Family Child Care Providers in Greater Minnesota:

Challenges and Innovations in Healthy Food Access

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Tomorrow's Table
food systems for a vibrant future

For the Center for Prevention at Blue Cross and Blue Shield of Minnesota
October 2014

Table of Contents

Executive Summary

Tomorrow's Table LLC contracted with the Center for Prevention at Blue Cross & Blue Shield of Minnesota to support the Center's planning effort around early childhood well-being. In particular, we focused on the issue of access to healthy foods among family child care providers in Greater Minnesota (i.e. those outside the seven county Metro Area), and more specifically, the identification of innovative models for connecting these providers with healthy food options.

We found that family providers in rural areas are highly reliant on supermarkets, and to a lesser extent on big box retailers, to meet the food needs of the children they serve. However, state-wide data shows that access to supermarkets is very uneven across the state and is particularly lacking in many communities in the Western and Northern portions of Minnesota.

In addition, participation in the federal Child and Adult Care Food Program (CACFP) is especially high among Minnesota's rural family providers (nearly 80%), making CACFP reimbursement practices an important driver in the economics of nutrition in these settings. The reimbursement rates for "Tier II" CACFP providers (i.e. those who do not qualify for higher reimbursements due to lower incomes or residence in low-income areas) have not kept pace with the rising cost of healthy options like fresh fruits and vegetables. Concerns abound that Tier II reimbursement rates, rising CACFP nutrition standards and other factors will contribute to family providers exiting the program, leaving their nutrition activities largely unregulated and unmonitored.

We also conducted a national scan of food access models, looking in depth at six chosen models from across the country. Of these, we found that two -- the large-scale purchasing alliance model and joint ordering with community institutions -- have the strongest potential for connecting family providers with a complete selection of healthy foods on a year-round basis at attractive prices.

Recommendations

We conclude this report with a set of recommendations to guide the Center's planning as it relates to rural family child providers. Major recommendations including the following:

1. **Learn from providers themselves:** Invest in additional research that draws directly on the knowledge and experience of rural family providers. This is essential for more fully understanding providers' perceptions about how well-served they are by existing food sources, the interplay between factors like food access, cost and convenience, the impact of CACFP reimbursement rates on food choices, and the attractiveness of various models for strengthening food access. Field representatives from CACFP sponsoring organizations could also be a valuable source of insight. Ground-truthing the degree to which new strategies could lead to actual behavior change by providers is key.

2. **Consider a policy-based intervention:** Consider developing a policy innovation strategy focused on CACFP meal reimbursement rates. The creation of a state-level child care reimbursement to supplement federal CACFP rates, particularly for Tier II providers, could potentially address a pervasive systems-level barrier. The Center could also explore the potential for updating current Child Care Licensing regulations (housed within the MN Department of Human Services) to incorporate support for healthier food environments in child care.

3. **Engage rural family providers in change efforts:** Weave efforts that mobilize rural family providers themselves directly into the Center's change strategy. This segment of the child care community is the least organized and the most under-represented of child care providers. As such, they could benefit from greater inclusion, while representing an under-tapped source of energy and potential capacity for policy efforts. While much effort has been directed thus far to childcare centers, BCBS could do a real service by committing to crack "the tougher nut" of rural family providers.

4. **Unpack the supermarket issue:** Given the predominant role of supermarkets in family providers' food purchases, work to more deeply understand providers' current and desired shopping patterns. Use that analysis to identify specific grocery-related strategies that could improve access to healthier choices, particularly in under-served areas.

5. **Consider an expansion of the Child Care Purchasing Alliance model**: Coordinate with the Child Care Purchasing Alliance in Wisconsin and participating distributors to explore a possible expansion of their group purchasing model into Minnesota.

6. **Pilot a program for joint food ordering with community institutions:** Engage motivated providers in priority communities and area nursing homes, hospitals, colleges, schools and/or Head Start centers that obtain more favorable wholesale pricing than family providers could obtain on their own. Test the model on a small scale, identify pros and cons, and hone it for broader replication.

7. **Collaborate with concerned institutions:** Given the considerable attention being paid to child care nutrition by various state agencies, community organizations and others in Minnesota, it will remain important to collaborate effectively with other actors in this field. This should include gathering input from key organizations as the Center formulates its strategic plan and making a concerted effort to leverage community assets and expertise when designing your implementation plans. Strive for more systemic strategies that can help take earlier efforts to a new level of impact.

A. Research Methodology

This project was begun when the Center for Prevention was mid-way through an effort to develop a five year strategic plan on early childhood wellbeing. As a part of this planning process, Early Childhood staff at the Center have completed an extensive array of research on best practices for creating healthier child care settings.

This project was designed to build on existing findings and address an area that had received relatively less attention – that of access to healthy foods for family child care providers in Greater Minnesota (i.e. those outside the seven county Metro Area) and particularly, the identification of models for connecting these types of providers with healthy food options.

We also sought to leverage available data about these providers' existing food purchasing patterns, the availability of food through retail outlets in Greater Minnesota, and the inter-relationships between factors such as the perceived cost of healthier foods, convenience in food preparation, and meal reimbursement rates under the Child and Adult Care Food Program (CACFP).

Research methodologies included the following:

- One-on-one interviews were conducted with 31 local and national stakeholders ranging from county public health coordinators, CACFP sponsors, the Centers for Disease Control (CDC), child care trade associations, representatives from the emergency food system, and organizations managing various food access initiatives around the country. A full list of interviewees and their contact information is provided in Appendix A.
- A web search was conducted to identify available research on food access and related issues among family child care providers. (See Appendix B for a list of relevant resources.)
- An outreach effort was made to identify relevant food access models around the U.S. This included internet research and requests through stakeholder interviews, the National Farm to Pre-K committee, the Comfood list-serve, and School Food FOCUS.
- Data gathering on historical CACFP reimbursement rates, Minnesota family provider participation in CACFP, and family providers' food-related practices and perceptions was aided by assistance from the USDA-Food and Nutrition Service, Providers Choice, and Dr. Marilyn S. "Susie" Nanney at the University of Minnesota, respectively.

B. The Context: A brief sketch of family child care providers in Greater Minnesota

In Minnesota, the majority of children in licensed care are in family child care home settings as opposed to center-based care. In 2012, 10,642 licensed family child care homes served over 82,000 Minnesota children [1]. This compares to a reported 962 centers serving 57,992 children. Of these licensed family child cares, 61% or nearly 6,500 are located outside the Twin Cities metro area. Legally unlicensed Family, Friends and Neighbor Providers also operate within the state although their numbers have not been documented in detail.

The context for family providers operating outside the Twin Cities metro area is typified by the following qualities:

- About 15% of Minnesota's children live in poverty. This includes 46% of African American children, 49% of American Indian children and 30% of Hispanics children. About 45% of all children living in poverty in Minnesota reside in Greater Minnesota. In 2010, more than 86,000 children in poverty lived outside of the seven county metro area.[2]
- In Minnesota, 80% of licensed family child care providers (nearly 8,500) participate in the Child and Adult Care Food Program (CACFP)[3]. This is much higher than the national average. Among other roles, the CACFP provides reimbursement for meals and snacks served to children receiving non-residential child care in private homes that are approved to provide family child care. CACFP also provides health and safety standards, training and monitoring support.
- Family child care providers, particularly in rural areas, are often quite isolated from one other given that their professional lives are centered in their homes. Also, the family child care sector is much less networked with fewer support systems and organizational infrastructure than child care centers such as Head Start, for-profit child care chains and other center-based child care platforms.
- As Minnesota's family child care providers serve an average of 7.7 children[4], food purchasing is similar to shopping for a large family in terms of the overall volume of food needed.
- Many nutrition-related capacity building initiatives in Minnesota have focused largely on centers, with less attention paid specifically to the unique needs of family providers. Nevertheless, there has been significant investment in recent years in nutrition-related training for providers and the development of a wide array of practical tools like recipes, menus and food budgeting tools focused on fresh fruits and vegetables and whole grains.
- Given the very high rate of CACFP participation among Minnesota's family providers, the CACFP sponsoring organizations are likely to have the closest on-going interaction with this segment of the child care community. This includes periodic trainings and site visits conducted by the sponsors' field representatives to each home three times per year.

As with child care providers across the nation, Minnesota's family providers are confronted by rising scrutiny from parents about the foods being served, new quality rating systems, and the advent of higher nutritional standards under the CACFP. Particularly given the risk that higher CACFP standards may spur some providers to leave the program, this is a critical juncture for understanding and addressing the challenges rural family providers face in expanding healthy food offerings to the children under their care.

C. Current Food Purchasing Practices for Rural Family Providers

As a prelude to exploring innovative food access models, we analyzed available data on how family providers outside the metro area currently obtain food.

In 2010, Dr. Susie Nanney and her team at the University of Minnesota surveyed child care providers across the state to gather their input on various nutrition and physical activity issues.[5] Her data reflects the most detailed available on a state-wide basis and provides a helpful window into such key issues as how providers currently purchase child care foods and the barriers they perceive in using healthier options. To support the analysis captured in this report for the Center for Prevention, Dr. Nanney also generated an additional break-down of the data focused specifically on survey responses from family providers in rural areas and small towns.[6]

That analysis revealed, for instance, that 99.5% of these respondents prepare child care food on-site in the home, with virtually no use of caterers, food from local school districts, child care centers or restaurants reported. This highlights the critical role of providers' individual shopping patterns in determining what foods are made available to the children they serve.

In response to the question, "Where do you get the food that is prepared for child care meals and snacks? Please check all that apply", rural/small town respondents gave the following feedback:

Supermarket / grocery store	96%
Bulk food store (e.g. Sam's Club, Costco)	57%
Farmer's Market	26%
On-site garden	25%
Food distributor	13%
Food assistance program	0%

Clearly, reliance on grocery stores is pervasive. Further, 57% of respondents purchase at bulk stores such as Sam's Club and Costco. This use of bulk stores was somewhat lower than anticipated by many child care leaders who were interviewed for this project. (Interestingly, the share of family providers using bulk stores was higher in the metro area than among rural/small town providers.)

A full quarter of responding providers obtain a portion of their food from farmers markets and on-site gardens provide. Thirteen percent of rural/small town respondents also say the obtain food from a "distributor" (although this term was not defined in the survey).

While this survey data gives us insight into where providers are obtaining food, it doesn't tell us what proportion of their food is coming from these sources. For instance, for providers that use both bulk stores and supermarkets, we don't know how much of their purchasing happens at each type of location or how this influences the types of foods they purchase. While use of farmers markets and on-site gardens is becoming more prevalent, it is likely that the portion of a provider's annual food supply coming from these sources is modest given seasonality challenges and the like.

We also don't know to what degree providers in Greater Minnesota might be availing themselves of home grocery delivery services. CobornDelivers and Schwan's are well known for their home delivery services. However, these services do have their limitations. For instance, CobornDelivers[7] offers a full range of fresh produce and grocery items, but their delivery range is limited to the Twin Cities and St. Cloud areas.

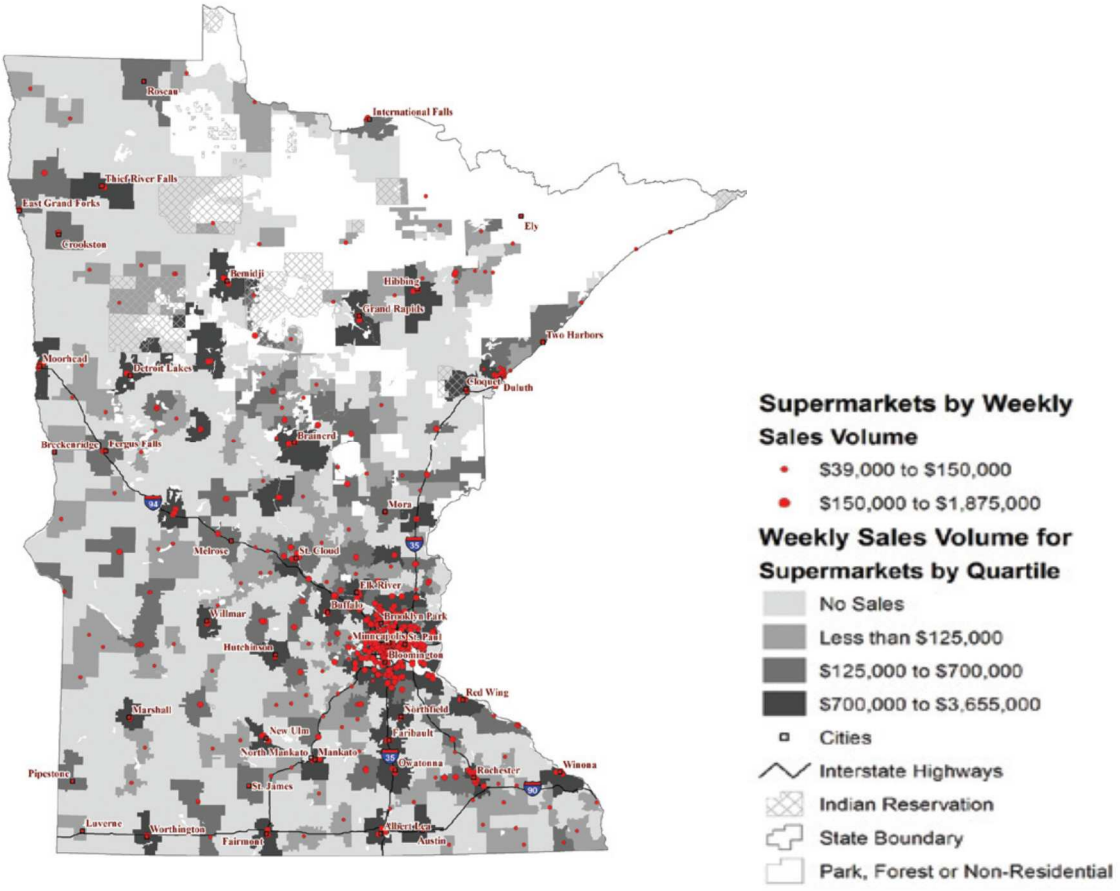
Schwan's[8] has a much greater geographic reach, whether through mail order or home delivery. However, products like frozen meat, prepared entrees, various starches, snacks and desserts are prominent among their offerings. They do offer a fairly extensive line of frozen vegetables and some frozen fruits.

Given that providers in Greater Minnesota are heavily reliant on supermarkets, we dig deeper into the issue of supermarket access below.

D. Access to Supermarkets

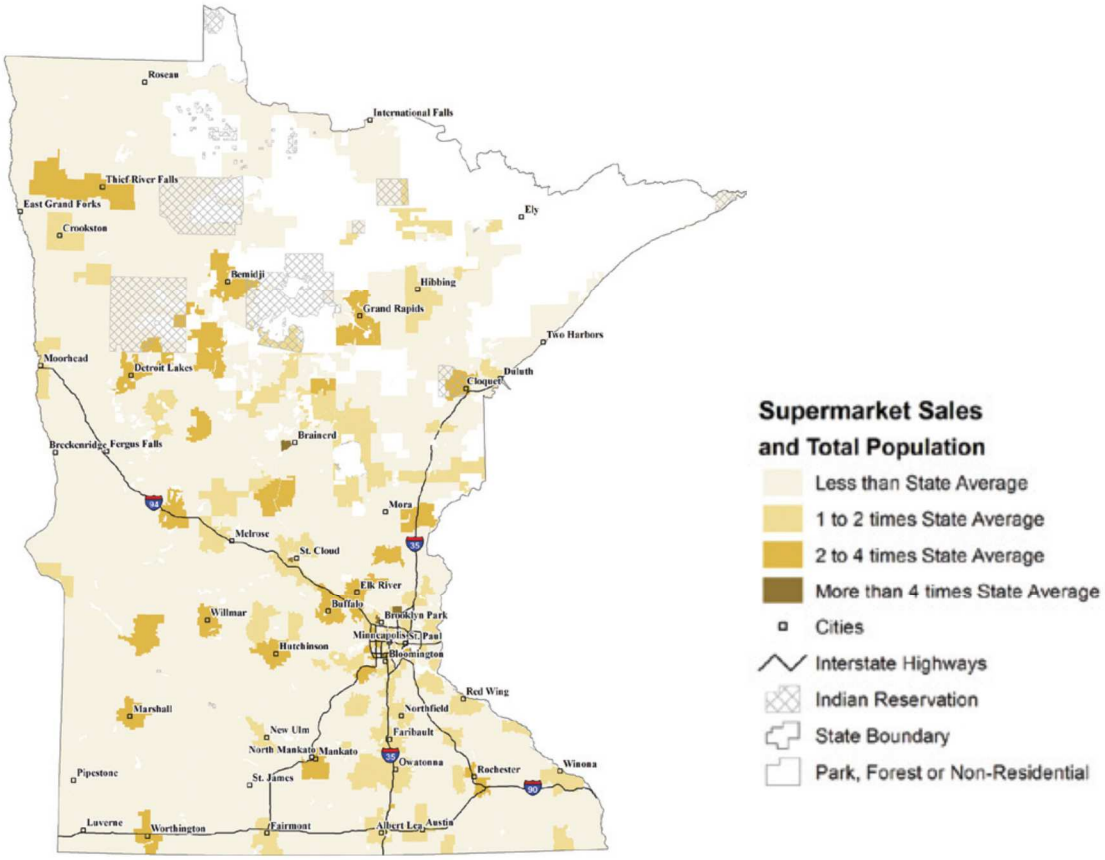
Extensive research[9] by The Food Trust on Minnesota's supermarkets highlights significant variation in supermarket access across Minnesota as depicted below.

Weekly Sales Volume for Supermarkets in Minnesota[10]



This map shows those grocery stores with annual sales over $2 million (note that this excludes some smaller grocery stores). According to the Food Trust, "The red dots in above map shows the location of 568 grocery stores throughout Minnesota and weekly sales volume at each store. The gray shading indicates how supermarket sales are distributed. The darkest areas have the highest concentration of supermarket sales, whereas the light areas have the lowest sales, indicating that few or no supermarkets are located there. Supermarkets in Minnesota are highly concentrated along major highways and in wealthier suburban areas, while many small towns and rural communities are relatively underserved."

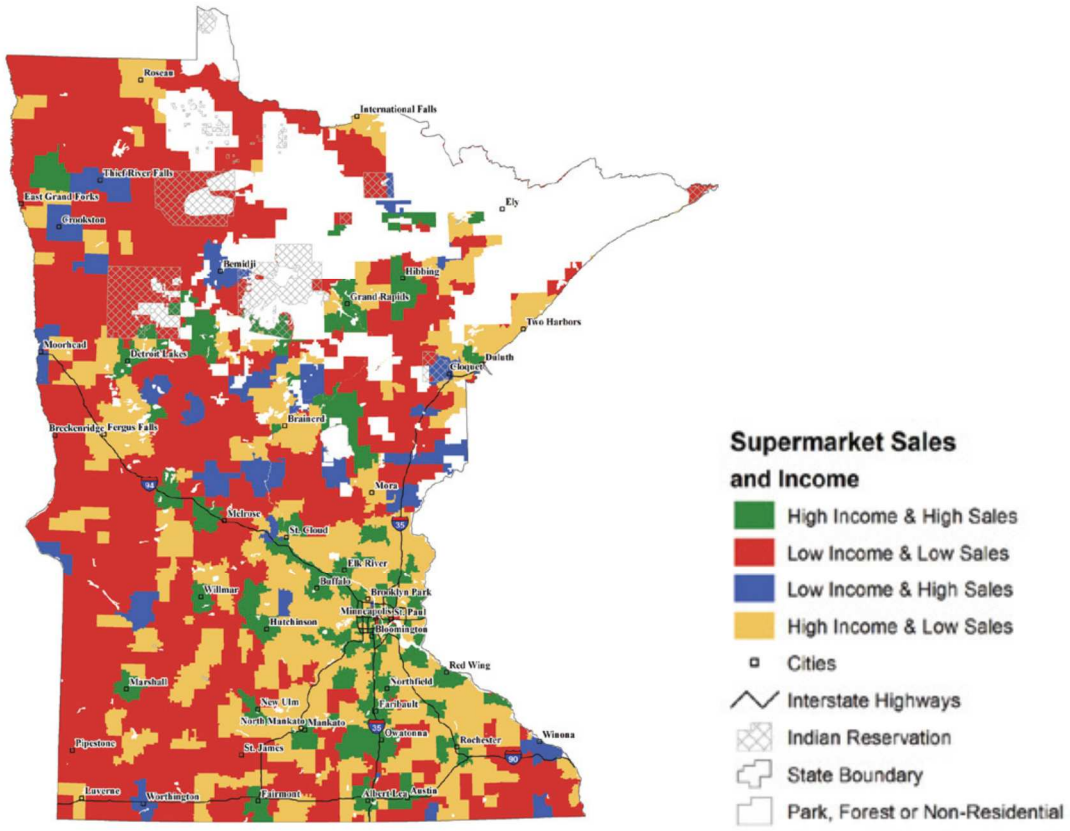
Supermarket Sales and Total Population in Minnesota[11]



The above map of Supermarket Sales and Total Population highlights how supermarket sales relate to population in a given area, and highlights the lengthy distances that many rural residents must drive to reach a supermarket. As Food Trust points out, "Communities with greater than average supermarket sales relative to total population are shown in yellow and brown tones. In these communities, people are either spending more than average in supermarkets, as might be the case in higher-income communities, or more people are buying groceries in these communities than the number of people who live there, indicating that people are traveling from outside the area of shop there."

As such, the regional centers highlighted above are likely the locations frequented by providers in Greater Minnesota when their purchasing needs can't be met from smaller stores in their community or other available food sources. The map above highlights the significant travel distances that can be involved, particularly in the Western and Northern portions of the state.

Supermarket Sales and Incomes in MN[12]



Lastly the Supermarket Sales and Income map above "shows the distribution of supermarket sales and the distribution of incomes throughout the state... People in the (higher income) areas shown in yellow have fewer supermarkets to shop at in their community. The red areas represent lower-income communities that have fewer supermarkets and lower per capita supermarket sales." As such, these areas – which comprise much of the state – are particularly challenged in terms of both lower income levels and limited access to supermarkets.

Analysis

The Food Trust's data highlights that access to supermarkets is very uneven across the state, that many low income areas are particularly challenged, and that rural residents are often reliant on long distance travel to meet their food needs. For family child care providers, grocery shopping can use a significant amount of time, typically in the evening or on weekends during the "free" time when they aren't attending to children.

However, despite this, only 21% of family child care providers from small towns/rural Minnesota who participated in Dr. Nanney's survey chose "healthy foods are not available in my area" as among the top five barriers they experience in using healthier foods. (This figure was 7% for the full pool of survey respondents.)

This suggests that providers perceive that healthy foods are reasonably available in their area or that other factors pose greater barriers to their use of healthy foods. Some observers suggested that rural providers may expect and accept driving distances to do their shopping. Others noted that providers may fold shopping for their child care into the shopping they are already doing to feed their own family, making shopping responsibilities feel less onerous.

In any event, many questions remain about the degree to which healthy options are truly available to family providers outside the metro area, and the implications this has for the foods being served. In particular, additional input from family providers themselves is needed to more fully gauge:

- What share of their food purchases throughout the year are coming from different types of sources.
- How this influences what foods are available to providers and with what implications for quality and price.
- Providers' perceptions about how well-served they are by their existing sources of food, including factors like time spent driving, the frequency of purchases given their geographic access to food sources (which, for instance, might influence use of fresh produce relative to frozen or canned), how long distances and bad weather may affect shopping patterns, and the like.

In turn, that could inform the design of additional support systems for providers, for instance, through:

- Menus that make optimal use of healthy items that are the most available in under-served areas (e.g. canned beans, onions, carrots, apples).
- Menus tailored to particular shopping pattern such a monthly trip to a discount store (where perishables could be purchased and used for a week), followed by less perishable items and other items that are available close to where the provider lives.
- Strategies to accommodate missed trips to a full-service grocery store due to bad winter.

E. Other barriers to using healthier foods

While this report focuses primarily on models for healthy food access, it is important to recognize that provider perceptions about food access are entwined with perceptions about food cost, convenience and other factors. Looking at other perceived barriers can help put this issue into a larger context and shed light on those provider concerns that have the greatest impact on the use of healthier foods.

As part of the U of M survey, providers were asked this question: "Thinking about the (healthy nutrition practices outlined earlier in the survey), please choose what you feel would be the top five barriers for your program from the following list." The data specific to family providers in small towns/rural areas are as follows:

Cost of purchasing healthier foods	94%
Children would not respond well	55%
Lack of time to prepare and serve healthy foods	53%
Limited space for food storage (refrigerator and cabinet space)	36%
Healthy foods are not available in my area	21%
Lack of equipment or space to adequately prepare healthful foods	15%
Unsure how to prepare healthier foods	13%
Parents would not support provider's efforts	11%
Unsure of the differences between health and unhealthy foods	8%
Other areas in our program have high priority at this time	8%

The prevalence of concerns about the perceived cost of healthier choices is striking, with 94% of responding small town/rural family providers identifying cost as one of their "top five" barriers. (This figure was 91% for all respondents.) This is followed by concerns that children would not respond well to healthier options (at 55%, compared to 48% for the survey pool as a whole). Lack of time to prepare healthy foods and limited store space are also widely perceived barriers.

While conducting original research with providers or delving deeply into perceived cost issues was beyond the scope of our research, we did ask a number of well-informed stakeholders about the widespread perception that healthier options are more costly. Particularly for family providers in Greater Minnesota who may face longer drive times to reach healthy options, a variety of factors emerged:

- Healthier options could potentially be relatively more expensive than less healthy options in the outstate locations where the responding providers shop.
- When survey participants considered "cost" issues, they may have factored in costs like the time and fuel to drive longer distances to purchase healthier foods. If obtaining healthier choices means shopping at more locations or making more frequent trips for perishable items, for instance, this likely contributes to the perception of higher costs.
- This may also reflect concerns about needing to spend extra time to plan, prepare and serve healthier options.

Perceived "cost" may also be associated with another barrier highlighted in Dr. Nanney's study – that 55% of family providers in small towns/rural areas felt that children would not respond well to healthier food. That in turn can contribute to elevated rates of food waste.

As noted by one source, "Food waste is a big deal with family providers. It is wasting the providers' own money, which leaves providers feeling burned. They may feel that 'if I give them healthy food, more gets wasted and then they are hungry and I'll have to give them more food'. Child care centers do not have this same issue and are run more like schools – children eat lunch and then it is not an option to get more food later if a child is still hungry. But with a family provider, there are many incentives to keep kids from going home hungry. Parents take this more personally."

Other interviewees suggested that perceptions about cost may sometimes be a misperception. As one stakeholder observed, "People say cost is the main issue, but what is the difference between perceived cost barriers and actual costs? The data shows that a serving of goldfish actually costs more than a serving of grapes. LANA (Learning about Nutrition through Activities) training talked about how to substitute foods to make it cost effective, but people don't really take that in." This is clearly an issue that deserves more in-depth collaboration with providers themselves to fully understand their perceptions and experiences.

CACFP Meal Reimbursement Rates

Lastly, the interplay between the perceived cost of food and meal reimbursements under the CACFP must be acknowledged. As noted above, close to 8,500 licensed family child care providers in Minnesota (79.9%) participate in the CACFP program.[13] Dr. Nanney's data suggests that participation may be even higher in Greater Minnesota.[14] CACFP meal reimbursements have a significant impact on the finances of family child care providers and undoubtedly have considerable impact on perceptions about the affordability of different types of food, particularly given the advent of higher CACFP nutrition standards.

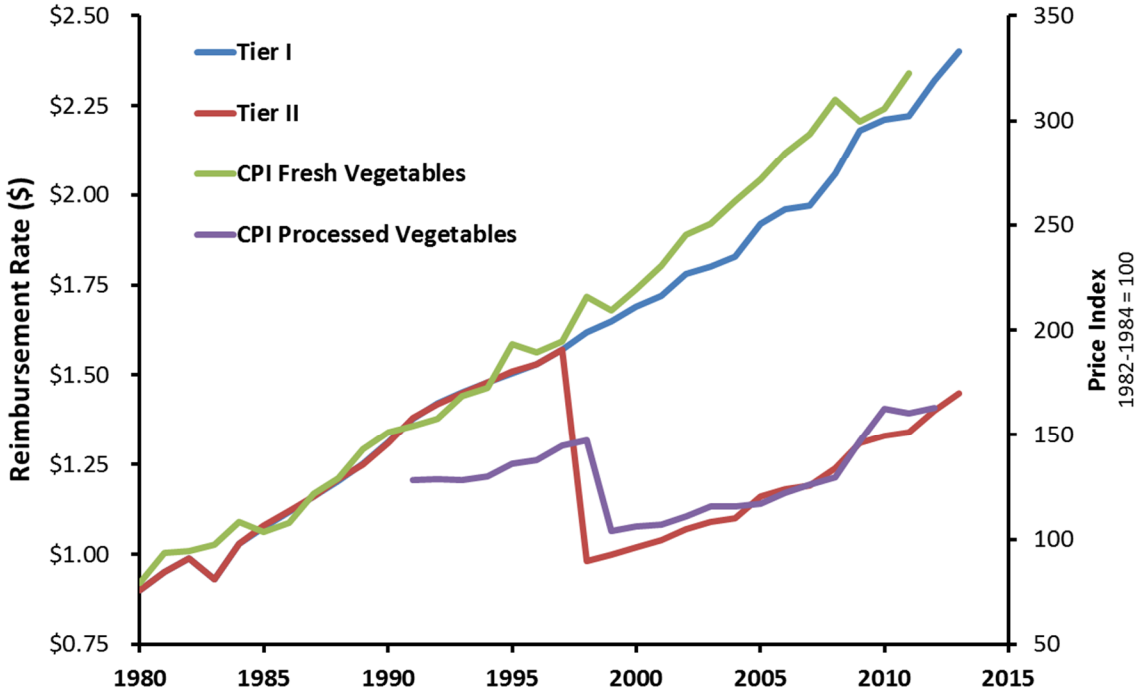
Prior to 1997, the reimbursement rates provided to family child care providers (or "day care homes" in USDA parlance) did not vary based on the income level of the provider or related factors. But in that year, a two-tier system was established that aimed to steer more resources to lower income contexts.

To receive the higher "Tier 1" meal reimbursements, a provider must meet provider income criteria or live in an area recognized as being lower income (by census tract or school district). The provider in a Tier II home may also elect to have their CACFP sponsoring organization identify specific income-eligible children, so that meals served to those children can be reimbursed at the higher Tier I rates. If these requirements are not met, the provider is reimbursed at the much lower Tier II rates. The Tier I rate for lunch and supper for family providers in the contiguous 48 states is currently $2.40 per meal, while the Tier II rate is $1.45.

According to the Food Research and Action Center (FRAC), 66.8% of Minnesota family child cares operate under Tier II, the highest rate of all US states.[15],[16]. Data from CACFP sponsor Providers Choice[17] shows that 39% of those non-metro providers served by Providers Choice are being reimbursed at the Tier II rates.

As shown in the chart below, CACFP reimbursement rates for all family providers were the same until 1997. At that point, Tier II rates were instituted at roughly half the prior level. From there, both Tier I and II rates have been adjusted annually based on changes in the Consumer Price Index as shown in the red and blue lines.

CACFP Reimbursement Rates for Home CC Providers and Price Trends for Fresh and Processed Vegetables[18]



Meanwhile, the cost of food has continued to increase. The green and purple lines above show how the reimbursement rates relate to the cost of vegetables. The purple line reflects the cost of processed vegetables (using the CPI, with the index set to 100 in the early 1980's). The green line shows the cost of fresh vegetables, which has tripled over the past three decades.

This chart illustrates the very substantial gap between Tier II rates and the increasing cost of healthy choices like fresh vegetables. As Tier II rates have fallen behind fresh vegetable costs, this may have contributed to concerns that healthier choices are not only more costly but increasingly unaffordable for providers who are operating under Tier II reimbursements and are unable to pass on rising food costs to parents.

An analysis from the University of Washington Center for Public Health Nutrition titled "The Case for Increasing Federal Food Subsidies in Child Care"[19] also highlights the impact of reimbursement rates on food served in child care contexts. They report that:

- Providers receiving high reimbursement spent significantly more on food ($2.36 per child per day) than those getting lower reimbursement ($1.96 per child per day).[20]

- Providers receiving high reimbursements served healthier food with more protein, more whole grains and more vitamins and minerals of concern for child health.
- Aligning CACFP nutrition standards with the 2005 Dietary Guidelines for Americans would require increasing reimbursements to home (family) child care providers by 31 – 34%.[21]

And although many factors are at play, it is likely that lowered reimbursement rates have contributed to declining CACFP participation at the national level. As FRAC points out[22], "These changes have had negative consequences that continue to affect the program. Between 1996 and 2011 the number of family child care homes participating in CACFP dropped by 32 percent, while the number of children served fell by 161,801."

While some would argue that CACFP meal reimbursements were never intended to cover the full cost of healthy meals, it is likely that depressed Tier II rates – especially when combined with the newly raised nutrition standards under CACFP – are contributing to growing financial strain for Tier II providers and may spur some providers to leave CACFP. [23] This is widely viewed as undesirable as providers who leave CACFP become ineligible for professional development opportunities afforded by CACFP participation and their nutrition services become largely unregulated and unmonitored.

These realities raise some important questions about the role of federal and state policy initiatives as a driver of nutritional quality in the child care sector. At the state level, Minnesota does not have a state-funded reimbursement for child care meals, in contrast to the state supplement for K-12 meals. BCBS is strongly encouraged to consider policy efforts that could redress this fundamental economic barrier to healthier food offerings by Tier II providers.

F. Models for Improving Healthy Food Access

Now we turn our attention to strategies that could potentially strengthen access to healthy foods for family child care providers in Greater Minnesota.

To explore the possibilities, we conducted a national scan for innovative models and sought advice from key stakeholders in various sectors across the country including public health, Farm to Child Care, school nutrition, local foods, emergency food assistance, community food access and other arenas.

We found myriad initiatives targeted at child care centers, but many fewer designed to suit family providers. A scan of the National Farm to Pre-K website's list of programs around the country shows that food access strategies for family providers are mentioned infrequently. By contrast, collaborations with centers are quite numerous (particularly with Head Start). Similarly, the majority of food-related efforts emerging from the philanthropic and non-profit

communities are aimed at centers, which typically have different needs and opportunities given their larger scale.

We also explored various food access models that could potentially be applied to family providers, even if they hadn't been implemented in this context before. Many of the programs we highlight below focus on improving food access for families or individuals, and several do (or could) serve child care providers.

These models offer many lessons learned, but also illuminate the challenge of designing access models that could be palatable and compelling to family providers. Indeed, the degree to which a given model might be a good fit depends on providers' current food environment and whether a new model would be an improvement upon their current circumstances. (This makes it all the more important to gather more input from providers about the pros and cons of their current procurement practices and gauge the attractiveness of various alternatives.)

In assessing the attributes that food access models should have, we identified the following qualities as being optimal:

- the food source is more convenient (or no more inconvenient) than the current way that providers buy food, e.g. shorter driving distances, a less stressful shopping experience, reduced impact of bad weather on shopping activities, etc.
- a full range of foods is available through a given channel (rather than the provider needing to visit multiple locations to obtain different foods)
- prices are more affordable than current options
- the approach can be integrated into food purchasing that the provider would already be doing for themselves/their family
- it involves minimal administration, coordination or paperwork (e.g. it doesn't require "learning a whole new system")

With these considerations in mind, we explored the following food access models and have highlighted the pros and cons of each below.

1) Large-scale purchasing alliance: Child Care Purchasing Alliance
2) Joint ordering with community institutions
3) Value-priced box purchasing: The Food Group's Fare for All Model
4) Comprehensive foodbank programming: Foodlink
5) Community Supported Agriculture
6) Farmers markets

Overall, we found that the first two – the large-scale purchasing alliance model and joint ordering with community institutions – have the strongest potential for connecting family providers with a complete selection of healthy foods on a year-round basis at attractive prices.

Child Care Purchasing Alliance

How the model works

Cooperative buying models are a promising vehicle for connecting child care providers with healthy foods, potentially at prices well below retail. We found a very intriguing example of cooperative buying in the nascent Wisconsin-based Child Care Purchasing Alliance (CCPA)[24]. Not only is CCPA a promising model to learn from, but it could potentially be expanded to family providers in Minnesota, given the extensive groundwork already laid in Wisconsin.

CCPA is a purchasing consortium that contracts with broadline distributors such as Reinhart, Sysco and US Foodservice to make affordable healthy foods (and a collection of other services) available to child care providers. CCPA launched operations in August 2012, catalyzed by the Celebrate Children's Foundation (CCF)[25], a Madison, WI-based foundation. CCF is dedicated to helping "communities throughout Wisconsin create the most effective early learning systems for children from birth to age five". CCF's early development of group purchasing efforts in the child care sector have been partially funded by Blue Cross and Blue Shield of Wisconsin.

CCPA is now providing services to hundreds of child care centers in 14 states including Wisconsin, Minnesota and Illinois. In Minnesota, CCPA is working with two providers that have about half a dozen centers in the state.

Members of the Purchasing Alliance can purchase a wide array of foods at prices that have been negotiated at a national level by Food Source Plus[26], a food and supply purchasing company. Foodservice buyers across the country that purchase from FSP's distribution partners benefit from FSP-negotiated prices that are typically well below common wholesale prices. For instance, CCF estimates that FSP pricing is often 15% below the wholesale prices that institutions like individual school districts or nursing homes negotiate with these distributors (which themselves are typically well below retail prices).

CCPA has focused on child care centers (not family providers) thus far, but is keen to see their model expand to new constituencies and new geographies across the country. Initial conversations with Reinhart-LaCrosse suggest that this distributor is also interested in reaching new customers in Minnesota through expansion of this model. Reinhart-LaCrosse has confirmed that they will deliver orders within their service area in Minnesota that meet a $500 minimum (including food, paper products, cleaning supplies and other products).

Potential benefits of this model

- Availability of a full range of foods including pre-cut fresh produce, frozen produce, healthier meat products, grains and legumes that CCPA has identified as meeting forthcoming CACFP requirements.
- Pricing that is likely to be below retail prices and the wholesale prices that a child care provider could potentially obtain by ordering under the umbrella of an individual

institution such as a school district or nursing home that doesn't benefit from nationally negotiated pricing.

- Availability of some locally grown food items through Reinhart.
- Direct delivery to any location served by Reinhart if a) the $500 minimum order is met (by one child care provider or by a few providers ordering together with one drop location) and b) driving restrictions on residential streets do not prevent access by distributors' trucks. Other distributors will have their own policies about minimum order size and the geography that they serve.
- If home delivery isn't feasible, there is the potential to arrange delivery to the site of a local institution that is already served by a participating distributor while still obtaining FSP-negotiated pricing (which may be preferable to the local institution's pricing directly with the same distributor).
- Entities that purchase through CCPA's model also gain free access to FSP's nutritional software, menus, recipe books and budgeting tools that can provide price breakdowns per food item per meal or per child. CCPA also offers a range of other services including health and general liability insurance for providers, office and cleaning supplies, and credit card processing, among others.

This model works well when these conditions prevail

- A broadline distribution partner is available that delivers widely in rural areas and that will set a minimum delivery amount low enough to be workable for family providers.
- The purchasing alliance (or a partner like Food Source Plus) is large enough to negotiate pricing with the distributor that is below the pricing that family providers could either obtain at retail or that they could potentially obtain by ordering jointly with a community partner such as a nursing home or school.
- A backbone organization (such as CCPA) is available to market the model to family providers, coordinate with the distribution partner(s), and provide ancillary services that encourage provider participation.

Other considerations

- This type of purchasing model could potentially reach large numbers of family providers with a full line-up of healthy foods, year-round, under one umbrella.
- This could be an opportunity to leverage the significant investment already made in developing this model in other states. The parties also appear interested in exploring the possibility of expanding more fully into Minnesota. As such, CCPA's model would be considerably more "shovel-ready" than creating a separate entity from scratch to serve Minnesota.
- Soliciting participation from child care providers requires a significant investment in marketing and outreach.
- If the Center for Prevention is interested in exploring this further, it will be important to look more deeply into the model's applicability to Minnesota's rural family providers. Key questions include the following:

- Given how providers currently purchase their groceries, how significant could the cost savings be?
- Are the pack-sizes available through Reinhart workable given the more modest needs and storage limitations of family providers?
- Would the $500 minimum order be a significant barrier, and if so, how could it be overcome?
- What geographic areas in Minnesota could be served by interested distribution partners?
- Would municipal restrictions on truck access to residential streets be a significant barrier in some communities? If so, could that be addressed through the "joint ordering with institutions" model discussed below?

These questions could be pursued through more intensive dialogue with distributors and family providers. Given Reinhart's track record, current delivery policies and openness to an exploratory dialogue, Reinhart-LaCrosse would be a great starting point to assess this model further.

Comprehensive foodbank programming: Foodlink, Rochester, NY

How the model works

Based in Rochester, NY, Foodlink began as a foodbank and has become a major catalyst behind a comprehensive array of food and hunger initiatives in their region. Five hundred organizations are members of Foodlink, distributing food and other resources in a ten county region around Rochester. Nine of these counties are rural.

Foodlink provides food to emergency food organizations such as pantries, soup kitchens and shelters. They also coordinate with non-emergency programs such as group homes, child care centers, senior centers, and after-school programs to make food available at wholesale prices. Foodlink runs more than 30 food-related programs aimed at ending hunger, improving nutrition, empowering individuals with food literacy, community and economic development, and strengthening the regional food system. Their mission: to end hunger and to leverage the power of food to build a healthier community.

Foodlink also goes beyond traditional food banking by focusing on workforce and economic development, promoting child nutrition, and offering nutrition and culinary education throughout their region. Foodlink expands food access through numerous channels including pop-up farmers markets, buying clubs, and mobile pantries, as well as buying and re-distributing local and non-local foods and food processing. They also conduct trainings for member organizations and participate in various Farm to Institution initiatives.

Foodlink has the capacity to distribute over 18 million pounds of food annually. Over half of the food distributed is perishable product: fresh produce, meat and dairy. Their infrastructure includes a 100,000 square foot operating warehouse and distribution facilities, industrial size freezers and coolers, a fleet of trucks, and a commercial kitchen. This capacity allows Foodlink to purchase high-volumes of food and redistribute it to the 500 agencies in their network.

Programs of most relevance to rural family child care providers in their area include Foodlink's mobile pantries, the $AVE program and cooperative purchasing through their Food Hub facility as highlighted below.

Mobile Pantries: Foodlink has a cluster of mobile pantries, which deliver nutritious food across their ten county service area. Volunteers from area intermediary organizations help connect clients with the pantries. The mobile pantries allow Foodlink to engage a much larger circle of organizations in supplying food, increasing the number of people served and extending service into new geographies. The pantries make food available for free to low income individuals and for purchase by other individuals and organizations.

$AVE Program: Foodlink is able to purchase food items in large quantities at wholesale prices and pass these savings to paying customers through the $AVE program. Foodlink operates this service with member agencies through the mobile pantries described above, typically delivering twice per month, and through their other programs as well. There are no income guidelines or restrictions – anyone can participate at any time and orders for desired items can be placed in advance. $AVE focuses on providing affordable meats, poultry and seafood because these high value items tend to have significant mark-ups at retail stores.

Although Foodlink has not attempted to document purchases by family child care providers, child care centers have purchased food through the $AVE program. This approach works best where child care providers have a relationship with a nearby intermediary agency that hosts a pantry and coordinates orders.

Food Hub Procurement and Processing: In addition to procuring non-local foods, Foodlink has long-term relations with farmers in their area. This enables them to purchase fresh local produce like apples, pears, and cabbage that have long shelf-life and are popular with their constituents. They sometimes purchase local produce as "seconds" and over-supplies.

Foodlink has also made effective use of their capacity to wash, cut and bag fresh produce to bolster linkages between local farmers and institutions. For example, nearby school districts were frustrated when they had difficulty obtaining apples from local producers. In response, Foodlink bought apples from local farmers, transported them into their processing facility, and then sliced, bagged and distributed them to nearby school districts. This is a great illustration of how a foodbank leveraged its broadly defined mission and significant food handling infrastructure to meet area food needs in non-traditional and sophisticated ways.

Potential Benefits

- Through a program like $AVE, family child care providers could purchase high value items such as seafood and meat at below-retail prices, as well as locally grown produce.
- The mobile pantry system offers a decentralized way to distribute foods into rural areas. The collaboration between Foodlink and a large number of community-based organizations make food ordering and deliveries in dispersed rural areas possible.
- Because of the large volumes, Foodlink can buy in bulk and make nutritious foods available on a more affordable basis.
- Foodlink's relationship with area farmers can put locally grown produce into the hands of area residents, child care providers, institutions and others that might otherwise lack a convenient way to access local foods.

The model works well when these conditions prevail

- The emergency food organization defines its mission broadly and uses multiple, creative strategies to expand food access for multiple populations.
- The emergency food organization is committed to providing healthy options, and builds relationships with area farmers and other entities that can provide healthy produce, proteins and other foods, whether donated or purchased.
- The service area includes both urban and rural counties and operates on a large enough scale that significant investments in infrastructure are possible, and can be deployed efficiently to the benefit of both rural and urban populations.
- A wide network of intermediary organizations can organize food purchasing and distribution among their clientele in rural areas.

Other Considerations

Foodlink has a 30-year history of progressive food and community service. Through a recent strategic planning process they re-visioned the role they could play, further pushing the envelope on what they do and how they do it. Based on this experience, they have come to believe that all foodbanks need to be encouraged to push beyond traditional roles to serve their communities more fully.

For them, success has been predicated on solid relationships with local stakeholders and a large network of intermediary agencies. Like many food banks, Foodlink has a wide array of assets and resources at their disposal (e.g. trucks, warehouses, ordering capacity, relationships across the food supply-demand chain, processing capacity, food storage, etc.). The organization has distinguished itself by leveraging these assets in very creative and ambitious ways to strengthen their area's food system and expand access to healthy choices.

For more information on Foodlink's model, see http://foodlinkny.org/fight_hunger/programs-initiatives/#102.

Joint Ordering with a Community-based Institution

How the model works

While many rural communities lack a full-service grocery store, many others are home to institutions that provide regular foodservice. This includes nursing homes, hospitals, K-12 schools, correctional facilities and colleges, among others. These institutions are typically served by a broadline food distributor that makes deliveries on a weekly or every-other-week basis. Some will also be served by produce distributors, or other distributors that focus on particular product categories like dairy products.

Family child care providers could potentially tap into foods from such distributors by placing orders jointly with an institution in their community. Interviews with Reinhart-LaCrosse indicate that this joint ordering format is not uncommon with other types of businesses and institutions.

In these situations, the child care provider, for instance, would submit a credit application to Reinhart and set up payment terms (likely Cash on Delivery). The provider would be assigned their own customer number (separate from the partner institution) and would receive their own invoices. Their products would be physically segregated on the truck and all boxes would be coded with the name of the buyer so that it can be easily distinguished from product purchased by the partner institution.

Based on negotiations with the partner institution, the child care provider could potentially obtain the wholesale pricing that has been negotiated by the institution with the broadliner or Group Purchasing Organization (which for institutions like hospitals, may reflect very advantageous pricing negotiated by national group purchasing organizations). If a model like the Child Care Purchasing Alliance was expanded to Minnesota, participating providers could potentially obtain the pricing that has been negotiated nationally by Food Source Plus.

Efforts to explore the feasibility of this approach should include identifying potential institutional partners and child care providers in priority communities, testing the water with potential distribution partners, and conducting more focused dialogues to illuminate the details around product availability, pricing, delivery, pick-up mechanisms, etc.

Potential benefits

- A distributor like Reinhart offers a comprehensive, year-round supply of fresh and frozen produce, proteins that meet Child Nutrition labeling requirements, dairy, grains, beans and other items. They also offer paper products, cleaning products and other foodservice items needed by family child care providers.

- Reinhart has distribution centers in LaCrosse, WI, Rogers, MN and Marshall, MN. They indicate that as long as their minimum order of $500 is met, they can deliver to most areas of the state, even to those communities that are not close to major freeways. Reinhart may have less coverage in some sections of Northwest and Northeast Minnesota.
- Ordering jointly with a community institution would essentially ensure that a child care provider can meet the $500 minimum order, enabling them to order much smaller amounts if they so choose.
- Wholesale pricing is likely to be more advantageous than the retail prices that providers would otherwise pay.

This model works well when these conditions prevail

- Providers are willing to drive to a drop-site to pick up their food.
- A willing distribution partner is available that serves a wide variety of institutional accounts in interested communities.
- Providers are able to partner with a willing institution in their community that already purchases from the distribution partner and that has appropriate storage space, staff, and inclination to facilitate unloading, temporary storage and pick-up by the child care provider.
- An intermediary organization is available to develop and manage relationships with distribution partners, enlist appropriate community institutions, and link providers to those institutions and distributors.

Other considerations

- Reinhart focuses primarily on foodservice pack-sizes (e.g. 12 and 25 pound bags of pre-cut frozen produce and 20+ pound cases of whole produce), but they also offer various retail sizes, split cases, individually wrapped cut produce for use in K-12 settings, and the like. Smaller pack sizes will tend to cost more per pound than larger volumes, and it would be important to gauge providers' capacity to store items of various sizes. Pre-cut fresh produce provided by Reinhart-LaCrosse is cut by Cut Fruit Express, just outside the Twin Cities and includes a variety of locally grown items.
- The choice of community institutions should take into account the hours of operation in which providers could pick-up their orders. For instance, providers may be challenged to pick up their order at a school during school hours when their child care is also operating. Nursing homes, hospitals and other institutions with longer hours may be advantageous in this regard.
- This model could be aided by development of a set of menus using the distributor's product list that are well-suited to family child care providers, along with shopping lists, product ordering numbers and related tools that would make ordering and menuing easy for providers. (Note that the Child Care Purchasing Alliance may already have begun a similar effort based on Reinhart's approved product list.)

- One interesting angle on this model might be to foster the use of recipes that are being menued by a K-12 partner in the providers' community. Such recipes would already be compatible with National School Lunch Program requirements. Efforts could be focused on recipes that require limited preparation time, and that have been taste-tested and embraced at the elementary school level. Schools might be motivated to partner if the effort was framed as a way for providers to usher young children into the K-12 system who already know and like the healthy options that schools are trying to introduce.
- An alternative to ordering with a community institution would be for groups of family child care providers to place joint orders and have the product dropped at some central drop site. This is feasible but is complicated by the need for greater coordination among providers, the availability of a drop site that has proper refrigeration and storage space, the need for someone to be present when the food is delivered by the distributor, and a process for managing pick-ups by providers.
- Joint ordering with a community institution could be tested through a pilot effort involving a motivated broadline distributor, one to two community institutions, and a cluster of family providers in a given community. That would allow the Center for Prevention to start small, test the model, and hone it for future expansion.

Fare For All: Boxed, discounted food sales

How this model works

The Food Group (formerly the Emergency Foodshelf Network), a food bank located in the Twin Cities suburbs, operates a program called Fare for All that connects shoppers with fresh produce and frozen meats at highly discounted prices. The Food Group (TFG) purchases foods from broadline and produce distributors, food manufacturers and food processors (such as Jennie-O and Gold 'n Plump). Products are sometimes close to their expiration date or are available in surplus, enabling FFA to purchase at highly discounted rates. Foods are delivered to TFG's central warehouse in New Hope, MN, and then are packed by volunteers. TFG has a nutritionist on staff and strives to obtain healthy meat products, along with fresh produce.

Fare for All (FFA) takes two different forms – Express and Traditional:

- Fare for All Express – The larger of the two programs, FFA Express provides pre-boxed foods for a fixed price (such as a 15 pound box of produce for $10, or a similarly sized box of frozen meats for $25). Content of the boxes varies based on what FFA is able to purchase from its suppliers and shoppers cannot choose the specific products that are in their box of produce or meat. Shoppers pay when they purchase the food at a sales site and they don't need to pre-order. The Express program operates in the nine county metro area with about 30 sales sites that are typically open once per month.

- Fare for All Traditional model – Under the Traditional model, interested individuals pre-order and pre-pay for meat or produce packages. The specific content of the packages is based on the items that TFG is able to make available during a given month. The organizations that host FFA Traditional sites drive to TFG's New Hope warehouse once a month, pick up orders for members of their community and distribute it to customers. There are 40 – 50 FFA Traditional distribution sites in the metro area and in Greater Minnesota, with one distribution date per site per month.

FFA is typically able to sell product at 30 – 40% below retail prices. About 65% of FFA sales are made to low income individuals under 200% of the poverty line, with the balance going to people of other economic levels that are looking for a bargain. Although TFG has not done any work with child care providers, family providers located in FFA service areas can currently purchase through the program if they would like to.

Potential Benefits

- Significant price discounts for the fresh (uncut) produce and frozen meats that are available through the program.
- Leverages an existing program run by a well-established organization.
- Although Fare for All Express is currently focused on the metro area, TFG has expanded operations to St. Joseph, Northfield and Blaine, making the program more accessible to some rural communities in nearby areas.

This model works well when these conditions prevail

- Buyers place a priority on obtaining significant price discounts.
- Buyers are able to accommodate a limited array of products and quantities that are not of their own choosing.
- Buyers are able and willing to obtain products on a once-a-month basis and to pick up product on the date and time when a given sales site is in operation.

Other considerations

One important question is whether FFA's product offerings are an appropriate fit for child care providers. The lack of control that providers would have over product selection may be a barrier to participation.

TFG is currently scaling back the Fare for All Traditional program as they have found that the pre-order/pre-pay format is less attractive to shoppers due to the pre-planning and early payment that it requires. By contrast, their Express model is growing rapidly in the metro area and now into St. Joseph, Northfield and Blaine.

TFG has expressed some interest in exploring the feasibility of expanding the Fare for All Express program into rural areas of Minnesota by converting some Traditional sites to Express sites. If BCBS is interested in exploring this further, TFG could potentially explore strategies for adapting the model to rural family child care providers, for instance by offering more individual a la carte items that child care providers could choose among to suit the needs of their children.

Community Supported Agriculture

How the model works

Farms that offer a Community Supported Agriculture (CSAs) program can potentially provide local fresh food for family child care providers. While most CSAs focus on fresh produce in the summer/fall, a growing number of CSA offer grains, meat, dairy or other local foods. A few are beginning to offer value-added farm products like frozen vegetables and salsa over the winter.

A CSA farm typically makes periodic deliveries of food at drop sites where CSA members can pick up their box, typically every other week. The member pays a fee early in the season, effectively reserving their share of the bounty and helping the farmer "cash flow" the inputs needed to grow the food. Many CSAs welcome the involvement of members on the farm and offer farm visits, seasonal celebrations and other means of community involvement.

The CSA Farm Directory published by the Land Stewardship Project identified 87 CSAs in 2014. While some serve locations in Greater Minnesota, about two-thirds of the CSAs deliver to the Twin Cities

Looking nationally there are several interesting models for linking CSAs with family child care providers. Some nonprofit programs, such as The Food Project in Greater Boston, use CSAs as part of their community food programming and collaborations with the Head Start program. The Food Project has farms that are part of their training and youth development program, with the produce sold through CSA's and other means. Eight Head Start partners serve as CSA drop sites for subsidized shares that will be picked up by families participating in Head Start programs.

The Food Project also coordinates with the Head Start sites to identify the Head Starts' upcoming food needs and plan production on the farm accordingly. Head Start sites provide related educational activities for their children before these local foods are served.

In another case, the Townes Harvest CSA, a hands-on learning center for Montana State University agricultural and food systems students, sells CSA shares to family home providers and other participants around Bozeman. According to Child Care Connections, a Bozeman-based regional child care services program and CACFP sponsor, about one-quarter of the family providers in the area participate in a CSA. Child care providers coordinate directly with farmers, and Child Care Connections weaves local food issues into their provider trainings. In some cases, CSA farms adjust the food included in CSA shares for family providers to ensure the food is appealing to young children and feasible for the provider to prepare.

Potential Benefits

- CSAs provide fresh local food in season.

- An individual family child care provider can arrange for a CSA share without working through some type of intermediary agency, if preferred.
- CSAs can introduce young children to new foods.
- CSAs can be a helpful vehicle for getting kids onto farms and developing their appreciation for where their food comes from and how it is grown.

The model works well when these conditions prevail

- Child care providers are located in areas served by a CSA farm.
- The provider is highly motivated to use local foods and/or uses a CSA membership for their own family meals.
- Farmers are willing to make some adjustments in the foods provided to suit the circumstances of child care providers. (This is more likely to be feasible for the farmer if he/she is supplying a significant number of child care providers that have jointly identified a consistent set of product preferences.)
- Providers have the cooking skills and facilities to refrigerate and prepare fresh foods, and can make the needed financial commitment to purchase a CSA share early in the growing season.
- Providers highly value farm-related learning opportunities for children and have the means to make use of the educational opportunities afforded by a relationship with a nearby farmer.

Other Considerations

CSA-based approaches can be challenged by a less-than-predictable selection and volume of farm products, and the need for providers to be able to store and prepare fresh foods. CSA models can be aided by the participation of an intermediary organization to identify appropriate farms, clarify product needs, support pickup site logistics, and provide support with menuing and food prep skills that are linked to CSA offerings.

Farmers Markets

How the model works

Farmers markets are an opportunity for the public to buy fresh fruits, vegetables, and other foods directly from the producers who grew them. Many markets that operate through the summer and fall are held on a regular basis in community gathering spaces, and a growing number offer more limited winter sales as well. The Minnesota Farmers Market Association identifies 109 summer markets in its interactive on-line directory.

According to Dr. Nanney's survey data, 28% of responding child care providers purchase some of their food at farmers markets. However, this data does not tell us how much of their food needs are met through farmers markets or how frequently they shop there.

Farmers market visits can be a fun and educational opportunity for children, particularly if they are located nearby and are scheduled during weekday hours when child cares are in operation. Farmers markets also give providers the flexibility to purchase the specific types and volumes of food that best suit their circumstances and the taste preferences of their children.

Potential Benefits

- Are a source for a variety of locally grown produce items and other products.
- Providers can purchase the types and volumes of food suited to their needs.
- Market visits can be a compelling educational opportunity for children.
- Teaching modules about food that is available at the farmers market, farming, and related topics can be woven into child care curriculum and creative arts.

The model works well when these conditions prevail

- A farmers market is located close by and offers an appropriate range of products on a reliable, affordable basis.
- Providers are interested in local foods.
- Providers know how to store, prepare and incorporate these foods into menu plans and have adequate storage facilities for perishables.
- There is an intermediary organization that can support providers' use of farmers markets through tools like seasonally appropriate menu development, food prep training, and farmers market-related educational activities for children.

G. Recommendations

We conclude this report with a set of recommendations to guide the Center's planning as it relates to rural family child providers.

1. **Learn from providers themselves:** Invest in research that draws directly on the knowledge and experience of rural family providers. This is essential for more fully understanding providers' perceptions about how well-served they are by existing food sources, the interplay between factors like food access, cost and convenience, the impact of CACFP reimbursement rates on food choices (particularly for Tier II homes), and the attractiveness of various models for strengthening food access. Field representatives from CACFP sponsoring organizations could also be a valuable source of insight given their on-going interaction with family providers. Ground-truthing the degree to which new strategies could lead to actual behavior change by providers is key.

2. **Consider a policy-based intervention:** Consider developing a policy education or innovation strategy focused on CACFP meal reimbursement rates. The creation of a state-level child care reimbursement to supplement federal CACFP rates, particularly for Tier II providers, could potentially address a pervasive systems-level barrier. The Center could also explore the potential for updating current Child Care Licensing regulations (housed within the Minnesota Department of Human Services) to incorporate support for healthier food environments in child care.

3. **Engage rural family providers in change efforts:** As the Center considers how to move forward, make sure to weave efforts to mobilize rural family providers themselves into your change strategy. This segment of the child care community is the least organized and the most under-represented of child care providers. As such, they could benefit from greater inclusion in broader change efforts. At the same time, they also represent an under-tapped source of energy and potential capacity for policy advocacy. While much effort has been directed thus far to childcare centers, BCBS could do a real service by committing to crack "the tougher nut" of rural family providers.

4. **Unpack the supermarket issue:** Given the predominant role of supermarkets in family providers' food purchases, use the engagement effort recommended above to more deeply understand providers' shopping patterns (e.g. the frequency of shopping trips, the interplay between supermarkets and bulk stores, and how access to different types of retail venues affects what providers purchase and the costs they incur). Use that analysis to identify specific grocery-related strategies that could improve access to healthier choices, particularly in the most under-served areas of the state.

5. **Consider an expansion of the Child Care Purchasing Alliance model**: Pursue a dialogue with the Child Care Purchasing Alliance in Wisconsin and participating distributors to explore a possible expansion of their group purchasing model into

Minnesota and the adaptations needed to make it workable for rural family child care providers.

6. **Pilot a program for joint food ordering with community institutions:** This could potentially include motivated providers in priority communities and area nursing homes, hospitals, colleges, schools or Head Start centers. Test the model on a small scale, identify pros and cons, and hone it for broader replication.

7. **Gauge the feasibility of Fare for All for rural childcare providers:** Coordinate with The Food Group to more fully assess the feasibility of targeting the Fare for All Express program to rural family providers.

8. **Continue to support the use of farmers markets and CSAs:** This should include a periodic assessment of how these approaches are working for providers and how their use can be expanded where appropriate.

9. **Collaborate with concerned institutions:** Given the considerable attention being paid to child care nutrition by various state agencies, community organizations and others in Minnesota, it will remain important to collaborate effectively with other actors in this field. This should include gathering input from key organizations as the Center formulates its strategic plan, and making a concerted effort to leverage community assets and expertise when designing your implementation plans. Strive for more systemic strategies that can help take earlier efforts to a new level of impact.

Appendix A: Interviewees

Name	Organization	Contact info
Joe Alexander	Reinhart Foodservice (LaCrosse, WI)	608/793-9278 JMAlexander@RFSDelivers.com
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Kathy Draeger	U of M Regional Sustainable Development Partnerships	320-273-2437 draeg001@umn.edu
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Mitch Gruber	Foodlink (Rochester NY)	585.328.3380 x113 mgruber@foodlinkny.org
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Paul Hugunin	Minnesota Department of Agriculture	651-201-6510 Paul.hugunin@state.mn.us
Sutton Kiplinger	The Food Project (Dorchester, MA)	617-442-1322 x28 skiplinger@thefoodproject.org
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Lori Kratchmer, Sophia Lenarz-Coy and Anita Berg	Emergency Foodshelf Network	763-450-3862 lkratchmer@emergencyfoodshelf.org
Jim Leonhart	Celebrate Children's Foundation (Wisconsin)	608-266-6953 james.leonhart@celebrate-children.org

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Sharon Rasmussen	Child care & Nutrition Inc. (Ivanhoe MN)	800-634-3359 rasmussensharon@gmail.com
Bonnie Sachetello-Sawyer	Hopa Mountain (Bozeman, MT)	(406) 586-2455 bsawyer@hopamountain.org
Chera Sevcik	SHIP coordinator, Faribault, Martin & Watonwan Counties	507.236.5376 chera.sevcik@fmchs.com
Stacey Sobell	Farm to Pre-K Committee of the National Farm to School Network (Portland OR)	(503) 467.0751 ssobell@ecotrust.org
Christine Twait	Providers Choice	952.345.8121 ctwait@providerschoice.com

Appendix B. Additional Resources

Child care in Minnesota

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Appendix C. Endnotes

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