFP. Family child care providers are uniquely structured to serve the needs of low-income working parents because of their close proximity and longer hours of service available. In 2012, there were about 33,365 family child care homes in California (~52 percent of which do not participate in CACFP),<sup>11</sup> and they have the capacity to serve 335,719 children.<sup>12</sup> In a 2012 California survey of 429 child care providers, CACFP sites and Head Start centers served more fruits, vegetables, milk, and meat/meat alternatives, and fewer sweetened beverages and other sweets and snack-type items than non-CACFP sites. Reported barriers to providing nutritious foods included high food costs and lack of training.<sup>13</sup> Further, more than 20 percent of California's children live in households that are in poverty, for which healthy food may be prohibitively expensive or difficult to access; for these children the nutritional quality of the meals and snacks they consume in child care is especially critical to their health and development.

Developing nutrition standards that are both evidence-based and feasible for this population is an important first step toward laying the groundwork for improving the nutrition landscape of family child care homes in California and in other states that lack nutrition

standards for family child care homes not participating in CACFP. Therefore, the goals of this project were to first develop evidence-based nutrition standards for the children served by family child care homes, and then refine those standards so that they would be actionable and achievable for family child care providers.

### **Scientific Advisory Process**

The Nutrition Policy Institute (NPI) at the University of California's Division of Agriculture and Natural Resources (UC ANR) and California Food Policy Advocates (CFPA) worked together to first convene a group of Science Advisors and then a group of Community Advisors.

Science Advisors (**Table 1**) were selected based on their expertise in nutrition and obesity prevention for children and in child care and included scientists from across the country. They were tasked with developing a comprehensive set of evidence-based nutrition recommendations for infants (0- <1 year of age) and children (1-18 years of age). Age groups were selected to be consistent with the proposed CACFP age groups.<sup>7</sup> Science advisors were asked not to include practical considerations of family child care homes in the deliberations, but focus on standards optimal for child nutrition and obesity prevention.

First, current child care standards and guidelines were selected from authoritative bodies that developed nutrition standards in child care settings. These included the current and proposed CACFP standards;<sup>7,14</sup> Academy of Nutrition and Dietetics;<sup>15</sup> Nutrition And Physical Activity Self Assessment for Child Care (NAP SACC) Best Practices;<sup>16</sup> Institute of Medicine;<sup>6</sup> Dietary Guidelines for Americans;<sup>17</sup> American Academy of Pediatrics, American Public Health Association and National Resource Center for Health and Safety in Child Care and Early Education's Caring for Our Children;<sup>18</sup> and Nemours.<sup>19</sup> Recommendations on *what* foods and beverages should be offered (dietary intake) as well as *how* the recommended foods and beverages should be offered (feeding practices) were identified.

The guidelines were tabulated by each expert body and organized by food groups (e.g., fruit juice, other fruit, vegetable) or other feeding practices (e.g., supporting healthy eating). There were 25 infant feeding practices and 173 child feeding practices identified. To help expedite the process, NPI highlighted the most comprehensive nutrition recommendations for each food group or feeding practice prior to the meeting. Using a Delphi process, group consensus was reached among the Science Advisors by discussing each highlighted standard and identifying additions, deletions, or revisions. After the completion of this group consensus process, each Science Advisor independently ranked each nutrition standard according to potential impact (high, medium, low) on child nutrition, obesity, and health. The Science Advisor rankings were compiled into three groups according to the following criteria:

- High impact:  $\geq 70\%$  ranked high impact and no low impact;
- Medium impact: mixed responses in between high and low;
- Low impact:  $\geq 30\%$  ranked low impact and no high impact; or  $> 50\%$  ranked low impact.

### **Community Advisory Process**

A separate group of Community Advisors (**Table 2**) was convened to review the final set of nutrition standards compiled by the Science Advisors. The Community Advisors included representation from child care advocates, CACFP sponsors, and family child care provider representatives (unions, resource and referral networks).

The primary goal of this group was to critically review the Science Advisors' evidence-based nutrition standards and come to a consensus about which could be applied without jeopardizing the solvency and operation of family child care homes. The group deliberated collectively and then independently rated each standard for ease of implementation (easy, medium, or difficult) taking into account the typical needs and resources of family child care settings.

The Community Advisor rankings were grouped as follows:

- Difficult:  $\geq 70\%$  rated difficult and no easy responses;
- Medium: other mixed responses in between high and low;
- Easy:  $\geq 30\%$  rated easy and no difficulty OR  $> 50\%$  rated easy responses.

The nutrition standards were then grouped into tiers based on both impact and feasibility of implementation: Tier 1 (high/easy, medium/easy, or high/medium); Tier 2 (medium/medium or high/difficult); Tier 3 (low/easy, low/medium, or medium/difficult); and Tier 4 (low/difficult). The tiers were included to provide implementation options to researchers, as well as those that implement programs for family child care providers and for policy-makers. The final nutrition standards for infants and for children are displayed in **Table 3** and **Table 4**, respectively.

### **Implications for Research and Practice**

The nutrition standards developed by a Delphi process involving both scientific experts and community-based advisors have the potential to impact children in licensed family child care homes in California and in other states without standards. These standards could be tested in an intervention trial to assess both the feasibility for providers and the impact on child nutrition and, over time, child obesity. A number of communities that are focused on improving early childhood nutrition may welcome the opportunity to voluntarily implement the developed standards. The recommended standards may also inspire quality indicator-focused child care leaders to incorporate the science- and practice-based nutrition standards into their own efforts. Further, the standards could be used to inform the establishment of a statewide nutrition standards policy tied to child care licensing or through training and technical assistance for providers.

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<b>Table 1. List of Science Advisors<sup>1</sup></b>		
<b>Name</b>	<b>Title and Affiliation</b>	<b>Expertise</b>
Karen Cullen, DrPH	Professor, Pediatrics-Nutrition, Baylor College of Medicine	Maternal and child nutrition, WIC
Jane Heinig, PhD	Academic Administrator, Department of Nutrition Director & International Board Certified Lactation Consultant, Human Lactation Center, University of California, Davis	Maternal and child nutrition
Kathryn Henderson, PhD	Independent Consultant (formerly Director of School and Community Initiatives and Associate Scientist at the Rudd Center for Food Policy and Obesity at Yale University)	Child obesity prevention
Donna Johnson, PhD	Professor, Health Services, University of Washington	Public health nutrition, child obesity prevention
Susie Nanney, PhD, MPH, RD	Associate Professor, Dept. of Family Medicine & Community Health, University of Minneapolis	Obesity prevention in community settings, health disparities, nutrition policy
Sara Benjamin Neelon, PhD, MPH, RD	Associate Professor, Health Behavior and Society, John Hopkins University	Child nutrition, child care nutrition
Angela Odoms-Young, PhD	Associate Professor, Kinesiology and Nutrition University of Illinois at Chicago	Child obesity prevention, community-based participatory research, health equity
Dianne Stanton Ward, EdD	Professor, Nutrition, University of North Carolina at Chapel Hill	Child obesity prevention, child care nutrition
Mary Story, PhD, RD	Professor, Community & Family Medicine and Global Health Associate Director for Academic Programs, Duke University	Child nutrition and childhood obesity prevention
Elsie Taveras, MD, MPH	Chief, Division of General Academic Pediatrics, Department of Pediatrics Director, Pediatric Population Health Management Mass General Hospital <i>for</i> Children Associate Professor of Pediatrics, Harvard Medical School Associate Professor of Nutrition, Harvard School of Public Health	Child obesity prevention and treatment
Shannon E. Whaley, PhD	Director of Research and Evaluation, Public Health Foundation Enterprises-WIC	Child development and nutrition, WIC

<sup>1</sup>All Science Advisors have given permission to have their names included.

<b>Table 2. List of Community Advisors<sup>1</sup></b>		
<b>Name</b>	<b>Organization</b>	<b>Position</b>
Shanice Boyette	California Department of Social Services, Child Care Licensing Program	Child Care Program Licensing
Aaron Ross	California Department of Social Services, Child Care Licensing Program	Child Care Program Licensing
Kelley Knapp	California Department of Education, Nutrition Services Division	Nutrition Education Consultant
Nina Buthee	California Child Development Administrators Association	Executive Director
Domenica Benitez	California Child Care Resource and Referral Network	Provider Services Manager
Barbara Terrell	California Association for Family Child Care	President
Kula Koenig	American Heart Association	Government Relations
Kate Miller	Children Now	Senior Associate, Early Childhood Policy
Jacqueline Deader	FRAMAX / Child Care Food Program Roundtable	Administrative Director
Debbie Zaragoza	Child Development Associates, Inc. / Child Care Food Program Roundtable	Nutrition Program Manager
Karen Farley	California WIC Association	Executive Director
Tonia McMillian	Family Child Care Provider	Family Child Care Provider
Roseanne Galli-Adams	Family Child Care Provider	Family Child Care Provider
Nanette Rincon-Ksido	Service Employees International Union (SEIU)	External Organizing Director, SEIU Local 99
Bobbie Rose	UCSF School of Nursing, California Childcare Health Program	BSN, Child Care Consultant
Paula James	Contra Costa Child Care Council, Child Health and Nutrition Program	Director, Child Health and Nutrition Program
Veronica Klinger	YMCA San Diego	Field Services
Natalie Dunaway	California Department of Social Services, Child Care Licensing Program	Child Care Advocate-Northern CA
Doris Fredericks	Healthy Living: Nutrition, Fitness and Mindful Eating	Consultant

<sup>1</sup>All Community Advisors have given permission to have their names included.



**Table 3. Family Child Care Home Nutrition Standards: Infants up to 12 months<sup>a</sup>**

<b>Tier 1</b>
Breastfeeding supported and encouraged <sup>1-4</sup>
Adequate refrigerator/storage space for breastmilk <sup>2</sup>
Offer only breast milk and/or iron-fortified infant formula for infants 0-12 months old <sup>5</sup>
No cow's milk, unless doctor's note <sup>2</sup>
No 100% juice, juice drinks or other beverages <sup>1,3</sup>
No solid food and no beverages other than breastmilk or iron-fortified infant formula in bottle <sup>6</sup>
At 6 months old, introduce developmentally appropriate solid foods in age-appropriate portion sizes <sup>3,5</sup>
Introduce foods gradually, one at the time, and wait for at least 2 to 3 days, watch for allergic reactions such as diarrhea, rash or vomiting <sup>6</sup>
Start with iron fortified-infant cereal, and then pureed vegetables and fruits, and then protein-rich foods <sup>6</sup>
At 9 months old, begin self-feeding with finger foods and transition to foods served at the table as developmentally appropriate <sup>6</sup>
For infants 6-12 months old:
Offer iron-fortified infant cereals <sup>6</sup>
Offer pureed, mashed or whole vegetables <sup>2</sup>
Vegetables can be fresh, frozen or canned (all with no added salt, <sup>2</sup> fat, or sugar)
Offer unsweetened whole, mashed, or pureed fruits to infants <sup>3</sup>
Fruit can be fresh, frozen, or canned (all with no added sugars)
Serve proteins such as soft cooked egg yolks, beans, meat, poultry, and fish without bones <sup>2,3</sup>
Avoid choking hazards (e.g., by cutting grapes into smaller pieces) <sup>6</sup>
Younger infants are fed on demand by provider recognizing feeding cues (e.g., rooting, sucking) <sup>7</sup>
Infants are guided by own feelings of hunger and satiety; not pressured to eat all that is offered <sup>6</sup>
Older infants self-feed with their fingers and drink from a cup with assistance
<b>Tier 2</b>
Breast milk and iron-fortified formula best sources of water
Infants held in one's arms or sitting up on one's lap while bottle feeding <sup>3</sup>
Bottles never propped; infants not allowed to carry, sleep, or rest with bottle <sup>3</sup>
At 6-9 months: begin using a cup for drinking water <sup>8</sup>
Protein foods are served with no added salt <sup>2</sup>
Solid foods offered at regular meal and snack times
Older infants are included at family style meals where provider and infant(s) eat together
Distractions are minimized at mealtime (e.g., no TV, toys, phones, video games) <sup>4</sup>
<b>Tier 3</b>
Ensure access to a private area (not a bathroom) with a chair and an electrical outlet available for breastfeeding or pumping <sup>2,4</sup>
<sup>a</sup> Nutrition standard tiers based on both impact and feasibility of implementation: Tier 1 (high/easy, medium/easy, or high/medium); Tier 2 (medium/medium or high/difficult); and Tier 3 (low/easy, low/medium, or medium/difficult).

**Table 4. Family Child Care Home Nutrition Standards: Children ages 1-18 years<sup>a</sup>****Tier 1**

Water is easily available for self-serve indoors and outdoors and actively offered with meals and snacks and at other times as appropriate<sup>2-4,9</sup>

100% fruit juice rarely or never offered<sup>2</sup>

100% fruit juice when offered, given no more than one age-appropriate serving 1 time per day<sup>2</sup>

Offer fruit  $\geq 2$  times per day<sup>4</sup>

Offer only fruit that is fresh, frozen, or canned fruit in water (all with no added sugars)<sup>4,9,10</sup>

Offer vegetables  $\geq 2$  times per day<sup>4</sup>

Do not offer deep fried or pre-fried baked vegetables

Offer lean protein  $\geq 2$  times per day, such as seafood, fish, lean meat, poultry, eggs, beans, peas, soy products, tofu, unsalted nuts/seeds

Do not offer processed meats or deep-fried or pre-fried meats or fish<sup>3,4</sup>

No foods with added sugar or sugar equivalents (e.g. high fructose corn syrup, fructose, corn syrup, can sugar, evaporated cane juice, sucrose, etc) listed as the first or second ingredients. No foods having a combination of 3 or more of sugar/sugar equivalents.

No sugar-sweetened beverages<sup>3,4</sup>

Use dishware and utensils that are sized appropriately<sup>3</sup>

Allow enough time to eat<sup>2</sup>

Foods and beverages not used as reward or punishment<sup>4</sup>

No pressure to eat or clean plate; mealtime conversation does not focus on the amount of food that is or isn't eaten<sup>4</sup>

**Tier 2**

Children are asked if they are full before removing plates and asked if they are hungry before serving seconds<sup>4</sup>

No high salt foods ( $>200$  mg sodium per snack item or  $>480$  mg sodium per entrée)

Dark green, orange, red, or deep yellow veggies served  $\geq 1$  time per day<sup>4</sup>

No white (non-whole) grains or grain-based desserts (e.g. cake, cookies, pie, pastries, donuts)<sup>1</sup>

For children 12-24 months old offer unflavored whole milk  $\geq 2$  times per day<sup>5,11</sup>

For children  $>24$  months old offer unflavored fat-free or 1% milk  $\geq 2$  times per day<sup>3,10</sup>

Offer only non-dairy milk substitutions (e.g. soy milk) that are nutritionally equivalent to milk<sup>5</sup>

Offer yogurt  $\leq 1$  time per day, must have  $<20$  grams sugar per cup<sup>5</sup>

Use only liquid non-tropical vegetable oils instead of solid fats<sup>3,9</sup>

No low calorie sweeteners or items containing low-calorie sweeteners (e.g. diet foods or diet beverages)<sup>6</sup>

No salt added at table

Offer natural cheese<sup>5</sup> no more than 1-2 times per day

$\geq 1$  meal and 1 snack offered for care  $< 8$  hours<sup>10</sup>

$\geq 2$  meals and 2 snacks offered for care  $\geq 8$  hours<sup>10</sup>

Meals and snacks every 2-3 hours at regularly scheduled times<sup>10</sup>

A variety of culturally-relevant items are offered

Meals and snacks served family style; providers teach children to serve themselves age-appropriate portion sizes with assistance as needed<sup>4</sup>

At least one child care provider sits with children at table and eats same meals and snacks<sup>2,4</sup>

Provider models healthy eating and doesn't consume other items in front of children<sup>4,10</sup>

Distractions are minimized while eating (e.g., no TV, toys, phones, video games)<sup>4</sup>

Young children expected to: eat a lot some meals and very little at others; not eat everything offered; change likes/dislikes; be messy; take months or years to accept new foods<sup>2,4</sup>

When food is provided at celebrations or fundraisers serve only healthy items, such as fruit, vegetables and water<sup>2,4</sup>

**Tier 3**

Offer only cereals that are WIC approved breakfast cereals ( $\leq 6$  g sugar per dry ounce and  $\geq 28$  mg iron per 100 mg)<sup>5</sup>

Offer non-foods at celebrations and fundraisers<sup>2,4</sup>

100% whole grains offered  $\geq 2$  times per day<sup>1</sup>

<sup>a</sup>Nutrition standard tiers based on both impact and feasibility of implementation: Tier 1 (high/easy, medium/easy, or high/medium); Tier 2 (medium/medium or high/difficult); and Tier 3 (low/easy, low/medium, or medium/difficult). An additional standard (No eating between scheduled meals and snacks, except for water) was included by the Science Advisory group but not included in Tiers 1-3 because it is not allowed by the California Department of Social Services.

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