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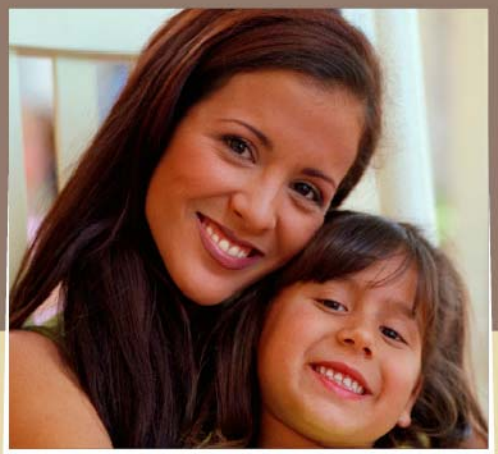
Efforts to Meet Children's Physical Activity and Nutritional Needs: Findings from the *I Am Moving, I Am Learning*

Implementation Evaluation



FINAL REPORT

February 2010

Enhancing Efforts to Meet Children's Physical Activity and Nutritional Needs: Findings from the *I Am Moving, I Am Learning* Implementation Evaluation

Final Report

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EXECUTIVE SUMMARY

There are two to three times as many obese children in the United States today as there were 20 years ago (Ogden et al. 2002). Data from the National Health and Nutrition Examination Survey (NHANES) indicate that more than one in four preschoolers in the United States were overweight or obese in 2003–2004 (Ogden et al. 2006).[1] Obesity poses serious problems for children's health and emotional well-being (Institute of Medicine 2005). Many obese children will become obese adults and will experience health problems associated with obesity, such as type 2 diabetes and coronary heart disease, earlier than the current generation of adults (Olshansky et al. 2005). Even more alarming, escalating rates of childhood obesity may lead to a reduction in life expectancy (Fontaine et al. 2003). To arrest this trend, both the Surgeon General (U.S. Department of Health and Human Services 2001) and the Institute of Medicine (2005) have suggested that efforts to prevent obesity should begin early in life.

Creative approaches to obesity prevention are underway in Head Start with a program enhancement called *"I Am Moving, I Am Learning"* (IM/IL). IM/IL was designed not as an add-on program, but as one that fits seamlessly into what programs are already doing, including corresponding with the Head Start Program Performance Standards.[2] IM/IL has three goals: (1) increase the amount of time children spend in moderate to vigorous physical activity (MVPA) during their daily routines, (2) improve the quality of structured movement activities that are facilitated by teachers and adults, and (3) promote healthy food choices for

[1] Following the recommendation of the Institute of Medicine (2005) in its report on preventing childhood obesity, this report uses the terms *overweight* and *obese* to describe children whose body mass index (weight in kilograms divided by height in meters squared) is at or above the 85th or 95th percentile, respectively, for age and sex.

[2] The Performance Standards require programs to (1) provide a proportion of children's daily nutritional needs; (2) adhere to the menu planning requirements of the U.S. Department of Agriculture's Child and Adult Care Food Program or, if meals are provided by school districts, the National School Lunch and School Breakfast programs; (3) ensure that staff and children eat together family style and share the same foods; (4) provide sufficient time, indoor and outdoor space, equipment, materials, and adult guidance to promote active play that supports the development of gross and fine motor skills; and (5) provide parents with educational opportunities to improve their food preparation and nutritional skills (Administration for Children and Families 2008).

children each day. Programs decide to whom they would like to target the IM/IL enhancement: children, parents, staff, and/or the broader community. The tenets of IM/IL are then to be incorporated into the daily routine. The use of music and songs to enhance structured movement activities, promote MVPA, and communicate health messages is a core strategy.

In the spring of 2006, Head Start Region III provided 53 Head Start programs with a 2.5-day IM/IL training-of-trainers (TOT) event for up to five staff members per program. The trainers and Region III staff encouraged participants to tailor the IM/IL enhancements to their own programs. During the training, participants gained hands-on experience with the use of music and songs through several activities that featured an animated character named "Choosy" (**C**hoose **H**ealthy **O**ptions **O**ften and **S**tart **Y**oung).[3] Choosy was introduced as a potential IM/IL mascot or role model that encourages children to engage in physical activity and to practice healthy eating habits.

The Office of Planning, Research, and Evaluation (OPRE) under the Administration for Children and Families (ACF) contracted with Mathematica Policy Research to conduct a two-year implementation evaluation of the IM/IL enhancements in Region III. The purpose of the study was to examine how grantees that participated in the spring 2006 regional TOT event implemented IM/IL enhancements; the evaluation was <u>not</u> designed to assess IM/IL's impact on children's health outcomes.

Five primary research questions guided the evaluation:

1. What is the theory of change employed by the Head Start programs using IM/IL?

2. How do programs translate the TOT model into the implementation of IM/IL?

3. What determinants are associated with program implementation of activities in the classroom and/or with parents and families?

4. What are the requirements for sustainability of IM/IL throughout the year?

5. What challenges and/or supports the implementation of IM/IL in Head Start programs?

To answer these research questions, a three-stage evaluation was designed. In Stage 1, a mail survey of the 53 Region III Head Start programs that participated in the spring 2006 TOT event was conducted. Data were collected in March and April 2007, about a year after

[3] The Choosy character, developed by Dr. Linda Carson and colleagues, is the mascot of Choosy Kids LLC [www.choosykids.com] and is used in IM/IL under an agreement between the Administration for Children and Families (ACF) and Choosy Kids LLC.

the TOT event. In Stage 2, in-depth telephone interviews were completed with IM/IL coordinators and two teachers/home visitors in 26 of the programs that completed the Stage 1 survey (the 26 programs were purposefully selected). The interviews gathered detailed information about implementation strategies, challenges, and successes during the first year of IM/IL (conducted June through August 2007). Finally, in Stage 3, site visits and one classroom observation per program were completed with a purposeful selection of 13 of the programs interviewed during Stage 2. The site visits were completed when programs were in the second year of IM/IL implementation (November 2007 through January 2008).[4]

Overall, IM/IL directors surveyed in Stage 1 indicated that programs found the TOT engaging and almost all tried to implement IM/IL in the 2006–2007 program year, with most concentrating on enhancements that focused on movement rather than nutrition (ACF 2007). The IM/IL directors identified implementation supports, such as broad staff enthusiasm for IM/IL, as well as potential barriers, such as limited time for program managers to support and conduct IM/IL activities.

This report focuses on stages 2 and 3 of the study, with a particular emphasis on understanding how programs went about implementing IM/IL and on assessing sustainability of the program enhancements that were implemented. A theory of change approach[5] served as the conceptual framework for the analyses and as the structure for organizing the report.

KEY FINDINGS

IM/IL programs that participated in the spring 2006 TOT event reported implementing a range of activities for children, staff members, and parents. At the end of the first year of implementation, the 26 programs participating in the Stage 2 interviews reported that they had implemented one or more IM/IL program enhancements and were planning to continue or expand their efforts during the 2007–2008 program year. Staff were enthusiastic about IM/IL, particularly about the music and movement activities, which they reported were easily integrated into daily activities in Head Start classrooms and as part of home visits. Some programs reported successfully reaching out to staff members and parents, with the focus on increasing their movement activities and improving their eating habits to help them serve as better role models for the children. Program administrators, classroom teachers, and home visitors in most Stage 2 programs reported that they had increased children's movement time and improved the food choices available to children. However, some contradictory evidence, including relatively few minutes of observed movement, was noted

[4] The site visit for one program was completed in early March 2008.

[5] A *theory of change* describes an intervention and the outcomes it hopes to achieve. One tool that is often used to provide a visual representation of a theory of change is a logic model. Logic models graphically represent the theoretical/assumed relationships between a program's activities and its intended effects or the connections between the *planned activities* and the *intended results* (W. K. Kellogg Foundation 2004).

in the on-site observations completed in the 12 Stage 3 programs.[6] This may be indicative of implementation challenges.

A brief summary of the evaluation's main findings follows, organized by research question.

What is the theory of change employed by the Head Start programs using IM/IL?

Figure 1 provides a reference logic model, developed for the purposes of this evaluation. The logic model illustrates how the theory of change that underlies the IM/IL initiative might be articulated.[7] The theory of change used by any individual program begins with the goals selected from the three main child-focused goals of IM/IL (increasing MVPA, enhancing structured movement, and promoting healthy food choices) and extends to specific audiences (children, parents, staff, and/or communities) who are then targeted with IM/IL activities.

During Stage 3 site visits, interviewers reviewed with IM/IL coordinators and other program managers a draft program-specific logic model that had been developed using information collected during Stage 2 interviews. These discussions made it clear that none of the Stage 3 program administrators and staff had explicitly developed a logic model or a similar tool to summarize their vision or assumptions about how IM/IL implementation should be structured or about what impacts IM/IL was expected to have.[8]

In the program-specific logic models, there was little variation across programs in the types of enhancements used within the three IM/IL target goals related to movement and nutrition. For example, programs that reported implementing enhancements to increase MVPA and/or augment structured movement activities among Head Start children all used similar approaches to incorporate MVPA/structured movement into children's daily routines (for example, the use of music), regardless of the other audiences they targeted.

The main differentiating factor in IM/IL implementation across programs was the specific audiences that were targeted with IM/IL activities. Only 5 of the 26 Stage 2 programs addressed children, parents, and staff. Twelve programs targeted children and parents, two targeted children and staff,[9] and seven targeted children only. Although some programs developed partnerships with community members or organizations in

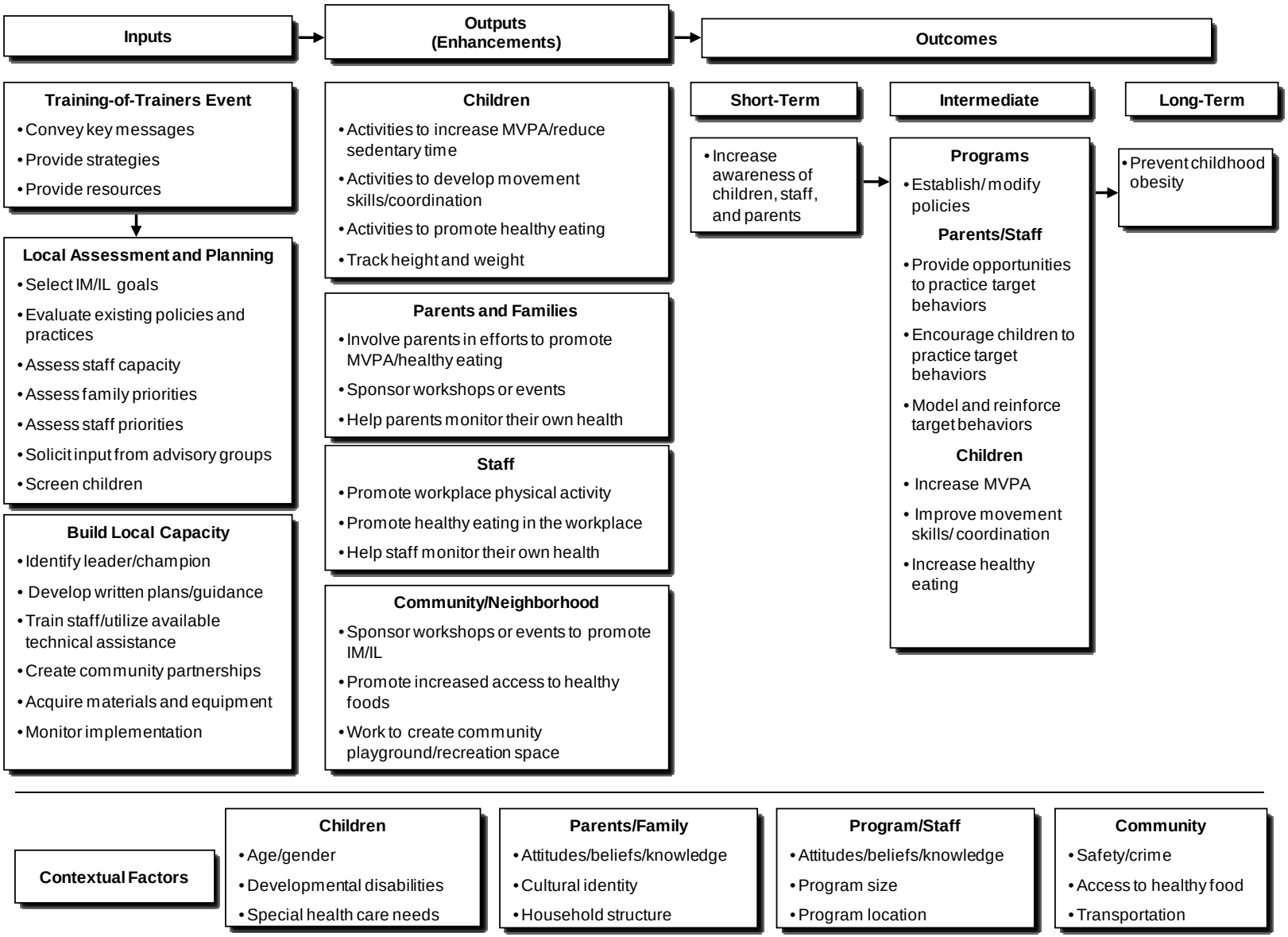
[6] Although there were 13 programs in Stage 3, only 12 classroom observations were completed. One program could not be observed because of inclement weather.

[7] The logic model was derived largely from the summary report that describes the pilot of IM/IL in Region III (Region III ACF with Caliber 2005).

[8] This was not surprising, given that a logic model was not presented during the TOT event and development of a logic model was not a requirement of IM/IL implementation.

[9] For analysis purposes, these programs were combined with the children and parents group, yielding a group of 14 programs that targeted children and one other adult audience.

Figure 1. Reference Logic Model for *I Am Moving, I Am Learning*



implementing IM/IL, none of the Stage 2 programs implemented specific activities that targeted the community at large.

The four groupings of programs based on these target audience distinctions reveal differences in a number of program characteristics, including:

- **Program size.** Smaller programs tended to target children only more often than larger programs.

- **Program approach.** Programs that included home visiting were more likely than center-based programs to target parents.

- **Staff experience.** IM/IL coordinators in programs that took the broadest approach to IM/IL implementation—targeting children, parents, and staff—had more experience working with Head Start children or other preschoolers than IM/IL coordinators in programs that targeted fewer audiences, and these coordinators had been with their current Head Start program longer.

- **Prior efforts to implement movement and nutrition activities.** Programs that had not focused on movement/physical activity or nutrition prior to IM/IL were more likely to target children, staff, and parents than were programs that had focused on these issues previously.

- **Focus on obesity prevention.** Programs that reported obesity prevention as a priority of their policy councils were more likely than other programs to target parents and/or staff.

- **Challenges related to available management time.** Programs targeting children only were less likely than other programs to report that lack of management time was a challenge in implementing IM/IL.

IM/IL coordinators in most Stage 2 and 3 programs had expectations about short-term and intermediate outcomes that were generally consistent with the logic model shown in Figure 1.

How do programs translate the TOT model into the implementation of IM/IL?

To translate the strategies introduced at the TOT into local implementation, programs (regardless of target audience) conducted activities in the following areas:

- **Assessment, planning, and goal setting.** All 26 of the Stage 2 programs reported that planning for IM/IL was a collaborative process that involved staff that had attended the TOT as well as some who had not. Most programs reported using informal means to assess local practices, needs, and priorities. Twenty-three Stage 2 programs reported obtaining input to the planning process from stakeholder and advisory groups. One-third of the Stage 2

programs used pilot tests, typically in a subset of classrooms or centers, to inform plans for future IM/IL implementation.

With regard to IM/IL goals, almost half of all programs (12 of 26) targeted only the MVPA goal. Five programs targeted MVPA and structured movement and three programs focused on MVPA and nutrition. Six programs focused on all three IM/IL goals. Three programs took the most comprehensive approach to implementing IM/IL, addressing all three IM/IL goals and all three target audiences.

- **Staffing and staff training.** IM/IL coordinators in each Head Start program had primary responsibility for assessment, planning, and capacity building. All of the Stage 2 programs assigned responsibility for IM/IL coordination to one or more members of the management team The two staff members most commonly responsible for IM/IL coordination were education specialists (10 of 26 programs) and health specialists (5 of 26).

  Most programs (20 of 26) provided staff with multiple training opportunities, including pre-service training (conducted before the start of the program year), in-service training (conducted during the program year), and special IM/IL-focused workshops. The time devoted to training activities varied widely from 1 to 24 hours (median of 6 hours) over the program year.

  Most Stage 2 programs (15) focused their initial training on lead teachers. However, nine programs trained all frontline staff, including bus drivers, cooks, and assistant teachers.

  Almost all of the Stage 2 programs (23) reported introducing the Choosy character at the initial IM/IL training and more than half (17) reported dancing or moving to music during the training, which was most often Choosy compact discs (CDs). Only half of the programs explicitly reported demonstrating potential IM/IL classroom activities, for example, how to actively lead children in a Choosy dance or movement activity.

  Reports from teachers/home visitors about the usefulness of the initial training were mixed. Teachers/home visitors in most Stage 2 programs (14 of 26) thought that the initial training was sufficient. Teachers/home visitors who thought the initial training was insufficient wanted more examples of potential IM/IL activities, guidance about how to implement IM/IL with specific groups, and/or more opportunities to share ideas with other teachers/home visitors.

  Most programs in the Stage 3 sample provided minimal or no training during the second year of implementation. Programs reported that they trained new teachers as part of orientation but did not provide returning teachers with additional training. Programs that did offer training tended to put more emphasis on specific guidelines and expectations for teachers than they had the

first year. This included, for example, how to document IM/IL activities in lesson plans and how to track child outcomes and movement.

- **Community partnerships.** Eighteen of the 26 Stage 2 programs reported engaging other organizations in the community to support planning for or implementation of IM/IL. Most often, these community partners provided supports for training or workshops for staff or parents. During the second year of IM/IL implementation, 3 of the 13 Stage 3 programs formed partnerships with other Head Start programs that were implementing IM/IL to enhance their capacity to provide ongoing training and plan IM/IL implementation.

  In addition, seven Stage 3 programs reported activities during the second year of IM/IL implementation that targeted the broader community—individuals other than Head Start children, parents/families, and staff. These activities included workshops or events promoting healthy eating and physical activity that were open to the entire community (five programs), training/awareness events for staff in other organizations that serve children and families (two programs), outreach to local pediatricians to encourage routine measurement of children's body mass index (BMI) (one program), and booths at service fairs and in malls to encourage families to adopt healthier lifestyles and set up similar booths at local malls (one program).

- **Written plans and guidance.** In the first year of implementation, only 2 of the 26 Stage 2 programs developed a formal, written plan for IM/IL implementation. Twelve of the 26 Stage 2 programs incorporated IM/IL as a category or unit into the lesson plan templates that teachers completed on a daily or weekly basis, which reminded teachers/home visitors to implement IM/IL activities. The strength of these reminders was enhanced by the fact that supervisors in all 12 programs used the lesson plans to monitor IM/IL implementation.

- **Materials and equipment acquired to support IM/IL implementation.** All but one of the 26 Stage 2 programs reported acquiring materials or equipment to support IM/IL implementation. Sixteen programs purchased additional Choosy music CDs and/or posters that featured the Choosy character.[10] Nine programs purchased equipment for use in outdoor physical activity.[11] The same number of programs purchased props for MVPA and structured movement activities in the classroom. Six programs reported making some of the homemade props introduced at the TOT event.

[10] Attendees at the spring 2006 TOT event received up to two Choosy music CDs in their take-away materials.

[11] Most programs that purchased outdoor equipment reported that they were planning to do so prior to IM/IL, but IM/IL helped inform their decisions about which equipment to purchase.

During the second year of IM/IL implementation some Stage 3 programs (5 of 13) purchased additional equipment or props.

Most Stage 2 programs (23 of 26) continued to use the nutrition/fitness curriculum they had in place before implementing IM/IL. During the second year of IM/IL implementation, about half of the Stage 3 programs (6 of 13) reported adding a nutrition/fitness curriculum or changing the ones they had been using.

What determinants are associated with program implementation of activities in the classroom and/or with parents and families?

There was little variation across programs in the types of enhancement activities programs conducted (physical activity versus nutrition). Findings by target audience include the following:

- **All 26 of the Stage 2 programs implemented IM/IL enhancements that targeted children.** However, programs varied in the IM/IL goals (MVPA, structured movement, and nutrition) they chose to focus on with children.

  In planning to implement enhancement activities for children, programs reported that they did not need to make significant accommodations, in the daily lesson plan or otherwise, for children with Individualized Education Programs (IEPs) in implementing movement-oriented IM/IL enhancements.

  Among the programs included in Stage 3 site visits, most (11 of 13) programs established or modified program policies related to physical activity or nutrition and most (11 of 13) expected to increase the amount of time children spent in MVPA while at Head Start.

- **Seventeen of the 26 Stage 2 programs targeted parents.** Programs that targeted parents tended to be larger and were more likely to offer home-based services or Early Head Start services than programs that did not target parents.

  Thirteen of the 17 programs that targeted parents provided a general introduction of IM/IL to parents rather than encouraging physical activity and healthy food choices in a more informal manner.

  Programs that targeted parents reported three different areas of focus for IM/IL activities: (1) education and information about healthy eating and/or exercise, (2) practical examples of activities parents could do with their children to increase MVPA, and (3) education and guidance about healthy food preparation techniques. Programs used a variety of strategies to deliver parent-focused IM/IL activities with the most common approach being parent newsletters.

- **Only 7 of the 26 Stage 2 programs reported targeting staff as part of IM/IL**. Programs that conducted IM/IL activities sponsored activities specifically for staff to encourage staff to become more physically active. For example, three programs created walking groups for staff. Additionally, some programs also reported offering staff incentives for exercising.

- **About half of the programs made substantial adjustments in their approaches to IM/IL during the second year of implementation.** Six of the 13 Stage 3 programs reported appreciable alterations in their approaches to IM/IL after the first year of implementation. One program expanded IM/IL implementation to target parents; two programs substantially expanded the staff component of IM/IL, in large part because of staff enthusiasm for IM/IL and its goals. Another Stage 3 program cut back on the staff component of IM/IL by dropping the requirement that each staff member set a personal health goal. This program also added incentives during Year 2 to revitalize staff activities that had diminished over the course of the Year 1.[12]

  Three of the six Stage 3 programs that reported a substantial change in approach adopted a new nutrition/fitness curriculum during the second year of implementation.

What challenges and/or supports the implementation of IM/IL in Head Start programs?

Programs reported a number of different issues that posed challenges for IM/IL implementation as well as a number of factors that supported implementation.

Challenges

- ***Insufficient* training.** The challenge reported most frequently (16 of 26 Stage 2 programs) was insufficient training. Concerns about the adequacy of training varied for management and frontline staff. IM/IL coordinators and other program managers typically wanted more guidance about how to expand and maintain IM/IL implementation after the first year or about how to monitor IM/IL implementation. Teachers wanted more materials and resources, more or better instruction about how to implement IM/IL activities, and guidance on how to assess and monitor children's movement skills. Home visitors noted that more training specifically related to their interactions with children and/or families would have been helpful.

- ***Support/buy-in.*** Many programs reported challenges related to getting buy-in—from parents (15 of 26 Stage 2 programs), staff (12 programs), and children

[12] The IM/IL coordinator obtained community donations to use as rewards for staff that walked regularly. Rewards included a membership at a fitness club and a massage.

(8 programs). In describing the challenges posed to getting parent buy-in, most programs mentioned that getting *parental* participation in IM/IL activities was difficult.

In the 12 Stage 2 programs in which IM/IL coordinators and program managers reported difficulties with *staff* buy-in, the most common explanation was that some teachers/home visitors were less than enthusiastic or complained about IM/IL because they saw it as yet another activity or curricular requirement being added to an already tightly scheduled day (or home visit). Comments from teachers/home visitors suggest that, in general, they did not disagree with the importance or value of IM/IL. Rather, their resistance reflected worries about their ability to implement IM/IL without sacrificing quality in some other program area. In most of the programs in which staff reluctance was cited as a challenge (7 of 12 Stage 2 programs), program managers reported that the resistance lessened over time. However, in the remaining 5 programs in which staff buy-in was cited as a challenge, managers reported that staff buy-in decreased over the course of the first year of IM/IL. In most of these programs, the decrease in enthusiasm was associated with specific strategies programs were using to implement IM/IL rather than IM/IL more generally.

Although the majority of programs reported that *children* enjoyed IM/IL activities, 8 of 26 Stage 2 programs encountered difficulties in getting some children to eat new foods or try new activities. To address this, teachers reported encouraging children to try small "no thank you" or "thank the cook" bites of food when new (or traditionally avoided) foods were offered. Teachers also worked with children who were reluctant or embarrassed to dance by giving them Choosy cutouts to wave until they got used to doing the movements and felt more comfortable.

- **Lack of time.** Fifteen of the 26 Stage 2 programs cited time constraints as a challenge for IM/IL implementation. IM/IL coordinators found it difficult to devote an adequate amount of time to program-level IM/IL planning activities or staff training. Teachers voiced concerns about having enough time to implement IM/IL activities throughout the program day. This was particularly true in programs that modified or established policies about the number of minutes of physical activity children should receive each day and/or about how this physical activity should be distributed.

- **Other challenges.** Other challenges, reported by no more than 6 of the 26 Stage 2 programs, included lack of funding (6 programs); space limitations, such as small classrooms that are not well suited for movement-oriented activities (5 programs); inclement weather, which made it difficult to reach MVPA goals because children could not go outside (4 programs); staff turnover (4 programs); and monitoring IM/IL implementation (4 programs). Teachers in at least 3 Stage 2 programs said that their personal/health conditions (such as

their age, weight, or having bad knees) made it difficult for them to participate fully in or demonstrate IM/IL activities.

In the second year of implementation, staff buy-in seemed less problematic. Although some teachers in Stage 3 focus groups voiced concerns about finding time to implement IM/IL activities, only one of the three IM/IL coordinators in Stage 3 programs who reported teacher resistance/reluctance as a problem at the end of Year 1 reported continued difficulty in this area during Year 2.

New challenges reported during the second year of IM/IL implementation centered on programs' uncertainty about how to expand or sustain IM/IL activities in the future. IM/IL coordinators in 5 of the 13 Stage 3 programs reported that that they needed additional training to determine how the program could "take IM/IL further."

Supports

IM/IL coordinators and teachers/home visitors found it easier to identify challenges they faced in implementing IM/IL than to identify factors that supported or enhanced IM/IL.

- **The TOT event**. IM/IL coordinators in all 26 Stage 2 programs reported that they enjoyed the TOT event and that the training, materials, and resources they received at the TOT were useful in planning and implementing IM/IL.

- **Enthusiastic support among key stakeholders.** Teacher, IM/IL coordinator, and parent enthusiasm were reported to be influential in the success of IM/IL implementation. IM/IL coordinators in 11 of the 26 Stage 2 programs mentioned the support of their policy councils, governing boards, or health services advisory committees as a contributing factor to successful implementation.

- **Characteristics of the IM/IL program.** All 26 Stage 2 programs reported that teachers and children alike enjoyed the music and the associated movements/activities. The Choosy character was also mentioned as an important program element, with children responding very positively to the character. Finally, IM/IL coordinators and/or teachers in 20 Stage 2 programs reported that the flexibility of the IM/IL model, which enables programs to develop their own approaches, contributed to successful implementation.

- **Existing focus on IM/IL goals.** IM/IL coordinators in 14 of the 26 Stage 2 programs reported that the success of IM/IL implementation was influenced by the fact that their programs had already begun to focus on increasing physical activity, increasing nutrition education, and/or improving the nutritional quality of meals and snacks.

- **Low program costs.** IM/IL coordinators in 8 of the 26 Stage 2 programs mentioned the low cost of IM/IL—start-up and/or maintenance costs—as a factor that contributed to successful implementation.

- **Other supports.** Other implementation supports mentioned by IM/IL coordinators or teachers in one or more programs included the following: a well-educated staff; access to the facilities, staff, or resources of the affiliated school districts; community support and resources; and the fact that the program could be implemented easily in homes as well as classrooms.

What are the requirements for sustainability of IM/IL throughout the year?

The evaluation's ability to assess sustainability is limited by the small sample size (13 programs) for the final phase of data collection (Stage 3) and by the fact that all of the Stage 3 programs had achieved at least a medium level of implementation during the first year of IM/IL (based on findings from Stage 2 interviews). Thus, the Stage 3 sample did not include any programs that appeared to be facing significant challenges with IM/IL implementation;[13] however data from Stage 3 interviews and focus groups provide some insights about the sustainability of the IM/IL initiative in these programs. The Stage 3 data, collected when programs were in the second year of implementation, suggest that several factors may promote sustainability:

- **Adaptability.** IM/IL is highly adaptable, enabling programs to modify their approaches to fit the priorities/interests and capacities of their particular programs.

- **Program champion.** Twelve of the 13 Stage 3 programs reported having an IM/IL coordinator who was enthusiastic about continuing and, in some cases expanding, IM/IL. Teachers and other managers in these programs perceived the IM/IL coordinator to be an enthusiastic leader/program champion.

- **Perceived benefits/fit with the organization's mission.** In all 13 Stage 3 programs, there was broad support for the goals of IM/IL among both management and frontline staff. No Stage 3 programs reported that they expected to curtail IM/IL activities. Programs that did expect to make changes hoped to expand the program to include additional target audiences.

Factors that may inhibit sustainability relate to organizational capacity, community partnerships, and program costs.

[13] This was not intentional. The original design called for inclusion of both low- and high-implementing programs. However, all 26 of the programs included in the final Stage 2 sample were found to have achieved at least a medium level of implementation.

Organizational Capacity. Based on findings from Stage 2 and 3 interviews and focus groups, three aspects of organizational support may be especially important in the sustainability of IM/IL—staff training, program policies, and written plans and guidance.

1. **Staff training.** Findings from Stage 2 and Stage 3 suggest that staff training may influence the sustainability of IM/IL. As noted previously, teachers/home visitors in 12 of the 26 Stage 2 programs thought their initial IM/IL training was insufficient. Training of frontline staff was generally delivered by program staff rather than the IM/IL TOT trainers. Most likely there were differences in the competence and comfort level of the program staff that provide the IM/IL training, as well as potential variations in the content provided. The model currently being used to provide IM/IL training to frontline staff, which uses a core group of trainers in each region rather than a TOT approach, may improve this situation.

   In addition, as previously noted, IM/IL coordinators had some concerns of their own about training in IM/IL. Findings from Stage 3 interviews suggest that IM/IL coordinators might benefit from additional training and technical assistance or a networking system that would allow them to share experiences and learn from others. The Office of Head Start is working with the Head Start Body Start (HSBS) National Center for Physical Development and Outdoor Play to provide resources, training, and technical assistance for IM/IL, which may assist with these issues.

   Another training-related issue that may affect sustainability is providing training for new staff in the event of staff turnover. Staff turnover was not a major problem in the programs that participated in this evaluation—only 4 of the 26 Stage 2 programs encountered staff turnover during the first year of IM/IL implementation. However, it is inevitable that programs will eventually experience some turnover.

2. **Program policies.** Almost two-thirds of the Stage 2 programs (15 of 26) modified or established policies related to the amount of time children are active or moving throughout the day. The data collected during Stage 3 classroom observations indicate that the presence of a policy does not guarantee that the policy is fully implemented. Additionally, weather was shown to have an impact on physical activity, but policies for overcoming this challenge did not appear to be present. Nonetheless, formal policies confer a level of importance to specific activities and practices, raise staff awareness, and provide a mechanism for management staff to use in monitoring performance and working with teachers/home visitors to improve usual practices.

3. **Written plans and guidance.** Only about half of the Stage 2 programs (14 of 26) developed either a formal written plan for IM/IL or some other form of written guidance. The lack of a formal written plan or other written guidance may compromise IM/IL implementation and sustainability. The absence of a

plan may be related to the concerns expressed both by management and frontline staff about having adequate time to devote to IM/IL implementation (16 of 26 Stage 2 programs) and their report that they needed more training (managers in 5 Stage 2 programs and frontline staff in 10 Stage 2 programs).

Community partnerships. At the TOT, trainers pointed out that community partners—such as local hospitals, the Women, Infants and Children (WIC) program, and university extension programs—can lend their expertise to provide staff training and to develop and potentially implement IM/IL activities (for example classroom activities for children or workshops for parents). Moreover, a community's awareness of and support for a program may make it easier for staff to access funding sources or in-kind donations to fund additional IM/IL activities.

Program costs. The TOT event stressed that implementing IM/IL would not require programs to purchase equipment or a curriculum. Instead the TOT event provided examples of props that programs could make or how to use existing classroom items in new ways. Some programs decided to make an investment in materials or equipment to facilitate physical movement or nutritional activities. The scope of this study did not include a cost analysis, but 4 of the 6 Stage 2 programs volunteered that their implementation success was at least partly due to obtaining outside funding and six Stage 2 programs identified the lack of financial support for IM/IL as a barrier to implementation or sustainability. These programs noted that additional funding would make it possible to expand IM/IL to more target audiences, or to provide more in-depth training for staff.

Stage 2 programs that partnered with community organizations often worked creatively with these partners to provide expertise to targeted audiences, primarily staff and parents. In the second year of IM/IL implementation, several Stage 3 programs partnered with other Head Start programs that were implementing IM/IL to expand capacity of both their own program and the partner program to train staff and plan IM/IL activities. This was seen as a way of bringing "new blood" into the IM/IL program: experienced individuals who could bring new ideas for implementation, monitoring, expansion, and sustainability. In addition, the access to additional staff that are able to train frontline staff provided a safety net for dealing with staff turnover.

Next Steps for IM/IL

This report provides information about how Region III grantees that attended the spring 2006 TOT implemented IM/IL—the goals they selected, the audiences they targeted, and the activities they implemented—as well as information about the challenges and successes they experienced. Overall, IM/IL was met with enthusiasm among staff members, children, and parents. By the spring of 2008, the Office of Head Start had sponsored one IM/IL TOT event in all but one of the 12 ACF regions. The Office of Head Start staff report that programs were calling the office to request IM/IL training.[14] In May 2008, a new

[14] Amanda Bryans, personal communication, April 2008.

IM/IL training model was launched. This approach uses, in place of the TOT event, 100 specially trained facilitators (former training and technical assistance providers or program staff members) who provide a structured, two-day training for program teams (both management and frontline staff). The new model includes videotaped segments of training conducted by the core team of the original TOT trainers as additional supports for implementation, as well as CDs, presentation materials, and a resource binder. Findings from this evaluation are relevant to the new model and Stage 1 findings have been used to inform the new training as well as the development of additional supports for local implementation specifically related to the creation of written plans. Findings from this final report may provide additional insights about how implementation of IM/IL can be strengthened and supported.

CHAPTER I

INTRODUCTION

There are two to three times as many obese children in the United States today as there were 20 years ago (Ogden et al. 2002). Data from the National Health and Nutrition Examination Survey (NHANES) indicate that more than one in four preschoolers in the United States were overweight or obese in 2003-2004 (Ogden et al. 2006).[15] Obesity poses serious problems for children's health and emotional well-being (Institute of Medicine 2005). Many obese children will become obese adults and will experience the health problems associated with obesity, such as type 2 diabetes and coronary heart disease, earlier than the current generation of adults (Olshansky 2005). Even more alarming, escalating rates of childhood obesity may lead to a reduction in life expectancy (Fontaine et al. 2003). To arrest this trend, both the Surgeon General (U.S. Department of Health and Human Services 2001) and the Institute of Medicine (2005) have suggested that efforts to prevent obesity should begin early in life.

In formulating strategies for preventing obesity in early childhood, there are compelling reasons to focus on low-income children in racial/ethnic minority groups. There are marked disparities in the prevalence of obesity across racial/ethnic groups of U.S. adults (Ogden et al. 2006). The root of these disparities, which are apparent by adolescence (Gordon-Larsen et al. 2003; Winkleby et al. 1999), may lie in the preschool years because it is in early childhood that the foundations for healthy eating and physical activity habits are established (Westenhoefer 2002; Birch and Fisher 1998).

Head Start, with its almost one million low-income preschool children from diverse racial/ethnic backgrounds, is potentially an ideal setting for developing and implementing obesity prevention efforts. Although there are no detailed studies of the prevalence of obesity in the Head Start population, available evidence shows that low-income preschoolers have experienced greater increases in the prevalence of overweight and obesity than middle-

[15] Following the recommendation of the Institute of Medicine (2005) in its report on preventing childhood obesity, this report uses the terms *overweight* and *obese* to describe children whose body mass index (weight in kilograms divided by height in meters squared) is at or above the 85th or 95th percentile, respectively, for age and sex.

income preschoolers (Polhamus 2006; Kim 2006). It is likely that between 15 and 20 percent of children enrolled in Head Start are obese (Story et al. 2006; Dennison et al. 2006).

The causes of obesity are complex and multi-faceted. However, a primary cause is energy imbalance—too many calories consumed in food and beverages and too few expended in physical activity. Head Start, which provides children with meals and opportunities for physical activity, is in a unique position to address these issues. Head Start Program Performance Standards require that meals offered in center-based programs provide one-third to one-half of children's daily nutritional needs, depending on the number of hours children are in attendance (National Archives and Records Administration 2006). Meals must adhere to menu planning requirements of the U.S. Department of Agriculture's Child and Adult Care Food Program or, if meals are provided by school districts, the National School Lunch and School Breakfast Programs. In addition, performance standards require that staff and children eat together family style and share the same foods, which provides an opportunity for adults to reinforce and model healthy eating behaviors. For physical activity, programs are required to provide sufficient time, indoor and outdoor space, equipment, materials, and adult guidance to promote active play that supports the development of gross and fine motor skills. Finally, performance standards require that programs provide parents with educational opportunities to improve their nutrition knowledge and food preparation skills.

THE *I AM MOVING, I AM LEARNING* INITIATIVE

As the premier federal early childhood program, Head Start has often served as a national laboratory for launching, evaluating, and refining initiatives designed to improve the health, education, and well-being of the nation's most vulnerable children. Head Start has made a commitment to addressing childhood obesity in its ongoing *I Am Moving, I Am Learning* (IM/IL) initiative. IM/IL was developed in 2004 by Head Start Region III in response to a request from the Office of Head Start. The effort was led by Nancy Elmore, Head Start Program Manager, Region III; Amy Requa, Pediatric Nurse Practitioner and Region III Technical Assistance Health Specialist; and Dr. Linda Carson, Director of the West Virginia Motor Development Center at West Virginia University.

The goals of IM/IL are to: (1) increase the amount of time children spend in moderate to vigorous physical activity (MVPA) during their daily routine to meet national guidelines for physical activity; (2) improve the quality of structured movement experiences that are intentionally facilitated by teachers and adults; and (3) promote healthy food choices for children every day.

IM/IL is not a stand-alone curriculum or a prescriptive program. Rather, it provides a flexible framework of strategies and resources that can be used to design an individualized program enhancement that fits unique program needs and can be integrated into ongoing routines and practices. The program enhancement can target center environments and resources, daily center routines, and staff behaviors. It can also involve children's homes and neighborhoods (for example, by educating parents and reaching out to community leaders and organizations). The IM/IL approach recognizes that a young child's weight is affected by what goes on at preschool, at home, and in the community.

In addition, IM/IL was designed to fit within the Head Start Program Performance Standards in two areas—education and early child development (1304.21) and child nutrition (1304.23)—and to address the Head Start Child Outcomes Framework. The outcomes framework focuses on a comprehensive, whole-child approach to providing services and tracking outcomes. Domain 8—Physical Health and Development—includes outcomes related to gross motor skills, fine motor skills, and health status and practices.

Another key feature of IM/IL is that it is implemented using a "training of trainers" (TOT) approach. Programs interested in implementing IM/IL send several key staff, generally program managers, to a TOT event. The expectation is that attendees will return to their home programs, train their colleagues, and work with them to develop and implement an IM/IL action plan. Trainees received a resource binder that included data on the prevalence of childhood obesity and recommendations from expert panels and professional organizations about how to support children in maintaining healthy weight, increasing physical activity, and improving diet quality. Trainees also received copies of all handouts used in the training, hard copies of Power Point slides, a backpack that contained a variety of potential program supports (including two music CDs and a pedometer) and several books about ways to support children in increasing physical activity and practicing healthy eating habits. (The IM/IL TOT event is described in detail in Chapter II).

IM/IL was piloted with 17 Region III programs in fiscal year (FY) 2005. Based on the success of the pilot, 53 additional Region III programs were trained in the spring of 2006. In early 2007, the Director of the Office of Head Start requested that all regions receive IM/IL training. By April 2008, about 471 programs in 11 of 12 Head Start regions (all but Region XII) had been trained. In May 2008, the Office of Head Start began a national roll-out of IM/IL. About 100 IM/IL facilitators were trained, including at least one team from each of the 12 federal regions. Facilitators, who completed one week of intensive training and were issued IM/IL toolkits, were charged with training staff in specific Head Start programs in 2008-2009.

THE *I AM MOVING, I AM LEARNING* IMPLEMENTATION EVALUATION

In the fall of 2006, Office of Planning, Research, and Evaluation (OPRE) under the Administration for Children and Families (ACF) contracted with Mathematica Policy Research to conduct an implementation evaluation of IM/IL in Region III. The purpose of this study was to examine implementation in the 53 Region III programs that participated in IM/IL training in the spring of 2006. Each of the 53 programs sent a team of up to five representatives to a 2.5-day IM/IL TOT event. As noted above, the expectation was that TOT attendees would return to their home programs, train their colleagues, and work with them to develop and implement an IM/IL action plan.

OPRE identified five research questions for the evaluation:

1. What is the theory of change employed by the Head Start programs using IM/IL?

2. How do programs translate the TOT model into the implementation of IM/IL?

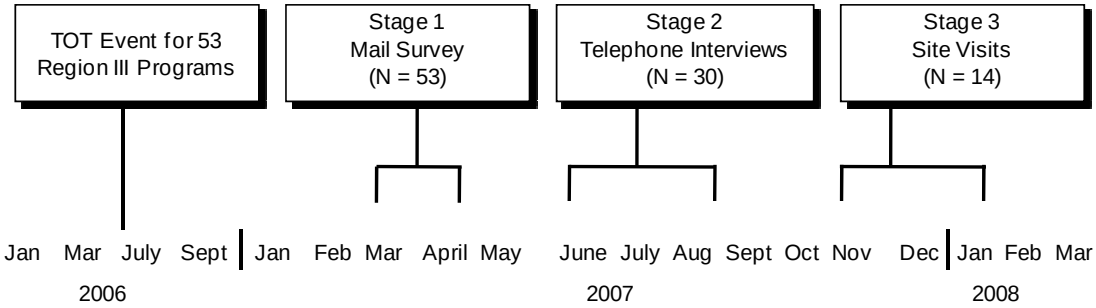
3. What determinants are associated with program implementation of activities in the classroom and/or with parents and families?

4. What are the requirements for sustainability of IM/IL throughout the year?

5. What challenges and/or supports the implementation of IM/IL in Head Start programs?

To address these questions, a three-stage evaluation was designed (Figure I.1). Stage 1 was a mail survey of the 53 Head Start programs that participated in the spring 2006 TOT event. Data were collected about a year after the event, in March and April 2007. The mail survey, which was completed by the individual staff member designated to lead implementation of IM/IL (the IM/IL coordinator), assessed perceptions of the TOT event and experiences during the first year of IM/IL implementation (2006-2007 program year). A total of 50 programs (94 percent response rate) returned completed questionnaires. A copy of the Stage 1 questionnaire is in Appendix A. Findings from the Stage 1 survey are summarized in a separate report (ACF 2007); key findings are summarized in Table I.1.

Figure I.1 Timeline for *I Am Moving, I Am Learning* Implementation Evaluation



Note: Sample sizes are beginning samples. Final analysis samples were somewhat smaller because of non-response and low implementation of IM/IL.

In Stage 2, in-depth telephone interviews were attempted with IM/IL coordinators and two teachers/home visitors in 30 of the programs that returned the Stage 1 survey. The interviews, which were completed about three to five months after the Stage 1 survey (June through August 2007), gathered detailed information about implementation strategies, challenges, and successes during the first year of IM/IL. Finally, in Stage 3, site visits were attempted with 14 of the programs interviewed during Stage 2. These visits were scheduled for the late fall and early winter of 2007 to 2008 (November through January), when programs were in the second year of IM/IL implementation. In addition to interviews with IM/IL coordinators and other program managers, site visits included separate focus groups with teachers and parents and a classroom observation.

Table I.1 Key Findings from the Stage 1 Survey

- One year after the TOT event, IM/IL coordinators gave the training a positive overall rating. They rated the event highly on its organization and the information that was presented. However, 40 percent of IM/IL coordinators said they wanted more time to plan their own implementation during the TOT event.
- Ninety-six percent of programs tried to implement IM/IL in the year following the TOT. Over 60 percent of programs provided pre-service and in-service training on IM/IL. The median amount of IM/IL training provided was 6 hours (range 1 to 24 hours).
- Programs reported implementing more activities related to MVPA and structured movement than nutrition.
- Almost half of the programs perceived that they were successful in implementing IM/IL. Enthusiasm of staff and the quality of the TOT event were the two most commonly reported factors contributing to the success of implementation. Programs that perceived themselves to be very successful were more likely to have left the TOT with a written plan for their IM/IL implementation than programs that perceived themselves to be less successful.
- It was not clear that existing program-level implementation efforts could be sustained. One year after the TOT, only half of the programs reported having a written plan for IM/IL implementation. Many programs had enthusiastic staff and a capable leader directing IM/IL efforts, but many reported that program staff did not have enough time to devote to IM/IL.

This report focuses on stages 2 and 3 of the study, with a particular emphasis on understanding how programs went about implementing IM/IL and in identifying factors that may affect sustainability of the program enhancements that were implemented as part of IM/IL. The rest of this chapter describes study methods for stages 2 and 3.

Stage 2 Methods

The goal for Stage 2 was to interview the IM/IL coordinator and two teachers in 30 of the Head Start programs that returned completed Stage 1 questionnaires. To ensure that the interviews could be completed before the end of the program year, the 30 programs were selected from a pool of 47 programs that returned completed questionnaires by April 27, 2007.[16]

Sample Selection

To select the Stage 2 sample, data from the 2005-2006 Program Information Report were used to stratify the 47 programs into two groups by program size, based on median enrollment. This was done to ensure that the sample included equal numbers of large and small programs. Subsequently, data from the Stage 1 survey were used to rank programs based on IM/IL coordinators' perceptions about the success of IM/IL implementation up to that point. The ranking was based on responses to four questionnaire items that asked

[16] Three programs returned the Stage 1 questionnaire after April 27th and were not eligible to participate in Stage 2.

respondents to rate the success of IM/IL implementation, overall, as well as in the three IM/IL goal areas (MVPA, structured movement, and nutrition). Responses were on a scale of 1 (not at all successful) to 5 (extremely successful). Programs were ranked within two strata (large and small programs)—first on the score for overall perceived success in implementation and, secondarily, on a summary score, which was computed by summing responses for the three IM/IL goal areas. The summary score ranged from 3 to 15.

The Stage 2 sample of 30 programs was purposively selected to include 10 self-perceived high-implementing and 5 self-perceived low-implementing programs within each program size stratum, for a total of 20 high-implementing programs and 10 low-implementing programs. Programs were selected in rank order (from highest down for high-implementing programs and lowest up for low-implementing programs). Geographic location (most often state) and program year end date were used to break ties in ranking.

A two-stage selection approach was used to identify the teachers and home visitors to be interviewed in each program. First, two centers (and two alternates) were randomly selected from a list of centers in which IM/IL was being implemented. In programs that were implementing IM/IL in classrooms only, one lead teacher was randomly selected from each center. (If the center only had one teacher, that teacher was "selected.") In programs that were implementing IM/IL in home visits as well as classrooms, a similar process was used to randomly select one lead teacher and one home visitor. Early Head Start home visitors were not included in the sample.

Telephone Interviews

Trained qualitative interviewers familiar with the program's responses to the Stage 1 questionnaire completed separate interviews with IM/IL coordinators and lead teachers/home visitors. All respondents were directly involved in implementing IM/IL activities.[17] Interviews with IM/IL coordinators lasted about an hour. Interviews with teachers/home visitors lasted about 30 minutes and included, depending on how the program was implementing IM/IL, separate interviews with either two lead teachers or one lead teacher and one home visitor. Table I.2 provides a summary of major topics included in each interview and interview protocols are provided in Appendix B.

Several steps were taken to ensure consistent, high-quality data collection across programs. All telephone interviews were completed by individuals experienced in working with Head Start grantees or other early childhood programs. Interviewers and senior

[17] In all but four of the 26 Stage 2 programs, the IM/IL coordinator interviewed in Stage 2 was the same person who completed the Stage 1 questionnaire. In three of the four programs where there was a change in respondent between stages 1 and 2, the Stage 1 questionnaire was completed by the program director or another senior manager who was functioning as the IM/IL coordinator at the time. By Stage 2, responsibility for IM/IL had been transferred to another individual and that person was interviewed during Stage 2. In the fourth program, the original IM/IL coordinator left the program between stages 1 and 2, and the Stage 2 interview was completed by the new coordinator.

Table I.2 Topics Covered in Stage 2 Telephone Interviews

IM/IL Coordinators	Teachers/Home Visitors
• Program and community context • Regional TOT event • Design and planning • Initial local training • IM/IL activities • Outreach to parents and community • Ongoing internal and external training and technical assistance • Sustainability and resources • Successes and challenges	• Program and community context • Design and planning • Initial local training • IM/IL activities • Outreach to parents • Ongoing training • Sustainability and resources • Successes and challenges

members of the study team completed a detailed training in which the protocols, procedures, and reporting format were reviewed. A note-taker was available during interviews to allow the questioner to maintain maximum focus. In addition, senior team members observed several initial calls and provided feedback on the notes made by other team members.

Final Sample

Interviews were completed with IM/IL coordinators and teachers/home visitors in 28 of the 30 programs sampled for Stage 2 (93 percent response rate). One of these programs indicated that, despite responses to the Stage 1 questionnaire, they had never really implemented IM/IL and another was implementing IM/IL at such a low level that they were not able to provide answers to most of the Stage 2 questions. These programs were two of the 10 "low-implementing" programs included in the Stage 2 sample. Examination of Stage 2 data for the other eight "low-implementing" programs included in the Stage 2 sample revealed that these programs looked more like the "high-implementing" programs than this very-low-implementing program. For this reason, it was not possible, in the Stage 2 analysis, to compare and contrast low-implementing programs with programs that achieved a higher level of implementation.[18]

Because the non-implementing program and the very-low-implementing program looked so different from the other 26 Stage 2 programs, they were excluded from the Stage 2 analysis. Thus, the effective sample for purposes of describing IM/IL implementation—the main focus of this report—was 26 programs. Information about reasons the two omitted

[18] Given that the Stage 2 sample included 10 low-implementing programs, it was surprising that only two of the Stage 2 programs were considered to be low-implementing on the basis of the data collected in Stage 2. This may be due to limitations of the Stage 1 questionnaire data used to rate implementation for purposes of Stage 2 sample selection and/or to changes in the programs implementation between stages 1 and 2. It may also reflect differences in the individuals who rated implementation status (IM/IL coordinator perceptions for Stage 2 sample selection; analyst-assigned ratings for Stage 2 data).

programs did not implement IM/IL or implemented at a very low level is included in Chapter VI, which focuses on lessons learned, including implementation challenges.

Data Analysis

Notes taken during the IM/IL coordinator and teacher/home visitor interviews were summarized using standardized reporting formats. Each write-up was reviewed by a senior member of the study team for completeness and level of detail. Atlas.ti, a qualitative analysis software package (Scientific Software Development 1997), was used to organize and synthesize the interview data. The software enabled analysts to use a structured coding system for organizing and categorizing the data. Once the interview data were coded, analysts used Atlas.ti to conduct searches and retrieve data on specific questions and subtopics related to the overarching research questions. Data were then analyzed across programs to identify common themes that emerged, as well as patterns related to IM/IL implementation and other program dimensions.

A total of 52 interviews were completed with teachers and home visitors in the 26 Stage 2 programs.[19] Because the unit of analysis for all Stage 2 data was the program, teacher/home visitor interviews, like IM/IL coordinator interviews, were coded at the program level. In situations where teachers and home visitors offered different perspectives or dissenting opinions, responses within the summarized reports were coded so that individual responses could be analyzed.

Stage 3 Methods

The goal for Stage 3 was to complete in-depth site visits with 14 of the 26 programs included in the Stage 2 analysis. Each site visit lasted 1.5 to 2 days and included the following data collection activities:

- Interview with the program director, IM/IL coordinator, and other program managers involved in IM/IL implementation (see Appendix C)[20]
- Focus group with teachers (see Appendix D)
- Focus group with parents (see Appendix E)
- Classroom observation (see Appendix F)

[19] One home visitor was interviewed in each of the seven Stage 2 programs where IM/IL was being implemented in home visits as well as classrooms. Forty-five teachers were interviewed across the 26 Stage 2 programs (one teacher per program in the seven programs that were implementing IM/IL in both classrooms and home visits and two teachers per program for the other 19 programs).

[20] Generally, IM/IL coordinators and program directors were interviewed together and a separate interview was done with other program managers involved in IM/IL implementation. In some programs, only one interview was needed/completed, depending on the number of management staff involved in IM/IL implementation, staff availability, and other scheduling constraints.

Table I.3 Topics Covered in Stage 3 Interviews and Focus Groups

Interviews with Program Director, IM/IL Coordinator, and Other Program Managers	Teacher Focus Group	Parent Focus Group
• Program and community context • Theory of change (logic model) • Staffing • Training and technical assistance • IM/IL activities • Outreach • Measuring outcomes • Sustainability and resources • Successes and challenges	• Program and community context • Sustainability and resources • IM/IL activities • Outreach to parents • Ongoing training • Successes and challenges	• Parent attitudes and beliefs: physical activity and healthy eating • IM/IL services • Opinions about IM/IL activities

Topics covered in the interviews and focus groups are summarized in Table I.3.[21]

Sample Selection

Sample selection procedures for Stage 3 mirrored those used in Stage 2. First, the 26 Stage 2 programs were stratified into two groups by program size (based on median enrollment). This was done to ensure that the sample included equal numbers of large and small programs. Subsequently, data from the Stage 2 interviews was used to assess programs' level of implementation. Analysts reviewed qualitative data provided in the Stage 2 interviews and rated six different dimensions of implementation—(1) design and planning, (2) staff training and buy-in, (3) IM/IL activities, (4) outreach to parents, (5) capacity building, and (6) sustainability—and assigned ratings of low, medium, or high implementation for each dimension as well as for overall implementation. (The rubric used in assessing reported implementation is provided in Appendix G.) Senior members of the analysis team reviewed summary notes to ensure that analysts' ratings of program implementation were consistent with interview data. There was relatively little variation across programs in analyst-assigned implementation ratings. Twenty-one of the 26 Stage 2 programs were rated as having achieved a medium level of implementation and five were rated as having achieved a high level of implementation.

Next, information from the Stage 2 interviews was used to characterize programs' implementation strategies along two key dimensions: (1) target audiences and (2) types of IM/IL activities being implemented. Programs were divided into three groups based on

[21] Home visitors were not included in Stage 3 focus groups because only three of the programs sampled for Stage 3 were implementing IM/IL in home visits and not all of the centers sampled in these programs had home visitors. Moreover, a primary focus of the Stage 3 analysis was to compare and contrast data from classroom observations and teacher reports of IM/IL implementation in classrooms.

target audience: (1) children only; (2) children and parents or children and staff; and (3) children, parents, and staff. These groups were further divided into three subgroups based on the types of IM/IL activities being implemented: (1) MVPA only; (2) MVPA and structured movement, but no nutrition-related activities; and (3) MVPA and/or structured movement and one or more nutrition-related activities. Programs that were characterized as having implemented structured movement activities mentioned activities that focused on body awareness and movement and/or skill development. Programs that were coded as having implemented one or more nutrition-related activities reported making changes in menus, policies about foods offered in Head Start, or policies about foods brought from home. A table was created that included information about these two aspects of program implementation and each of the 26 Stage 2 programs was assigned to a cell, as shown in Table I.4.

After all 26 Stage 2 programs had been stratified by size, assigned an implementation rating, and assigned to an implementation strategy cell in Table I.4, seven large programs and seven small programs were selected for Stage 3 site visits. All five of the programs that analysts rated as having achieved a high level of implementation, based on Stage 2 data, were selected (this included 3 large programs and 2 small programs). The other nine programs were selected to ensure representation of the range of implementation strategies shown in Table I.4. Five programs were selected with certainty because they were the only programs within their size stratum assigned to a particular cell in Table I.4. The remaining 4 programs were selected to represent the remaining cells in the table, while maximizing geographic diversity and ensuring roughly equivalent numbers of part-day and full-day programs. Table I.5 shows the IM/IL implementation strategies represented in the 14 programs selected for Stage 3.

Table I.4 Typology Used to Characterize IM/IL Implementation Strategies for Purposes of Stage 3 Sample Selection

	Target Audience		
	Children Only	Children and Parents or Children and Staff	Children, Parents, and Staff
	Number of Stage 2 Programs		
MVPA Only	3	8	1
MVPA + Structured Movement Only	3	1	1
MVPA and/or Structured Movement + Nutrition	2	5	2
Sample Size	**8**	**14**	**4**

Source: Stage 2 (summer 2007) IM/IL Coordinator and Teacher/Home Visitor Interviews.

Note: Distribution varies slightly from subsequent tables because one program's target audience was reclassified from the Children Only group to the Children, Parents, and Staff group based on Stage 3 data.

N = 26 programs that completed Stage 2 interviews and achieved a medium or high-level of IM/IL implementation.

Table I.5 IM/IL Implementation Strategies Used in Programs Selected for Stage 3 Visits

	Target Audience		
	Children Only	Children, Parents, and Staff	Children and Parents or Children and Staff
	Number of Stage 3 Programs		
MVPA Only	2	1	2
MVPA + Structured Movement Only	1	1	1
MVPA and/or Structured Movement + Nutrition	2	2	2
Sample Size	**5**	**4**	**5**

Source: Stage 2 (summer 2007) IM/IL Coordinator and Teacher/Home Visitor Interviews.

To identify specific Head Start centers for the teacher and parent focus groups and the classroom observation, the random selection procedures used in Stage 2 were modified slightly. To promote efficient use of the time on site, the list of centers eligible for selection was limited to those within 50 miles of the program's administrative offices (where the director and other management staff would be interviewed). Two centers were randomly selected from this list and one of these was randomly selected for the classroom observation. If the selected center had more than one classroom, one classroom was randomly selected. Program directors were asked to invite all teachers in the two sampled centers to participate in the teacher focus group and to recruit 10 to 12 parents for the parent focus group. Parents who participated in focus groups received $20 compensation per family.

Site Visits

Site visits were completed by researchers experienced in working with Head Start grantees or other early childhood programs. Site visitors completed a two-day training in which all interview and observation protocols and procedures were reviewed. Training on the observation protocol included a detailed review of coding guidelines for every item in the observation instrument, including guidance on how to code specific situations that were likely to be observed (see Appendix F). Photographs of Head Start classrooms and playgrounds, sample Head Start menus, and a video that provided an overview of IM/IL, including footage of children involved in IM/IL activities in Head Start classrooms,[22] were used to provide illustrative examples of what observers might encounter and to review associated coding rules.

The classroom observation was intended to provide a snapshot of IM/IL implementation in action and to capture information about nutrition and physical activity environments and policies in the Stage 3 centers. In each sampled classroom, one site visitor observed for the entire program day (all day for full-day programs; morning or afternoon

[22] The IM/IL video is available at: http://www.iian.ibeam.com/events/vide001/21580.

session for part-day programs). An existing, validated observation tool—the Environment and Policy Observation and Assessment (EPAO) instrument (Ward et al. 2008)—was used, with some modifications.[23] The EPAO captures information about (1) availability and use of play/physical activity equipment (fixed and portable), (2) practices used for meal preparation and service, (3) staff behavior during meals and during opportunities for physical activity and free play, (4) availability and use of water (as a beverage), (5) availability and use of televisions, video equipment, and computers, and (6) foods offered for meals and snacks. For purposes of this study, the section of the EPAO that focused on time spent in physical activity was modified to separately capture time spent in MVPA, structured movement activities, free play, and sedentary behavior (other than meal and nap times). In addition, items were added to capture the presence and use of IM/IL-recommended resources and materials (for example, music CDs, posters, and home-made props).

Prior to each site visit, site visitors reviewed Stage 2 interview summaries and prepared a logic model (see Chapter II) that summarized their understanding of the approach or "theory of change" the program was taking in implementing IM/IL. Each component of the logic model was reviewed with the program director and IM/IL coordinator during the Stage 3 interview and was revised as needed.

Final Sample

Stage 3 site visits were completed with 12 of the 14 sampled programs between November 2007 and January 2008. A site visit was completed with a 13th program in early March 2008. The remaining program was dropped because of lack of response from program staff (93 percent response rate).

In all 13 of the Stage 3 programs where site visits were completed, IM/IL coordinators and other program managers were interviewed and focus groups were completed with teachers and parents.[24] Forty program managers (IM/IL coordinators, program directors, and other program managers involved in IM/IL planning, implementation, or monitoring) were interviewed across the 13 Stage 3 programs (mean = 4; range = 1-7) and 54 teachers (mean = 4; range = 2-15) and 72 parents (mean = 6; range = 2-12) participated in focus groups.[25] The classroom observation was completed in only 12 of the 13 programs because, in one program, the sampled center was closed due to inclement weather.

[23] The observations were included as a first step in assessing whether the tool (as revised for this study) seemed to capture how IM/IL was being implemented in program classrooms. As noted above, the tool was adapted from an instrument that has been validated (Ward et al. 2008), but the adapted instrument was not validated under this study.

[24] In two programs, teachers had to be interviewed over the phone because of inclement weather. Focus groups for some programs were smaller than anticipated because of inclement weather.

[25] In one program, the director invited all teachers to attend the teacher focus group.

Data Analysis

Because of the small sample size for Stage 3, these data were used primarily to enrich and expand the data collected in Stage 2 by providing information about: (1) how IM/IL might have changed during the second year of implementation, (2) parents' perceptions of and experience with IM/IL, (3) teachers' perceptions about continued IM/IL implementation, (4) what IM/IL looked like "in action," and (5) the nutrition and physical activity environments in Stage 3 programs.

Notes taken during interviews and focus groups were summarized using standardized reporting formats. Three write-ups were prepared for each program: one for each of the focus groups and one for the program manager interview(s). The program manager write-up synthesized comments from the IM/IL coordinator, program director, and other program managers to describe how IM/IL was being implemented in Year 2. Each write-up was reviewed by a senior member of the study team for completeness and level of detail.

As in the Stage 2 analysis, Atlas.ti (Scientific Software Development 1997) was used to organize and synthesize the interview and focus group data and the program was the unit of analysis. Data were coded so that differing opinions and perspectives expressed by interview and focus group participants were captured. After the data were coded, analysts used Atlas.ti to conduct searches and retrieve data on specific questions and subtopics related to the overarching research questions. Data were then analyzed across programs to identify common themes that emerged, as well as patterns related to IM/IL implementation and other program dimensions.

Data from the classroom observations were tabulated and used to compute the cumulative minutes of MVPA and structured movement observed, as well as the proportion of programs with different observed characteristics.

Limitations

While this evaluation was carefully designed and implemented, it does have limitations that should be recognized when drawing conclusions from study findings. First, the study was designed to describe implementation of IM/IL in a sample of Head Start programs, not to assess the impact of IM/IL on children's weight status or other outcomes for children, staff, parents, or communities. Second, because the study includes a non-random sample of programs in Region III, findings may not be generalizeable to other Head Start programs that implement IM/IL. A third factor that limits generalizability is the fact that the strategies used in training Head Start staff to implement IM/IL have changed since the time the programs included in this report attended the TOT event. For example, IM/IL developers continued to make refinements to the TOT event, including allowing more time for program teams to work on their implementation plans and requiring that teams submit their plans to TOT trainers before leaving (verbal communication with Linda Carson, April 2008). Moreover, the next phase of the IM/IL rollout, which began in May 2008, uses a different TOT model. This model incorporates regional IM/IL trainers rather than relying on the

"core" training team that conducted all previous IM/IL TOT events.[26] Finally, participation in each of the study's three stages was voluntary. Although high response rates were achieved at each stage, it is important to note that programs that elected not to participate may have had IM/IL experiences that differ from those of the programs that did participate.

CHARACTERISTICS OF PROGRAMS PARTICIPATING IN THE *I AM MOVING, I AM LEARNING* IMPLEMENTATION EVALUATION

The Head Start programs included in this study (the 53 Region III grantees that participated in the 2006 TOT event) were not randomly selected. Characteristics of these programs (the Stage 1 sample for this study) were generally similar to those of Region III programs that were not included in this study (ACF 2007). However, Stage 1 programs did differ from other Region III programs in some ways. On average, the Stage 1 programs had more teachers with postsecondary education, fewer minority children, more children from single-parent families, and more children who had a disability or an Individualized Education Plan than other Region III programs.

Characteristics of the programs included in stages 2 and 3 of the study are summarized in Table I.6, along with characteristics for Region III programs overall. In stages 2 and 3, equal numbers of large and small programs were selected (so average enrollment is somewhat higher than for Region III overall). In Stage 3, the sample of programs was selected to provide a balance of rural and urban locations and equal numbers of full-day and part-day programs.

ROAD MAP TO THE REPORT

The rest of this report presents findings from stages 2 and 3 of the evaluation. A logic model framework is used to organize the discussion of findings. Chapter II provides an overview of how IM/IL is organized and structured, describes the TOT event, and introduces the logic model framework. Chapters III, IV, and V examine components of the logic model framework in more depth. Chapter III describes program "inputs"—the resources that are contributed toward implementing a program, such as the staffing structure; the design and planning process; staff training; and resources, material and equipment used to support program implementation. Chapter IV focuses on program activities and strategies (sometimes referred to as program "outputs")—the services, activities, or products that a program delivers to specific target audiences. For IM/IL,

[26] For the next phase of the IM/IL rollout, the IM/IL training team that has led all prior TOT events (the "core" training team) will not be training program staff. Rather, TOT events will be conducted by a team of about 100 IM/IL facilitators who completed an intensive week-long training led by the "core" training team. To promote standardization in approach, facilitators were provided with slides and materials the "core" team used, as well as video clips of the team conducting selected parts of the training (verbal communication with Linda Carson, April 2008).

Table I.6 Program Characteristics of Region III Head Start Programs and Those Included in Stages 2 and 3 of the IM/IL Implementation Evaluation

	All Region III	Stage 2	Stage 3
Average Program Enrollment	432	474	503
Average Number of Centers per Program	11	11	11
Average Number of 3- and 4-Year-Old Children per Center	47	48	41
Average Number of Teachers per Center	3	3	2
Average Percentage of Teachers with a Postsecondary Degree in Early Childhood Education	89	91	89
Program Auspice (Percentage)			
Nonprofit	43	41	46
Community action agency	30	33	23
School system	23	22	31
Government agency	4	4	0
Type of Service Provided (Percentage)[a]			
Full-day	83	85	85
Part-day	47	48	55
Center-based	93	92	92
Home-based	32	44	38
Combined Early Head Start/Head Start	26	30	46
Metropolitan Location (Percentage)			
Metropolitan	57	59	46
Nonmetropolitan	43	41	55
Average Enrollment of Children with Child Characteristic (Percentage)[a]			
Non-Hispanic Black or African American	28	23	22
Hispanic	11	11	8
Non-Hispanic White	60	60	64
Live in Spanish-speaking homes	7	9	5
Live in single-parent homes	46	46	49
Have health insurance	90	92	92
Have a disability	16	18	19
Have an Individualized Education Plan	16	18	19
Sample Size	**53**	**26**	**13**

Source: 2005-2006 Head Start Program Information Report.
Note: Due to rounding, not all column entries total 100 percent.
[a]Percentages not intended to add to 100 because the characteristics are not mutually exclusive.

outputs vary across programs depending on the audiences that are targeted (children, parents, and staff) and the IM/IL activities that are implemented (MVPA, structured movement, nutrition). Chapter V examines "outcomes"—the changes or benefits that result from a program. Because the intent of this evaluation was to describe IM/IL implementation, the chapter focuses on programs' progress toward intermediate outcomes rather than on longer-term child-level outcomes. Examples of intermediate outcomes include staff and parental buy-in and support of IM/IL's goals, establishment of program policies to support IM/IL goals, and availability of opportunities for children to increase MVPA, enhance movement skills and coordination, and improve food choices. Chapter VI discusses lessons learned about IM/IL implementation, including programs' successes and challenges, and factors that could affect sustainability.

CHAPTER II

I AM MOVING, I AM LEARNING: OVERVIEW OF THE INITIATIVE AND COMMON APPROACHES TO IMPLEMENTATION

A hallmark of the IM/IL initiative is its flexible approach. IM/IL was intentionally designed to allow Head Start programs to develop a customized approach to the prevention of obesity. IM/IL does not require that programs adopt a formal curriculum or a prescribed set of policies and practices. Rather, IM/IL is a program enhancement that provides Head Start staff with "strategies and resources for infusing quality physical movement and healthy nutrition choices within their familiar curriculum approaches and daily classroom routines" (Region III Administration for Children and Families [ACF] and Caliber 2006). Programs can vary in the type and number of activities and policies they incorporate or change and in their expectations regarding outcomes for children, parents, and staff. This inherent flexibility means that there is no one way to implement IM/IL—IM/IL may look very different from one Head Start program to the next.

Another key feature that may contribute to variability in IM/IL implementation among the programs included in this evaluation is the use of a "Training of Trainers" (TOT) approach to dissemination. With the TOT approach, self-selected teams of Head Start staff, including directors, specialists/coordinators, and lead teachers/home visitors were trained by IM/IL facilitators and then returned to their individual Head Start programs to train teachers and other staff. The extent to which frontline staff understood and embraced the goals of IM/IL and incorporated IM/IL activities into their classroom routines and interactions with parents and community members was dependent on what the TOT-trained staff did to "bring IM/IL home" to their organizations.

ORGANIZING PRINCIPLES

IM/IL was designed to fit within the Head Start Program Performance Standards in two areas: education and early child development (1304.21) and child nutrition (1304.23). Specifically, this includes the following standards:

- 1304.21–(a)(5)(i). In center-based settings, to promote each child's physical development by providing sufficient time, indoor and outdoor space, equipment, materials and adult guidance for active play and movement that support the development of gross motor skills
- 1304.21–(a)(6). In home-based settings, to encourage parents to appreciate the importance of physical development, provide opportunities for children's outdoor and indoor active play, and guide children in the safe use of equipment and materials
- 1304.21–(b)(3)(i). To promote the physical development of infants and toddlers by supporting the development of physical skills, including gross motor skills, such as grasping, pulling, pushing, crawling, walking, and climbing
- 1304.23–(c)(1-4,7). To ensure that nutritional services in center-based settings contribute to the development and socialization of enrolled children by providing that:
  - A variety of food is served which broadens each child's food experiences
  - Food is not used as punishment or reward, and that each child is encouraged, but not forced, to eat or taste his or her food
  - Sufficient time is allowed for each child to eat
  - All toddlers and preschool children and assigned classroom staff, including volunteers, eat together family style and share the same menu to the extent possible
  - As developmentally appropriate, opportunity is provided for the involvement of children in food-related activities
- 1304.23–(d). To provide family assistance with nutrition through parent education activities that include opportunities to assist individual families with food preparation and nutritional skills

In addition, IM/IL is intended to provide programs with tools to address outcomes in the Head Start Child Outcomes Framework, which comprises eight domains of child development that focus on a comprehensive, whole-child approach to providing services and tracking outcomes. Domain 8, Physical Health and Development, includes three elements: gross motor skills, fine motor skills, and health status and practices. Within these elements, there are several indicators that relate to physical activity and nutrition, including:

- Progresses in physical growth, strength, stamina, and flexibility
- Participates actively in games, outdoor play, and other forms of exercise that enhance physical fitness
- Shows growing independence in hygiene, nutrition, and personal care

IM/IL targets three specific areas:

1. **Moderate to Vigorous Physical Activity (MVPA).** The goal is to increase the amount of time children spend in MVPA during their daily routine in order to meet national guidelines for physical activity. The National Association for Sports and Physical Education (2002) recommends that preschool children spend two hours a day being physically active—half structured and half unstructured free play. It is further recommended that, except when sleeping, preschool children should not be sedentary for more than 60 minutes at a time.

2. **Structured Movement.** IM/IL aims to improve the quality of structured movement activities intentionally facilitated by teachers and other adults. IM/IL hopes to help educators understand that developing movement skills and coordination is a critical component of early childhood development, and that children do not necessarily develop these skills through independent play (Carson 2001). By engaging in physical activities that develop action awareness, effort awareness, space awareness, and relational awareness, children can gradually increase structured movements and MVPA (Carson 2001).

3. **Healthy Eating.** IM/IL emphasizes promoting healthy food choices every day including six nutrition messages (see box) that (1) promote food consumption patterns consistent with preventing obesity and maintaining health, and (2) encourage staff and parents to be thoughtful in how they prepare, offer, and serve food and beverages to children, for example, by making meal times casual and pleasant and avoiding "force feeding."

THE *I AM MOVING, I AM LEARNING* TRAINING-OF-TRAINERS EVENT

The IM/IL TOT event was a major component of IM/IL implementation. The 53 Region III programs included in the IM/IL implementation evaluation attended one of three TOT events held in the spring of 2006. Each program was allowed to send up to five representatives, usually including the director and the health manager, as well as the family and community partnerships manager, and the child development and education manager. The TOT spanned 2½ days and included plenary sessions, breakout groups, and workshops. All attendees from a particular program were assigned to one of four groups that rotated through a series of four core workshops as a team. This arrangement provided an opportunity for attendees to work with staff from other Head Start programs as well as their own. A sample TOT agenda is shown in Figure II.1.

IM/IL Nutrition Messages

Crave your FAV (Fruits and Veggies)
- Fruits and vegetables are delicious and good for you

Shop the Sides
- The healthiest foods are located around the perimeter of the supermarket

Drink Less Sugar
- Water is the best beverage
- Limit juice and sweetened beverages

Think Tiny Tummies
- Appropriate portions
- Don't force feed

Chat 'n' Chew
- Make meal times slow, pleasant, and interactive
- Adults should model healthy eating behaviors
- No television during meals

Choosy Snacks
- Snacks should be planned and healthful

Source: Handout from Spring 2006 TOT Event

The use of music and songs to enhance structured movement activities, promote MVPA, and communicate health messages is a core IM/IL strategy. During the training, participants gained hands-on experience with the use of music and songs through several activities that featured an animated character named "Choosy" (**C**hoose **H**ealthy **O**ptions **O**ften and **S**tart **Y**oung).[27] Choosy was introduced as a potential IM/IL mascot or role model that encourages children to engage in physical activity and to practice healthy eating habits. Take-home materials provided to trainees included two Choosy music CDs.[28]

Trainees also received a resource binder that included data on the prevalence of childhood obesity and recommendations from expert panels and professional organizations about how to support children in maintaining healthy weights, increasing physical activity, and improving diet quality. Copies of all handouts used in the training and hard copies of PowerPoint slides were also provided to trainees, along with a backpack that contained a variety of potential program supports (including a pedometer) and several books about ways to support children in increasing physical activity and practicing healthy eating habits.

[27] The Choosy character, developed by Dr. Linda Carson and colleagues, is the mascot of Choosy Kids LLC [www.choosykids.com] and is used in IM/IL under an agreement between ACF and Choosy Kids LLC.

[28] The IM/IL training team used Choosy music and other materials throughout the TOT event, but informed trainees that they could implement IM/IL using other materials and music.

Figure II.1 Agenda for I am Moving, I am Learning Training-of-Trainers Event

Day 1

9:00-9:45	Welcome and Opening Remarks
9:45-10:45	Opening Plenary Session *Obesity Epidemic Overview*
10:45-11:00	Break
11:00-11:45	Plenary Session *"I Am Moving, I Am Learning:" What Is It All About*
11:45-1:00	Lunch
1:00-2:30	Workshop Session #1 One of four core workshops, in assigned small groups • *Moving With the Brain in Mind* • *Nutrition Building Blocks* • *Body Language* • *MVPA—It's Everywhere!*
2:30-3:00	Reflection for planning (workshop groups)
3:00-3:15	Break
3:15-4:30	Plenary Session • *Best Practices* • *One Size Does Not Fit All* • *Sharing Successful Program Strategies*

Day 2

9:00-10:30	Workshop Session #2
10:30-10:45	Reflection for planning (workshop groups)
10:45-11:00	Break
11:00-12:30	Workshop Session #3
12:30-12:45	Reflection for planning (workshop groups)
12:45-1:45	Lunch
1:45-3:15	Workshop Session #4
3:15-3:30	Reflection for planning (workshop groups)
3:30-3:45	Break
3:45-4:30	Plenary Session • *The Squiggle* • *Engaging Adults: Parents & Staff in I Am Moving/I Am Learning* • *Healthy Games for Adults* • *Demonstration/Opportunity to try Dance, Dance Revolution*

Day 3

9:00-10:30	Plenary Session *Utilizing Child Assessment and Homemade Play Materials to Improve Planning for Movement and Learning*
10:30-10:45	Break
10:45-11:45	Small Group Work Sessions *Developing Action Plans and Integrating I Am Moving, I Am Learning Within Your Program*
11:45-12:15	Closing Session • *Inside Mouse, Outside Mouse* • *Choosy Movement Finale*

Findings from the Stage 1 survey indicate that the TOT was both well attended and well received.[29] Nearly 90 percent of programs sent four or five staff members; more than half (56 percent) sent five. The child development and education manager was the staff member most commonly sent (72 percent of programs), followed by the health services manager (66 percent) and the family and community partnerships manager (58 percent). More than half the programs (52 percent) sent the Head Start program director to the training, and more than a quarter (28 percent) sent a teacher.

TOT attendees gave the training a positive overall rating. On a scale of 1 (poor) to 5 (excellent), 71 percent rated the event as a 5. Respondents rated the event highly on its organization and the information that was presented (Table II.1). For example, on a scale of 1 (strongly disagree) to 4 (strongly agree), 85 percent strongly agreed that the IM/IL goals were clearly explained; 82 percent strongly agreed that the workshops presented ideas for activities that addressed these goals; and 71 percent strongly agreed that the TOT event provided new information and resources.

Programs rated the TOT event somewhat lower on the practical aspects of implementing IM/IL in their own programs. For example, on a scale of 1 (strongly disagree) to 4 (strongly agree), only a third of programs strongly agreed that the training prepared them to implement IM/IL. Moreover, when asked about the allocation of time to the topics during the TOT, many programs reported that not enough time was spent on engaging adults in IM/IL and planning their program's implementation (37 and 40 percent, respectively[30]; Table II.2). Indeed, one-third of programs reported leaving the TOT event without a written action plan for implementing IM/IL (data not shown).

DESCRIBING *I AM MOVING/I AM LEARNING* IMPLEMENTATION: A LOGIC MODEL FRAMEWORK

A major focus of the IM/IL implementation evaluation is understanding what programs that participated in the TOT event in spring 2006 did to implement IM/IL. Specific research questions identified by the Office of Planning, Research, and Evaluation (OPRE) were:

1. What is the theory of change employed by the Head Start programs using IM/IL?

2. How do programs translate the TOT model into the implementation of IM/IL?

3. What determinants are associated with program implementation of activities in the classroom and/or with parents and families?

[29] These results and other findings from the Stage 1 survey are summarized in a separate report (ACF 2007).

[30] Respondents rated the amount of time spent on this topic as a 1 or 2 on a 5-point scale with anchors at 1 (too little time), 3 (about the right time), and 5 (too much time).

Table II.1 Ratings of Agreement with Statements About the Spring 2006 IM/IL Training-of-Trainers Event

	Strongly Agree	Agree	Disagree	Strongly Disagree
	Percentage of Stage 1 Programs			
The three IM/IL goals were clearly explained	85	12	0	2
The workshops presented ideas for program enhancements that addressed the goals of IM/IL	82	16	0	2
The training event provided new information and resources	71	26	0	2
The instruction received at the training was adequate to train my own staff to implement IM/IL	50	46	2	2
Quality of the "take-home" materials (resource materials and handouts) was adequate to train my staff	49	49	0	2
The trainers explained how to adapt IM/IL to meet the needs of a program like ours	49	45	4	2
The ideas for program enhancements seemed like they would work in our program	49	49	0	2
The training prepared us to implement IM/IL	35	60	2	2

Source: IM/IL Implementation Evaluation Stage 1 Questionnaire. Completed by IM/IL coordinators in spring 2007, approximately one year after the spring 2006 TOT event.

Note: Sample sizes ranged from 45 to 49, depending on the item (some respondents did not complete all items). Due to rounding, not all rows total to 100 percent.

Table II.2 Ratings of the Amount of Time Spent on Topics During the Spring 2006 IM/IL Training-of-Trainers Event

	1 (Too Little Time)	2	3 (About the Right Time)	4	5 (Too Much Time)
	Percentage of Stage 1 Programs				
Time for lecture and direct instruction	0	2	94	2	2
Time on how to engage adults in *IM/IL*	2	35	61	0	2
Time for asking questions	0	10	80	8	2
Time for practicing movement activities	6	8	78	6	2
Time for planning our implementation	13	27	57	2	0
Time for the topic of improving children's nutrition	4	18	69	6	2

Source: IM/IL Implementation Evaluation Stage 1 Questionnaire. Completed by IM/IL coordinators in spring 2007, approximately one year after the spring 2006 TOT event.

Note: Sample sizes ranged from 47 to 50, depending on the item (some respondents did not complete all items).

A *theory of change* describes the content or focus of a program or intervention and the outcomes it hopes to achieve. One tool that is often used to provide a visual summary of a theory of change is a logic model. Logic models graphically represent the theoretical or assumed relationships between a program's activities and its intended effects or the connections between the *planned work* and the *intended results* (W.K. Kellogg Foundation 2004).

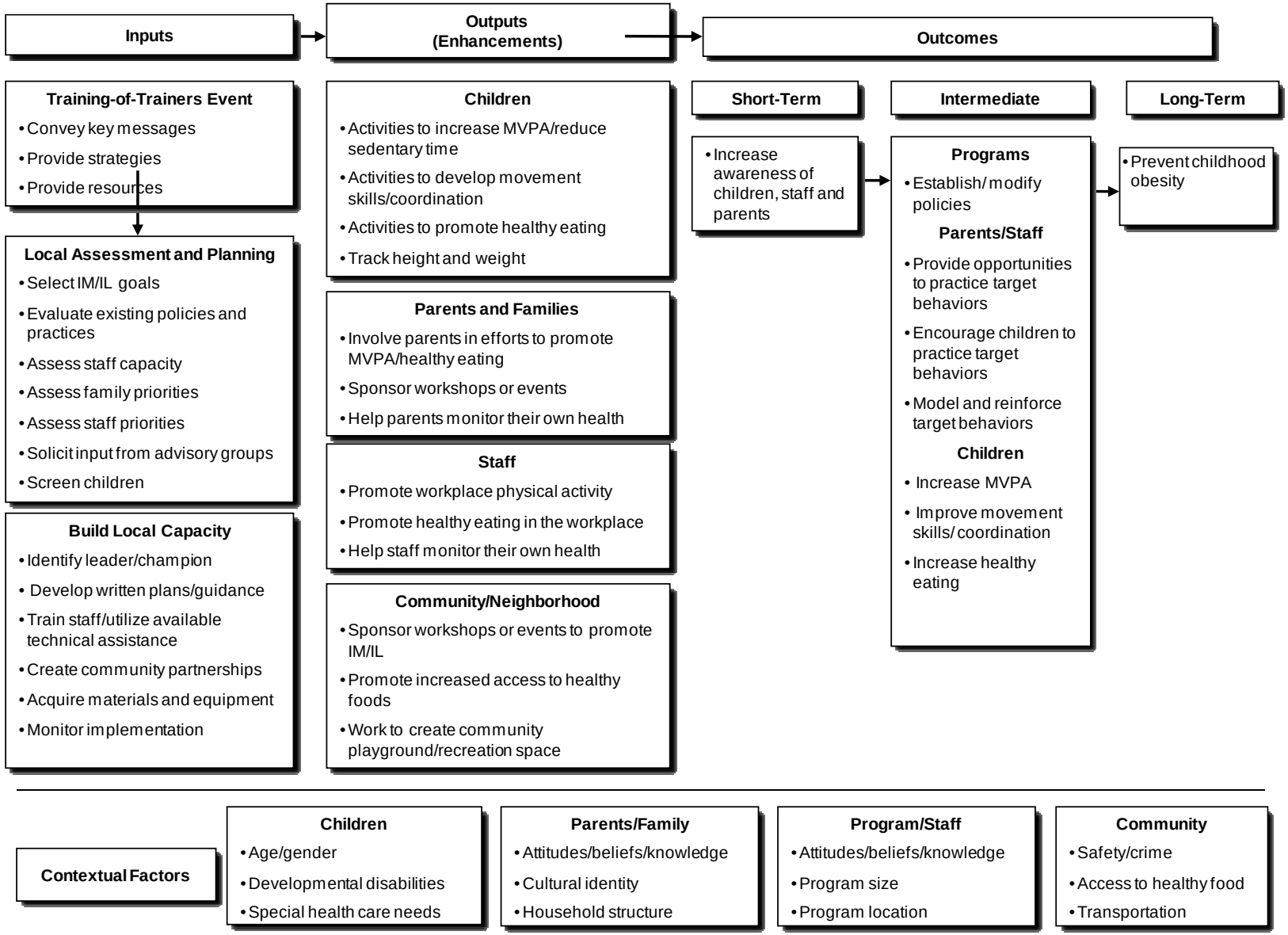
Figure II.2 provides a reference logic model that illustrates how the theory of change that underlies the IM/IL initiative might be articulated. The model, which was derived largely from the Summary Report that describes the pilot of IM/IL in Region III (Region III ACF with Caliber 2005), has three major components:

1. **Inputs** are investments that organizations make in a program—the time and resources they contribute such as staff time, materials, equipment, partnerships, and financial resources. For IM/IL, a major input is the TOT event, after which program managers return to their home programs and develop their own approaches to implementing IM/IL. The expectation is that, in developing their implementation plans, program managers will assess current program practices as well as other important inputs such as existing capacity, priorities, and resources.

2. **Outputs** consist of both strategies (broad approaches a program uses to influence the conditions that motivated an initiative's existence) and activities (the specific activities and services a program implements under each broad strategy). For IM/IL, a key characteristic of a program's strategy is the audiences targeted for IM/IL activities. IM/IL recognizes that children's physical activity and nutrition behaviors can be influenced by adults who interact and care for them at home, at Head Start, and in the broader community. Thus, IM/IL activities can target parents and families, Head Start staff, and community members, as well as Head Start children.

3. **Outcomes** are the changes or benefits that result from implementation of a program. Outcomes are often differentiated as short-, intermediate-, and long-term. Short-term outcomes may include changes in awareness, knowledge, or attitudes of program staff, parents, and/or children. Short-term outcomes are expected to lead to intermediate outcomes among Head Start programs, staff, and parents. For example, Head Start programs may establish or modify policies related to physical activity and nutrition to support IM/IL goals. In addition, Head Start staff and parents may provide children with opportunities to practice targeted behaviors; encourage children to practice these behaviors; and personally model and reinforce these behaviors. For children, anticipated intermediate outcomes reflect the three stated goals of the initiative: increased MVPA, improved movement skills/coordination, and healthier food choices. Long-term outcomes, which can take years to accomplish, flow from intermediate outcomes and reflect the ultimate goal of an intervention. The ultimate long-term outcome of IM/IL is prevention of childhood obesity.

Figure II.2 Reference Logic Model for *I Am Moving, I Am Learning*



Finally, all programs exist within the context of an external environment. Examples of contextual factors at several levels (child, parent/family, program/staff, and community) are shown across the bottom of Figure II.2. These (and other) external factors can interact with and influence resource availability, implementation strategies, the extent to which planned implementation actually occurs, and the receptivity of target audiences to a program's activities and goals. These interactions could in turn affect program outcomes.

A Logic Model Framework: At the Local Level

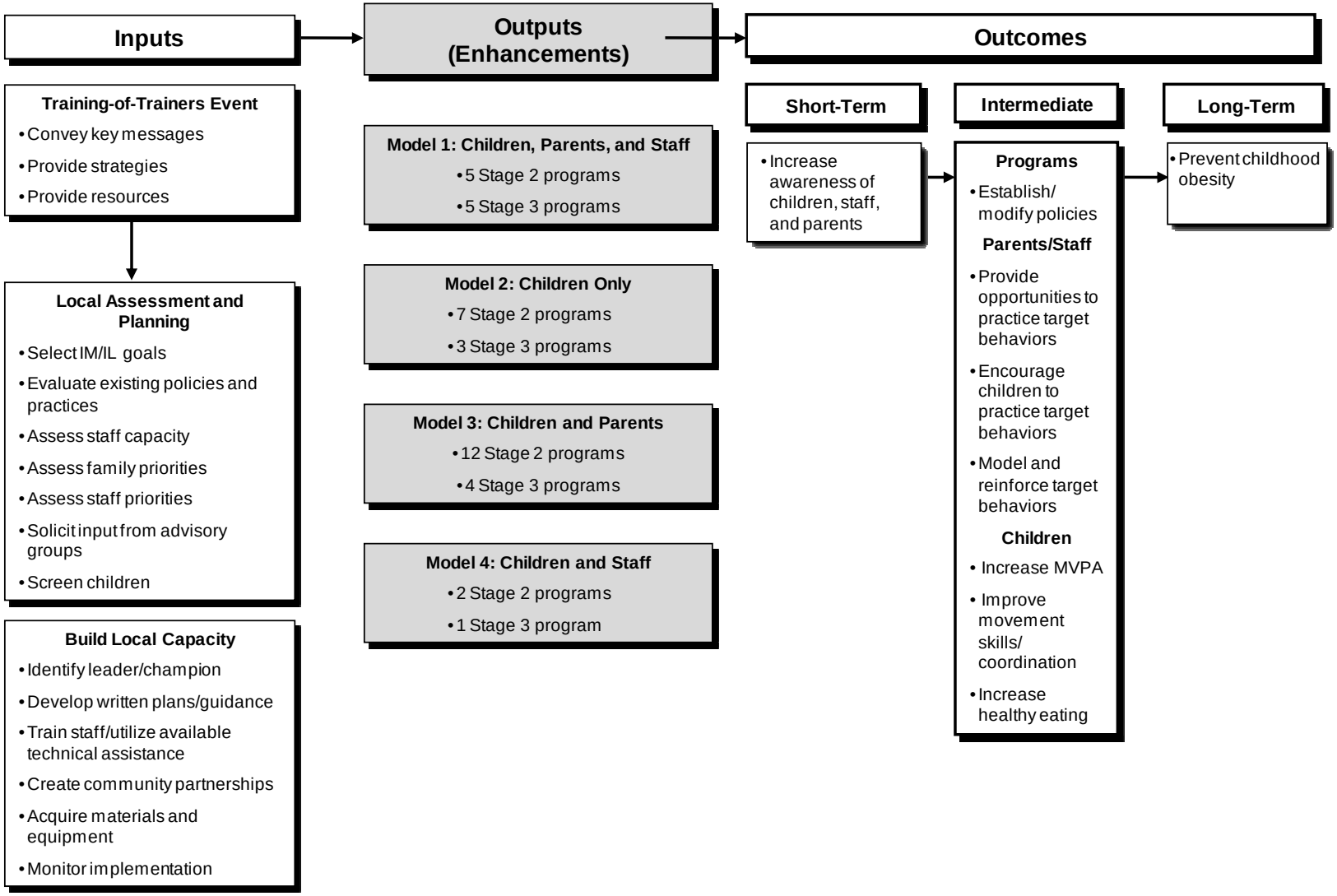
As a first step toward answering the research questions and understanding how Head Start programs implemented IM/IL, information obtained from the Stage 2 interviews was used to identify commonalities in programs' approaches to IM/IL implementation. For each of the 26 programs included in Stage 2, this sorting characterized two common elements of the "Outputs" section of the logic model (see Figure II.2)—(1) target audiences and (2) activities.

As described in Chapter I, this information was used to create a typology of Stage 2 programs (see Table I.4, p.10). This typology was used to select programs for Stage 3 site visits to ensure that a diverse array of implementation strategies would be represented. The full typology, which summarized all of the combinations of target audiences and activities reported in Stage 2 programs, was not practical for use in identifying common approaches to implementation because several of the target audience/activity combinations were so rare. Moreover, analysis of data from stages 2 and 3 revealed little variation across programs in the types of activities used within the three IM/IL focus areas (MVPA, structured movement, nutrition). For example, all programs that implemented activities to increase MVPA or enhance activities targeting gross motor development used similar approaches to incorporate these elements into children's daily routine, regardless of whether they were also targeting parents and/or staff. Similarly, programs that targeted parents and staff used similar approaches to reach these audiences with messages about IM/IL's goals. Thus, the most meaningful variation in the "theory of change" programs used in implementing IM/IL was associated with the audiences they elected to target. For this reason, this dimension of program implementation was used to create four variations of the reference logic model.

Figure II.3 shows these variations, along with information about the number of Stage 2 and Stage 3 programs to which each variation applies. The variation is reflected in the "Outputs" section of the model. Model 1 applies to programs that targeted children, parents, and staff.[31] This model is most similar to the reference logic model. Model 2 applies to programs that targeted only children. This model is the least like the reference logic model in that it includes only one of four potential target audiences. Models 3 and 4 apply to programs that targeted children and one other target audience (parents or staff).

[31] Some Stage 2 programs formed partnerships with community members or organizations who provided assistance in implementing IM/IL, but none of the Stage 2 programs reported specific activities that targeted the community at large.

Figure II.3 Variations in Reference Logic Model Observed in *I Am Moving, I Am Learning* Programs



These logic models provided a framework for exploring IM/IL implementation in Stage 2 and Stage 3 programs. The remaining sections of this chapter explore differences in the characteristics of programs that used each of these variations in IM/IL implementation. In subsequent chapters, the logic model framework is used to explore differences in program inputs, program outputs, and short-term and intermediate outcomes.[32]

CHARACTERISTICS OF STAGE 2 PROGRAMS BY TARGET AUDIENCE

To address the research question about factors associated with differing approaches to IM/IL implementation, Stage 2 programs in the different logic model groups were compared along a number of dimensions, including program characteristics, measures of staff enthusiasm, implementation supports, implementation challenges, and IM/IL coordinators' perceptions about obesity as a health problem. Because of the small sample of Stage 2 programs in the Children and Staff group (n = 2), this group was combined with the Children and Parents group, creating a group that targeted one audience other than children. The statistical significance of differences observed between groups was not tested because of small sample sizes and the non-random nature of the sample. Rather, analysis of the data focused on identifying patterns of differences in the characteristics of programs that used different implementation strategies. When interpreting these data, it is important to recognize that, given the small sample size and the selection of programs into the spring 2006 TOT event, the findings are not generalizeable to other Head Start programs in Region III or to Head Start programs nationwide.

Table II.3 presents data on program characteristics of Stage 2 programs by target audience groups.[33] Noteworthy patterns in the characteristics of programs that selected different target audiences include the following:

- Programs that limited their IM/IL implementation to children only were smaller than programs that also targeted parents and/or staff (median program enrollment of 171 versus about 450 and a median of 26 three- and four-year-olds per center versus about 40).

- IM/IL coordinators in programs that took the broadest approach to IM/IL implementation—targeting children, parents, and staff—had more experience working with Head Start children or other preschoolers than IM/IL coordinators in programs that targeted fewer audiences (median of 20 years versus 13-14 years), and had been with their current Head Start program longer (median of 17 years versus 8-10 years).

[32] This implementation evaluation did not attempt to measure outcomes. Rather, the emphasis is on describing programs' perceptions about progress toward outcomes and steps programs took to measure their progress.

[33] The distribution across target audience varies from the original Stage 2 typology (Table I.4) because one program's target audience was reclassified from the Children Only group to the Children, Parents, and Staff group based on Stage 3 data.

Table II.3 Characteristics of Stage 2 Programs, by Target Audience Group

		Target Audience		
	All Programs	Children, Parents, and Staff	Children and Parents or Children and Staff	Children Only
Median Program Enrollment	348	453	451	171
Median Number of Centers per Program	8	10	7	8
Median Number of 3- and 4-Year-Old Children per Center	39	42	40	26
Median Number of Teachers per Center	2	2	2	2
Median Percentage of Teachers with a Postsecondary Degree in Early Childhood Education	93	100	90	100
Median Years Experience Working with Head Start/Preschool (IM/IL Coordinators)	14	20	13	14
Median Years Working with this Program (IM/IL Coordinators)	10	17	10	8
	Number (Percentage) of Programs			
Type of Service Provided[a]				
Full-Day	22 (85)	5(100)	12 (86)	5 (71)
Part-Day	12 (46)	3 (60)	6 (43)	3 (43)
Center-Based	24 (92)	5(100)	12 (86)	7(100)
Home-Based	12 (46)	1 (20)	9 (65)	2 (29)
Combined Early Head Start/Head Start	8 (31)	1 (20)	6 (43)	1 (14)
Program Auspice[b]				
Nonprofit	11 (41)	2 (40)	7 (50)	2 (29)
Community Action Agency	8 (31)	1 (20)	5 (36)	2 (29)
School System	6 (23)	2 (40)	1 (7)	3 (43)
Government Agency	1 (4)	0 (0)	1 (7)	0 (0)
Sample Size	**26**	**5**	**14**	**7**

Source: 2005-2006 Head Start Program Information Report.

[a] Percentages not intended to sum to 100 because programs can provide more than one type of service.
[b] Percentages sum to 100 (with rounding error) within column.

- Almost all programs that provided home-based or Early Head Start services (10 of 12 and 7 of 8, respectively) targeted parents.

Some interesting patterns were also observed across Stage 2 programs in staff enthusiasm and other factors that may have supported or challenged IM/IL implementation, as perceived by the IM/IL coordinator in the Stage 1 questionnaire, as well as perceptions about the relative importance of obesity as a health problem for children, parents, and staff (Table II.4). For example:

- IM/IL coordinators in all of the Stage 2 programs that targeted either children only (7 out of 7) or children, parents, and staff (5 of 5) rated staff enthusiasm as high, compared with just over half of programs that targeted children and parents or children and staff (8 of 14).[34]

- Few of the programs that targeted only children (2 of 7) reported that obesity prevention was a priority of their policy council, compared with more than half of the programs that targeted children and parents or children and staff (7 of 13) and programs that targeted all three audiences (3 of 5).

- Only 1 of the 5 programs that targeted children, parents, and staff had tried to increase MVPA or promote healthy eating prior to IM/IL, compared with about half the programs that targeted children only (3 of 7) or children plus parents or staff (6 of 13).

- Only 1 of the 7 programs that targeted children only reported that lack of management time was a challenge in implementing IM/IL, compared with about half the programs that targeted additional audiences (7 of 13 and 2 of 4, respectively, for programs that targeted children and parents or children and staff [7] and programs that targeted children, parents, and staff).[35]

- All five of the programs that targeted children, parents, and staff thought obesity was a moderate, large, or very large problem for all three target audiences. Some programs in the other two target audience groups did not perceive obesity to be a problem of this magnitude for children (2 of 7 and 8 of 14, respectively, for programs that targeted only children and programs that targeted children and parents or children and staff).

[34] Rated as a 4 or 5 on a 5-point scale with anchors at 1 (resistant) and 5 (enthusiastic).

[35] Data were missing for one of the Stage 2 programs in this group.

Table II.4 Staff Enthusiasm, Implementation Supports and Challenges, and Perceptions About Obesity Problem in Stage 2 Programs by Target Audience

		Target Audience		
	All Programs	Children, Parents, and Staff	Children and Parents or Children and Staff	Children Only
	Number (Percentage) of Programs			
Staff Enthusiasm About IM/IL Goals[a]				
Enthusiastic about IM/IL overall	20 (77)	5 (100)	8 (57)	7 (100)
Enthusiastic about increasing MVPA	20 (77)	5 (100)	9 (64)	6 (86)
Enthusiastic about improving structured movement experiences	20 (77)	5 (100)	8 (57)	7 (100)
Enthusiastic about improving healthy food choices	18 (69)	4 (80)	9 (64)	5 (71)
Factors Supporting Implementing IM/IL[b]				
Had resources (either money or in-kind support) needed to implement IM/IL	8 (32)	1 (20)	3 (23)	4 (57)
Believed the TOT provided what was needed to train frontline staff	21 (84)	5 (100)	10 (77)	6 (86)
Had good technical assistance	8 (32)	0 (0)	4 (31)	4 (57)
Parents were enthusiastic about IM/IL goals	11 (44)	2 (40)	6 (46)	3 (43)
Obesity prevention was a priority of policy council, governing board, or health services advisory committee	12 (48)	3 (60)	7 (54)	2 (29)
Before the TOT, program was already actively involved in efforts to increase children's physical activity and improve their nutrition	10 (40)	1 (20)	6 (46)	3 (43)
Factors That Posed Challenges for IM/IL Implementation[c]				
Management staff did not have enough time to devote to IM/IL	10 (42)	2 (50)	7 (54)	1 (14)
Frontline staff did not have enough time to participate in training	6 (25)	2 (50)	2 (15)	2 (29)
Other program areas/issues were a higher priority	9 (38)	2 (50)	5 (38)	2 (29)
Needed materials to implement IM/IL, but did not have the funds to purchase them	8 (33)	1 (25)	4 (31)	3 (43)
Perceptions About Obesity				
IM/IL coordinator perceived obesity to be a moderate, large, or very large problem affecting…[d]				
Children	16 (62)	5 (100)	6 (43)	5 (71)
Parents	25 (96)	5 (100)	13 (93)	7 (100)
Staff members	24 (92)	5 (100)	13 (93)	6 (86)
Sample Size	**26**	**14**	**5**	**7**

Source: IM/IL Implementation Evaluation Stage 1 Questionnaire. Completed by IM/IL coordinators in spring 2007, approximately one year after the spring 2006 TOT event. Programs were assigned to target audience groups based on data collected in Stage 2 (summer 2007) telephone interviews.

[a] Rated as a 4 or 5 on a 5-point scale with anchors at 1 (resistant) and 5 (enthusiastic).

[b] For this section of table, sample size for All Programs column = 25 and sample size for Children and Parents or Children and Staff column = 13 because one IM/IL program coordinator did not complete this section of the Stage 1 questionnaire.

[c] For this section of the table, sample size for the All Programs column = 24, sample size for the Children and Parents or Children and Staff column = 13, and sample size for the Children, Parents, and Staff column = 4, due to item non-response.

[d] Questionnaire items asked: "To what extent do you feel that obesity is a health problem affecting the [children/parents/staff members] in your program?" Available responses were: Not a problem at all; a small problem, a moderate problem, a large problem, and a very large problem.

CHAPTER III

I AM MOVING, I AM LEARNING IMPLEMENTATION: INPUTS

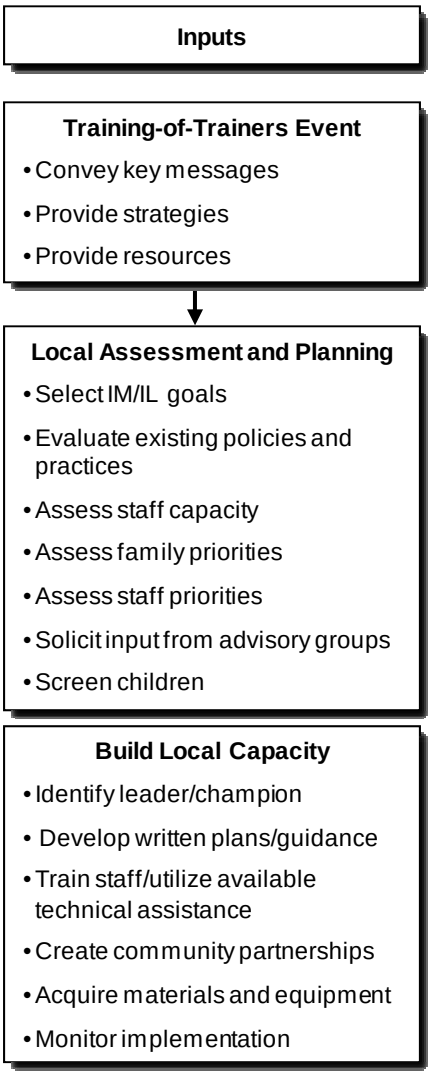
Inputs are the investments an organization makes in designing and implementing a program. The Training-of-Trainers event (TOT) described in Chapter II is the main input to implementation of IM/IL in any program. This chapter describes how Stage 2 programs used the information provided in the TOT to design their approach to IM/IL implementation. The discussion is organized around two main program inputs included in the IM/IL reference logic model—assessment and planning and building local capacity (Figure III.1).[36]

A key activity in the assessment and planning process is selecting program goals. The process also includes activities that programs may have undertaken to assess local needs, priorities, and resources. Steps involved in building local capacity to implement and sustain a program include: assigning a leader/champion to assume responsibility for the program within the organization, developing a written plan or other guidance, training staff, monitoring implementation, creating community partnerships, and acquiring materials and equipment.

The data presented in this chapter are drawn primarily from the Stage 2 telephone interviews and the Stage 1 questionnaire. Data from Stage 3 are brought in, as appropriate, to provide detail about how inputs may have been enhanced or changed between the first and second year of IM/IL implementation (for example, programs may have provided additional staff training or acquired additional materials or equipment). In most cases, data summarized in tables are broken out for the target audience groups defined in Chapter II. Data are not broken out by target audience when there was no apparent variation across groups or when doing so would have resulted in many empty cells.

[36] The complete IM/IL reference logic model is shown in Chapter II, Figure II.2.

Figure III.1 Reference Logic Model for *I Am Moving, I Am Learning*: Inputs Component



ASSESSMENT AND PLANNING

The assessment and planning phase is an important step in implementing any program or initiative. During this phase, program planners clarify program goals, assess needs and priorities, and begin developing implementation strategies that can help the program achieve its goals within the context of existing priorities, needs, and resources.

All of the Stage 2 programs reported that planning for IM/IL after the TOT event was a collaborative process that involved staff who had attended the TOT as well as some who had not. Besides the IM/IL coordinators, participants in the process included other leadership staff, teachers, and home visitors. In two programs, the assessment and planning process was led by teachers who had attended the TOT. In one program, the IM/IL coordinator formed an advisory committee comprised of seven teachers who had completed

local IM/IL training. The committee met weekly throughout the year to develop a formal plan for IM/IL implementation.

Two-thirds of the Stage 2 programs reported that the binder of materials and handouts they received at the TOT event was the most valuable resource they used during the planning process. In particular, programs found instructions for making toys, props, and exercise aids to be helpful. They also appreciated the literature and statistics about childhood obesity, which they shared with staff and parents. One program emphasized that, because of their creative ideas for classroom activities, teachers were the most valuable resource during the planning phase.

Goal Setting

Few Stage 2 programs reported going through a formal goal-setting process.[37] Rather, goal setting involved deciding which of the three core IM/IL goals the program would address and whether IM/IL would target parents or staff in addition to children. Table III.1 shows the IM/IL goals and target audiences reported by Stage 2 programs. The table illustrates the flexibility Head Start programs have in implementing IM/IL. Across the 26 Stage 2 programs, 12 different combinations of IM/IL goals and target audiences were identified.

As shown, all 26 Stage 2 programs reported that increasing the amount of time children spent in MVPA was a goal for their IM/IL initiative. Eleven programs reported that enhancing structured movement activities was a goal and nine programs reported that promoting healthy food choices for children was a goal. Almost half of the Stage 2 programs (12 of 26) reported focusing exclusively on the MVPA goal. Eight programs reported goals that included MVPA and one of the other two IM/IL goals, and about a quarter of Stage 2 programs (6 of 26) reported focusing on all three IM/IL goals.[38] Three programs took the broadest approach to implementing IM/IL, electing to address all three IM/IL goals and involve all three target audiences.

[37] It is important to note that none of the Stage 2 programs developed a logic model for their version of IM/IL. However, there was no guidance on logic model creation nor a requirement that programs create one.

[38] There was some inconsistency between the goals reported by Stage 2 programs in the Stage 1 questionnaire and the Stage 2 telephone interviews. In the Stage 1 questionnaire, 24 of the 26 Stage 2 programs reported that they were addressing the structured movement goal and 21 reported that they were addressing the healthy food choices goal. Potential reasons for these discrepancies include change in goals over time, different respondents (as noted in Chapter I, four programs had different respondents for the Stage 1 questionnaire and the Stage 2 IM/IL coordinator interview) and confusion about responses during Stage 1. In the Stage 2 interviews, it became clear that during Stage 1, some IM/IL coordinators did not understand the difference between the structured movement and MVPA goals and thought that any goal that focused on "movement" addressed both of these goals. Similarly, it appears that some IM/IL coordinators conflated the IM/IL goal related to healthy food choices with their program's ongoing focus on nutrition (in keeping with the Head Start performance standards described in Chapter II) when responding to the Stage 1 questionnaire. In the Stage 2 interviews, it was clear that these programs had not established a specific goal to promote healthy food choices as part of IM/IL.

Table III.1 IM/IL Goals Reported by Stage 2 Programs

		Target Audience			
	All Programs	Children, Parents, and Staff	Children and Parents	Children and Staff	Children Only
	Number (Percentage) of Programs				
Specific Goals					
Increase the amount of time children spend in moderate to vigorous physical activity (MVPA)	26 (100)	5 (100)	12 (100)	2 (100)	7 (100)
Improve the quality of structured movement experiences intentionally facilitated by teachers and other adults	11 (42)	4 (80)	3 (25)	0 (0)	4 (57)
Promote healthy food choices for children every day	9 (35)	3 (60)	4 (33)	1 (50)	2 (29)
Combinations of Goals					
MVPA only	12 (46)	1 (20)	7 (58)	1 (50)	3 (43)
MPVA + structured movement only	5 (19)	1 (20)	1 (8)	0 (0)	3 (43)
MVPA + healthy food choices only	3 (12)	0 (0)	2 (16)	1 (50)	0 (0)
All three goals	6 (23)	3 (60)	2 (16)	0 (0)	1 (14)
Sample Size	**26**	**5**	**12**	**2**	**7**

Source: IM/IL Implementation Evaluation Stage 2 Telephone Interviews completed with IM/IL coordinators in summer 2007 at the end of the first year of IM/IL implementation.

Note: Percentages are calculated within each column. Percentages in the top panel total to more than 100 percent because programs could report more than one IM/IL goal.

Programs that did not elect to target nutrition did not necessarily think it was unimportant. Rather, they reported a belief that their programs were already offering healthy meals and snacks and doing an adequate job of providing nutrition education. Two of these programs reported that they had recently worked (before starting IM/IL) with a nutritionist to redesign their menus. This pre-IM/IL focus on nutrition was apparent in the Stage 1 data: 25 percent of IM/IL coordinators who completed the Stage 1 questionnaire said that prior to the TOT event, they would have rated nutrition as the most important of the three IM/IL goals (compared to 8 and 6 percent, respectively, for MVPA and structured movement) (ACF 2007). It is also possible that the TOT did not place enough emphasis on nutrition—22 percent of IM/IL coordinators who completed a Stage 1 questionnaire indicated that the TOT did not devote enough time to the topic of improving children's nutrition (ACF 2007).[39] A combination of these factors and others may be the reason behind

[39] Respondents rated the amount of time spent on this topic as a 1 or 2 on a 5-point scale with anchors at 1 (too little time), 3 (about the right time), and 5 (too much time).

the limited number of programs setting a goal for improving nutritional choices as part of their IM/IL enhancement.

Changes to IM/IL Goals, Year 2

Of the 13 Stage 2 programs included in Stage 3 site visits (when programs were in the second year of IM/IL implementation), only one reported a change in IM/IL goals. This program, which had originally focused exclusively on increasing children's MVPA, added a goal to increase healthy food choices. As discussed in the next chapter, Stage 3 programs that did make changes in the second year of implementation were more likely to change the strategies and activities they implemented in order to achieve their goals than to modify their overall goals.

Assessing Local Practices, Needs, and Priorities

Most programs reported using informal means to assess local practices, needs, and priorities. Most commonly, IM/IL coordinators solicited input from stakeholder and advisory groups. Twenty-three of the 26 Stage 2 programs obtained input from one or more stakeholder or advisory groups. The groups consulted most frequently were the health services advisory committee (15 programs), the policy council (10 programs), parent committees (9 programs), and governing boards (5 programs).

Only three of the 26 Stage 2 programs conducted a formal needs assessment by collecting standardized information from parents and/or staff. One program used a survey to assess staff eating habits and lifestyles. The IM/IL coordinator in this program reported that findings from the survey played a key role in their decision to target staff as well as children as a target audience for their IM/IL initiative. Another program surveyed teachers to find out what types of movement-oriented equipment and materials they had in their classrooms. This information was used to plan purchases for individual classrooms to ensure that all teachers had access to the equipment and materials recommended for IM/IL activities.

Some IM/IL coordinators used current child health data, health assessments, or classroom observations to gain perspective on existing needs, priorities, and practices. IM/IL coordinators in two programs reported examining program data on children's body mass index to get a perspective on the prevalence of obesity in their program. One IM/IL coordinator reported examining the program's existing health plan and another examined the program's most recent self-assessment to identify how IM/IL could complement or fit in with existing program goals and priorities. IM/IL coordinators in two programs used informal classroom observations to get a sense of how much movement was going on in classrooms.

Pilot Tests

Eight of the 26 Stage 2 programs reported using pilot tests to inform plans for IM/IL implementation. Pilot test approaches varied, but generally focused on assessing the feasibility and acceptance/success of IM/IL concepts, themes, and activities. Two of the eight programs that conducted pilot tests did their pilots over the summer of 2006. The

other six programs took a staged approach to IM/IL implementation, starting out with a subset of classrooms or centers (range from one-quarter to about two thirds) before a program-wide rollout.[40] Teachers and other classroom staff involved in the pilots provided feedback to coordinators that was used to make adjustments to IM/IL materials and recommended practices before IM/IL was implemented in all centers/classrooms.

Programs that used pilot tests reported several benefits of this approach. Four of the eight programs that used pilot tests reported that piloting allowed planning staff to identify implementation strategies that would be well received by other teachers. For example, the summer pilot conducted in one program led to a decision to introduce new IM/IL activities to teachers in three-month intervals to avoid overwhelming them with too much information or too many activities at once. Another benefit of pilot testing, reported by two programs, was that teachers involved in the pilot were able share their positive experiences and enthusiasm for IM/IL, and describe how much children enjoyed IM/IL activities to other teachers/home visitors.

BUILDING CAPACITY

A vital input for any program or initiative is ensuring that the individuals responsible for implementation understand their role in the process, are adequately trained, and have the resources they need to implement the program as planned. In the case of IM/IL, the IM/IL coordinator plays a key role in overseeing planning and implementation. Teachers, home visitors, and other frontline staff who are responsible for implementing IM/IL on a daily basis are equally important. Other organizations and individuals within the local community can also play important roles by supporting implementation of IM/IL in a variety of ways.

Responsibility for IM/IL Coordination

IM/IL coordinators in each Head Start program had primary responsibility for assessment, planning, and capacity building. All of the Stage 2 programs assigned IM/IL coordination to one or more members of the management team (Table III.2). In 10 of the 26 Stage 2 programs, the education specialist assumed responsibility for IM/IL coordination and in 5 programs, the IM/IL coordinator was the health specialist. In five programs, responsibility was shared by two or more staff members.

[40] One of these programs planned to stagger IM/IL implementation across three program years (five centers in Year 1, seven more in Year 2, and four in Year 3). The program was implementing a new reading curriculum at the same time as IM/IL and they wanted to be sure that teachers had time to implement both initiatives well.

Table III.2 Staff Member with Primary Responsibility for IM/IL Coordination

	Number (Percentage) of Programs
Education specialist	10 (38)
Health specialist	5 (19)
Disability specialist/special needs coordinator	3 (12)
Director	3 (12)
Child development specialist	3 (12)
Nutrition specialist	2 (8)
Center manager or supervisor	2 (8)
Management team	2 (8)
School district physical education teacher	1 (4)
Sample Size	**26**

Source: IM/IL Implementation Evaluation Stage 2 Telephone Interviews completed with IM/IL coordinators in summer 2007 at the end of the first year of IM/IL implementation.

Note: Percentages do not total to 100 because responsibility for IM/IL coordination in five programs was shared by two or more staff members.

There was no noteworthy difference across target audience groups in the type of staff assigned to coordinate IM/IL. However, as noted in Chapter II, coordinators in programs that targeted all three target audiences (children, parents, and staff) had more experience than coordinators in other programs.

Staff Training

All 26 Stage 2 programs provided some training for frontline staff during the first year of IM/IL implementation. Basic information about staff training was collected in the Stage 1 questionnaire. As summarized in Table III.3, programs used a number of different approaches to provide training. Most Stage 2 programs (20) provided multiple training opportunities, including pre-service training (conducted before the start of the program year), in-service training (conducted during the program year), and special IM/IL-focused workshops.

The time devoted to training varied widely (range of 1 to 24 hours, with a median of 6 hours). There were no systematic differences in the hours of training provided by programs in the different target audience groups (Table III.3) or in programs that targeted different combinations of IM/IL goals (data not shown).[41,42] In fact, the total amount of training

[41] In Table III.3 and other tables that break data out by target audience group, the children and staff group (n=2) has been combined with the children and parent group (n=12) because of the small sample size.

[42] There was also no systematic difference in the total hours of training provided by programs that used different combinations of training approaches.

Table III.3 Types and Amount of Training Provided By Stage 2 Programs During the First Year of IM/IL Implementation

		Target Audience		
	All Programs	Children, Parents, and Staff	Children and Parents or Children and Staff	Children Only
	Number (Percentage) of Programs			
Types of Training				
Pre-service, in-service, *and* specialized workshop	9 (36)	2 (40)	4 (31)	3 (43)
Pre-service *and* in-service	9 (36)	3 (60)	4 (31)	2 (29)
In-service only	3 (12)	0 (0)	2 (15)	1 (14)
Pre-service *or* in-service *and* specialized workshop	2 (8)	0 (0)	1 (8)	1 (14)
Pre-service only	2 (8)	0 (0)	2 (15)	0 (0)
Hours of Training				
Median	6	6	6	9
Range	1-24	3-12	1-18	1-24
Sample Size	**25**	**7**	**13**	**5**

Source: IM/IL Implementation Evaluation Stage 1 Questionnaire completed by IM/IL coordinators in spring 2007, about one year after the spring 2006 TOT event.

Notes: Percentages are calculated within each column. Percentages in the top panel total to more than 100 percent because programs could report more than one IM/IL goal.

Detailed data about the types and amount of training were missing for one Stage 2 program in the Child and Parent target audience group.

provided by the three programs that took the broadest approach to IM/IL implementation (by addressing all three IM/IL goals and all three target audiences) was equivalent to or less than the median for all Stage 2 programs (3, 4, and 6 hours versus 6 hours) and the two programs that provided the most training (20 and 24 hours) targeted only children and only MVPA (data not shown).

In Stage 2 interviews with IM/IL coordinators, additional information was collected about the focus and content of IM/IL training. Fifteen Stage 2 programs focused their initial training on lead teachers. Nine programs trained all frontline staff, including bus drivers, cooks, and assistant teachers.[43]

Initial trainings covered a variety of content areas (Table III.4). Almost all Stage 2 programs (23 of 26) reported introducing the Choosy character at the initial IM/IL training. More than half (17) reported dancing or moving to music during the training, which was often music from the Choosy CDs provided at the TOT. Only half the programs reported

[43] Data about training attendees were missing for two Stage 2 programs.

Table III.4 Content of Initial IM/IL Training Sessions

	Number (Percentage) of Programs	
Introduce Choosy character	23	(88)
Dance or move to music/songs	17	(65)
Review materials provided at TOT event	15	(58)
Demonstrate classroom activities	13	(50)
Review literature on childhood obesity	11	(42)
Introduce IM/IL movement vocabulary	9	(35)
Review IM/IL behavioral goals	8	(31)
Explain or describe nutrition activities	8	(31)
Make homemade equipment/props	5	(19)
Review plans or techniques for monitoring IM/IL implementation/ progress toward goals	4	(15)
Watched Region III video about IM/IL	3	(12)
Listen to Choosy music (no movement)	1	(4)
Sample Size	**26**	

Source: IM/IL Implementation Evaluation Stage 2 telephone interviews completed with IM/IL coordinators in summer 2007 at the end of the first year of IM/IL implementation.

Note: Programs reported multiple content area, thus percentages do not sum to 100.

explicitly demonstrating planned classroom activities including hands-on practice where teachers/home visitors went through the entire activity as it would be implemented with children. Less than half of the programs (11) reported reviewing literature on childhood obesity during the initial training and only four programs reported providing guidance about plans or techniques for measuring IM/IL implementation or progress toward goals. A few programs (5) reported using the initial training session as an opportunity to build homemade equipment and props to support IM/IL activities.

Stage 2 interviews collected information about the reactions of teachers and home visitors to the initial training and their recommendations for improvement.[44] Teachers/home visitors in about half the Stage 2 programs (14 of 26) thought that the initial training was sufficient (Table III.5). Teachers/home visitors in five programs thought the initial training should have been longer and teachers/home visitors in seven programs thought follow-up training was needed.

[44] As described in Chapter I, data from teacher/home visitor interviews were summarized at the program level. Responses were generally consistent within a program. However, when this was not the case, the coding structure captured different responses provided by teachers and home visitors.

Table III.5 General Reaction of Teachers/Home Visitors to Initial IM/IL Training and Recommendations for Improvement

		Target Audience		
	All Programs	Children, Parents, and Staff	Children and Parents or Children and Staff	Children Only
	Number (Percentage) of Programs			
General Reaction				
Thought training was sufficient	14 (53)	4 (80)	6 (43)	4 (57)
Thought follow-up training was needed	7 (27)	0 (0)	6 (43)	1 (14)
Thought training should have been longer	5 (19)	1 (20)	2 (14)	2 (29)
Recommendations for Improvement				
Provide more examples of potential classroom activities	6 (23)	1 (20)	4 (29)	1 (14)
Provide guidance on how to implement IM/IL with specific subgroups (e.g., parents, children with special needs)	6 (23)	1 (20)	3 (21)	2 (29)
Provide opportunities to share ideas with other teachers/home visitors	3 (12)	0 (0)	3 (21)	0 (0)
Sample Size	**26**	**5**	**14**	**7**

Source: IM/IL Implementation Evaluation Stage 2 telephone interviews completed with teachers/home visitors in summer 2007 at the end of the first year of IM/IL implementation.

Note: Percentages are calculated within each column. Percentages in the bottom panel do not sum to 100 because teachers/home visitors had multiple reactions.

Teachers/home visitors who thought the initial training was insufficient cited several ways in which training could be improved (either by adding to the initial training or providing follow-up training). These included:

- Provide more examples of potential classroom activities, including detailed information about how to implement the movements that go with the various Choosy (or other) songs (6 programs).

- Provide more information about implementing IM/IL with specific subgroups, such as parents or children with special needs (6 programs).

- Provide opportunities for teachers/home visitors to interact and share ideas for IM/IL implementation (3 programs).

About half of the Stage 2 programs (14 of 26) reported receiving assistance from non-program staff in planning or implementing their initial IM/IL training (not shown). Nine of these programs hired a trainer from the TOT training team to conduct their initial training. Another program brought in staff from a nearby Head Start program that had already

implemented IM/IL. Three programs received assistance from Region III technical assistance specialists. Programs also reported receiving assistance from staff at local school districts, hospitals, and other community organizations (some programs received assistance from more than one outside source).

Only 6 of the 26 Stage 2 programs offered follow-up training sessions during the first year of implementation (not shown). These sessions were reportedly used as "refreshers" to review IM/IL activities and to maintain staff enthusiasm for and focus on the initiative. Two programs brought in one of the trainers from the TOT training team to conduct follow-up training (bringing the total number of Stage 2 programs that brought in core TOT trainers to 11). IM/IL coordinators in three of the Stage 2 programs that did not offer follow-up training on a formal basis mentioned that IM/IL concepts were presented and discussed at staff meetings and that management staff were always available to assist frontline staff with any issues or questions related to IM/IL implementation. Training in the second year of implementation was minimal (see box).

TRAINING, YEAR TWO

Most programs in the Stage 3 sample provided minimal or no training during the second year of implementation. Programs reported that they trained new teachers as part of orientation but did not provide returning teachers with additional training.

Programs that did offer training tended to put more emphasis on specific guidelines and expectations for teachers than they had the first year. This included, for example, how to document IM/IL activities in lesson plans and how to track child outcomes and movement. One program noted that the year two training was designed to encourage more active staff participation in IM/IL activities in the form of movement and dancing with children.

Written Plans and Guidance

One way to maximize the likelihood that a program or initiative will be implemented as planned is to ensure that the staff responsible for implementation understand their roles and responsibilities. This understanding can be facilitated in many ways. One way is to develop and disseminate a formal written plan or other type of written guidance. Only 2 of the 26 Stage 2 programs developed a formal, written plan for IM/IL implementation (not shown). One program developed a detailed implementation plan that included training objectives, targeted outcomes, and planned purchases specific to IM/IL. Another program made IM/IL-specific additions to the existing education manual to provide teachers with clear instructions about the how IM/IL was to be implemented in the classroom, such as the number of minutes children were supposed to be physically active.

A more common strategy programs used for providing guidance to staff was to incorporate IM/IL as a category or unit into lesson plan templates that teachers completed on a daily or weekly basis. This strategy, used by 12 of the 26 Stage 2 programs, reminded teachers/home visitors to implement IM/IL activities. The strength of these reminders was enhanced by the fact that, as discussed below, supervisors in all 12 programs used the lesson plans to monitor IM/IL implementation.

Monitoring Implementation

Another strategy program planners can use to increase the likelihood that a program will be implemented as planned is to observe the program in operation and make corrections/adjustments as needed. In the case of IM/IL, this involves observing and monitoring curriculum and teachers'/home visitors' behaviors. Information obtained through observation and monitoring can help program planners assess whether current plans and strategies are working and can also identify needs for additional training or technical assistance. By identifying and addressing factors that may affect implementation, program planners may increase the ability of IM/IL to promote meaningful changes in children's diets and physical activity.

Almost two-thirds of the Stage 2 programs (17 of 26) reported using one or more techniques to monitor IM/IL implementation (Table III.6). This included close to three-quarters of programs that targeted children only (5 of 7) and programs that targeted children and parents or children and staff (10 of 14) and a smaller proportion of programs that targeted children, parents, and staff (2 of 5). Programs that monitored IM/IL implementation used three different approaches: (1) reviewing lesson plans, (2) observing classrooms, and (3) obtaining informal feedback from teachers/home visitors or management staff. Most commonly (12 programs), teachers/home visitors were required to document IM/IL activities in lesson plans. A supervisor then reviewed the plans to ensure that appropriate movement and nutrition activities were being implemented in the classroom or during home visits.

Seven programs reported that supervisors observed teachers in the classroom to assess whether they were facilitating activities related to movement or nutrition. These observations were not done explicitly for IM/IL. Rather, a focus on implementation of IM/IL activities was added to an existing staff evaluation/observation system. Five programs reported using informal feedback from teachers/home visitors or management staff to learn about the progress of IM/IL implementation and any issues/concerns raised by staff.

ENGAGING COMMUNITY PARTNERS

Eighteen of the 26 Stage 2 programs reported engaging other organizations in the community to support implementation of IM/IL. Most often, these community partners contributed to IM/IL training efforts, as described above. For example, one program invited trainers from a local dance organization to teach staff how to stretch and get the most out of every movement, as well as provide handouts and other materials related to movement. Other programs contacted local health departments, WIC programs, school districts, or hospitals to obtain materials and resources that were used in training sessions. Less often, community partners were recruited to provide resources or materials to be used in implementing IM/IL or to actually participate in implementation. The ways in which community partners assisted with IM/IL implementation are described in Chapter IV.

Table III.6 Ongoing Monitoring of IM/IL Implementation

		Target Audiences		
	All Programs	Children, Parents, and Staff	Children and Parents or Children and Staff	Children Only
	Number (Percentage) of Programs			
Programs monitoring IM/IL implementation	17 (65)	2 (40)	10 (71)	5 (71)
Review lesson plans	12 (46)	1 (20)	7 (50)	4 (57)
Classroom observation	7 (27)	0 (0)	5 (36)	2 (29)
Informal feedback	5 (19)	1 (20)	1 (7)	3 (43)
Did not monitor IM/IL implementation	9 (35)	3 (60)	4 (29)	2 (29)
Sample Size	**26**	**5**	**14**	**7**

Source: IM/IL Implementation Evaluation Stage 2 Telephone Interviews completed in summer 2007 at the end of the first year of implementation.

Note: Programs could report multiple monitoring methods, thus percentages do not sum to 100.

During the second year of IM/IL implementation, some of the Stage 3 programs formed partnerships with other Head Start programs that were implementing IM/IL to enhance their capacity to provide ongoing training and plan IM/IL implementation. In one case, the coordinator reached out to staff from other programs that had participated in a TOT event to form a committee that could lead staff trainings and plan classroom implementation across programs. Two other programs that lost key management staff after the first year of implementation built alliances with managers and teachers from other programs who had received the IM/IL TOT.

MATERIALS AND EQUIPMENT

Twenty-five of the 26 Stage 2 programs acquired materials or equipment to support IM/IL implementation (Table III.7). Sixteen programs purchased additional Choosy music CDs and/or posters that featured the Choosy character.[45] Nine programs purchased equipment for use in outdoor physical activity. The same number purchased props for MVPA and structured movement activities in the classroom. Equipment obtained to facilitate MVPA included jump ropes, hula hoops, tricycles and bicycles. Purchased props included lummi sticks, scarves, ribbons, and bean bags.[46] Most programs that purchased

[45] Staff who attended the spring 2006 TOT event received two Choosy music CDs in their take-away materials.

[46] Lummi sticks are cylindrical sticks that are struck against one another and used in teaching children about rhythm and movement. Ribbons, scarves, and beanbags can be waved or tossed and caught in various movement activities, often done to music. Bean bags can also be tossed at targets or balanced on different body parts.

outdoor equipment reported that they were planning to do so prior to IM/IL, but IM/IL helped inform their decision regarding which equipment to purchase. Six programs reported making some of the homemade props introduced at the TOT event, such as pantyhose paddles, yarn balls, and liter-bottle weights.

The funds to purchase materials and equipment came primarily from general program funds, although programs also used training and technical assistance funds, grants, and other resources to cover costs. Of the nine Stage 2 programs that provided information about how much they spent on implementation in Year 1, total initial expenditures ranged from $100 to $5,000, with a median of $1,200. For example, one Stage 2 program obtained grant funding from Kraft Foods to cover the cost of purchasing Choosy CDs for all of their classrooms. During the second year of implementation, this program used funds from another grant to cover costs associated with implementing a new parent component of IM/IL. They used the funds to provide incentives for parent attendance at program events and to pay for copying handouts and recipes.

During the second year of IM/IL implementation some Stage 3 programs (5 of 13) purchased additional equipment or props. These included outdoor play equipment, scarves, hula hoops, parachutes, Choosy CDs, and games such as "Bucket Blast." One program purchased the Dance, Dance Revolution game (to be shared by all centers) and the equipment to support it (a Nintendo Play Station and a television).

Classroom Curricula

Most Stage 2 programs (23 of 26) incorporated existing nutrition/fitness curricula into their IM/IL implementation. The two reported most often were *Color Me Healthy* and *Chef Combo*. For the second year of IM/IL implementation, about half of the Stage 3 programs (6 of 13) reported adding a nutrition/fitness curriculum or changing the one they had been using. Curricula selected included *Color Me Healthy; Food, Fitness and Fun;* and a curriculum being piloted by Nemours Health and Prevention Services called *5-2-1 Almost None.*[47] In addition, one Stage 3 program reported that IM/IL implementation had revitalized their use of the *Chef Combo* curriculum.

[47] The name *5-2-1 Almost None* reflects the four key messages stressed in the curriculum: (1) eat five servings of fruits and vegetables each day, (2) limit "screen time" to two or fewer hours per day, (3) get one or more hours of physical activity each day, and (4) drink almost no sugary beverages.

Table III.7 Materials and Equipment Obtained for IM/IL

		Target Audience		
	All Programs	Children, Parents, and Staff	Children and Parents or Children and Staff	Children Only
	Number (Percentage) of Programs			
Purchased Choosy products	16 (62)	2 (40)	10 (71)	4 (57)
Purchased outdoor equipment	9 (35)	1 (20)	5 (36)	3 (43)
Purchased props	9 (35)	1 (20)	5 (36)	3 (43)
Made homemade props	6 (17)	1 (20)	3 (21)	2 (29)
Did not obtain any new materials or equipment	1 (4)	0 (0)	1 (7)	0 (0)
Sample Size	**26**	**5**	**14**	**7**

Source: IM/IL Implementation Evaluation Stage 2 Telephone Interviews completed with IM/IL coordinators in summer 2007 at the end of the first year of IM/IL implementation.

Note: Percentages are calculated within each column. Percentages do not sum to 100 because programs obtained multiple types of materials/equipment.

CHAPTER IV

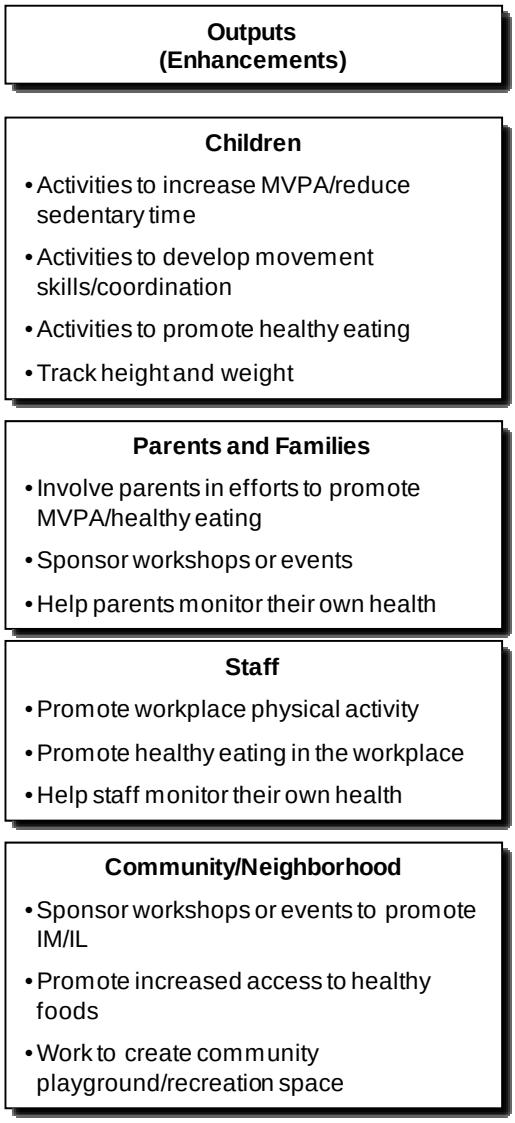
I AM MOVING I AM LEARNING IMPLEMENTATION: OUTPUTS

The "Outputs" column in a logic model answers the questions, "What did the program do?" and "Whom did the program reach?" (University of Wisconsin, Cooperative Extension 2003). Outputs consist of both strategies and activities. Strategies are the broad approaches a program uses to influence the conditions or causes that motivated the program's existence (Harvard Family Research Project 2002). Activities, on the other hand, reflect day-to-day operations of a program—the specific activities and services a program implements under each broad strategy.

Figure IV.1 shows the Outputs column included in the reference IM/IL logic model introduced in Chapter II. For IM/IL, a key characteristic of a program's implementation strategy is the audiences they elect to target. All programs target children. Programs may also target parents and/or staff in an effort to build a network of adults that can support children in developing and sustaining healthful physical activity and eating habits. IM/IL programs may also promote changes at the community level to facilitate physical activity and healthy eating.

As discussed in Chapter II, data from the Stage 2 interviews were used to identify four different strategies used by the Stage 2 programs in implementing IM/IL. Five programs targeted children, parents, and staff; 12 programs targeted children and parents; two programs targeted children and staff; and seven programs targeted only children. Some Stage 2 programs formed partnerships with community members or organizations who provided assistance in implementing IM/IL, but none of the Stage 2 programs reported specific activities that targeted the community at large. This chapter describes the specific activities Stage 2 programs implemented for their various target audiences. Child-focused activities are described first. These activities involved altering children's experiences at Head Start to increase MVPA, enhance structured movement activities, or promote healthy food choices. IM/IL activities implemented with parents and staff are described next. The chapter concludes with a discussion of changes in program strategies and activities between Years 1 and 2 reported by staff in Stage 3 programs. With the exception of the concluding section, the data presented and discussed in this chapter are drawn from Stage 2 telephone interviews.

Figure IV.1 Reference Logic Model for *I Am Moving, I Am Learning* Outputs Components



IM/IL ACTIVITIES FOR CHILDREN

All but one of the 26 Stage 2 programs reported that IM/IL activities for children were implemented in all of their centers and classrooms during the first year of implementation.[48] In addition, all but one of the Stage 2 programs *required* that all teachers implement IM/IL. The one program that did not require teachers to implement IM/IL strongly encouraged them to do so, but left the decision up to each individual teacher.

[48]The one program that did not implement IM/IL in all centers and classrooms planned a staged implementation across three years because teachers were also implementing a new curriculum. Program managers believe that the staged roll-out would allow teachers to implement both new initiatives well.

All 26 Stage 2 programs reported implementing activities that were intended to increase the amount of MVPA children received while at Head Start. Eleven programs also reported activities that were designed to enhance the quality of structured movement experiences in Head Start classrooms by focusing on children's movement skills and coordination. Nine programs reported implementing activities designed to promoted healthy food choices.

Sixteen of the 26 Stage 2 programs had one or more children with Individual Education Plans (IEPs) that addressed children's physical limitations. Staff in these programs reported that they did not have to make substantial adjustments in their IM/IL implementation plans to accommodate these children. If a child needed assistance with an activity, teachers or assistants would work with the child (for example assist the child with a particular movement, help the child climb a set of stairs, or work with the child using existing adaptive equipment), but the activity itself would not be modified. One teacher reported that participation in classroom activities among children with fine or gross motor delays increased after IM/IL implementation began.

Increasing MVPA and Enhancing Structured Movement Experiences

IM/IL activities that are designed to increase MVPA or improve movement skills do not require expensive equipment and can be implemented with or without the use of props. IM/IL coordinators in Stage 2 programs reported a number of different activities used with children to promote MVPA or enhance movement skills and coordination (see box). Activities that were used specifically to increase children's levels of MVPA included moving/dancing to music, running outdoors, doing calisthenics or aerobic routines, and going on neighborhood walks. Other activities emphasized body or action awareness and, depending on children's developmental readiness and teachers' implementation approaches, could also have increased MVPA. These included, for example, jump rope, dances/games with scarves or hula hoops, and having the children skip, hop, jump, or march. Some activities focused specifically on movement/action awareness, such as throwing and catching balls, walking on balance beams, stretching exercises, and yoga.

Indoor Activities

All 26 Stage 2 programs reported conducting MVPA and structured movement activities indoors. Most often (22 of 26 programs) music was used in combination with dancing or a structured movement activity during circle time, choice time, or free time. Teachers reported using a variety of different music, but tracks from the Choosy CDs introduced to program managers at the TOT were most popular. Teachers also played "freeze dancing" games to music or used specific dance routines. Dancing with scarves or other props such as ribbon sticks, streamers, or instruments was another popular activity.

Teachers reported using IM/IL movement-focused activities at a variety of different points during the day. For example, teachers reported leading children in stretching exercises, sit-ups, push-ups, or aerobics routines to start the day. Games such as "follow the leader," "bean bag toss," "passing a ball over your head and under your legs," and "Simon Says" were used to integrate MVPA or structured movement into daily routines.

Reported IM/IL Activities Focused on MVPA or Structured Movement

Without Props	With Props
Moving/dancing to music	Throwing or catching balls
Running outdoors	Riding bikes/tricycles/scooter boards
Calisthenics/aerobics	Dancing with scarves
Walking	Dancing/games with hula hoops
Skipping	Jumping rope
Hopping	Walking on balance beams
Jumping	Using playground equipment
Galloping	Tossing/parachute games
Marching	Hitting balloons with paddles
Stretching	Using "movement wheels" or "exer-dice"
Yoga	Completing obstacle courses
	Lifting liter-bottle weights

Source: IM/IL Implementation Evaluation Stage 2 telephone interviews completed with IM/IL coordinators in summer 2007 at the end of the first year of IM/IL implementation.

Teachers also reported working with children individually or in small groups during choice time. At these times, teachers generally used activities that focused on developing movement skills, for example, teaching children to throw and catch a ball, jump rope, or walk on balance beams. Teachers from two programs reported creating props such as a "movement wheel" or "exer-dice" to lead children through different types of movement.[49]

Teachers from 10 Stage 2 programs reported conducting activities that integrated movement and learning, which typically occurred during circle time or other periods devoted to reading, numeracy, or other learning domains. For example:

- *Literacy:* Making letters in the air with scarves while dancing (1 program); acting out stories with streamers (1 program); hopping to letters in the child's name (1 program); "musical alphabet" where the children march to music and run to an alphabet tile on the classroom rug when the music stops (1 program).

- *Numeracy:* Children counted together as they did jumping jacks (2 programs).

[49] These props are labeled with a variety of movements (for example, jump, run, hop, skip). When the teacher/home visitor spins the wheel or rolls the die, children must do the movement that "shows up."

- *Body Health:* Children learned about their heart rate and the importance of MVPA by using the song "My Heart Says Thanks," or by monitoring their heart beat while resting and after MVPA (4 programs); teachers taught body parts when passing balls (1 program).

- *Spatial Awareness:* Children drew chalk lines within which to stretch (1 program); teachers/home visitors used hula-hoops to designate personal space, and facilitated movement within the space (2 programs).

- *Colors:* Children moved around on scooters to match colored balls with colored boxes (1 program); teachers posted colored paper on walls and called out a color for children to run to (1 program); children hopped to different colors in the classroom (1 program).

Finally, teachers from seven Stage 2 programs reported using transition times (times when children were lining up, moving from one activity to another, being taken to wash their hands, or waiting for meals and snacks) to incorporate movement-focused IM/IL activities. Teachers reported using "follow the leader" during transition times, playing "Choosy freeze dance," or playing other Choosy movement songs. Teachers also reported leading children in using different types of traveling actions (for example, skipping, hopping, sliding, alternating fast and slow walks, and moving up and down while walking) to get from one place to the next.

Outdoor Activities

All 26 Stage 2 programs reported that movement-focused IM/IL activities were also implemented outdoors, either through teacher-led structured games and activities or through unstructured, child-initiated activities. Most of the Stage 2 programs (23 of 26) reported that teachers led IM/IL activities in outdoor settings. For example, teachers created obstacle courses using cones, tunnels, or ropes, and directed relay races for children. Teachers led children in tossing games using parachutes or throwing balls into wheelbarrows and also facilitated games such as tag, "red light, green light," kickball, soccer, and basketball. Unstructured child-initiated physical activities included playing on playground equipment such as slides, "monkey" bars, and large playground structures, riding tricycles and bicycles, playing hopscotch, and other child-initiated games such as "tag."

Home Visit Activities

Home visitors in at least 9 of the 11 Stage 2 programs that had a home visiting component reported incorporating IM/IL movement activities into each home visit. Many of the activities home visitors reported were similar to those used by classroom teachers, but home visitors also reported some creative implementation strategies. One home visitor placed a large piece of butcher paper on the floor and encouraged the child to dance on it after she had painted the bottom of his feet with washable paint. Other home visitors asked children to hop to the letters of their name, used Styrofoam balls to teach children about throwing and catching while indoors, and took children on walks to local parks. Home visitors in three programs reported teaching children about their heartbeat after active

movement; one home visitor used a stethoscope to help children hear their heartbeats and another helped children find their pulse and count their heartbeats.

Program-Wide Events

Three Stage 2 programs reported sponsoring program-wide special events or gathering multiple classrooms to focus on physical activity. One program held a "Small Fry Showdown" where children participated in relay races, dances, and other physical activities as part of the program's end-of-the-year celebration. Another program culminated the year with presentations and activities using different equipment such as balls, rackets, or jump ropes for everyone to learn about and use. Finally, on rainy days, one program set up "fun days" where children rotated through physical activity stations in the program's multi-purpose room.

Promoting Healthy Food Choices

As noted in Chapter III, only 9 of the 26 Stage 2 programs chose in their IM/IL implementation to focus on the IM/IL goal related to promoting healthy food choices. Teachers and home visitors in these programs reported a variety of child-focused activities used in addressing this goal. In six of the nine programs, classroom staff and home visitors initiated discussions with children about nutrition and healthy food choices on a daily or weekly basis. In two programs, teachers/home visitors described activities that were designed to help children identify fruits and vegetables; staff in two other programs reported taking children on field trips to local farmer's markets to learn about or purchase fresh fruits and vegetables. Teachers/home visitors in four programs reported cooking demonstrations or taste-testings where children could prepare or taste healthy foods. When children were introduced to a new food and were reluctant to try it, they were asked to take small bites, called "no-thank-you" bites. Teachers/home visitors also reported using books, games, and other media to teach children about good nutrition and promote healthy eating.[50]

IM/IL ACTIVITIES FOR PARENTS

As discussed previously, 17 of the 26 Stage 2 programs targeted parents in their implementation of IM/IL—5 programs targeted children, parents, and staff and 12 programs targeted children and parents. Programs that targeted parents tended to be larger and were more likely to offer home-based services or Early Head Start services than programs that did not target parents (see Chapter II, Table II.3). The rationale for programs' decisions about targeting parents was not explored explicitly in the Stage 2 interviews. However, the IM/IL coordinator in one Stage 2 program reported that they decided not to target parents because they were concerned about how difficult it is to get parents involved in any Head Start activity. They were also concerned about whether parents would respond

[50] Some of the programs that focused on nutrition in their IM/IL implementation made policy changes related to the types of food parents could bring or send in to the center and/or the types of foods offered in Head Start meals and snacks. In the IM/IL reference logic model, policy changes such as these are considered intermediate outcomes. Intermediate outcomes are discussed in Chapter V.

positively to IM/IL activities. It is possible that some programs elected not to target parents because they did not feel prepared to do so after the TOT. Thirty-seven percent of the IM/IL coordinators who completed a Stage 1 questionnaire indicated that the TOT did not devote enough time to strategies for engaging adults in IM/IL (ACF 2007).[51]

Thirteen of the 17 programs that targeted parents reported formally introducing parents to IM/IL. One program relied on written materials for this introduction, but most programs sponsored a parent meeting or workshop or held some other type of kick-off event.[52] Program staff reported presenting background information (provided to program managers at the TOT) about the connection between brain development and physical activity and the concepts and goals behind IM/IL. Staff also introduced plans for IM/IL implementation. Typically, meetings and workshops included hands-on experience for parents in singing and dancing to Choosy songs.

Programs that targeted parents reported three different areas of focus for IM/IL activities: (1) education and information about healthy eating and/or exercise, (2) practical examples of activities parents could do with their children to increase MVPA, and (3) education and guidance about healthy food preparation techniques. Programs used a variety of strategies to deliver parent-focused IM/IL activities over the course of the first year of implementation. Use of parent newsletters was the most common approach, but only one program relied solely on this mechanism (Table IV.1). Topics covered in newsletters included healthy meal and snack choices, food-purchasing tips, and strategies for portion control. Many newsletters also included suggested recipes.

Programs reported a variety of other mechanisms for reaching parents (see Table IV.1). These included:

Five or more programs

- Providing information through handouts or newsletters about obesity, healthy eating, or activity suggestions such as "go on a walk and pick out a pretty leaf"
- Demonstrating IM/IL movement activities that parents could do with their children and providing resources, which may have included making homemade props or providing music CDs[53]
- Sponsoring cooking demonstrations, typically at monthly parent meetings, to introduce parents to healthy foods and food preparation techniques

[51] Coordinators rated the amount of time spent on this topic as a 1 or 2 on a 5-point scale with anchors at 1 (too little time), 3 (about the right time), and 5 (too much time).

[52] All the programs with a home-visiting component introduced IM/IL to parents at a parent meeting rather than during a home visit.

[53] Programs encouraged parents to use the Choosy songs and dances at home with their children by allowing parents to borrow CDs.

Table IV.1 Parent-Focused IM/IL Activities Implemented By Programs That Targeted Parents

	All Programs	Target Audience: Children, Parents, and Staff	Target Audience: Children and Parents
	Number (Percentage of Programs)		
Provide information through handouts/ newsletters	8 (47)	2 (40)	6 (50)
Demonstrate IM/IL activities to do with children at home	8 (47)	2 (40)	6 (50)
Sponsor cooking demonstrations	6 (35)	1 (20)	5 (42)
Hold nutrition-focused discussions	5 (29)	1 (20)	4 (33)
Invite parents to visit classrooms to see/participate in IM/IL activities	3 (18)	1 (20)	2 (17)
Offer parents help in tracking their own health (blood pressure monitoring, nutrition counseling)	2 (12)	1 (20)	1 (8)
Provide parents with materials to use in documenting healthy eating and physical activity at home	2 (12)	0 (0)	2 (17)
Offer incentives for participation in IM/IL activities	2 (12)	1 (20)	1 (8)
Sample Size	**17**	**5**	**12**

Source: IM/IL Implementation Evaluation Stage 2 telephone interviews completed with IM/IL coordinators in summer 2007 at the end of the first year of IM/IL implementation.

Note: Table includes only programs that targeted parents. Percentages are calculated within column. Percentages do not sum to 100 because programs could report multiple parent-focused activities.

- Holding nutrition-focused discussions at monthly or bi-monthly parent meetings

One to three programs

- Inviting parents to classrooms to lead IM/IL activities
- Offering parents the opportunity to have their blood pressure measured and to have a private consultation with a nutritionist
- Providing parents with forms they could use to document family eating and physical activity behaviors

- Offering incentives to parents for participating in IM/IL activities[54]
- Inviting parents to program-sponsored events such as a presentation given by a regional IM/IL trainer

IM/IL ACTIVITIES FOR STAFF

Only 7 of the 26 Stage 2 programs reported targeting staff as part of their IM/IL enhancement. Two of these programs targeted children and staff and five targeted staff in addition to children and parents (Table IV.2). All of these programs sponsored activities to encourage staff to become more physically active. For example, three programs created walking groups for staff. Staff could sign up to participate in a walking group before or after the program day, or during breaks. Two of these programs set up competitions to see which team could take the most steps in a given period of time (two weeks, for example). Some programs also reported offering staff incentives for exercising. Two of the programs that sponsored walking groups provided staff with pedometers or a luncheon for joining the group. One program provided gym memberships to staff members who expressed an interest in and commitment to exercising regularly. Other programs encouraged increased physical activity among staff by offering yoga classes or by purchasing the video game "Dance, Dance Revolution."

Table IV.2 Staff-Focused IM/IL Activities Implemented By Programs That Targeted Staff

		Target Audience	
	All Programs	Children, Parents, and Staff	Children and Staff
	Number (Percentage) of Programs		
Organize walking groups	3(43)	1 (20)	2 (100)
Provide incentives for exercise	3(43)	2 (40)	1 (50)
Purchase exercise-oriented video game	2(29)	2 (40)	0 (0)
Provide exercise classes	1(14)	1 (20)	0 (0)
Sample Size	**7**	**5**	**2**

Source: IM/IL Implementation Evaluation Stage 2 telephone interviews completed with IM/IL coordinators in summer 2007 at the end of the first year of IM/IL implementation.

Note: Table includes only programs that targeted staff. Percentages are calculated within column. Percentages do not sum to 100 because programs could report multiple staff-focused activities.

[54] One program gave prizes from a local store to parents who documented IM/IL activities done with their children at home, and another implemented a walking program for parents that included distribution of pedometers to participants.

CHANGES IN PROGRAM STRATEGIES AND ACTIVITIES (OUTPUTS) IN YEAR 2

Prior to Stage 3 site visits, study staff developed a draft logic model for each program, based on information collected during Stage 2 interviews. During the site visits, interviewers reviewed the draft logic model with IM/IL coordinators and other program leaders. As part of the discussion, program staff were asked to describe changes they made to their IM/IL implementation strategies and activities (outputs) for Year 2, if any, and to explain why the adjustments were made. During Stage 3 focus groups, teachers were also asked to describe changes made between the first and second years of IM/IL implementation.

More than half of the Stage 3 programs (7 of 13) reported making little to no adjustment in their approach to IM/IL implementation for Year 2. These programs reported that they generally retained the approach they had begun in Year 1 but were using Year 2 to reinforce and further integrate IM/IL into classroom and home visiting routines. Some of these programs did mention purchasing additional resources or adding new activities in Year 2, but none of the new purchases or activities represented a major departure from the focus established during Year 1. IM/IL coordinators and program directors reported that providing new resources or props in the new school year was a way to keep staff enthusiasm high and sustain IM/IL implementation. Examples of resources that programs invested in during Year 2 included additional CDs for classrooms, installation of a tricycle path in an outdoor play area, the "Dance, Dance Revolution" video game, and world menus to introduce children to different types of food and eating behaviors.

With regard to child-focused activities added during Year 2, one program reported a "preschool Olympics" competition and a visit to a local nursing home where children did movement activities with residents. Another program invited an expert from a local non-profit organization to visit the centers and teach children about using different types of balls (for example, soccer ball, football, baseball). A third program outfitted two classrooms with "movement centers" that included tumbling mats, a CD player, and other "play" equipment in a designated area for children to use during choice time. All of the equipment in the movement centers was available and had been used in Year 1; the change made in Year 2 was designed to increase children's use of the equipment and, consequently, their MVPA, especially during inclement weather when outside play time was restricted.

Six of the 13 Stage 3 programs reported making more substantial changes in their approach to IM/IL implementation for Year 2. One program expanded IM/IL implementation during Year 2 to target parents. This expansion had been planned for from the beginning, but the program needed resources to support the additional programming. To support this new parent component, the program staff obtained a grant from Kraft Foods (their second grant; they also received a grant during Year 1). Grant funds were used to provide incentives to parents who attended IM/IL activities and to cover the cost of handouts and pamphlets for parents.

Two programs substantially expanded the staff component of IM/IL, in large part because of staff enthusiasm for IM/IL and its goals. One program incorporated development of personal wellness plans, which helped staff improve both their lifestyles and the Head Start environment. The second program went from just encouraging staff walking

clubs to sponsoring a healthy recipe contest, offering a "Zumba" (a type of aerobics) class, and serving healthier snacks at staff meetings.

Another Stage 3 program changed their staff component in the opposite direction. This program cut back on the staff component of IM/IL by dropping the requirement that each staff member set a personal health goal. This requirement was unpopular with staff, who viewed it as intrusive, so program managers decide to omit the requirement in Year 2. This program also added incentives during Year 2 to revitalize staff activities that had diminished over the course of Year 1. To encourage staff to participate in a walking club, the IM/IL coordinator obtained community donations to use as rewards for staff who walked regularly. Rewards included a membership at Curves fitness club and a massage.

Three of the six Stage 3 programs that reported a substantial change between Year 1 and Year 2 implemented a new nutrition-focused curriculum in Year 2. One program adopted a new curriculum because they were given the opportunity to serve as a pilot site for a new (non-Head Start) obesity prevention initiative that they believed complemented IM/IL. The other two programs that adopted a new curriculum did so to expand staff resources with interesting and fun activities to do with children and reaching/involving parents.

Finally, seven Stage 3 programs reported activities during the second year of IM/IL implementation that targeted the broader community—individuals other than Head Start children, parents/families and staff. Four programs that were associated with school districts sponsored workshops or events promoting healthy eating and physical activity that were open to the entire school community. One of these programs also sponsored a similar event for members of a local YMCA. Two of the programs that reported activities that targeted the broader community sponsored training/awareness events for staff in other organizations that serve the broader community. These events were designed to encourage staff in the collaborating organizations (cooperative extension in one case and child care staff in the county social services department in the other) to incorporate IM/IL messages into their work with children and families. The remaining program reached out to local pediatricians to encourage routine measurement of children's BMIs. They also staffed a booth at service fairs organized by local community groups to encourage families to adopt healthier lifestyles and set up similar booths at local malls.

CHAPTER V

I AM MOVING, I AM LEARNING IMPLEMENTATION: OUTCOMES

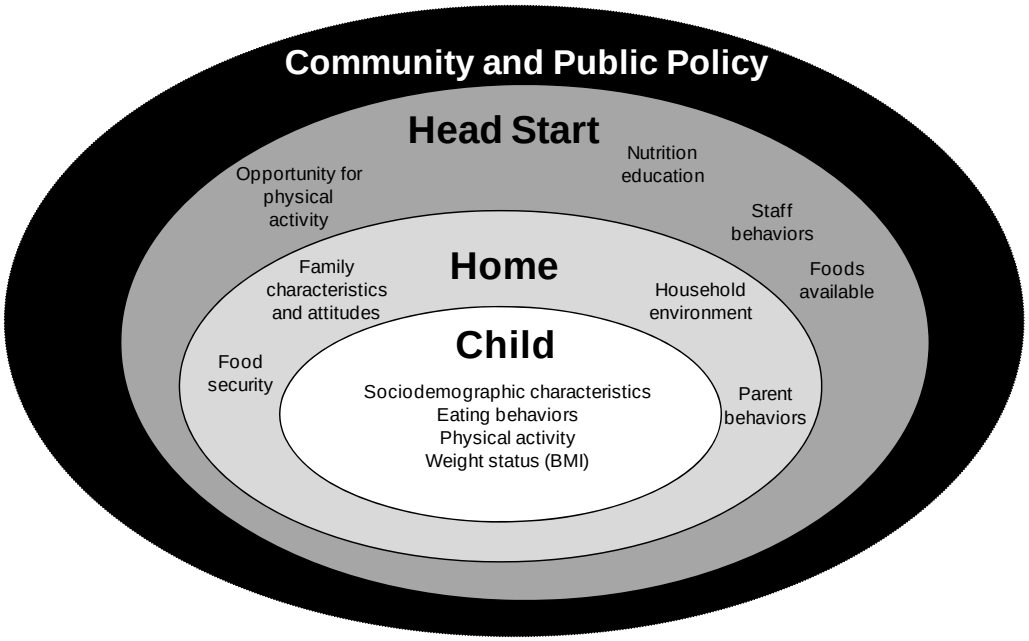
Outcomes answer the question, "What happened as a result of the intervention?" Outcomes can be short-term, intermediate, or long-term. Short-term outcomes include changes in awareness, knowledge, motivation, and attitudes of program staff or target audiences. Intermediate outcomes follow from the short-term outcomes and include changes in behaviors of organizations and program staff as well as changes in key behaviors among the target audiences. Long-term outcomes flow from intermediate outcomes and reflect the ultimate goal of an intervention. Long-term outcomes can take years to accomplish (McCawley 2001; Centers for Disease Control and Prevention 2004).

The long-term goal of IM/IL is the prevention of childhood obesity. In thinking about short-term and intermediate goals that might precede this outcome, it is useful to recognize that the tenets that underlie IM/IL, as described at the TOT event and summarized in Chapter II, are grounded in a socio-ecological approach to health promotion (see FigureV.1). This approach recognizes that health-related behaviors are influenced by a number of factors, including personal/family characteristics and the physical and social settings in which key behavioral decisions are made. The implication is that obesity prevention efforts need to target systems change rather than just promote individual behavior change. That is, for children to adopt recommended eating and physical activity behaviors, the environments in which they live and the individuals and organizations caring for them must promote and support these behaviors.

Thus, the short-term and intermediate outcomes included in the reference logic model developed for this evaluation (see Figure V.2) reflect the assumption that changing the child involves changing the behaviors of important adults who shape the child's environment at school and at home. The first step (short-term outcome) toward meeting IM/IL's long-term goal is to increase awareness, knowledge, and attitudes of program staff, parents, and children[55] about physical activity and healthy food choices. For parents and staff, this

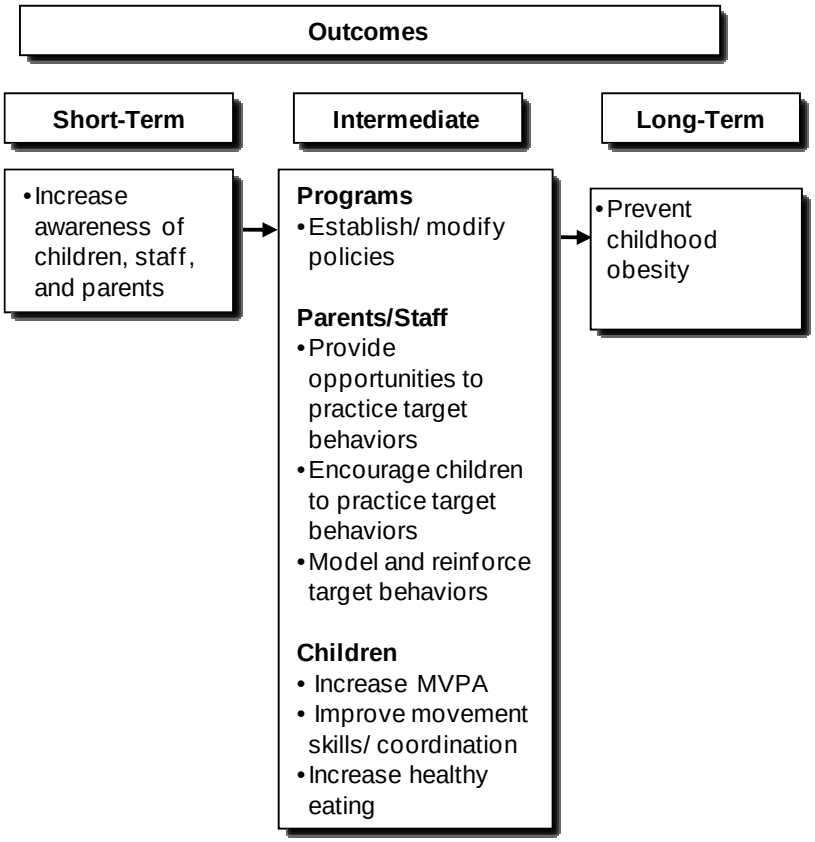
[55] The available data did not permit assessment of children's awareness.

Figure V.1 Socio-Ecological Model of Health Promotion



Source: Adapted from McLeroy et al. 1988, and Sallis et al. 1998.

Figure V.2 Reference Logic Model for *I Am Moving, I Am Learning:* Outcomes Component



includes an understanding of the important role they play in providing children with healthy foods and opportunities for physical activity, and in reinforcing targeted behaviors. Increased knowledge and awareness is expected to lead to intermediate outcomes among Head Start programs, staff, and parents. For example, Head Start programs may establish or modify policies related to physical activity and nutrition to support IM/IL goals. In addition, Head Start staff and parents may provide children with opportunities to practice targeted behaviors; encourage children to practice these behaviors; and personally model and reinforce these behaviors. These intermediate outcomes among programs, staff, and parents are expected to lead to key child-level intermediate outcomes—increased MVPA, improved movement skills and coordination, and improved eating habits. Ultimately, changes in children's MVPA and eating habits are expected to lead to a decrease in the prevalence of childhood obesity.

This implementation evaluation was not intended to measure outcomes of IM/IL. However, two different approaches were used to provide descriptive information about potential outcomes of IM/IL, as implemented in the programs that participated in the evaluation. First, data collected in Stage 2 telephone interviews with IM/IL coordinators were used to describe the types of outcomes program leaders expected IM/IL to produce. Second, data collected in Stage 3 on-site interviews and focus groups were used to assess whether there was any evidence of the awareness and behaviors (on the part of staff, parents, and/or children) associated with the short-term and intermediate outcomes included in the reference IM/IL logic model (Figure V.2). When possible, data from the Stage 3 classroom observations were used to amplify or extend findings from interviews and focus groups.

The available data describe what was reported or observed in Head Start programs included in stages 2 (n = 26) and 3 (n = 12 or 13)[56] of the study. Findings are not generalizable to all Region III Head Start programs or to Head Start programs nationwide. Moreover, because data were collected only at one point in time, after IM/IL implementation had begun, it is not possible to attribute any IM/IL-related awareness or behaviors to the influence of IM/IL. Without baseline (pre-IM/IL) data, it is not possible to say whether awareness or behaviors are different than they were prior to IM/IL.

OUTCOMES EXPECTED BY IM/IL COORDINATORS

During the Stage 2 interviews, IM/IL coordinators were asked to identify the outcomes they hoped IM/IL would achieve. Specifically, interviewers asked IM/IL coordinators to discuss the changes they expected IM/IL to bring about in behaviors of children, staff, and/or parents (depending on the audiences being targeted by IM/IL). These data are summarized in Table V.1.

[56] In one of the 13 programs included in Stage 3, inclement weather forced the closing of the sampled center, so the observation was not conducted. The other Stage 3 data collection activities (interviews and focus groups) were completed with this program.

Table V.1 Expected Changes in Awareness or Behaviors of Children, Parents or Staff Reported by IM/IL Coordinators in Stage 2 Programs, By Target Audience

	Number (Percentage) of Programs
Children	
Physical Activity/Movement Skills	
Children will get more physical activity while at Head Start	17 (65)
Children will experience more/improved structured movement activities in Head Start classrooms	8 (31)
Children will be more aware of the importance of physical activity	5 (19)
No specific changes mentioned	6 (23)
Nutrition	
Children will be more aware of healthy food choices	15 (58)
Other	
Children's social emotional or academic development will be improved	3 (12)
Children's overall health will be improved	2 (8)
Sample Size	**26**
Parents[a]	
Parents Will Be More Aware of Healthy Food Choices	7 (41)
Parents Will Increase Their Level of Physical Activity	5 (29)
Parents Will Reinforce Healthy Eating and Physical Activity Behaviors at Home	4 (23)
Parents Will Be More Aware of the Importance of Physical Activity	2 (12)
No Specific Changes Mentioned	6 (23)
Sample Size	**17**
Staff[b]	
Staff Will Be More Aware of the Importance of Physical Activity	3 (43)
Staff Will Be More Aware of Healthy Food Choices	2 (28)
Staff Will Make Changes in Food and Physical Activity Behaviors	2 (28)
Staff Will Model Healthy Nutrition and Physical Activity Behaviors for Children	1 (14)
No Specific Changes Mentioned	3 (43)
Sample Size	**7**

Source: IM/IL Implementation Evaluation Stage 2 Telephone Interviews completed with IM/IL coordinators in summer 2007 at the end of the first year of IM/IL implementation.

Note: Programs could report more than one anticipated outcome per target audience.

[a] Sample is limited to the 17 programs that targeted parents.

[b] Sample is limited to the 7 programs that targeted staff.

Overall, the data indicate that IM/IL coordinators in most Stage 2 programs had expectations about short-term and intermediate outcomes that were generally consistent with the reference IM/IL logic model. However, some IM/IL coordinators did not identify specific behavior changes that related back to their goals and/or to the program strategies and activities (outputs) they reported. For example, although all 26 Stage 2 programs reported targeting the IM/IL goal to increase children's MVPA (see Table III.1) and all of these programs reported implementing activities that were consistent with this goal (see Chapter IV); IM/IL coordinators in nine programs did not indicate that they expected IM/IL to increase children's physical activity while at Head Start. Similarly, IM/IL coordinators in 6 of the 17 programs that targeted parents and three of the seven programs that targeted staff did not indicate that they expected to change awareness or behaviors of these target audiences.

IM/IL coordinators who did not report expected changes in awareness or behaviors related to physical activity or nutrition focused on other perceived benefits of IM/IL. Examples include that children and staff would find IM/IL's music and movement activities to be enjoyable and interesting, or that parents' involvement in IM/IL activities would increase their participation in parent meetings and other outreach events. Other tangential benefits reported by one or more IM/IL coordinators included fewer behavior problems among children, smoother lesson planning for teachers, increased enthusiasm among teachers for child-focused enhancements and other health promotion initiatives.

EVIDENCE OF AWARENESS OR BEHAVIORS ASSOCIATED WITH SHORT-TERM AND INTERMEDIATE OUTCOMES IN THE IM/IL LOGIC MODEL

The sections that follow discuss the extent to which the short-term and intermediate outcomes included in the reference IM/IL logic model (Figure V.2) were evident in reports from program staff and parents or in observations of Head Start classrooms. Data are drawn from Stage 2 interviews and Stage 3 interviews, focus groups, and observations. In keeping with accepted approaches to analysis of qualitative data, summaries of focus groups provide a general synthesis of teacher and parent discussions rather than tabulated responses.

As noted previously, findings are not generalizable to all Region III Head Start programs or to Head Start programs nationwide. Moreover, because data were collected only at one point in time, after IM/IL implementation had begun, it is not possible to attribute any IM/IL-related awareness or behaviors to the influence of IM/IL.

Short-Term Outcome: Increase Awareness of Staff and Parents

For IM/IL to achieve its long-term goal, staff and parents need to provide children with opportunities to be more physically active and to practice healthy eating habits. An important first step in making this happen is ensuring that staff and parents "buy into" IM/IL—that they understand and support the need for children to be more active and eat more nutritious food and that they are motivated to support these activities.

In general, teachers/home visitors in Stage 2 programs reported that IM/IL made them aware of the importance of providing children with opportunities for MVPA throughout the

day and of the developmental skills required of children to complete specific types of movements. For example, one teacher reported that IM/IL opened her eyes to what is involved in children's learning to jump or march. Teachers from Stage 2 programs also reported being more conscious of the quality of the foods that are brought into the classrooms by parents and served in Head Start meals and snacks. One teacher reported that she does not serve high-fat condiments to the children when they are provided as optional additions to meals or snacks (for example, regular mayonnaise that could be added to sandwiches). Another teacher commented that she has stopped encouraging children to eat until they cannot eat any more. At least one teacher/home visitor from 23 (of 26) Stage 2 programs reported understanding that they serve as role models for children, and teachers/home visitors from 16 programs indicated that IM/IL has made them more aware of their own eating habits.

Parents who participated in the Stage 3 focus groups were generally aware of the importance of good nutrition and physical activity for children's overall health and development.[57] In response to questions about whether physical activity was important, parents reported that physical activity was important for developing children's coordination and gross motor skills. They also said that physical activity helps with the physical development of the body such as the heart, and believed that physical activity improved children's ability to learn and be emotionally balanced. Parents noted that children need to eat a healthy diet in order to develop properly and have adequate energy. They also said that eating nutritious foods early in life prepares children to have good eating habits later in life and that healthy eating leads to better health. Parents identified fruits and vegetables, whole grains, and milk as healthy foods that children should be encouraged to eat, and soda, fast foods, candy, and chips as unhealthy foods that should be avoided or limited.

It was not possible to determine whether parents' awareness of the importance of physical activity and nutrition resulted from activities associated with IM/IL (activities which may have been targeted at parents or children), from other previous or ongoing Head Start outreach and activities, or from other (non-IM/IL or Head Start) experiences. Parents in all but one of the 13 Stage 3 programs were aware of IM/IL. This included the nine Stage 3 programs that specifically targeted IM/IL to parents as well as three of the four programs that were not targeting parents. In addition, during focus group discussions that centered on activities that might have promoted awareness of physical activity and nutrition, parents in all programs reported receiving relevant information from Head Start or participating in relevant activities, especially information/activities related to nutrition. However, parents generally did not specifically identify IM/IL as the source of the information or activities. Moreover, there was no apparent difference in the level of awareness of parents in programs where IM/IL did and did not specifically target parents.

[57]"Parent" focus groups actually included mothers, fathers, and grandparents. For ease in discussion, the term parent is used throughout this discussion. Focus group participants were not randomly selected to participate, and are likely representative of parents in Stage 3 programs who were interested and willing to get involved in Head Start activities.

Intermediate Outcome for Programs: Establish or Modify Policies to Support Program Goals

Policy change is an important intermediate outcome in institutionally based interventions because it promotes desired changes in staff behavior, increases the likelihood that participants will experience an intervention in the manner intended, and builds sustainability. In the case of IM/IL, potentially important policies include those related to the amount and type of physical activity children are exposed to each day and the types of foods they are offered while at Head Start.

Polices Related to Physical Activity

Almost two-thirds of the Stage 2 programs (15 of 26) modified or established policies related to the amount or type of physical activity required each day (Table V.2). This was true for most (5 of 7) of the programs that targeted only children or targeted children, parents and staff (4 of 5). However, only 6 of the 14 programs that targeted children and parents or children and staff implemented a policy change related to physical activity.

Among the 15 programs that established or modified policies, 7 established new policies that set specific targets for the number of minutes children should be active each day, through either teacher-led IM/IL activities or unstructured periods of free play, and 5 programs modified existing policies to increase the number of required minutes of physical activity per day. Across new and modified policies, targets for daily physical activity ranged from 30 to 120 minutes per day, with 60 minutes being the most common. Five programs modified policies to stipulate how physical activity minutes should be distributed throughout the day. For example, three of these five programs began requiring that half of the time devoted to physical activity be spent in teacher-led structured movement activities. Finally, three programs established policies that required teachers to record the time they had allotted in their lesson plan to MVPA and structured movement activities prior to conducting the activities.

Some programs reported more than one policy change. Two of the programs that modified existing policies made changes that both increased the number of minutes of required physical activity and provided guidance about how the time should be distributed throughout the day. Two other programs increased the number of minutes of required activity and required that teachers record information about planned activities in lesson plans.

Of the 11 Stage 2 programs that did not establish or modify policies related to physical activity, only 2 had an existing formal policy that specified a required number of minutes of physical activity per day. The other nine programs, most of which targeted children and parents or children and staff, either had no guidelines in this area or reported following the Head Start performance standards (which do not specify a certain amount of time). IM/IL coordinators in these nine programs indicated that program managers were satisfied with the amount of physical activity children were receiving prior to IM/IL and that their implementation of IM/IL emphasized enhancing the current methods (activities) teachers used to promote physical activity rather than increasing the amount of daily physical activity.

Table V.2 Policy Changes Related to Physical Activity

		Target Audiences		
	All Programs	Children, Parents, and Staff	Children and Parents or Children and Staff	Children
	Number (Percentage) of Programs			
Implemented a Policy Change	15 (58)	4 (80)	6 (43)	5 (71)
Established policy to require specific number of minutes of physical activity per day	7 (27)	2 (40)	3 (21)	2 (29)
Modified existing policy to increase required number of minutes of physical activity per day	5 (23)	2 (40)	2 (14)	1 (14)
Modified existing policy to provide guidance on how minutes of activity should be structured or distributed throughout the day	5 (23)	1 (20)	2 (14)	2 (29)
Established policy to require that teachers record the number of minutes allotted in lesson plans to MVPA or structured movement prior to conducting activities	3 (12)	1 (20)	1 (7)	1 (14)
Did Not Implement a Policy Change	11 (42)	1 (20)	9 (64)	1 (14)
Had existing policy that specified required number of minutes of physical activity per day	2 (8)	0 (0)	1 (7)	1 (14)
Had no formal policy or no quantified guidelines about number of minutes of physical activity per day	9 (35)	1 (20)	7 (50)	1 (14)
Sample Size	**26**	**5**	**14**	**7**

Source: IM/IL Implementation Evaluation Stage 2 telephone interviews completed with IM/IL coordinators in summer 2007 at the end of the first year of IM/IL implementation.

Note: Programs could report multiple policy changes related to movement, thus percentages do not sum to 100.

Policies Related to Nutrition

As noted in Chapter I, only 9 of the 26 Stage 2 programs reported specific IM/IL enhancements related to nutrition. Four of these programs established or modified policies about the types of food that parents could bring or send into Head Start centers. These policies either prohibited food from home altogether or required that such foods be "healthy," which was generally defined as low in sugar and/or fat. The five programs that focused on nutrition but did not develop a formal policy about foods brought from home sometimes encouraged parents to limit high-sugar, high-fat foods, and provided this information to parents (for example in written materials, parent meetings, or informal discussions). In a Stage 3 focus group, a teacher in one of these programs that has a formal policy expressed hesitation about limiting the food that could be brought into the center and the message it might send to parents that Head Start was "telling them what to do."

Two programs reported changing policies and procedures for menu planning to incorporate healthier alternatives, such as offering low-fat milk instead of whole milk or flavored milk, serving whole wheat bread instead of white bread, using lower-fat meat and entrée items, and limiting or eliminating desserts. One program, which did a lot of cooking from scratch at the center, reviewed and modified all of their recipes to have lower fat and sugar content.

Intermediate Outcome for Staff and Parents: Provide Children with Opportunities to Practice Targeted Behaviors

If children are to develop physical activity and nutrition habits that will prevent obesity, they need opportunities to be physically active and eat nutritious foods. Such practice allows children to develop skills and confidence in moving their bodies and learn to enjoy and value physical activity and healthy eating.

During the Stage 3 site visits, observations were conducted in 1 classroom in 12 of the 13 programs (classroom observation in the remaining program was precluded because of program closure due to inclement weather).[58] In this section, these data are used to describe opportunities provided in Head Start classrooms for children to be physically active and eat nutritious foods. Opportunities to practice targeted behaviors outside of Head Start are also important but were not measured in this study. Some information about this is available from Stage 3 parent focus groups, but was reported in the context of what parents did to model and reinforce targeted behaviors (another intermediate outcome). These data are discussed in a subsequent section.

[58] The observation protocol is described in Chapter I.

Opportunities for Physical Activity

Across the 12 classrooms, site visitors observed a total of 70 teacher-led IM/IL activities (range = 1 to 15, with a median of 5) that targeted MVPA or structured movement (observations spanned the full Head Start day in both part-day and full-day programs). These opportunities for children to practice target behaviors included an array of different activities and were consistent with the types of activities and strategies reported by IM/IL coordinators and teachers in Stage 2 interviews (Table V.3).

Classroom observations also included assessment of opportunities for children to be sedentary, including access to and use of computers, televisions, and game systems; and the prevalence of extended periods of sitting during regular classroom activities (excluding meals and naps). None of the observed classrooms had a game system, and only two had a television or VCR/DVD player (Table V.4). In one of the classrooms that had a VCR/DVD player, children sat and watched a DVD for a short time at the end of day while waiting to be picked up. All but 1 of the 12 classrooms that were observed during Stage 3 had a computer. In five classrooms, children were allowed free access to the computer during designated parts of the day (for example, "free choice" periods). In the other six classrooms where computers were present, children were allowed to use the computer only with staff permission.

Opportunities to Eat Healthy Foods

The classrooms observed during Stage 3 also provided children with opportunities to practice recommended eating behaviors. Table V.5 summarizes characteristics of the foods offered to children on the day of observation. The findings suggest that children were provided with opportunities to practice healthy eating habits. For example:

- Low-fat milks were offered in all classrooms, and flavored milk was offered in only two classrooms.
- The majority of fruit offered was fresh (5 of 12 classrooms) or canned without added sugar (3 of 12).
- Fruit juice was offered in only four centers and only as part of a meal or snack.[59]
- Nutrient-dense dark-green or deep-yellow vegetables such as broccoli, spinach, and carrots were offered in five classrooms; french fries (which are commonly consumed by children but are less nutrient-dense) were offered in only one classroom.

[59] The American Academy of Pediatrics (2001) recommends that children's intake of fruit juice be limited to avoid overconsumption of calories.

Table V.3 Observed Teacher-Led Opportunities to Practice Physical Activity Behaviors

Movement Skills/ Coordination	Movement and Song	Other
Act out story using hand movements	*Head, Shoulders, Knees, and Toes*	Walk around the neighborhood
Counting activity with slow stretch to standing from crouch position	*Stir the Soup*	Choosy march
Chant while standing and clapping	*This is My Body*	Andean dance music
Leaf toss	*My Heart Says Thanks*	Relay races
Parachute games	*Choosy Hears*	Throw balls at target
Roll large dice and skipping, hopping, jumping	*Shake out Your Sillies Out*	Musical instrument march
Bean bag toss	*Going on a Bear Hunt*	
Stretches, twisting, toe-touching, sit-ups, push-ups, seal walks	*Five Little Apples*	
Jumping jacks and other jumping	*So Long Now*	
Walk/slide around the room	*Move Slowly*	
Balance a bean bag on various body parts	*Make My Lap*	
Yoga	*Walking to the A,B,C's*	
Waving, throwing, catching ribbons and scarves	*Wiggles*	
Balance beam	*How My Body Moves*	
Lifting liter-bottle weights	"Chicken" dance, hokey-pokey, and other dancing	

Source: IM/IL Implementation Evaluation Stage 3 Classroom Observations conducted between November 2007 and January 2008 when programs were in the second year of IM/IL implementation.

Note: Some songs were used more than once during the observation period, sometimes at the children's request.

N = 12 classrooms.

Table V.4 Opportunities to Engage in Sedentary Behavior: Screen Time

	Computer	Television or VCR/DVD Player	Game System
	Number (Percentage) of Programs		
Equipment was present in the classroom	11 (92)	2 (17)	0 (0)
Children had self-serve access (did not have to ask permission to use)	5 (42)	0 (0)	N/A
Equipment was used by one or more children	6 (50)	1 (8)	N/A
Sample Size	**12**	**12**	**12**

Source: IM/IL Implementation Evaluation Stage 3 classroom observations conducted between November 2007 and January 2008, when programs were in the second year of IM/IL implementation.

N/A = not applicable.

- Most classrooms (8 of 12) offered two or more different types of fruit and vegetables at lunch.
- The lunch entrées offered in five classrooms included lean meat or chicken; entrées offered in two classrooms included beans or lentils.
- Only two classrooms offered a dessert such as cookies or another baked treat.

Across the 12 classrooms, children were observed eating a variety of nutritious foods, including oatmeal; spinach salad; a homemade beef stew with carrots, peas, green beans and lima beans; French toast made from whole wheat bread; whole wheat bread sandwiches; pinto beans; and steamed cauliflower. However, the observation data suggest that there is still room for improving children's opportunities to practice healthy eating behaviors. Notably, few of the grain products offered to children were whole grain or high in fiber. In addition, in many classrooms (7 of 12), the entrée offered at lunch included cheese (not low-fat) or a breaded/pre-fried chicken item (patty or nuggets).

It is important to note that the foods offered in observed classrooms were not necessarily influenced by IM/IL implementation. Head Start centers are required to serve meals that meet menu planning standards for USDA's Child and Adult Care Food Program or National School Lunch and Breakfast Programs. Some programs have relatively little control over the foods served to children because meals and snacks are provided by the food service program in affiliated or contracted school districts. As noted previously, only nine

Table V.5 Foods Offered on Day of Observation, Across All Meals and Snacks

Food Offered	Number (Percentage) of Programs
Milk	
1%	7 (58)
2%	5 (42)
Flavored	2 (17)
Skim	1 (8)
Whole	0 (0)
Fruit	
Fresh fruit	5 (42)
Full-strength fruit juice (not juice drinks)	4 (33)
Canned/frozen fruit with no added sugar	3 (25)
Canned/frozen fruit with added sugar	3 (25)
Vegetables	
Two or more fruits or vegetables at lunch	8 (66)
Dark-green or deep-yellow vegetables	5 (42)
French fries or other fried potatoes	1 (8)
Grain Products	
Pre-sweetened cereals	4 (33)
High-fiber/whole-grain products	4 (33)
Lunch Entrees	
Cheese	5 (42)
Meat or chicken that was not breaded or fried	5 (42)
Breaded/pre-fried chicken patty or chicken nuggets	2 (17)
Dried beans (legumes)	2 (17)
Other	
Cookies or other baked goods	2 (17)
Fat usually added to cooked vegetables	4 (33)
Sample Size	**12**

Source: IM/IL Implementation Evaluation Stage 3 classroom observations conducted between November 2007 and January 2008, when programs were in the second year of IM/IL implementation.

Note: In some classrooms, children were offered more than one type of milk. Categories within each major food group are not mutually exclusive, thus percentages do not sum to 100. If cooked vegetables were not offered, observers asked cook or teacher about usual practice.

programs specifically targeted nutrition and even in these programs, implementation plans did not necessarily include making changes in menu offerings. While the sample size is small, there were no consistent differences in the healthfulness (as assessed with the observation tool) of meals and snacks offered in the Stage 3 programs that targeted nutrition and those that did not.

Intermediate Outcome for Staff and Parents: Encourage Children to Practice Targeted Behaviors

Children may not immediately embrace new activities or new foods, so it is important for staff to encourage them to do so. In this section, data from staff interviews and Stage 3 observations are used to describe staff efforts to encourage physical activity and healthy eating. Parental encouragement is also an important intermediate outcome. Some information about this is available from Stage 3 parent focus groups, but was reported in the context of what parents did to model and reinforce targeted behaviors (another intermediate outcome). These data are discussed in the following section.

Encouraging Physical Activity

All IM/IL coordinators and teachers/home visitors interviewed during Stage 2 demonstrated understanding of the importance of encouraging children to be active and to eat nutritious foods. In general, they reported that children were enthusiastic about MVPA and structured movement activities and did not need much encouragement to participate. IM/IL coordinators and teachers/home visitors in all 26 Stage 2 programs reported that children enjoyed the music, lyrics, and movements used in IM/IL activities. Some teachers reported that children even requested that IM/IL songs be played or that the class be allowed to do a specific IM/IL activity. In particular, staff reported that children loved "anything associated with Choosy," including the Choosy character and the Choosy CDs.

During visits to Stage 3 programs, site visitors observed teachers or aides in 12 Head Start classrooms encouraging children to participate in IM/IL activities that targeted MVPA or structured movement. As noted previously, a total of 70 staff-led IM/IL activities were observed across the 12 classrooms (observations spanned the full Head Start day). In all but two cases, staff were observed facilitating these activities by providing encouragement and prompts to children (for example, "Come on everyone, let's reach high!" or "That's great! Let's do the moves a little faster this time") rather than just by demonstrating the activities or providing instruction and observing. Site visitors also observed a total of 13 periods of unstructured free play, across the 12 classrooms, where children were free to choose activities on their own.[60] In nine of these instances, staff encouraged children to engage in some form of MVPA rather than choosing a sedentary activity.

[60] Two centers provided two free-play sessions and one center had no free play.

Encouraging Healthy Eating

In the Stage 2 interviews, IM/IL coordinators and teachers/home visitors reported that children generally need more encouragement to eat nutritious foods than to participate in physical activity. During Stage 3, site visitors observed Head Start staff encouraging or prompting children to make healthy food choices. In 9 of the 12 classrooms visited, staff talked with children about healthy foods during mealtime (Table V.6). In eight of the observed classrooms, staff (teachers, assistant teachers, or aides who supervised or ate with children during meal and snack times) provided positive and gentle encouragement to children at least to try new or "disliked" foods, and staff in six classrooms provided specific encouragement to promote children's consumption of fruits and vegetables.[61] These encouraging behaviors were observed in classrooms (programs) that did and did not specifically target nutrition in their IM/IL implementation plans. The presence of these behaviors in programs that did not target nutrition may reflect Head Start's overarching focus on health and nutrition.

Staff in some classrooms interacted with children in ways that were inconsistent with the "Think Tiny Tummies" nutrition message conveyed in the TOT event (see Chapter II).[62] In 6 of the 12 observed classrooms, staff encouraged children to eat more than they may have wanted (Table V.6) and staff in four classrooms served second helpings to children without waiting for them to ask. In one classroom, a staff member used the promise of dessert as a means of getting children to eat their vegetables. Staff in two of the classrooms where children were pushed to "clean their plate" or were served unrequested second helpings mentioned their concern that the Head Start meals were the only "decent" meals children received. In one case, the lead teacher said that staff "load up" children's plates on Thursdays and Fridays because "they [children] will go with little food at home from Friday to Sunday." Finding the appropriate balance between "Think Tiny Tummies" and concerns about children from disadvantaged families receiving adequate nutrition emerged as a challenge in some classrooms.

Intermediate Outcome for Staff and Parents: Model and Reinforce Targeted Behaviors

The final intermediate outcome for staff and parents in the IM/IL reference logic model is modeling and, thereby reinforcing, targeted behaviors. The expectation is that children will be more open to being physically active and making healthy food choices if they actually see the significant adults in their lives engaging in these behaviors. Stage 2 interviews

[61] It is possible that the absence of the latter two types of encouragement was due to children not "needing" such prompting (because they were eating the offered items on their own). The observation instrument did not include items that captured children's eating behaviors.

[62] The "Think Tiny Tummies" principles, which encourage adults to avoid forcing food on children and to appreciate the fact that children need smaller portions, may not have been conveyed to teachers, especially in programs that did not specifically target nutrition. Staff behaviors that were inconsistent with "Think Tiny Tummies" principles were observed in classrooms (programs) that did and did not specifically target nutrition.

Table V.6 Staff-Child Interactions at Meal Time

	Number (Percentage) of Programs	Sample Comments
Staff talked to children about healthy food during meal/snack times	9 (75)	*"Oranges have lots of vitamin C—they are so good for you!"*
Staff positively and gently encouraged children to try new or "disliked" foods	8 (67)	*"Do you want to try to eat some of your banana? I'll just put a little here and you can make that decision."*
Staff mentioned "choosing colors" or used other means of encouragement to promote consumption of fruits and vegetables	6 (50)	*"Look at all the colors in your stew! What color is corn—carrots…? All so good for you!"* *"Choosy loves his vegetables!"*
Staff encouraged children to eat more than they may have wanted	6 (50)	*"Eat everything on your plate."* *"I want everyone to drink all their milk."*
Staff served second helpings to children without being asked	4 (33)	
Staff used food to control behavior	1 (8)	*"Eat your zucchini and I'll go get dessert!"*
Sample Size	**12**	

Source: IM/IL Implementation Evaluation Stage 3 classroom observations conducted between November 2007 and January 2008, when programs were in the second year of IM/IL implementation.

and Stage 3 focus groups provide information about staff and parents' perceptions about whether they served as role models for children. The Stage 3 observations provide information about the extent to which reported staff behaviors were actually observed during the Head Start day.

Teacher/Home Visitor Reports

Data gathered in Stage 2 interviews with teachers/home visitors and Stage 3 focus groups provided comparable pictures of staff investment in serving as role models for IM/IL activities. Teachers/home visitors in the majority (23 of the 26) Stage 2 programs reported that they saw themselves as role models for MVPA and healthy eating. Teachers/home visitors who saw themselves as role models reported making a sincere effort to participate fully in IM/IL activities for MVPA or structured movement and to interact with children during free-play periods. For example, one teacher reported that she now does running games with children during their outdoor free-play period. Management staff in one program reported that since they began implementing IM/IL, they can hear teachers playing with children on the playground. Teachers also reported eating with children, talking with

them about the foods being served, and eating or at least tasting all the foods offered. Some teachers reported that since IM/IL, they drink only water in the classroom; previously, they drank soda or other sweetened beverages during the day.

Teachers from ten Stage 2 programs reported becoming so committed to modeling the behaviors targeted by IM/IL that they made changes in their personal behaviors outside the classroom. Three teachers from these programs reported exercising more regularly, being more careful about personal dietary choices, and eating breakfast daily. One teacher explained that after an IM/IL nutrition activity designed to educate children about the amount of sugar in a can of regular soda, he now tries to avoid it. Two teachers explained that they bought home exercise equipment or joined a gym so they could be more consistent about exercising. IM/IL coordinators in three Stage 2 programs reported that some teachers had lost weight—between 20 and 30 pounds—since IM/IL began.

Not all teachers reported fully committing to becoming role models to children for physical activity or healthy eating. In three Stage 2 programs, teachers said that their age or health conditions, such as being overweight or having bad knees, made it difficult for them to participate fully in all IM/IL activities. In addition, one teacher reported that she only considers herself a role model in front of the children. For example, she eats healthy food in front of the children, but has not established this as a habit before or after program hours.

Classroom Observations

Findings from Stage 3 classroom observations were generally consistent with data from Stage 2 interviews and Stage 3 teacher focus groups, in terms of staff efforts to model and reinforce physical activity behaviors. In particular, teachers were observed to be active participants (meaning that they did everything the children did from beginning to end) in the majority of MVPA activities (77 percent) and structured movement activities (88 percent) observed in Head Start classrooms.[63] When teachers did not participate fully, they demonstrated or modeled the movements involved in the activity. Teachers were less active role models during free-play periods, largely because these were unstructured. In 3 of the 13 observed free-play periods, teachers were active participants, either playing with children on the playground or leading an optional structured activity (data not shown).

The observation data portray a somewhat different picture of staff behaviors at mealtime, relative to reports made in interviews and focus groups, and raise potential challenges for staff's ability to model healthy eating behaviors at mealtimes.[64] One challenge to staff modeling healthy eating behaviors is that they may not eat meals with children. Staff in all 12 observed classrooms sat with children at lunch and ate with them, but findings were

[63] In classrooms with more than one teacher, observations about teacher involvement were based on the teacher leading the activity.

[64] There were no systematic differences across IM/IL target audience groups in the mealtime behaviors of staff.

less consistent for breakfast (Table V.7).[65] In 8 of the 10 classrooms where breakfast observations were completed, staff were observed sitting with children.[66] However, in two of these eight classrooms, staff reported having eaten breakfast at home before coming to the center and did not eat breakfast with the children. Staff in the two other classrooms where breakfast was observed neither sat with children nor ate with them. While children ate, staff in these classrooms were involved with other activities, such as dealing with paperwork or greeting parents and children who were arriving. Among the five classrooms that served an afternoon snack, staff in only one classroom sat and ate with children.

Table V.7 Staff Eating Behaviors at Meal Time

	Breakfast	Lunch	Snack
	Number (Percentage) of Classrooms		
Staff sat with children	8 (80)	12 (100)	1 (20)
Staff ate with children	6 (60)	12 (100)	1 (20)
Staff ate the same foods and beverages as children	5 (50)	8 (67)	1 (20)
Staff tasted at least some of the foods and beverages offered to children	2 (20)	5 (42)	1 (20)
Staff ate or drank unhealthy foods in front of children (not necessarily at meal times)	0 (0)	1 (8)	0 (0)
Sample Size	**10**	**12**	**5**

Source: IM/IL Implementation Evaluation Stage 3 classroom observations conducted between November 2007 and January 2008, when programs were in the second year of IM/IL implementation.

Notes: If staff within a classroom were inconsistent in their behaviors (for example, some staff ate with children and others did not), observers recorded the behavior of the lead teacher.

One part-day classroom did not serve breakfast, and breakfast was not fully observed in another program. Lunch was observed in all classrooms. Snack was offered and observed in five classrooms.

[65] The Head Start performance standards recognize that meal times provide a special opportunity for staff to model good nutrition habits and reinforce nutrition lessons from the curriculum. For this reason, the standards stipulate that children and staff eat together family style and, to the extent possible, share the same menu. This idea is emphasized in the "Chat and Chew" principle that is one of IM/IL's key nutrition messages (see box in Chapter II).

[66] One center did not serve breakfast and breakfast was not observed at another center.

Another challenge to staff's ability to model healthy eating behaviors at mealtimes is that, even if staff sit with children during mealtimes, they may not consume the foods provided by Head Start. In 4 of 12 classrooms where lunch was observed and 5 of 10 classrooms where breakfast was observed, some or all staff brought foods from home or did not eat at all (not eating at all was most common at breakfast although observers noted that some individual staff members ate nothing for lunch). In most cases, staff who brought food from home did so to avoid having to pay for meals consumed at Head Start (generally provided by a school district). Information about the types of foods and beverages brought in by Head Start staff (for their own consumption) were not recorded systematically. However, observers who did record information about the foods teachers brought from home mentioned a salad, sandwiches, frozen meals/entrées, yogurt and fruit, and granola/power bars. Only one classroom was noted as having staff who consumed unhealthy foods or beverages in front of the children. In this classroom, the lunches staff brought from home included regular and diet sodas and sweetened fruit drinks.

In addition, some of the staff who did eat Head Start meals skipped (did not taste) one or more items (that is, they did not at least taste every food or beverage that was offered to children). There were only 2 of 10 classrooms where staff tasted all of the foods that were served to children at breakfast and only 5 of 12 classrooms where staff tasted all of the foods that were served at lunch. The item that was most often skipped by staff was milk. Milk was served to children for breakfast and lunch in all observed classrooms. In eight classrooms, at least one staff member did not consume any milk. Other items that were skipped by at least one staff member included green vegetables, cereal, toast, and chicken. In one classroom, a broccoli, carrot, and raisin salad was offered and none of the staff tasted it.

Parent Reports

In Stage 3 focus groups, parents were divided about whether they considered themselves to be good role models for physical activity and nutrition habits. Some parents reported that they try to model important behaviors like eating fruits and vegetables and eating only when they are hungry. Other parents said they were not good role models, because they rarely eat, they do not eat the foods they serve to their children (that is, they serve healthy foods to their children and eat less healthy foods themselves), or they do not exercise. Some of these parents reported that children were aware of these discrepancies and had commented on them. Some parents expressed reluctance to change the foods they served at home because of concerns about cost (they reported that healthy foods cost more) or that children and other family members would not eat healthier foods. In one program, parents specifically commented that the handouts distributed by Head Start with recipes and other suggestions did little to change their shopping and food preparation behaviors.

Parents reported that being a good role model for physical activity can be challenging because they do not live near parks or recreation facilities that are safe and can not find affordable alternatives. Parents also commented on the challenges posed by busy schedules that leave little time for cooking nutritious meals or exercising. Parents said that the classroom seemed more conducive to physical activities, noting that it is easier for the teacher to get the children to dance, or that the interaction with other children encourages movement.

Intermediate Outcomes for Children

Key intermediate outcomes for children include changes in behaviors—increased MVPA, improved structured movement activities, and improved eating habits (see Figure V.2). Few Stage 2 programs reported observing and tracking children's progress toward IM/IL behavioral goals. No programs observed or evaluated children's eating behaviors in a systematic way. Eight of the 26 Stage 2 programs reported monitoring children's development of fine and gross motor skills, including movement skills. This was accomplished using a curriculum-based measure and/or the Choosy Assessment of Motor Patterns (CAMP) form, which was introduced at the TOT. Programs that used a curriculum-based measurement instrument may have been using it for more general tracking; the only instrument programs reported using to specifically track skill development was the CAMP form.

Thirteen of the 26 Stage 2 programs reported tracking children's BMI or height and weight. The majority (10 of 13) of these programs did this tracking before they began implementing IM/IL, as part of their general health screening, although one program reported measuring height and weight more frequently because of IM/IL. Two programs reported sending letters home to parents containing information about children's height, weight, and/or BMI. A third program that wanted to send such letters was unable to get approval for the plan from their Policy Council.

Data on child-level outcomes were not collected as part of this implementation evaluation. However, data from staff and parent focus groups and classroom observations conducted during Stage 3 provide some useful insights.

Staff and Parents' Reports

The Stage 3 focus groups provide information about teachers' and parents' perceptions about the extent to which children's behaviors changed after implementation of IM/IL. In general, both groups reported that children appeared to be changing their behaviors as a result of IM/IL.

Teachers in 9 of the 13 Stage 3 programs reported that parents had commented about changes they observed in their children's behaviors. For example, teachers reported that parents said children were asking them to buy fruits and vegetables or were less fussy when asked to eat vegetables at dinner. One teacher reported overhearing a conversation between children who were talking about drinking juice instead of soda, and another teacher said she heard children telling each other that they should not eat candy. Teachers in two programs reported that children had lost weight since the implementation of IM/IL.

Similarly, parents in Stage 3 programs noted changes in their children that they attributed to IM/IL. According to parents, children were calmer at mealtimes; they ate better, were more willing to try new foods, and started with smaller servings. Parents also

reported that children were more active, but acknowledged that inclement weather and small living spaces can affect this on a day-to-day basis.[67]

Classroom Observations

This implementation evaluation was not designed to assess outcomes. However, the one-day classroom observations conducted in Stage 3 provide some insights about the amount of physical activity children may be receiving while at Head Start. In each of the 12 Stage 3 classrooms that were observed, trained site visitors used stop watches to record the number of minutes children spent in different types of activity (including sedentary activities) over the course of their Head Start day.

Some IM/IL activities can be used to meet goals related to both MVPA and structured movement. For example, some Choosy songs teach children about body parts and movement using dance steps that can provide MVPA. To facilitate some separation of activities directed at these two IM/IL goals, the observation protocol defined MVPA activities as those that were designed to increase children's heart rates—activities that involved short bursts or sustained activity that was more intense than a normal walk. Structured movement activities were defined for the observation protocol as those that focused on building children's awareness of body parts and their movement skills rather than providing MVPA.

Table V.8 summarizes the minutes of physical activity observed in each classroom in three different areas: (1) teacher-led MVPA activities, (2) MVPA from free-play sessions, and (3) structured movement activities (all of which were teacher-led). To provide context, the table also includes information about each center's target audience(s), physical activity policy; and hours of care, as well as the weather on the day of observation. It was not feasible for observers to record data for each individual child. Thus, the data in Table V.8 should be interpreted as upper limits of physical activity, or the maximum amount of physical activity a child would have accumulated by participating fully in all teacher-led activities and by being physically active during the entire free-play period. In 5 of the 12 observed classrooms, no physical activity time was credited for free-play period(s) because few to none of the children engaged in any physical activity during these times. Instead, the children engaged in role playing, arts and crafts, or other sedentary activities. In all other instances, all or most children were observed engaging in MVPA during free-play.

Across all 12 classrooms, site visitors observed a total of 53 activities not associated with MVPA, structured movement, free play, meals, or naps. Of these, five activities (observed in four classrooms) involved at least some children sitting for more than 30

[67] Focus groups were conducted in late fall 2007 and winter 2008.

Table V.8 Minutes of Physical Activity Observed in One-Day Classroom Observations

Program	Target Audience	Physical Activity Policy (Minutes per Day)	Hours of Care	Weather on Observation Day	Minutes of MVPA: Teacher-Led	Minutes of MVPA: Free Play	Minutes of MVPA: Total	Minutes of Structured Movement	Minutes of Movement: Per Day	Minutes of Movement: Per Hour of Care	Comments
1	CP	ns	3.5	rainy, 42°	4	0	4	0	4	1	No outdoor play. Few children were active during indoor free-play period.
2	CPS	60[a]	6.0	rainy, 52°	8	0	8	5	13	2	No outdoor play. Few children were active during indoor free-play period.
3	CPS	120[a,b]	4.0	snowy, 25°	16	0	16	4	20	5	No outdoor play. Few children were active during indoor free-play period,
4	CO	ns	4.0	overcast, 50°	4	20	24	4	28	7	
5	CPS	ns	4.0	sunny, 20°	19	0	19	9	28	7	No outdoor play. Observer thought teacher did more teacher-led activities than normal because the study team was visiting.
6	CP	30[a,c,d]	3.5	drizzle, 44°	38	0	38	0	38	11	Went for a walk instead of outdoor play. Few children were active during indoor free-play period.
7	CPS	60[a,d]	5.5	clear, 40°	33	7	40	0	40	7	
8	CS	ns	3.5	sunny, 34°	10	27	37	8	45	13	
9	CPS	60[a]	5.0	cloudy, 35°	27	33	60	0	60	12	
10	CO	90[a,d,e]	6.0	sunny, 65°	13	42	55	9	64	11	
11	CP	90[a,f]	7.0	cloudy, 48°	30	20	50	25	75	11	Morning stretches, stretching after nap, yoga.
12	CP	>60[a]	6.5	rainy, 50°	31	27	58	18	76	12	No outdoor play but used school gymnasium. Lead teacher acknowledged that they did more activity than normal because the study team was visiting.

Source: Stage 3 classroom observations conducted between November 2007 and January-March 2008, when programs were in the second year of IM/IL implementation.

ns = not specified. CO=children only, CP= Children and Parents, CS= Children and Staff, CPS= Children, Parents, and Staff.

[a] Program established or modified goal for minutes of physical activity because of IM/IL.
[b] Program policy states that half the targeted time should be spent in MVPA and half in structured movement.
[c] Program policy has goal for full-day programs of 60 minutes.
[d] Program established policy that time spent in MVPA and structured movement must be documented in lesson plans.
[e] Program goal is 15 minutes of MVPA per hour or 90 minutes for full-day (6-hour) programs.
[f] Program goal is 60 minutes of MVPA and 30 minutes of structured movement.

minutes at a time. In one of these cases, an individual child sat at a computer for 39 minutes.[68] In two other classrooms, some children sat working on arts and crafts projects for 40 to 60 minutes. In the remaining classroom, children were seated for two separate circle/small group times that each lasted longer than 30 minutes.

The observation data reveal substantial variability in the amount of physical activity available to children while at Head Start. The total number of minutes of physical activity accumulated over the course of the Head Start day ranged from a low of 4 minutes to a high of 76. This translates into 1 to 13 minutes of physical activity per hour that children spent in Head Start.[69] In at least two classrooms, the amount of time children were involved in physical activity may have been influenced by the presence of the study team. In one case (classroom 5) the observer had the impression that the teacher implemented more IM/IL activities than she normally would if the observer was not there. In another (classroom 12, which had the highest total minutes of physical activity), the lead teacher acknowledged that they had implemented more IM/IL activities than they normally would on the day the classroom was observed.

In addition to illustrating the wide variability in the amount of physical activity children experienced, the observation data highlight several other interesting issues. First, weather may have an influence on children's opportunities for physical activity. Inclement weather was an issue for 5 of the 12 observed programs. In the three classrooms that provided the least physical activity (4 to 30 minutes or 1 to 5 minutes per hour), it was raining or snowing on the day of the observation and children were not allowed outdoors for free play. Staff in these classrooms did not appear to implement inside activities to compensate for the physical activity children could have engaged in during outdoor play.[70] In contrast, two other classrooms that were faced with rain or drizzle made up for lost outdoor playtime by going for a walk (classroom 6) or by using an available school gymnasium (classroom 12).

Second, the presence of policies that set targets for minutes of physical activity per day did not guarantee that children received the desired amount of physical activity. Two of the classrooms that provided the least physical activity had policies that were established or modified specifically because of IM/IL. Moreover, only two of the eight classrooms that had established policies actually provided children with the targeted amount of physical activity (classrooms 6 and 9).[71]

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[68] Children in half of the classrooms (6 of 12) used a computer for some period of time. (One classroom did not have a computer). Data on time spent were not collected for individual children unless the time spent was more than 30 minutes. Observers did not collect information about what children who used computers were doing during this time. Some children may have been working on computer-based curriculum activities.

[69] Very little research has been done to explore levels of physical activity of children in Head Start or child care settings. One study that used accelerometers to measure the activity levels of children in nine child care centers found that average physical activity levels ranged from 4 to 10 minutes per hour (Pate et al. 2004).

[70] The centers in which these classrooms were located did not have a separate gross motor play area or access to such an area that could be used during inclement weather.

[71] It is possible that the observed amount of physical activity represents an increase over what was happening before IM/IL.

CHAPTER VI

I AM MOVING, I AM LEARNING
IMPLEMENTATION: LESSONS LEARNED

This chapter summarizes what was learned about how Head Start programs implemented IM/IL at the local level and about factors that may support or challenge the implementation and/or sustainability of IM/IL.

The chapter begins by summarizing implementation in the 13 Stage 3 programs. This summary is presented in the context of the reference logic model that was presented in Chapter II (Figure II.2) and has been used as an organizing principal in this report. This logic model illustrates how the theory of change that underlies the IM/IL initiative (the socio-ecologic model of behavior change (see Chapter V, Figure V.1) might be articulated. The findings presented are based on discussions with program managers and teachers in the 13 Stage 3 programs and illustrate the diversity in approaches to IM/IL implementation in relation to the reference logic model.

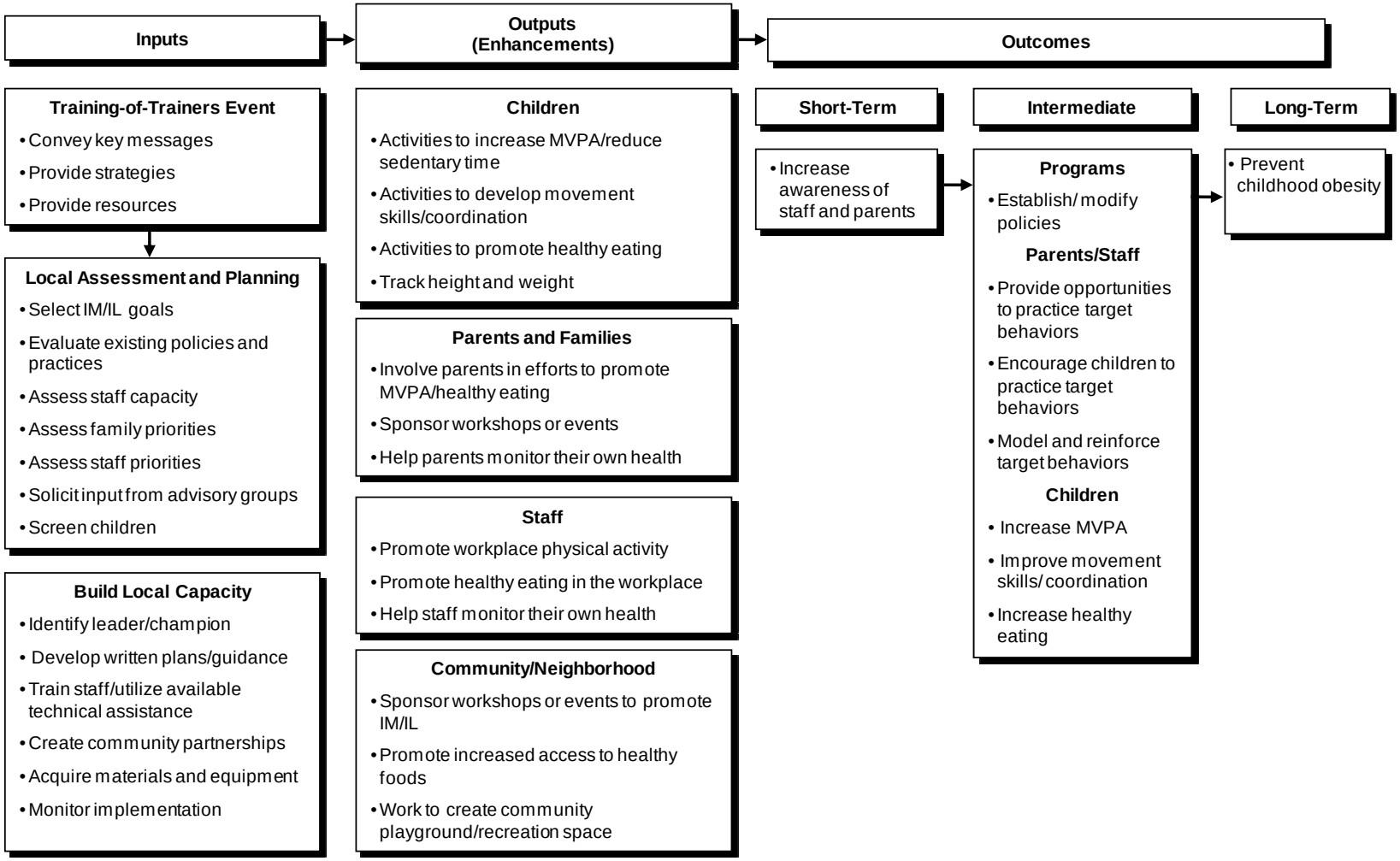
The second section of the chapter focuses on factors that may affect implementation and sustainability of IM/IL. Findings presented in this section are based on data from both Stage 2 (interviews with program managers, as well as 2 teachers/home visitors per program) and Stage 3 (interviews with program managers and focus groups with teachers and parents).

LOGIC MODELS

Figure VI.1 presents the reference logic model for IM/IL that was developed for purposes of this evaluation. As discussed in Chapter II, four variations on this model were created for the 26 Stage 2 programs, based on information collected in Stage 2 interviews with program managers and teachers/home visitors. The main differentiating factor was the specific audiences that were targeted with IM/IL activities—children, parents and staff; children only; children and parents; or children and staff.

During Stage 3 site visits, interviewers reviewed with IM/IL coordinators and other program managers a draft program-specific logic model that had been developed using information collected during Stage 2 interviews. These discussions made it clear that none of the Stage 3 programs had explicitly developed a logic model or a similar tool to summarize their "vision" or assumptions about how IM/IL implementation should be structured or

Figure VI.1 Reference Logic Model for *I Am Moving, I Am Learning*



about what impacts IM/IL was expected to have. This was not surprising, given that a logic model was not presented during the TOT event and development of a logic model was not a requirement of IM/IL implementation.

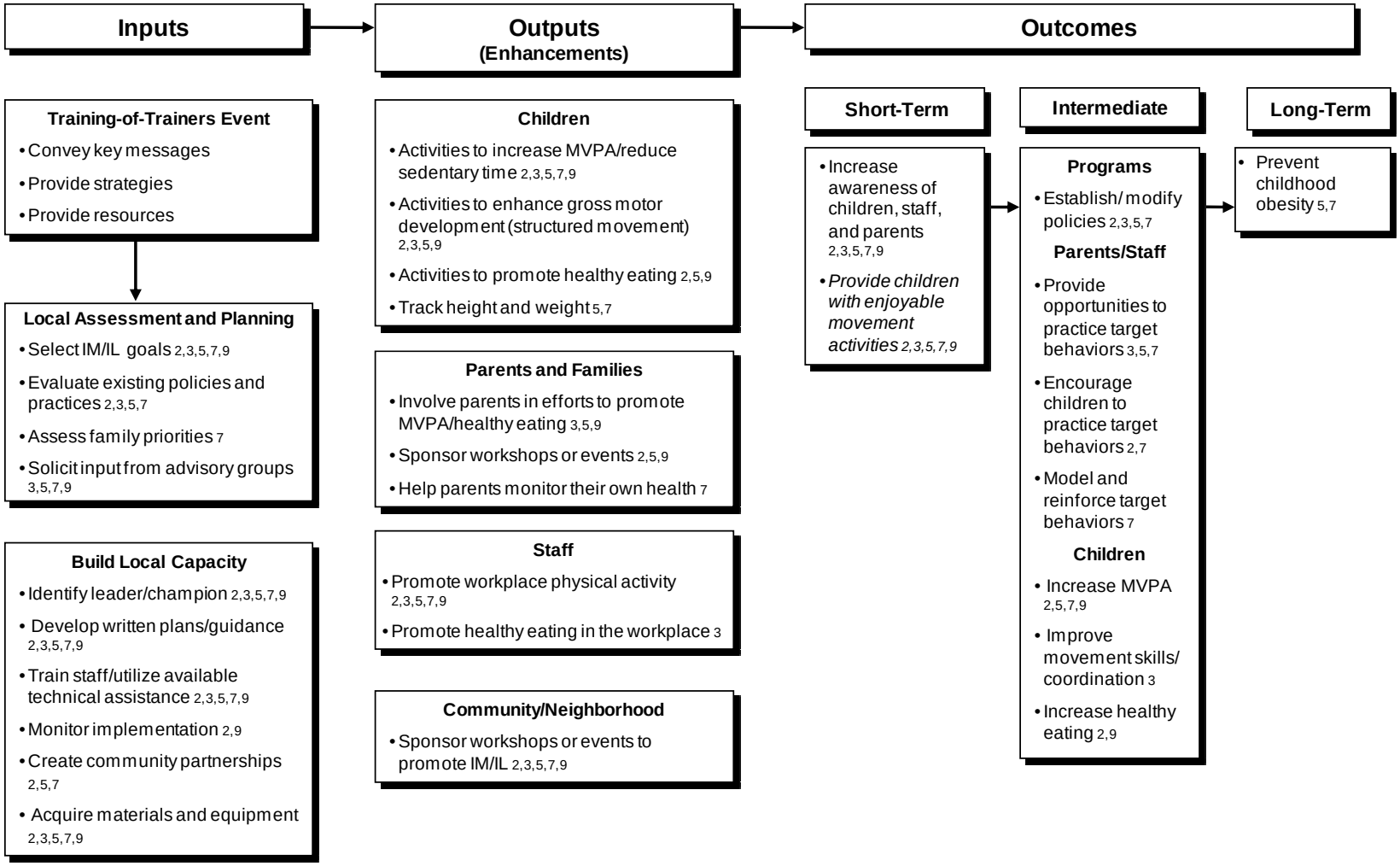
The four variations of the reference logic model observed among Stage 3 programs are presented in Figures VI.2 to VI.5. Each model reflects Year 1 implementation for a subset of Stage 3 programs (the number of programs in each variation of the logic model range from one to five). In each figure, the footnote provides information about the number of programs to which the logic model applies. In addition, within each model, numbers are used to identify programs that reported specific inputs, outputs, and outcomes. (The numbers used to identify programs are the same as those used in Table V.8 in the preceding chapter.) Using the program identification numbers, one can look across each model and get a comprehensive picture of how each program described their implementation of IM/IL and the outcomes IM/IL coordinators and program managers hoped to achieve.

The four logic models illustrate the flexibility of the IM/IL initiative. All of the Stage 3 programs implemented IM/IL, yet there was broad variation across programs in how they planned for and supported IM/IL (inputs), the audiences that were targeted and the activities that were implemented (outputs), and the outcomes that were expected. Figure VI.2 presents the logic model for programs that targeted parents, children, and staff. This model, which applies to five Stage 3 programs, is most similar to the reference logic model and, therefore, most reflective of the socio-ecological model of behavior change (see Chapter V). Figure VI.3 is the logic model for programs that targeted only children. This model, which applies to three Stage 3 programs, is the least like the reference logic model, in that it does not address several layers of the socio-ecologic model. The two other variations of the logic model (Figure VI.4 and Figure VI.5) omitted one group of adults (parents and/or staff) who influence children's environments at home and/or school. As noted, the models generally depict Year 1 implementation. By Year 2, one of the programs that targeted only children had begun adding enhancements that specifically addressed parents.

The outcomes sections of the logic models convey an important perspective about IM/IL implementation at the local level. All programs saw increasing awareness of parents, staff, and children as an important outcome of IM/IL. In addition, all programs saw providing *enjoyable* movement activities as an important outcome; the idea being that children would be more inclined to participate if the activities were fun and enjoyable. (This outcome appears in italics to indicate that it was not included in the reference logic model.)

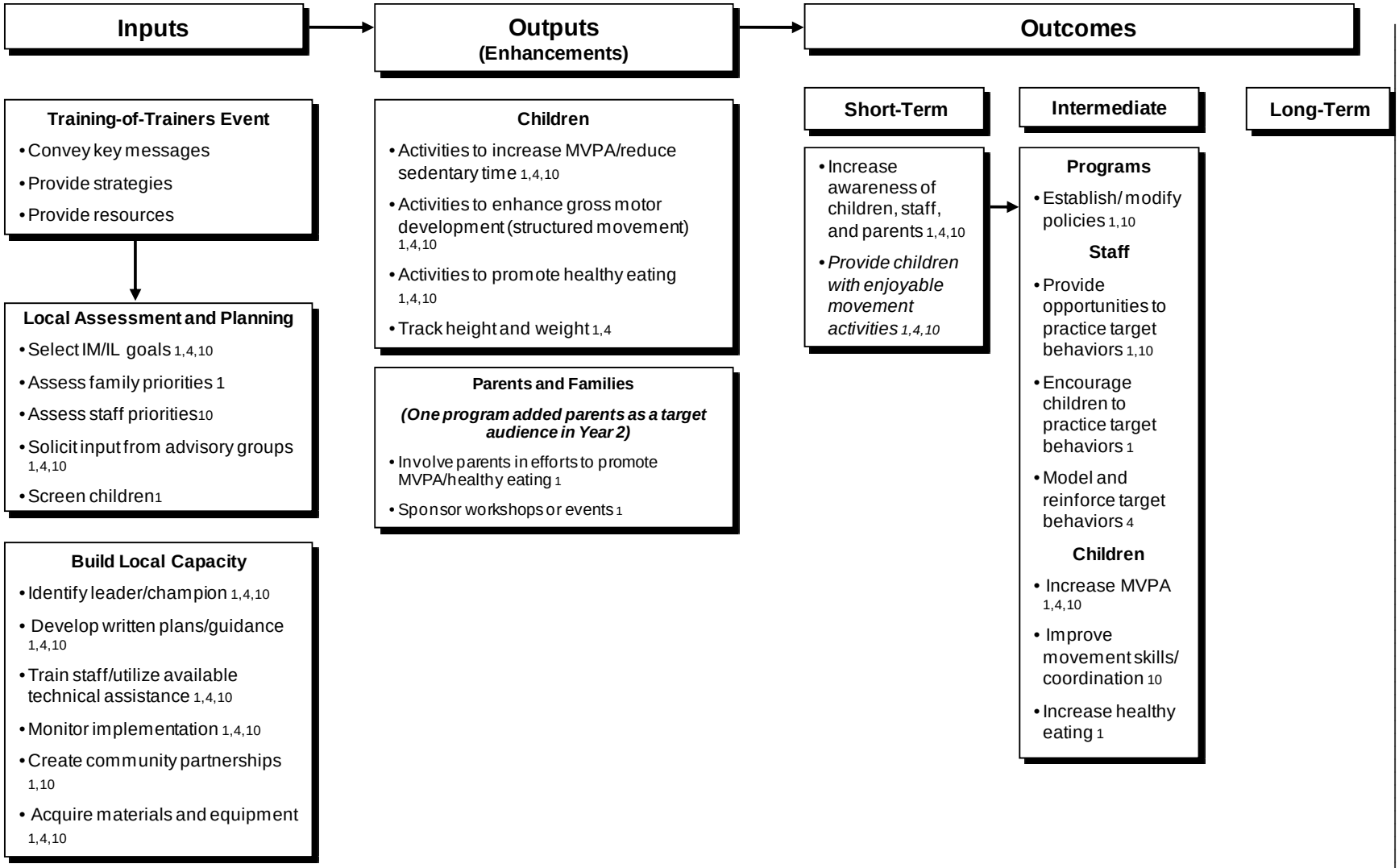
With regard to intermediate outcomes, most programs (11 of 13) established or modified program policies related to physical activity or nutrition and most (11 of 13) expected to increase the amount of time children spent in MVPA while at Head Start. Programs' expectations about the other intermediate outcomes included in the reference logic model varied. IM/IL coordinators and managers in some programs mentioned tangential outcomes that were not included in the reference logic model. These outcomes, included reduced behavior problems (one program that targeted children only and two programs that targeted children and parents); increased parent involvement in all types of program activities (not just those activities focused on IM/IL) (two programs that targeted children and parents); increased enthusiasm among teachers for child-focused enhancements and other health promotion initiatives (two programs that focused on children, parents, and

Figure VI.2 Logic Model for *I Am Moving, I Am Learning* Programs that Targeted Children, Parents, and Staff[a]



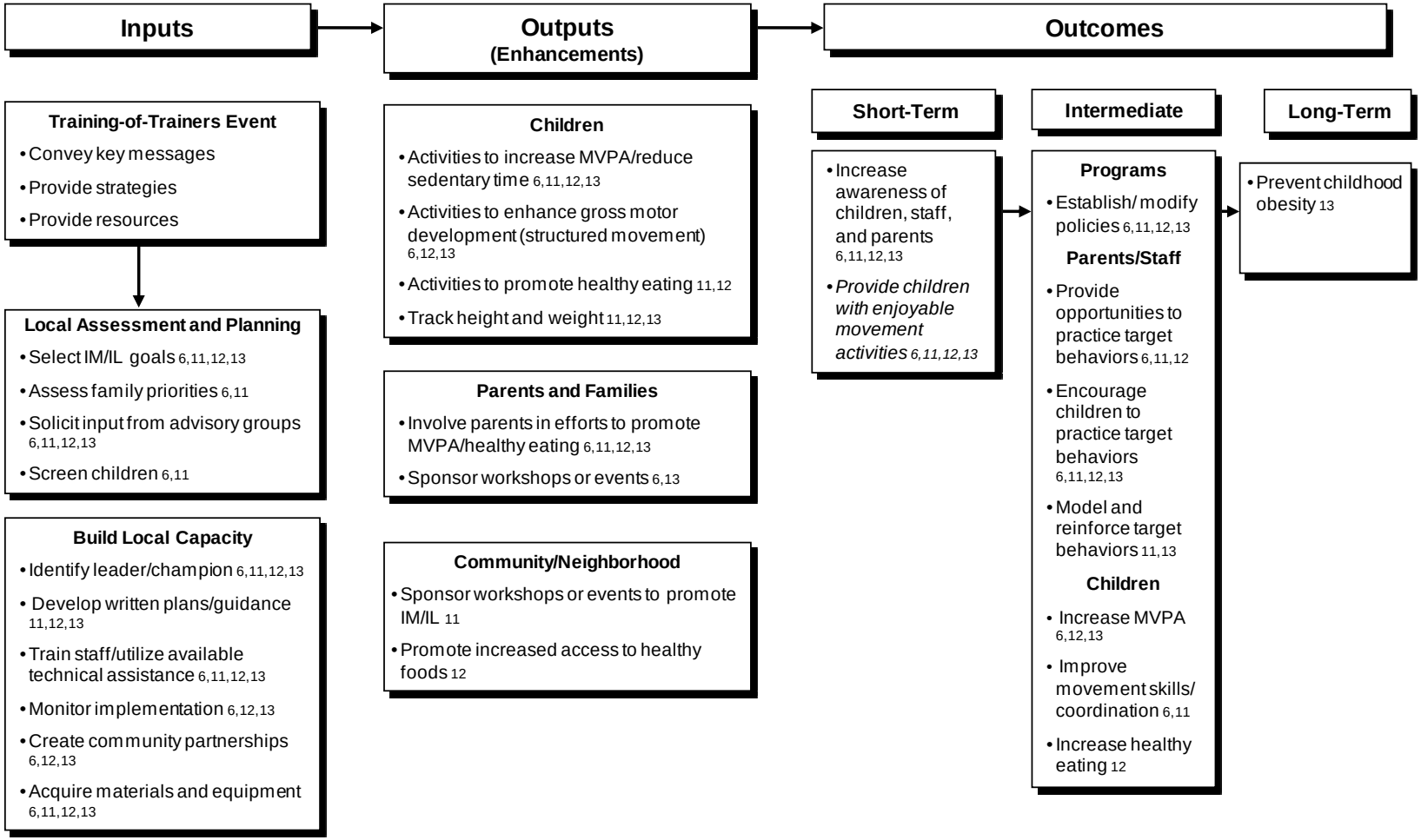
[a] This logic model is representative of 5 programs in the Stage 3 sample (programs 2, 3, 5, 7, and 9 from Table V.8). Program inputs, outputs, and outcomes are indicated by program number next to each logic model element. Italics indicate that this outcome was not included in the reference logic model.

Figure VI.3 Logic Model for *I Am Moving, I Am Learning* Programs that Targeted Children Only[a]



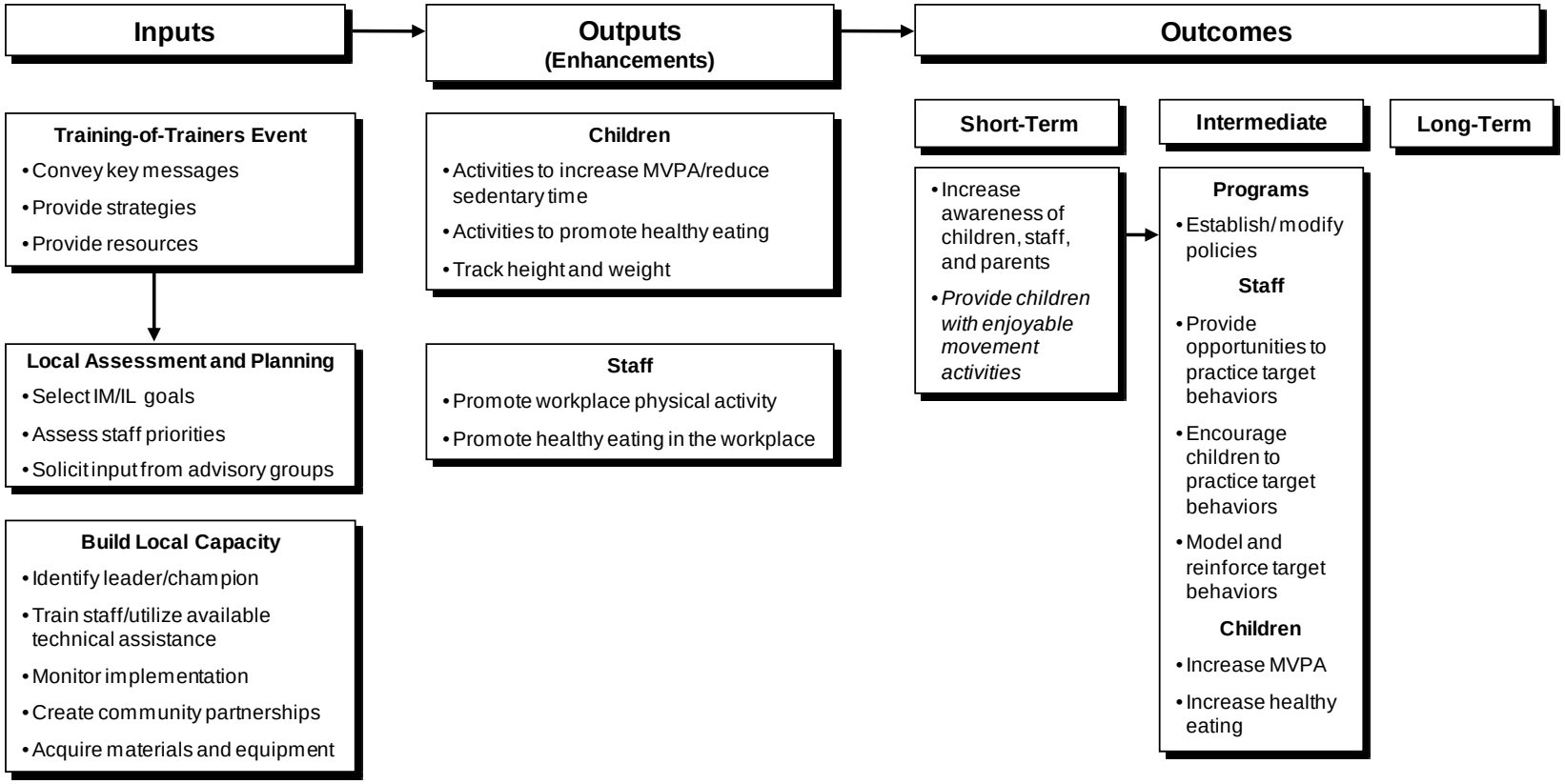
[a]This logic model is representative of 3 programs in the Stage 3 sample (programs 1, 4, and 10 from Table V.8). Program inputs, outputs, and outcomes are indicated by program number next to each logic model element. Italics indicate that this outcome was not included in the reference logic model.

Figure VI.4 Logic Model for *I Am Moving, I Am Learning* Programs that Targeted Children and Parents[a]



[a] This logic model is representative of 4 programs in the Stage 3 sample (programs 6, 11, 12 were included in Table V.8, as well as one unobserved program, program 13). Program inputs, outputs, and outcomes are indicated by program number next to each logic model element. Italics indicate that this outcome was not included in the reference logic model.

Figure VI.5 Logic Model for *I Am Moving, I Am Learning* Program That Targeted Children and Staff[a]



[a] This logic model is representative of 1 program in the Stage 3 sample (programs 8 from Table V.8). Program inputs, outputs, and outcomes are indicated by program number next to each logic model element. Italics indicate that this outcome was not included in the reference logic model.

staff); and increased self-confidence (among children) about participating in physical activity (one program that focused on children and parents). Finally, three programs (two that focused on children only and one that focused on children and parents) reported the expectation that children would influence parents' behaviors, essentially by "bringing IM/IL messages home."

Only 3 of the 13 Stage 3 programs specifically mentioned that they expected IM/IL to prevent or reduce childhood obesity. One IM/IL coordinator in a program that targeted only children indicated that she did not expect IM/IL to achieve this outcome because the program could not counteract the negative influence of the home environment. Other coordinators and program managers tended to view IM/IL in a more general way—as an addition to their "toolbox" that provided creative and appealing strategies for increasing children's activity while at Head Start and improving the quality of the activities used to promote development of movement skills, coordination, and healthy eating.

Data from the Stage 2 and Stage 3 interviews with IM/IL coordinators and program managers suggest that programs' decisions about their overall approach to IM/IL implementation was at least partially influenced by staff perceptions about the challenges or benefits associated with working with target audiences other than children. For example, one IM/IL coordinator explicitly stated that parents and staff were not targeted because of concerns that neither group would respond positively to IM/IL; another mentioned concerns about difficulties associated with getting parents involved in Head Start activities. One of the programs that targeted staff did so because the results of a staff survey on lifestyle behaviors highlighted the need for wellness activities for staff.

Emphases in the TOT event may also have influenced programs' decisions about implementation models. Twenty-two percent of IM/IL coordinators who completed a Stage 1 questionnaire indicated that the TOT did not devote enough time to the topic of improving children's nutrition (ACF 2007).[72] In addition, 37 percent of the IM/IL coordinators who completed a Stage 1 questionnaire indicated that the TOT did not devote enough time to strategies that can be used to engage adults in IM/IL (ACF 2007).[1]

CHALLENGES AND SUPPORTS

Understanding the challenges that programs faced in implementing IM/IL and the factors they felt supported their efforts can provide insights for policy makers as well as for programs that are implementing IM/IL or are considering doing so.

Challenges

Programs reported a number of different issues that posed challenges for IM/IL implementation. The types of challenges reported and the frequency across sites are summarized in Table VI.1. Data are based on Stage 2 interviews with IM/IL coordinators

[72] Respondents rated the amount of time spent on this topic as a 1 or 2 on a 5-point scale with anchors at 1 (too little time), 3 (about the right time), and 5 (too much time).

Table VI.1. Challenges Related to IM/IL Implementation

		Target Audience		
	All Programs	Children, Parents, and Staff	Children and Parents or Children and Staff	Children Only
	Number (Percentage) of Programs			
Lack of training	16(62)	2(40)	10(71)	4(57)
Parent buy-in	15(58)	3(60)	9(64)	3(43)
Staff buy-in	12(46)	2(40)	7(50)	2(29)
Lack of time to implement IM/IL activities	10(38)	2(40)	5(36)	3(43)
Child buy-in	8(31)	4(80)	4(28)	0 (0)
Lack of funding	6(23)	0 (0)	2(14)	4(57)
Space limitations	5(19)	2 (40)	3(21)	0 (0)
Lack of time for planning and training staff	5(19)	2(40)	2(14)	1(14)
Staff turnover	4(15)	0 (0)	4(29)	0 (0)
Difficulty monitoring IM/IL	4(15)	2(40)	2(14)	0 (0)
Bad weather	4(15)	0 (0)	3(21)	1(14)
Staff weight or movement problems	2 (8)	0 (0)	1 (7)	1(14)
Buy-in from community or policy council	2 (8)	1(20)	0 (0)	1(14)
Poor playground equipment	1 (4)	0 (0)	1 (7)	0 (0)
Sample Size	**26**	**5**	**14**	**7**

Source: IM/IL Implementation Evaluation Stage 2 telephone interviews completed with IM/IL coordinators and teachers/home visitors in summer 2007 at the end of the first year of IM/IL implementation.

Note: Programs could report multiple challenges. Challenges were self-reported in qualitative interviews rather than in response to a pre-coded list.

and teachers/home visitors. Data are reported at the program level; the program was coded as having reported a specific challenge if it was mentioned by the IM/IL coordinator or by a teacher/home visitor. In discussing the findings, data from Stage 3 focus groups are brought in, where appropriate, to add context or additional information.

Insufficient Training

The challenge reported most frequently (16 of 26 Stage 2 programs) was insufficient training. Concerns about the adequacy of training varied for management and frontline staff. IM/IL coordinators and other program managers typically wanted more guidance about how to expand and maintain IM/IL implementation after the first year or about how to monitor IM/IL implementation. Teachers wanted more materials and resources, more or better instruction about how to implement IM/IL activities, and guidance on how to assess

and monitor children's movement skills. Home visitors noted that more training specifically related to their interactions with children and/or families would have been helpful.[73]

Support/Buy-In

Many programs reported challenges related to getting buy-in—from parents (15 of 26 programs), staff (12 programs), and children (8 programs). In describing the challenges posed by parents, most programs mentioned that getting parents to participate in IM/IL activities was difficult. Programs reported that parents' work schedules or other commitments hindered attendance at program-sponsored events. In addition, some programs who had instituted new nutrition policies to restrict availability of desserts and other snacks (either offered to children through the program or brought in from home) reported that parents were resistant to the new policies. For example, one teacher reported that a parent made a special trip to bring sweets to her child after the program instituted a policy that parents could no longer include sweets in their children's lunches. In the Stage 3 parent focus groups in these sites, one parent explained that she disapproved of the program's restrictions on foods that could be brought in from home. She said that her daughters in the Head Start program sometimes felt left out because their brothers were allowed to take cupcakes to elementary school for special events. Another parent suggested that the food policies had "gone too far," noting that centers at her program were not letting children have ketchup, salad dressing, syrup, or other high-fat/high-sugar condiments and that she would prefer to see substitutions rather than elimination of food items.

In the 12 Stage 2 programs where IM/IL coordinators and program managers reported difficulties with staff buy-in, the most common explanation was that some teachers/home visitors were "less than enthusiastic" or complained about IM/IL because they saw it as "yet another" activity or curricular requirement being added to an already tightly scheduled day (or home visit). Comments made in teacher/home visitor interviews suggest that, in general, teachers did not disagree with the importance or value of IM/IL. Rather, their complaints or resistance reflected their worries about their ability to implement IM/IL without sacrificing quality in some other program area. In some cases, teachers were reluctant to change their existing teaching styles to incorporate IM/IL activities and approaches.

Most of the programs that reported initial reluctance on the part of staff (7 of 12 Stage 2 programs) found that the resistance lessened over the course of the year, particularly after follow-up training sessions. Teachers/home visitors reported that they came to understand that IM/IL was not an "add-on" curriculum and that they could implement IM/IL activities in a variety of settings throughout the course of the day. However, in the remaining five programs, managers and teachers/home visitors reported that staff buy-in *decreased* over the course of the first year of IM/IL. In most of these programs, the decrease in enthusiasm was

[73] In Chapter III, it was reported that teachers/home visitors in 12 of the 26 Stage 2 programs thought their initial IM/IL training was insufficient (that the training should have been longer or that followup training should have been provided). The data reported in Table VI.1 is based on reports from IM/IL coordinators, teachers, and home visitors and applies to general training needs rather than teacher/home visitor ratings of the initial training they received from management staff.

associated with specific strategies programs were using to implement IM/IL rather than IM/IL more generally. Implementation strategies that were not popular with frontline staff in some programs included policies about the number of minutes of physical activity children were supposed to have each day and/or how these minutes were to be distributed throughout the day; requirements that IM/IL activities be recorded in lesson plans; and a requirement that each staff member set a personal goal for health behavior change.

While the majority of programs reported that children enjoyed IM/IL activities, eight of 26 Stage 2 programs encountered some difficulties getting children to eat new foods or try new activities. To address this, teachers reported encouraging children to try small "no thank you" or "thank the cook" bites of food when new (or traditionally avoided) foods were offered. Teachers also worked with children who were reluctant or embarrassed to dance by giving them Choosy cutouts to wave until they got used to doing the movements and felt more comfortable.

Lack of Time

Another common challenge was lack of time for IM/IL implementation. Ten of the 26 Stage 2 programs mentioned this challenge. IM/IL coordinators said that time constraints made it difficult for them to spend an adequate amount of time on program level IM/IL planning activities or staff training. Teachers, on the other hand, voiced concerns about having enough time to implement IM/IL activities throughout the program day. This was particularly true in programs that modified or established policies about the number of minutes of physical activity children should receive each day and/or about how this physical activity time should be distributed.

Other Challenges

Other challenges were reported less frequently—by no more than 6 of the 26 Stage 2 programs. These included lack of funding (6 programs); space limitations (small classrooms that are not well suited for movement-oriented activities; 5 programs); and, for four programs each, staff turnover, monitoring IM/IL implementation, and bad weather.[74] Teachers in at least three Stage 2 programs said that their personal/health conditions (such as their age, their weight, or having bad knees) made it difficult for them to fully participate in or demonstrate IM/IL activities.

Finally, two Stage 2 programs struggled with getting school district or Policy Council buy-in. For example, one IM/IL program director affiliated with a school district lamented that the district's curriculum does not put as much emphasis on healthy lifestyle choices as Head Start and IM/IL so after children move to kindergarten, the foundation laid by IM/IL might be lost. Another program's policy council supported the program's implementation of IM/IL in general, but disagreed with the program's proposal to notify parents of their children's BMI.

[74] Chapter V discusses how inclement weather can affect children's ability to accumulate minutes of MVPA when teachers rely on outdoor play periods for substantial proportions of planned MVPA time.

Challenges During Year 2

Interviews conducted with Stage 3 programs suggest that challenges related to staff buy-in may have been less problematic during the second year of IM/IL implementation. While some teachers in Stage 3 focus groups voiced concerns about finding time to implement IM/IL in the Head Start day, only one of the three IM/IL coordinators in Stage 3 programs who reported teacher resistance/reluctance as a problem at the end of Year 1 reported continued difficulty in this area during Year 2.

New challenges reported during the second year of IM/IL implementation centered on programs' uncertainty about how to expand or sustain IM/IL activities in the future. IM/IL coordinators in 5 of the 13 Stage 3 programs reported that that they needed additional training to determine how the program could "take IM/IL further." In addition, two programs indicated that they needed guidance or assistance in how to systematically monitor implementation of IM/IL activities by teachers/home visitors. IM/IL coordinators in two other Stage 3 programs reported that they wanted training/guidance about how to measure the progress of children's motor development. Finally, IM/IL coordinators in the four Stage 3 programs that did not have policies that stipulated the number of minutes of MVPA to be provided each day wanted assistance in setting expectations in this area, to ensure that the current focus on MVPA would not taper off over time.

Supports

IM/IL coordinators and teachers found it easier to identify challenges they faced in implementing IM/IL than to identify factors that supported or enhanced IM/IL. One support factor that was cited by all 26 Stage 2 programs was the TOT event. Although Stage 2 programs identified some areas in which the TOT could be improved (as discussed in the following section on sustainability), IM/IL coordinators in all 26 Stage 2 programs reported that they enjoyed the TOT event and that the training, materials, and resources they received at the TOT were useful in planning and implementing IM/IL.

Another factor that was frequently cited as having a positive influence on the success of IM/IL implementation was the level of enthusiasm and support for the program among key stakeholders. Teachers in 14 of the 26 Stage 2 programs reported that the enthusiasm of the IM/IL coordinator had a lot to do with the success of IM/IL. Similarly, IM/IL coordinators in 14 Stage 2 programs (not all the same programs) reported that staff enthusiasm influenced the success of IM/IL implementation. IM/IL coordinators and/or teachers in 11 Stage 2 programs reported that the enthusiastic support of parents contributed to the success of IM/IL implementation. Finally, IM/IL coordinators in 11 Stage 2 programs (not all the same programs) mentioned that the enthusiastic support of their policy council, governing board, or health services advisory committee was an important factor in the success of IM/IL implementation.

Key characteristics of the IM/IL program were also mentioned as factors that supported or enhanced implementation. Prime among these was IM/IL's use of music featuring Choosy as well as other types of music. All 26 Stage 2 programs reported that teachers and children alike enjoyed the music and the associated movements/activities. The

Choosy character was also mentioned as an important program element. Most Stage 2 programs introduced Choosy to children and used him as a mascot for IM/IL. Staff reported that children responded very well to Choosy and "loved anything Choosy." Finally, IM/IL coordinators and/or teachers in 20 Stage 2 programs reported that the flexibility of the IM/IL model, which allowed programs to develop their own approach, contributed to successful implementation.

IM/IL coordinators in 14 of the 26 Stage 2 programs reported that their successful implementation of IM/IL was influenced by the fact that their program had already begun to focus on increasing physical activity, increasing nutrition education, and/or improving the nutritional quality of meals and snacks. Eight IM/IL coordinators mentioned the low cost of IM/IL—start-up costs and/or maintenance costs—as a factor that contributed to successful implementation.

Other implementation supports mentioned by IM/IL coordinators or teachers in one or more programs included the following: a well-educated staff; access to facilities, staff, or resources of affiliated school districts; community support and resources; and the fact that the program could be implemented easily in homes as well as classrooms.

SUSTAINABILITY

Sustainable programs are those that can maintain their benefits for population groups beyond their initial stage of implementation—that is, the activities or services provided by the program can continue within the limits of finances, expertise, infrastructure, resources and participation by key stakeholders (Smith et al. 2006). Achieving goals such as the prevention of childhood obesity in Head Start programs can take years or decades. Thus, it is important to develop and promulgate programs and policies that can be institutionalized and maintained over the long term.

The evaluation's ability to assess sustainability is limited by the small sample size for the final phase of data collection (13 programs) and the fact that all of the Stage 3 programs had achieved a high (5 programs) or medium (8 programs) level of implementation during the first year of IM/IL (see Chapter I). Thus, the Stage 3 sample did not include any programs that appeared to be facing significant challenges with IM/IL implementation.[75] Nonetheless, findings from Stage 3 interviews with IM/IL coordinators and program managers and focus groups with teachers provide some insights about the sustainability of the IM/IL initiative in these programs. In turn, these findings may inform ongoing and future implementation of IM/IL at the national and local level.

Research has shown that the sustainability of a program or initiative can be influenced by multiple factors including design features (adaptability, perceived or proven benefits, and cost); organizational factors (a program champion, overall capacity to support

[75] As discussed in Chapter I, this was not intentional. The original design called for inclusion of both low- and high-implementing programs. However, all 26 of the programs included in the final Stage 2 sample were found to have achieved at least a medium level of implementation.

appropriate/adequate implementation, and a fit with the organization's mission); and community-level factors (stability of external economic and political conditions, support of community stakeholders and leaders, and access to new funding sources) (Schreier 2005). The Stage 3 data, collected when programs were in the second year of implementation, suggest that several of these factors were well-positioned to promote sustainability:

- **Adaptability**. As the logic models presented earlier in this chapter illustrate, IM/IL is highly adaptable, allowing programs to modify their approaches to fit the priorities/interests and capacities of their particular programs.

- **Program champion**. Twelve of the 13 Stage 3 programs reported having an IM/IL coordinator who was enthusiastic about continuing and, in some cases expanding, IM/IL. Teachers and other managers in these programs perceived the IM/IL coordinator to be an enthusiastic leader/program champion. In the remaining Stage 3 program, IM/IL leadership may have been faltering. Although teachers and program managers saw the IM/IL coordinator as enthusiastic and committed, she reported being overwhelmed by IM/IL and the lack of support/involvement from other program managers who had attended the TOT event, stating "It is too much work for one person." [76]

- **Perceived benefits/fit with the organization's mission.** In all 13 Stage 3 programs, there was broad support for the goals of IM/IL among both management and frontline staff. No Stage 3 programs reported that they expected to curtail IM/IL activities. Programs that did expect to make changes hoped to expand the program to include additional target audiences.

Factors that may be less well-positioned for sustainability relate to organizational capacity, community support, and funding. Each of these is discussed in more detail below. Organizational capacity is not limited to "bricks and mortar." It also includes the robustness of key organizational features and functions, including the training and competence of staff and the quality of monitoring and supervision (Daro 2006; Carroll et al. 2007). Thus, the discussion of organizational capacity focuses on three elements that, based on findings from Stage 2 and 3 interviews and focus groups, may be especially important in the sustainability of IM/IL—staff training, program policies, and written plans and guidance. Community partnerships and program costs are two other factors that may affect sustainability.

Staff Training

Findings from Stage 2 and Stage 3 suggest that staff training may have a strong influence on the sustainability of IM/IL. As noted in Chapter III, teachers/home visitors in 12 of the 26 Stage 2 programs thought their initial IM/IL training was insufficient. They believed that the training should have been longer or that followup training should have been provided. Teachers reported that they wanted more or better instruction about how to

[76] This was a small program that targeted only children.

implement IM/IL activities, and guidance on how to assess and monitor children's movement skills. Home visitors noted that more training specifically related to their interactions with children and/or families would have been helpful.

IM/IL coordinators had some concerns of their own about training. Comments made in Stage 3 interviews echoed findings from Stage 1 and Stage 2. Specifically, coordinators indicated that the TOT event did not devote enough time to practical aspects of planning for IM/IL implementation in their own programs and that the TOT event spent too little time on how programs can engage adults in IM/IL activities. In Stage 3, IM/IL coordinators and other program managers who had attended the TOT event expressed the desire for more training for themselves so they could do a better job in both planning program implementation and training staff.

One of the potential challenges with the training received by frontline staff may have been that it was delivered by program staff. While program staff reported following guidance received at the TOT event, variation in the content and effectiveness of the training actually delivered may exist, given differences in the competence and comfort-level of IM/IL coordinators and variations in the length and formats of training sessions. The model currently being used to provide IM/IL training to frontline staff, which uses a core group of trainers in each Region rather than a TOT approach (see Chapter II), may mitigate this problem. A more challenging issue is providing continued training and support for IM/IL coordinators. Based on findings from Stage 3 interviews, IM/IL coordinators could benefit from additional training and technical assistance and/or a networking system that would allow them to share experiences and learn from others. The Office of Head Start is working with the Head Start Body Start (HSBS) National Center for Physical Development and Outdoor Play to provide resources, training, and technical assistance to Head Start and Early Head Start grantees who are implementing IM/IL.

Another issue related to staff training is dealing with training new staff in the event of staff turnover. Staff turnover was not a major problem in the programs that participated in this evaluation—only 4 of the 26 Stage 2 programs encountered staff turnover during the first year of IM/IL implementation (2 of these programs lost the IM/IL coordinator who had attended the TOT and 2 lost teachers and/or home visitors who had completed the program's IM/IL training). However, other programs not included in Stage 2 may have higher rates of staff turnover, and it is inevitable that every program will eventually experience some turnover. The loss of the IM/IL coordinator was seen as a greater threat to sustainability than turnover among teachers/home visitors. This was because IM/IL coordinators had in-depth knowledge about IM/IL (from the TOT event) and about plans for and experiences with implementation at the local level. Until someone assumed lead responsibility for IM/IL again, implementation in these programs was reported to lag. Issues of turnover may suggest that alternatives to in-person training may be helpful in sustaining IM/IL at the local level. Potential approaches suggested by IM/IL coordinators in Stage 3 programs included videotapes of the TOT event (this is being used in the current approach to IM/IL training), this could be videotapes of the in-person trainings conducted in specific regions or for specific programs; a networking system for IM/IL coordinators; or periodic refresher trainings that could be attended by new or continuing IM/IL coordinators.

Program Policies

One way of building organizational capacity that can support sustainability is to moderate existing rules and regulations so that program activities are more aligned with overall program goals (Hodges et al. 2007). Thus, establishing formal policies related to IM/IL program goals and objectives can enhance the sustainability of IM/IL program activities by institutionalizing expectations and/or practices. Almost two-thirds of the Stage 2 programs (15 of 26) modified or established policies related to the amount of time children are active or moving throughout the day. The data collected during Stage 3 classroom observations (see Chapter V; Table V.8) indicate that the presence of a policy does not guarantee that the policy is fully implemented. Nonetheless, formal policies confer a level of importance to specific activities and practices, raise staff awareness, and provide a mechanism for management staff to use in monitoring performance and working with teachers/home visitors to improve usual practices.

In addition, formal policies about children's physical activity while at Head Start could address an important issue noted during Stage 3 classroom observations—that weather can have a negative impact on the amount of physical activity children receive. (Teachers in Stage 3 focus groups also mentioned inclement weather as an impediment to IM/IL implementation.) For example, a policy could establish the expectation that the targeted level of physical activity should be achieved indoors if inclement weather precludes children playing or walking outdoors. In the Stage 3 observations conducted during inclement weather, there was no evidence that policies for dealing with the weather were in place.

Written Plans and Guidance

Systematic monitoring and feedback can enhance implementation and institutionalization of a program and, thereby, its sustainability (Fixsen et al. 2005). The first step in a monitoring and feedback system is to establish clear expectations for all staff involved in implementing the program. Written plans and other forms of guidance are tools that can be used to establish these expectations. Only about half of the Stage 2 programs (14 of 26) developed either a formal written plan for IM/IL or some other form of written guidance. The lack of a formal written plan or other written guidance may compromise IM/IL implementation. The absence of a plan may be related to the concerns expressed both by management and frontline staff about having adequate time to devote to IM/IL implementation (16 of 26 Stage 2 programs) and their report that they needed more training (managers in 5 Stage 2 programs and frontline staff in 10 Stage 2 programs). Without a written implementation plan, implementation may suffer when staff feel overtaxed and/or unsure of themselves.

Community Partnerships

At the TOT, trainers pointed out that community partners such as local hospitals, the Women, Infants, and Children (WIC) program, and university extension programs can lend their expertise to provide staff training and to develop and potentially implement IM/IL activities (for example classroom activities for children or workshops for parents). Moreover,

a community's awareness of and support for a program may make it easier for staff to access funding sources or in-kind donations to fund additional IM/IL activities.

Stage 2 programs that partnered with community organizations often worked creatively with these partners to provide expertise to targeted audiences, primarily staff and parents. In the second year of IM/IL implementation, several Stage 3 programs partnered with other Head Start programs that were implementing IM/IL to expand capacity of both their own program and the partner program to train staff and plan IM/IL activities. This was seen as a way of bringing "new blood" into the IM/IL program; experienced individuals who could bring new ideas for implementation, monitoring, expansion, and sustainability. In addition, the access to additional staff that are able to train frontline staff provided a safety net for dealing with staff turnover.

Program Costs

IM/IL does not rely on the purchase of a curriculum[77] or other expensive materials. The TOT event stressed that implementing IM/IL would not require programs to purchase equipment. Instead the TOT event provided examples of props that programs could make or how to use existing classroom items in new ways. Some programs decided to make an investment in materials or equipment to facilitate physical movement or nutritional activities. The scope of this study did not include a cost analysis, but 4 of the 26 Stage 2 programs volunteered that their implementation success was at least partly due to obtaining outside funding and 6 Stage 2 programs identified the lack of financial support for IM/IL as a barrier to implementation or sustainability. These programs noted that additional funding would make it possible to expand IM/IL to more target audiences, or to provide more in-depth training for staff.

NEXT STEPS FOR IM/IL

This report provides information about how Region III grantees that attended the spring 2006 TOT implemented IM/IL—the goals they selected, the audiences they targeted, and the activities they implemented—as well as information about the challenges and successes they experienced. Overall, IM/IL was met with enthusiasm among staff members, children, and parents. By the spring of 2008, the Office of Head Start had sponsored one IM/IL TOT event in all but one of the 12 ACF regions. The Office of Head Start staff report that programs were calling the office to request IM/IL training.[78] In May 2008, a new IM/IL training model was launched. This approach uses, in place of the TOT event, 100 specially trained facilitators (former training and technical assistance providers or program staff members) who provide a structured, two-day training for program teams (both management and frontline staff). The new model includes videotaped segments of training conducted by the core TOT team who trained the Region III programs included in this evaluation, as additional supports for implementation (CDs, presentation materials, and a

[77] There is no standardized curriculum for IM/IL.

[78] Amanda Bryans, personal communication April 2008.

resource binder). Findings from Stage 1 of this evaluation informed the new training model as well as the development of additional supports for local implementation, specifically related to the creation of written plans. Findings from this final report may provide additional insights about how implementation of IM/IL can be strengthened and supported.

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APPENDIX A

STAGE 1 QUESTIONNAIRE

OMB No.: 0970-0318
Expiration Date: 02/28/2010

6288-415

Program Name:_____

Program Director:_____

MPR ID: |__|__|__|__|__|__|__|__|

I am Moving, I am Learning

Implementation Evaluation

Stage 1 Questionnaire

March 2007

Mathematica Policy Research, Inc. (MPR)
Princeton, NJ

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For questions, call Linda Mendenko toll free at 866-627-9980

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0970-0318. The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health and Human Services, Administration for Children and Families, Washington, DC 20202.

A. INTRODUCTION AND SCREENER

In the spring of 2006, your Head Start program was offered an opportunity to attend a three-day training-for-trainer event for *I am Moving, I am Learning (IM/IL).* This training event presented strategies and resources to address childhood obesity in Head Start by increasing children's physical activity and improving their nutrition. The purpose of this questionnaire is to learn about your program's efforts to implement *IM/IL* activities. Now that you have had a chance to work on implementation, we would also like to know your views about the training and technical assistance that you received to assist you with the implementation. The information from this survey will be used to make improvements in *IM/IL,* such as changes in the type of training and technical assistance that programs receive to implement *IM/IL*.

The information you provide in the questionnaire will not be used for purposes of monitoring your program's performance. Information you provide will be treated in a private manner, to the extent permitted by law, and the responses on this survey will be kept separately from your name, contact information, or the name of your Head Start program. We will not report the responses of individual programs to anyone, including to the Office of Head Start or any other government agency. We will only report findings of this survey in aggregate form (for example: "X% of programs have tried to implement IM/IL activities").

This questionnaire should be completed by the person in your program who has been designated to lead the implementation of *IM/IL.* If this person did not attend the spring 2006 *IM/IL* training event, then section B of this questionnaire should be completed by the individual in your program with the most senior management responsibility who did attend the spring 2006 *IM/IL* training event. Please note that sections C and D should be completed by the person leading the implementation of *IM/IL.*

If there is no one currently at your program who attended the spring 2006 *IM/IL* training event, please contact us for guidance about completing section B of this questionnaire. Please call us toll free at 866-627-9980.

- **Please read each question carefully.**
- **Please use black or blue ink to complete this questionnaire.**
- **Always proceed to the next question unless special instructions tell you to go elsewhere.**
- **Most questions can be answered by simply placing a check mark in the appropriate box. For a few questions you will be asked to write in a response.**
- **If you are unsure about how to answer a question, please give the best answer you can rather than leaving it blank.**

If you have any questions, please contact our staff at Mathematica Policy Research, Inc. toll free at 866-627-9980.

Please return the completed questionnaire in the enclosed pre-paid mailer by April 16, 2007.

B. SPRING 2006 *IM/IL* TRAINING EVENT

B1. Including yourself, how many staff attended the training?

|___| **NUMBER OF STAFF**

B1a. Were all of the staff members who went to the training able to attend all days of the training?

1 ☐ **Yes**

0 ☐ **No**

B2. For each staff member who attended the spring 2006 *IM/IL* training event (including yourself), indicate the title of the staff member in the table provided below. If the staff member has more than one title, select the title for that staff member that is associated with their highest level of management responsibility.

	PLEASE MARK THE TITLE OF EACH STAFF MEMBER IN THE COLUMN PROVIDED				
Staff Title	**Staff Member 1**	**Staff Member 2**	**Staff Member 3**	**Staff Member 4**	**Staff Member 5**
a. Head Start Program Director.....	☐	☐	☐	☐	☐
b. Child Development & Education Manager ...	☐	☐	☐	☐	☐
c. Health Services Manager.....	☐	☐	☐	☐	☐
d. Family & Community Partnerships Manager.....	☐	☐	☐	☐	☐
e. Disability Services Manager.....	☐	☐	☐	☐	☐
f. Child Development Supervisors.....	☐	☐	☐	☐	☐
g. Home-Based Supervisors.....	☐	☐	☐	☐	☐
h. Teacher.....	☐	☐	☐	☐	☐
i. Home-Based Visitor ..	☐	☐	☐	☐	☐
j. Other (Specify)..... _____	☐	☐	☐	☐	☐
k. Other (Specify)..... _____	☐	☐	☐	☐	☐

B3. On a scale of 1-4, with 1 being "strongly disagree" and 4 being "strongly agree," how would you rate the following aspects of the spring 2006 *IM/IL* training event you attended?

	MARK ONLY ONE IN EACH ROW			
	Strongly Disagree	Disagree	Agree	Strongly Agree
a. The three *IM/IL* goals were clearly explained	1 ☐	2 ☐	3 ☐	4 ☐
b. The workshops presented ideas for program enhancements that addressed the goals of *IM/IL*	1 ☐	2 ☐	3 ☐	4 ☐
c. The instruction received at the training was adequate to train my own staff to implement *IM/IL*	1 ☐	2 ☐	3 ☐	4 ☐
d. Quality of the "take-home" materials (resource materials and handouts) was adequate to train my staff	1 ☐	2 ☐	3 ☐	4 ☐
e. The trainers explained how to adapt *IM/IL* to meet the needs of a program like ours	1 ☐	2 ☐	3 ☐	4 ☐
f. The ideas for program enhancements seemed like they would work in our program	1 ☐	2 ☐	3 ☐	4 ☐
g. The training prepared us to implement *IM/IL*	1 ☐	2 ☐	3 ☐	4 ☐
h. The training event provided new information and resources	1 ☐	2 ☐	3 ☐	4 ☐

B4. Looking back on the spring 2006 *IM/IL* training event, how would you describe the allocation of time during the training? Rate the allocation of time during the training with 1 being "too little time," and 5 being "too much time."

	MARK ONLY ONE IN EACH ROW				
	Too Little Time		About the Right Time		Too Much Time
	←				→
a. Time for lecture and direct instruction	1 ☐	2 ☐	3 ☐	4 ☐	
b. Time on how to engage adults in *IM/IL*	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Time for asking questions	1 ☐	2 ☐	3 ☐	4 ☐	
d. Time for practicing movement activities	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. Time for planning our implementation	1 ☐	2 ☐	3 ☐	4 ☐	
f. Time for the topic of improving children's nutrition	1 ☐	2 ☐	3 ☐	4 ☐	

B5. Looking back on the spring 2006 *IM/IL* training event, on a scale of 1 to 5, where 1 is "poor" and 5 is "excellent," how would you rate the overall quality of the training?

CIRCLE ONLY ONE

Poor ← → Excellent

1 2 3 4 5

B6. Did your program experience unexpected costs associated with attending the spring 2006 *IM/IL* training event?

1 ☐ **Yes**

0 ☐ **No** → **GO TO B7**

B6a. What were the costs?

_____

_____

B7. At the spring 2006 *IM/IL* training event, was your program made aware of technical assistance that would be available when your program implemented *IM/IL* activities?

1 ☐ **Yes**

0 ☐ **No**

B8. Did you leave the spring 2006 *IM/IL* training event with a written action plan for how your program would implement *IM/IL*?

1 ☐ **Yes**

0 ☐ **No**

B9. Looking back at the spring 2006 *IM/IL* training event, what did your program find most useful and least useful?

_____

_____

_____

_____

_____

_____

_____

C. IMPLEMENTATION

The questions in this section ask about how your program tried to implement activities discussed at the spring 2006 *IM/IL* training event.

C1. Has your program tried to implement any *IM/IL* activities?

1 ☐ **Yes → GO TO C4**

0 ☐ **No**

C2. What are the reasons your program did not try to implement any *IM/IL* activities? Indicate your reasons on the list below.

MARK ALL THAT APPLY

1 ☐ **We lacked the resources (either money or in-kind support) in the community to help us in our implementation**

2 ☐ **The training our program received at the spring 2006 *IM/IL* training event was not adequate preparation for us to train other frontline staff**

3 ☐ **The management staff did not have enough time to devote to *IM/IL***

4 ☐ **The management staff did not have adequate skills to train our frontline staff**

5 ☐ **The frontline staff did not have enough time to participate in training**

6 ☐ **We needed more technical assistance**

7 ☐ **Our frontline staff members were not enthusiastic about the goals of *IM/IL***

8 ☐ **We thought it would be difficult for our staff members to maintain interest in *IM/IL***

9 ☐ **The parents of children in our program were not enthusiastic about the goals of *IM/IL***

10 ☐ ***IM/IL* was not a priority of our program's Policy Council, Governing Board, or Health Services Advisory Committee**

11 ☐ **Other areas in our program were a higher priority**

12 ☐ **High staff turnover**

13 ☐ **We did not have enough space for the children to be physically active**

14 ☐ **The children are not at the program long enough each day**

15 ☐ **We felt we needed materials to implement *IM/IL*, but our program did not have the funds to purchase them**

16 ☐ **We felt we needed materials to implement *IM/IL*, but our program had trouble making the materials**

17 ☐ **Other (Specify)**

_____

C3. What is the single most important reason that your program did not try to implement any *IM/IL* activities? Choose the number from the list above.

|___|___| **NUMBER OF THE MOST IMPORTANT REASON**

GO TO SECTION D, PAGE 15

C4. Of the activities your program has implemented so far, which of the three *IM/IL* goals are these activities intended to address?

MARK ALL THAT APPLY

1 ☐ **Increase the quantity of time spent in moderate to vigorous physical activities during the daily routine to meet national guidelines for physical activity**

2 ☐ **Improve the quality of structured movement experiences intentionally facilitated by teachers and adults**

3 ☐ **Improve healthy nutrition choices for children every day**

C5. Compared with all other services and activities your program provides in Head Start, how would you rank the importance of the following activities in your program <u>before</u> the spring 2006 *IM/IL* training event?

	MARK ONLY ONE NUMBER IN EACH ROW				
	Not Important At All				Very Important
	←				→
a. Moderate to vigorous physical activity	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Structured movement experiences	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Healthy nutrition choices	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

C6. Compared with all other services and activities your program provides in Head Start, how would you rank the importance of the following activities in your program <u>after</u> the spring 2006 *IM/IL* training event?

	MARK ONLY ONE NUMBER IN EACH ROW				
	Not Important At All				Very Important
	←				→
a. Moderate to vigorous physical activity	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Structured movement experiences	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Healthy nutrition choices	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

C7. Regarding the activities your program has tried to implement so far, would you say these activities:

MARK ONLY ONE

1 ☐ **Place more emphasis on moderate to vigorous physical activity/structured movement experiences**

2 ☐ **Place more emphasis on healthy nutrition choices**

3 ☐ **Emphasize about equally both healthy nutrition choices <u>and</u> moderate to vigorous physical activity/structured movement experiences**

C8. Has your program stopped doing any of the *IM/IL* activities that it implemented after the spring 2006 *IM/IL* training event?

1 ☐ **Yes**

0 ☐ **No**

C9. There are many challenges your program may have faced while trying to implement *IM/IL* activities. How would you rate the success of your program in implementing the following on a scale from 1 to 5, where 1 is "not at all successful" and 5 is "extremely successful"?

	MARK ONLY ONE NUMBER IN EACH ROW				
	Not At All Successful ←				→ Extremely Successful
a. Moderate to vigorous physical activity.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Structured movement experiences.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Healthy nutrition choices.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. *IM/IL* overall.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

C10. What are the reasons that might have contributed to any success that your program has had in implementing *IM/IL*? Indicate your reasons on the list below.

MARK ALL THAT APPLY

1 ☐ **We had the community resources (either money or in-kind support) to help us in our implementation**

2 ☐ **The spring 2006 *IM/IL* training event provided us with the necessary training to train our staff**

3 ☐ **We had good technical assistance**

4 ☐ **We had an enthusiastic and capable leader to implement these activities**

5 ☐ **Our staff members were enthusiastic about the goals of *IM/IL***

6 ☐ **The parents of children in our program were enthusiastic about the goals of *IM/IL***

7 ☐ **Obesity prevention was a priority of our program's Policy Council, Governing Board, or Health Services Advisory Committee**

8 ☐ **Before the spring 2006 *IM/IL* training event, we were already actively involved in efforts to increase children's physical activity and improve their nutrition**

9 ☐ **We have not been too successful, so NONE of these reasons apply → GO TO C12**

10 ☐ **Other (Specify)**

_____

C11. What is the single <u>most</u> important reason that contributed to the success of implementing *IM/IL*? Choose the number from the list above.

|___|___| **NUMBER OF THE MOST IMPORTANT REASON**

C12. What challenges has your program experienced in implementing *IM/IL*? Indicate your reasons on the list below.

MARK ALL THAT APPLY

1 ☐ **We lacked the resources (either money or in-kind support) in the community to help us in our implementation**

2 ☐ **The training our program received at the spring 2006 *IM/IL* training event was not adequate preparation for us to train other frontline staff**

3 ☐ **The management staff did not have enough time to devote to *IM/IL***

4 ☐ **The management staff did not have adequate skills to train our frontline staff**

5 ☐ **The frontline staff did not have enough time to participate in training**

6 ☐ **We needed more technical assistance**

7 ☐ **Our frontline staff members were not enthusiastic about the goals of *IM/IL***

8 ☐ **It was difficult for our staff members to maintain interest in *IM/IL***

9 ☐ **The parents of children in our program were not enthusiastic about the goals of *IM/IL***

10 ☐ ***IM/IL* was not a priority of our program's Policy Council, Governing Board, or Health Services Advisory Committee**

11 ☐ **Other areas in our program were a higher priority**

12 ☐ **High staff turnover**

13 ☐ **We did not have enough space for the children to be physically active**

14 ☐ **The children are not at the program long enough each day**

15 ☐ **We felt we needed materials to implement *IM/IL*, but our program did not have the funds to purchase them**

16 ☐ **We felt we needed materials to implement *IM/IL*, but our program had trouble making the materials**

17 ☐ **Other (Specify)**

_____

C13. What is the single most important reason that your program might not have been as successful as you hoped it would be in implementing *IM/IL*? Choose the number from the list above.

|___|___| **NUMBER OF THE MOST IMPORTANT REASON**

C14. Does your program have a written plan for implementation of *IM/IL*?

1 ☐ **Yes**

0 ☐ **No**

C15. Before selecting *IM/IL* activities to implement, did you review your current program activities and identify areas in which you were not implementing activities like the ones presented at the spring 2006 *IM/IL* training event?

1 ☐ **Yes**

0 ☐ **No**

C16. In selecting *IM/IL* activities to implement, what did your program target to promote healthy weight in children?

MARK ONLY ONE

1 ☐ **Mostly children's level of physical activity**

2 ☐ **Mostly children's nutrition choices**

3 ☐ **Children's level of physical activity <u>and</u> children's nutrition choices by about the same amount**

C17. In selecting *IM/IL* activities to implement, in what setting did your program expect to bring about changes in children's physical activity and eating behaviors?

MARK ONLY ONE

1 ☐ **Mostly in the Head Start setting**

2 ☐ **Mostly in the home setting**

3 ☐ **In the Head Start and home settings by about the same amount**

C18. From the list below select the specific behavior changes your program expects to achieve, based on the *IM/IL* enhancements being implemented.

MARK ALL THAT APPLY

1 ☐ **Increase the amount of children's moderate to vigorous physical activity during the Head Start day**

2 ☐ **Increase the amount of children's moderate to vigorous physical activity when children are at home**

3 ☐ **Increase the quality of children's structured movement experiences during the Head Start day**

4 ☐ **Increase the quality of children's structured movement experiences when they are at home**

5 ☐ **Improve the quality of children's food choices during the Head Start day**

6 ☐ **Improve the quality of children's food choices when they are at home**

7 ☐ **Reduce children's portion sizes during the Head Start day**

8 ☐ **Reduce children's portion sizes when they are at home**

C19. What is the behavior your program <u>most</u> expects to change, based on the *IM/IL* enhancements being implemented? Choose the number from the list above.

|___| **NUMBER OF THE SPECIFIC BEHAVIOR CHANGE**

C20. Which of the following child assessment activities is your program doing as part of *IM/IL*?

MARK ALL THAT APPLY

1 ☐ **Recording the amount of time children spend outdoors**
2 ☐ **Recording the quality of children's movement experiences**
3 ☐ **Recording children's food intake or food selection**
4 ☐ **Measuring children's height and weight**
5 ☐ **Calculating children's body mass index percentiles**
0 ☐ **None**
6 ☐ **Other (Specify)**

_____

C21. Has your program offered any activities that are intended to alter the eating or physical activity behaviors of your staff members, but which do not focus primarily on the children's behaviors?

1 ☐ **Yes**
0 ☐ **No → GO TO C23**

C22. What are they?

_____

_____

C23. Has your program offered any activities that focus on altering the eating or physical activity behaviors of the parents of children in your program, but which do not focus primarily on the children's behaviors?

1 ☐ **Yes**
0 ☐ **No**

C24. Did your program receive input for its *IM/IL* implementation from any of the following groups?

MARK ALL THAT APPLY

1 ☐ **Parent committee(s)**
2 ☐ **Health Services Advisory Committee**
3 ☐ **Policy Council**
4 ☐ **Governing Board**
5 ☐ **Other (Specify)**

_____

C25. How many centers does your program operate?

|__|__| **NUMBER OF CENTERS**

C25a. What is the total number of classrooms in all the centers combined?

|__|__|__| **NUMBER OF CLASSROOMS**

C26. Altogether, how many of your centers are implementing *IM/IL* enhancements?

|__|__| **NUMBER OF CENTERS**

C26a. Altogether, how many of your classrooms are implementing *IM/IL* enhancements?

|__|__|__| **NUMBER OF CLASSROOMS**

C27. Has your program implemented *IM/IL* in <u>all</u> centers/classrooms?

1 ☐ **Yes → GO TO C28**

0 ☐ **No**

C27a. How did your program select the centers/classrooms in which *IM/IL* was implemented?

MARK ALL THAT APPLY

1 ☐ **Center/Classroom volunteered**

2 ☐ **By physical location of the center/classroom**

3 ☐ **Management selected the center/classroom**

4 ☐ **Other (Specify)**

_____

C28. Has your program conducted any training sessions for your frontline staff to implement *IM/IL*?

1 ☐ **Yes**

0 ☐ **No → GO TO C32**

C29. On average, how many training sessions has your program conducted for a given frontline staff member?

|__|__| **NUMBER OF TRAINING SESSIONS**

C29a. On average, how long did each of those training sessions last in hours and minutes?

|__|__| **HOURS** |__|__| **MINUTES**

C30. Has more than half of your frontline staff participated in more than one training session?

1 ☐ **Yes**

0 ☐ **No**

C31. Which approaches has your program used to train your staff to implement the *IM/IL* enhancements?

MARK ALL THAT APPLY

1 ☐ **Pre-service training conducted at the start of the program year**

2 ☐ **In-service training conducted during the program year**

3 ☐ **A workshop conducted by the TA specialist or content specialist**

4 ☐ **A workshop conducted by a consultant or outside expert**

5 ☐ **Written materials, such as curriculum guides**

6 ☐ **An online or internet-based course**

7 ☐ **Other (Specify)**

_____

C31a. What was the <u>main</u> approach your program has used to train your staff to implement the *IM/IL* enhancements? Choose the number from the list above.

|__| **NUMBER OF THE MAIN APPROACH**

C32. We want to know to what extent your staff endorses the *IM/IL* enhancements your program is trying to implement. On a scale of 1 to 5, where 1 would be "resistant" and 5 would be "enthusiastic," how would you rate your staff's interest in the following?

	MARK ONLY ONE IN EACH ROW				
	Resistant ←				→ Enthusiastic
a. Moderate to vigorous physical activity	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Structured movement experiences	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Healthy nutrition choices	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. *IM/IL* overall	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

C33. As part of implementing *IM/IL* in your program, which approaches has your program used to reach parents?

MARK ALL THAT APPLY

1 ☐ **Conducted workshops or events that involved parents**
2 ☐ **Distributed written information by flyer, pamphlet, or newsletter**
3 ☐ **Discussed nutrition and/or physical activity at parent/teacher conferences**
4 ☐ **We have not tried to involve parents**
5 ☐ **Other (Specify)**

_____

C34. Please respond "Yes" or "No" to the following questions regarding the implementation of *IM/IL*. As part of implementing *IM/IL*, has your program . . .

	MARK "YES" OR "NO" ON EACH LINE	
	Yes	**No**
a. **received any money from sources outside the Head Start program?**	1 ☐	0 ☐
b. **received any in-kind support from sources outside the Head Start program?**	1 ☐	0 ☐
c. **purchased new equipment for children's outdoor play areas?**	1 ☐	0 ☐
d. **purchased new equipment for children's indoor play areas?**	1 ☐	0 ☐
e. **increased the amount of space available for children's outdoor play?**	1 ☐	0 ☐
f. **increased the amount of space available for children's indoor play?**	1 ☐	0 ☐
g. **purchased any new equipment to teach children movements in a structured fashion?**	1 ☐	0 ☐
h. **made or constructed any new equipment?**	1 ☐	0 ☐
i. **established any new policies about the type of food that children can bring from home?**	1 ☐	0 ☐
j. **established any new policies about the type of food that is served at meetings of staff or parents?**	1 ☐	0 ☐
k. **established any new policies about the type of food that children are served at Head Start?**	1 ☐	0 ☐
l. **altered the type of food you serve to children for meals and snacks?**	1 ☐	0 ☐
m. **altered the amount of food you serve to children for meals and snacks?**	1 ☐	0 ☐
n. **offered any incentives to staff for meeting any goals related to *IM/IL*?**	1 ☐	0 ☐
o. **purchased new instructional materials, such as music, visual aids, or structured movement aids?**	1 ☐	0 ☐

C35. **As part of implementing *IM/IL*, has your program selected an available curriculum that focuses on physical activity and nutrition?**

1 ☐ **Yes**

0 ☐ **No → GO TO C36**

C35a. **What curriculum was selected?**

_____

_____

C36. **As part of *IM/IL,* has your program identified any community organization(s) as a partner?**

1 ☐ **Yes**

0 ☐ **No → GO TO C37**

C36a. **As part of *IM/IL,* how many different community organization(s) is your program working with?**

|___|___| **NUMBER OF COMMUNITY ORGANIZATIONS**

C37. **At the spring 2006 *IM/IL* training event, vocabulary was introduced to describe children's movement. It involved terms to describe children's "traveling actions," "stabilizing actions," "manipulating actions," and "effort awareness." On a scale of 1 to 5, with 1 being "not at all helpful" and 5 being "very helpful," how helpful has this vocabulary been in your program's efforts to increase children's movement?**

CIRCLE ONLY ONE

Not at all helpful ←→ Very helpful

1 2 3 4 5

C38. **Please respond "Yes" or "No" to the following questions:**

	MARK "YES" OR "NO" ON EACH LINE	
	Yes	**No**
a. **Has your program trained your staff to use this movement vocabulary to describe how children perform different movements?**.....	1 ☐	0 ☐
b. **Has your program introduced the character "Choosy" in implementing *IM/IL* activities?**.....	1 ☐	0 ☐
c. **Has your program reconfigured its existing space to allow children more opportunity for physical activity (e.g., moving furniture, using hallways, etc.)?**.....	1 ☐	0 ☐

C39. **As part of your effort to implement *IM/IL*, has your program received any technical assistance from the Region III TA System?**

1 ☐ **Yes**

0 ☐ **No → GO TO C40**

C39a. **From which staff member(s) within the Region III TA System has your program received technical assistance for *IM/IL?***

MARK ALL THAT APPLY

1 ☐ **Child development content specialist**

2 ☐ **Disabilities content specialist**

3 ☐ **Early literacy content specialist**

4 ☐ **Family and community partnership content specialist**

5 ☐ **Fiscal administration and management content specialist**

6 ☐ **Health content specialist**

7 ☐ **TA coordinator**

8 ☐ **TA manager**

9 ☐ **TA specialist**

C40. **Did your program receive technical assistance for *IM/IL* from anyone else?**

1 ☐ **Yes**

0 ☐ **No → GO TO SECTION D**

C40a. **Who provided this assistance?**

_____

_____

_____

C40b. **What is this person's title?**

_____

D. PROGRAM CONTEXT

D1. What term best describes the location of your program?

MARK ONLY ONE

1 ☐ **Urban**
2 ☐ **Suburban**
3 ☐ **Rural**

D2. Please indicate your program delegate status.

MARK ONLY ONE

1 ☐ **Grantee**
2 ☐ **Delegate**
3 ☐ **Grantee and Delegate**

D3. Does your program have an Early Head Start program?

1 ☐ **Yes**
0 ☐ **No** → **GO TO D4**

D3a. Have you implemented any *IM/IL* activities in your Early Head Start program?

1 ☐ **Yes**
0 ☐ **No** → **GO TO D3c**

D3b. What are these activities?

_____

_____

D3c. What has made it challenging to implement *IM/IL* activities in your Early Head Start program?

_____

_____

D4. Does your program deliver any Head Start services to children (not Early Head Start) through home visitors?

1 ☐ **Yes**
0 ☐ **No** → **GO TO D5**

D4a. Have any *IM/IL* activities been implemented as part of these home visits?

1 ☐ **Yes**
0 ☐ **No** → **GO TO D4c**

D4b. What are these activities?

_____

_____

D4c. What has made it challenging to implement *IM/IL* activities as part of the home visits?

_____

_____

The following questions are about you—the person designated to lead the implementation of *IM/IL* at your program.

D5. How many years of experience do you have working with Head Start or with programs serving preschool-aged children?

|___|___| **NUMBER OF YEARS**

D6. How many years have you been working with this Head Start program?

|___|___| **NUMBER OF YEARS**

D7. What is your highest degree?

MARK ONE ONLY

1 ☐ **Associate's Degree**
2 ☐ **Bachelor's Degree (B.A., B.S., B.E., etc.)**
3 ☐ **Master's Degree (M.A., M.A.T., M.B.A., M.Ed., M.S., etc.)**
4 ☐ **Education specialist or professional diploma (at least one year beyond Master's level)**
5 ☐ **Doctorate or professional degree (Ph.D., Ed.D., M.D., L.L.B., J.D., D.D.S.)**
6 ☐ **Do not have a postsecondary degree**
7 ☐ **Other (Specify)**

_____

D8. Of the health problems affecting children in your program, how would you rank the three conditions listed below?

Place a "1" next to the most important problem, a "2" next to the second most important problem, and a "3" next to the third most important problem. Use each number only once.

_____ **Asthma**

_____ **Obesity**

_____ **Oral health (tooth decay and cavities)**

D9. To what extent do you feel that obesity is a health problem affecting the <u>children</u> in your program?

MARK ONLY ONE

1 ☐ **Not a problem at all**
2 ☐ **A small problem**
3 ☐ **A moderate problem**
4 ☐ **A large problem**
5 ☐ **A very large problem**

D10. To what extent do you feel that obesity is a health problem affecting the <u>parents</u> of the children in your program?

MARK ONLY ONE

1 ☐ **Not a problem at all**
2 ☐ **A small problem**
3 ☐ **A moderate problem**
4 ☐ **A large problem**
5 ☐ **A very large problem**

D11. To what extent do you feel that obesity is a health problem affecting the <u>staff members</u> in your program?

MARK ONLY ONE

1 ☐ **Not a problem at all**
2 ☐ **A small problem**
3 ☐ **A moderate problem**
4 ☐ **A large problem**
5 ☐ **A very large problem**

D12. Prior to the spring 2006 *IM/IL* training event, was the Health Services Advisory Committee in your program involved in any activities to address childhood obesity?

1 ☐ **Yes**
0 ☐ **No**

Who had the primary responsibility for completing this survey?

Please print your name, title, program name, mailing address, program telephone number, and email address.

Name: _____

Job Title: _____

Program Name: _____

Mailing Address: _____

_____

Program Phone Number: (|__|__|__|)-|__|__|__|-|__|__|__|__|

Email Address: _____

Please record the date you completed the survey and mail it to MPR in the envelope provided.

DATE COMPLETED: |__|__| / |__|__| / |2|0|0|7|
Month Day Year

Thank you for completing this survey.

APPENDIX B

STAGE 2 PROTOCOLS

Part 1: Telephone Interview Guide For Program Managers
Part 2: Telephone Interview Guide For Classroom Teachers/Home Visitors

OMB No.: 0970-0318
Expiration Date: 02/28/2010

Region III Head Start Administration for Children and Families

Evaluation of the *I am Moving, I am Learning* Enhancement

Telephone Interview Guide for Program Managers
Spring 2007
(Estimated interview time: 60 minutes)

INTRODUCTION

Thank you for taking the time to speak with me today. My name is [X] and I am a [TITLE] with Mathematica Policy Research, Inc. (MPR), a nonpartisan research firm that has extensive experience conducting both early childhood and nutrition research. The Office of Planning, Research, and Evaluation (OPRE) under the Administration for Children and Families (ACF) contracted with MPR to conduct an implementation evaluation of the *I am Moving, I am Learning* (*IM/IL*) enhancement in Region III. This study will examine to what extent grantees are implementing *IM/IL* enhancement activities after attending the spring 2006 regional Training for Trainers (TOT) events.

To that end, during this call we will be discussing what efforts your Head Start program made since attending the regional TOT event to promote physical activity, structured movement, and healthy eating among children and families you serve; your impressions of the TOT event; how changes were implemented; progress on affecting intermediate outcomes; your thoughts on sustainability; and what initial successes and challenges your program has encountered. As part of this evaluation, we are currently in the process of speaking with the person in charge of overseeing *IM/IL* activities and two teachers and/or home visitors from 30 Head Start grantees. Your program was selected to participate in these interviews from among all of the Region III grantees that completed the March 2007 *IM/IL* Evaluation Questionnaire. We have reviewed your responses to that questionnaire and will use this interview to learn more about <u>how</u> you have used what you learned from the *IM/IL* training event.

During our conversation, I would like to hear about your experiences with the *IM/IL* enhancement, and will also ask you about your opinions. Everything you say will be kept private to the extent permitted by law. The information we gather will be used to write an interim report for OPRE about programs' experiences implementing *IM/IL* enhancements, including their successes, challenges, and lessons learned. Our interim report will describe experiences and views expressed by staff across the 30 grantees, but comments will not be attributed to specific individuals or programs. Staff members will not be quoted by name.

Do you have any questions before we get started?

A. PROGRAM AND COMMUNITY CONTEXT

Before we get started, I just wanted to ask some quick background questions about your Head Start/Early Head Start program.

1. Do you use mixed-age classrooms, or are classrooms organized by child age?
2. What percentage of enrolled families speak a language other than English at home? Which languages do they speak?
3. What percentage of children have an Individualized Education Plan (IEP)?
4. How common is the problem of overweight among the children in your program? About what proportion of the children in your program are overweight?
5. How common is the problem of underweight among the children in your program? About what proportion of the children in your program are underweight?
6. How common is it for the children in your program to make food choices that make it difficult to maintain a healthy weight? About what proportion of the children make these kind of food choices?
7. How common is sedentary behavior (i.e., little or no physical activity) among the children in your program, such as high levels of television viewing or living in a place that is not conducive to outside play? About what proportion of the children have limited physical activity outside of Head Start?

B. REGIONAL TRAINING EVENT

Now I'd like to talk to you about the spring 2006 regional Training of Trainers (TOT) event.

1. Why did you decide to attend the regional TOT event? Why did this opportunity appeal to your program?
2. Were any materials sent to you in advance of the training?

IF YES: What materials did you receive, and did you have a chance to review them beforehand?

IF NO: Would receiving the materials in advance have made the training a better experience?

3. How helpful were the presentations by guest speakers? Were there specific speakers/topics that you found to be particularly useful? If so, which one(s)?
4. How helpful and complete were the written training materials and resources?

PROBES:

- Which materials/resources were especially useful? What made them useful?
- Were the materials available in Spanish or other languages? If not, would it have been helpful to have materials in Spanish or other languages?
- Were any materials available in electronic form (PowerPoint, Word, PDF)? If not, would it have been helpful to have materials in an electronic format?

5. How similar was the content to what your program had done in the past to promote physical activity and good nutrition, with the overall goal of encouraging health and preventing childhood obesity?

PROBES:

- How much new information and resources on physical activity, good nutrition, health promotion, and childhood obesity prevention did you learn about? What did you learn about?
- Did you learn little new information? Why only a little?
- Did the training reinforce information that your program staff already knew but were not doing?

  IF YES, ASK → What factors and/or resources are now in place that enable your program to move toward implementing an *IM/IL* enhancement?

6. Do you think the presentations and materials were presented and targeted appropriately for Head Start? Why or why not?

PROBES:

- Was the content appropriate for your Head Start (and Early Head Start if applicable) staff, and for the populations that you serve?
- Could the materials easily be adapted to your local population (e.g., cultural/ethnic preferences, languages spoken, other demographic factors)?
- What about children with disabilities?
- What was the <u>most</u> helpful aspect of the training? What was the <u>least</u> helpful?

PROBES:

- What made this the most helpful aspect of training?
- What made this the least helpful aspect of training?

7. Did the regional TOT event adequately prepare participants to return and train local program staff to implement an *IM/IL* enhancement?

PROBES:

- Do you think that the length of training was too long, too short, or the right amount? Why?
- Did you leave the training with concrete ideas/plans for local implementation? What helped make this happen?
- Did you develop a written action plan at the training, or after the meeting? Who helped develop the plan? How detailed was it?
- Did you leave with contact information to follow up with questions or support (e.g., peers from other programs, presenters, Region III staff)? Were you encouraged to do so?
- Did the training leave you with a clear sense of how to provide guidance to other staff on how to promote MVPA, structured movement, and healthy eating among children and families served? If not, why not?
- Are there other types of training or materials that your program did not receive but would be helpful? If so, please describe.

8. Do you have any suggestions for improving the regional TOT event?

PROBE:

- If ACF was to consult with you on planning for the next TOT event for *IM/IL*, what feedback would you give them?

C. DESIGN AND PLANNING

Now let's talk about how your program went about conceptualizing *IM/IL*, identifying the goals, and who was involved in designing the services.

1. Did your program decide to implement any *IM/IL* activities after returning from the regional TOT event?

IF YES: *Skip to question #2 below.*

IF NO: Why did your program decide not to implement any *IM/IL* activities? What barrier(s) did your program face?

PROBES:

- Inadequate technical assistance and support after the TOT?
- Higher priority placed on other focus areas in your program by staff? By the Policy Council? By the Health Services Advisory Committee?
- No time to plan/prepare for any IM/IL activities over last summer?
- Program staff did not have time to conduct the local training?
- Program staff did not feel qualified to conduct the local training?
- Limited staff time?
- Costs of materials? Other costs?
- Little or no interest among staff?
- Little or no interest among children and parents?
- Little or no interest among community partners?
- Other?
- What kind of support or resources would your program need to be able to implement *IM/IL*?

Are there any other barriers that would need to be overcome to be able to implement any *IM/IL* activities?

If you were to imagine what that enhancement would look like, what goal(s) would you hope to accomplish?

PROBES:

- What behavior changes would you hope to achieve?
- Which kinds of activities and/or resources would you like to provide to help reach those behavior changes? (Observe/monitor curriculum/routines)
- What would your target audience be? Children only? Parents? Staff?
- Which resources, TA, or other support would you need to accomplish this?
- Which staff would be involved, and what would their roles be?
- Would any outside experts or organizations (e.g., TA Specialist or Content Specialist, local community group, local university) play a role?
- How would you measure progress? Track children's BMI or MVPA? Analyze daily breakfast and lunch offerings at Head Start? Observe classrooms to see if teachers were incorporating more structured movement in their routines?

Skip to "Wrap-Up" section at end of protocol.

2. What is/are the main goal(s) of *IM/IL* in <u>your</u> program?

PROBES:

- Did you intend to increase children's MVPA? If not, why not?

- Did you intend to improve the quality of structured movement activities facilitated by adults (e.g., teachers, home visitors, other staff, parents)? If not, why not?
- Did you intend to improve healthy nutrition choices for children every day? If not, why not?
- Did you have any other goals? What were they?

3. How did your program identify *IM/IL* goals and objectives, determine who you would target, and decide which activities to provide/promote? Who was involved in these decisions?

PROBES:

- Approximately how soon after returning from the regional TOT event did your program begin actively planning for an *IM/IL* enhancement?
- What was the rationale for focusing on particular needs and providing specific services? Why were these changes needed?
- Who is the intended audience of your *IM/IL* enhancement? Children? Their families? Staff? Combination? How did your program decide who would receive the *IM/IL* enhancement?
- Did you strategically decide to focus on MVPA/structured movement (physical activity), just healthy eating, or both? If so, why?

4. Did you conduct a needs assessment? If so, who did you consult? Did you do any formal data collection, such as a survey? If not, why not?

5. Did you conduct any "pilot" activities before implementing your goals? For example, did you begin implementation in a few classrooms or with a couple of teachers before you trained everyone?

6. Did you plan to reach all children in the program and in all classrooms? If so, how and over what period of time period?

7. What specific component(s) set this envisioned enhancement apart from what your program was doing <u>before</u> attending the regional TOT event in terms of MVPA, structured movement, and healthy eating?

PROBES:

- Did your program want to place more emphasis on structured play or movement, in terms of frequency and duration?
- Did your program want to place more emphasis on good nutrition, in terms of providing more healthy foods, encouraging healthy food choices, or teaching about healthy eating habits? Were activities targeted at improving children's behaviors related to healthy eating, parents' behaviors, or both? What about staff?

- Did your program want to place more emphasis on intentional/targeted obesity prevention efforts? Were activities targeted at improving children's behaviors related to healthy eating, parents' behaviors, or both?
- Did your program want to place more emphasis on promoting physical activities and healthy eating to parents? Were activities targeted at improving children's behaviors related to physical activity, parents' behaviors, or both? What about staff?
- Did your program want to incorporate a greater variety of activities, games, songs, materials, etc. that promote physical activities and healthy eating?

8. Did you use any materials from the Resource Binder provided at the regional training? For example, did you access any of the websites, like "5 A Day" or the "National Association for Sports and Physical Education"?

IF YES: What did you use? Which resources did you refer to? Were they helpful? Why or why not?

IF NO: Why did you not use the Resource Binder in your *IM/IL* planning? Did you seek out other resources that weren't included or mentioned at the training, and if so, which one(s) and where did you find them?

9. Which specific behavior changes (i.e., intermediate outcomes) did you hope to influence through *IM/IL*?

PROBES:

- What were the primary health promotion and obesity prevention behaviors you hoped to change through your *IM/IL* enhancement? For example, increase physical activity levels among staff and families? Encourage children and families to switch from whole milk and reduced-fat milk (2%) to low-fat milk (1%) and skim milk, for age appropriate groups? Other?
- Who was the target audience for this behavior change? Teachers/home visitors? Other staff? Children? Parents? Other?

10. How did/has your program hope/plan to achieve these behavior changes and target health promotion and obesity prevention efforts?

PROBES:

- Change curriculum (e.g., introduce a new supplemental curriculum or incorporate the *IM/IL* into existing curricula, increase frequency of MVPA)
- Change classroom or outdoor environment (e.g., types of materials, more play equipment)
- Change program's menu planning (less salty and sugary snacks, more healthy snacks, smaller portion sizes), both during the day and at socialization events
- Change the priority that staff place on health promotion and obesity prevention in their other work for Head Start, such as collaborating with health staff to

incorporate *IM/IL* goals into all Head Start services, form an *IM/IL* steering committee, demonstrate links to HSPS and child outcomes

- Change home environment (families and/or staff), such as educating parents on IM/IL goals promoting healthy food purchases at grocery store and preparing healthy meals through cooking classes and recipe sharing, reduce television viewing
- Change physical activity levels among families and staff and facilitate these efforts, such as including movement in meetings/programming, promoting local resources like community centers, wellness events, free recreational activities

11. Which of the following was involved in your *IM/IL* enhancement design? What role did they play?

- Region III Head Start staff
- Head Start-State Collaboration Office
- Your TA Specialist and/or a Content Specialist *N.B. Prompt for specific content area(s) if mentioned*
- Your Health Services Advisory Committee
- Policy Council or families as a whole
- *IM/IL* listserv set up by Region III
- Other

12. Did you consult with other organizations in the community or seek advice from experts to help design the *IM/IL* enhancement, such as local universities, hospitals, schools, cooperative extensions, or a dietitian or nutritionists?

IF YES: How and why did you approach them? Were they eager to participate, or did they have reservations? Who was involved in the design phase?

13. Did your program develop a written plan for implementation?

IF YES: Who wrote the plan? Was this plan approved by the Policy Council? By the Health Services Advisory Committee? Other?

IF NO: Why not?

14. Did your program select a specific curriculum to support *IM/IL* efforts?

IF YES: Which curriculum are you using? Was it designed by an outside vendor or internal staff? Are you using the curriculum in its entirety or certain parts of the curriculum? Is it a stand-alone curriculum, or did you modify/supplement your primary Head Start curriculum? Did you need to purchase the curriculum, and if so, did you obtain outside funding to do so? How have the staff responded to the curriculum? Do you monitor curriculum implementation by teachers?

IF NO: Have teachers [and home visitors] found ways to incorporate *IM/IL* activities into the regular Head Start curriculum? For example, is movement and/or healthy

eating now integrated into literacy or early math activities? How have staff incorporated *IM/IL* into the existing curriculum? Are transitions now more physically active?

15. Did you develop a manual, reference guide, lesson plans, or similar items for *IM/IL*?

16. Did your program take into account children with IEPs or IHPs in designing the *IM/IL* enhancement?

IF YES: How was this accomplished?

17. Did your program take into account English Language Learners in designing the *IM/IL* enhancement?

IF YES: How was this accomplished?

18. Did your program take into account cultural preferences and/or special dietary needs of children, families, and/or staff in designing the *IM/IL* enhancement?

IF YES: How was this accomplished?

19. Did your program need to acquire materials, equipment, and/or incentives to implement the *IM/IL* enhancement?

IF YES: Which kinds of items (e.g., music cassettes/CDs, coloring books, videos/DVDs, posters, scales, growth charts, cookbooks, jump ropes, exercise mats, balls, other toys that encourage movement, etc.)? Were these items purchased, donated, or were you able to make some of them? If purchased, did you receive outside funding to do so? Are they available for use at the centers only, or can families borrow them through a lending library?

20. What resources were <u>most</u> helpful to you in designing your *IM/IL* enhancement? Why were they helpful?

PROBE:

- *N.B. If program relies on outside experts or organizations for TA (<u>not</u> including Region III TA system), in-kind materials, etc., ask:* Do you think it would be possible to successfully implement an *IM/IL* enhancement in your program <u>without</u> the contributions made by these outside experts or organizations?

21. Would additional technical assistance or other resources have been helpful in designing your *IM/IL* enhancement?

PROBE:

- If so, what specifically, and how would that have been helpful during the planning stage?

22. What were the most challenging aspects of the design and planning process?

PROBES:

- What barriers did your program encounter?
- How did your program address these barriers?
- Did your program overcome these barriers, or do any of them continue?

23. What were the most successful aspects of the design and planning process? What went smoothly?

24. If you could give other Head Start programs advice about the design and planning stage, what would you tell them are the key ingredients they would need to have in place to increase the likelihood of successfully implementing an *IM/IL* enhancement?

PROBES:

- Strong leadership (i.e., "internal champion") and dedication of staff → *N.B. If program manager mentions strong leadership, ask which qualities this person would exhibit.*
- Interest among staff, children, and families
- Access to TA and/or other resources from outside experts and organizations
- Resources to purchase or make materials or access in-kind items
- Other

25. Looking back, is there anything that you would have done anything differently during the design and planning stage? Is so, what would you have done, and why?

D. STAFFING

Now I'd like to learn about which staff are directly involved in implementing your *IM/IL* enhancement.

1. As the point person for the *IM/IL* enhancement, what are your roles?

PROBES:

- How were you selected?
- What are your responsibilities for oversight? Do you observe and/or monitor teachers behavior? Do you observe and/or monitor curriculum routines?
- Approximately what percentage of your time do you spend on *IM/IL* per month?

2. How many other staff work on the *IM/IL* enhancement? What are their job titles and main duties for *IM/IL*?

3. How receptive were staff to implementing an *IM/IL* enhancement?

PROBES:

- Did staff seem to support the goals behind the *IM/IL* enhancement?
- Did staff voice any concerns about being overweight themselves in terms of being role models or participating with children in structured movement activities? If so, how did you address these concerns?
- Did staff think that other areas in your program were a higher priority? If so, which ones and why?
- Were staff concerned that they did not have the content knowledge to implement an *IM/IL* enhancement?
- Were staff worried that they did not have enough time to incorporate *IM/IL* activities into their daily routines?
- If they were hesitant or had concerns, how did you address them?

4. Has staff turnover affected *IM/IL* implementation?

PROBES:

- Does your program in general experience low, moderate, or high levels of staff turnover?
- Are certain types of positions more prone to turnover? If so, which one(s)?
- Do you have any current vacancies?
- Are there certain *IM/IL* activities that are not taking place and have been put "on hold" because of staff turnover? What strategies is your program using to address this turnover?

5. How well is the staffing structure working so far?

PROBES:

- Are there sufficient staff resources to implement the *IM/IL* enhancement? Enough staff dedicated to work on it?
- If you could, would you change the staffing structure? If so, how and why?

6. Do any outside organizations serve an active role in providing activities for the *IM/IL* enhancement, such as facilitating workshops for children or parents on healthy eating?

IF YES: If so, what are their job titles and what do they do for *IM/IL*?

IF NO: Do you think it is an obstacle for successful *IM/IL* implementation that there aren't outside organizations playing an active role?

E. INITIAL TRAINING

1. Following the spring 2006 TOT event, did staff receive initial training in preparation for *IM/IL*?

IF NO: *Skip to question #2 below.*

IF YES: Who developed the local training activities?

Who provided the training? Did you bring in any outside experts to do the training (e.g., presenters from the TOT)?

When did the training(s) take place? [*Specific month(s) is adequate.*]

How many and which types of staff participated? Were any volunteers trained?

What was the format of the training? What topics were covered? Which types of activities were included? Lecture? Modeling? Breakout sessions? Role play?

Were written materials distributed, such as a manual, curriculum, lesson plans, or list of resources to be used during implementation? If so, please describe.

Were staff introduced to Choosy? Did staff learn about how to incorporate the vocabulary of structured movement etc., at the local training?

Were staff trained on how to monitor progress made by children, such as observations of structured movement or tracking body mass index (BMI)?

Which part(s) of training did staff find most helpful, and why?

Was there anything about the training provided to your staff that wasn't helpful? If so, why?

Skip to question #3

2. Since there wasn't a formal training, did staff receive any special preparation to implement the *IM/IL* enhancement?

PROBES:

- Did you share the materials from the regional TOT event with staff? Which staff? Was it required that they review it, or was it voluntary? When did you share these materials? [*Specific month(s) is adequate.*]
- Do you plan to offer a local training for staff on the *IM/IL* enhancement? If so, who will be trained and what will be covered? When will the training take place, and how long will it last? If you don't plan to offer an initial training, why not?

3. How long after the training (either formal or informal review of materials) did your program began to implement the *IM/IL* enhancement? [*Specific month is adequate.*]

F. *IM/IL* ENHANCEMENT ACTIVITIES

Now I'd like to talk to you about any enhanced *IM/IL* activities that your program has implemented. We'll be discussing two general topics—physical activity and healthy eating. However, I'll ask you specific questions about the first two goals of I*M/IL* in turn—MVPA and structured movement—even though they are closely linked.

Early Head Start and Home Visits

Note to interviewers: Please keep in mind that some grantees may also be implementing the *IM/IL* enhancement among EHS children and/or families, as well as with children enrolled in the home-based option. Questions are geared towards classroom settings for the most part, as well as for 3 to 5 year-olds. Questions should be modified accordingly to the age group and the environment. For example, instead of asking about higher-level gross motor development such as throwing/catching a ball or hopping, you could ask about tummy time instead. Or, you can ask if expectant and new mothers learn about the benefits of breastfeeding.

1. Did your program have any formal policies in place <u>before</u> you attended the regional TOT, with regard to physical activity and/or healthy eating?

IF YES: Please describe.

2. What <u>new</u> physical activity (MVPA and structured movement) **policies**, if any, did your program institute to support your *IM/IL* enhancement?

PROBES:

- Require that children spend more time playing outside engaged in MVPA? If so, how often and for how long? Does this amount vary by age level?
- Require that teachers/home visitors incorporate guided, structured movement activities for certain amounts of time each day or week? Do you require teachers/home visitors participate in movement activities? Do you monitor teacher/children behaviors in physical activity?
- Other policy changes?

3. What <u>new</u> healthy eating **<u>policies</u>**, if any, did your program institute to support your *IM/IL* enhancement?

PROBES:

- Make changes to types of foods or beverages served during the day? At socializations? At staff trainings? How many servings of fruits/vegetables are children served each week, and how does that compare with what you served before?
- Have you reduced/eliminated unhealthy foods being served or made available to parents? To staff?
- Make changes to the portion sizes served to children during the day? To families at socializations? To staff at trainings?
- Other policy changes?

4. What enhancement activities does your program provide as part of its *IM/IL* enhancement, with regard to the three goals?

PROBES:

Physical Activity (MVPA)

- What kinds of MVPA activities are provided? For example, have staff (teachers or home visitors) increased the frequency of MVPA in their daily schedules?
- To whom are MVPA targeted? Children? Families? Staff?
- Is this primarily "free" play that was child-directed, or group physical activities that are facilitated by a teacher?
- On average, how much time (per day or week) do staff devote to MVPA? *N.B. For home visitors, can prompt if it's addressed at each visit, once a month, etc.*
- Did you think this amount of time is too much, too little, or about right? Why?
- How long do activity "sessions" last (e.g., active outdoor play)?
- Where do MVPA activities take place (e.g., indoors, playground, nearby park)?
- What kinds of equipment or materials are used (e.g., balls, swings)?
- Is the MVPA structured (e.g., group activity led by/modeled by teacher/home visitor) or unstructured (e.g. supervised outdoor play time)?
- How are children encouraged to participate in MVPA? How do staff reinforce children's participation in MVPA?
- How do staff model MVPA?
- What percentage of [centers/classrooms/home visitors] are implementing this area of *IM/IL*?
- Does the frequency/intensity of MVPA vary by classroom/teacher/home visitor?

Structured Movement

- What kinds of structured movement activities are provided? For example, do teachers now integrate structured movement into daily routines?
- Are any of these activities <u>brand new</u>, compared with what your program did before *IM/IL*?
- On average, how much time (per day or week) do staff devote to structured movement? *N.B. For home visitors, can prompt if it's addressed at each visit, once a month, etc.*

- Did you think this amount of time is too much, too little, or about right? Why?
- How long do activity "sessions" last (e.g., singing songs with body movements)?
- Where do movement activities take place?

- What percentage of [centers/classrooms/home visitors] are implementing this area of *IM/IL*?

- Does the frequency of attention to structured movement vary by classroom/teacher/home visitor?
- How are children encouraged to participate in structured movement? How do staff reinforce children's participation in structured movement?
- How do staff model structured movement?
- Do Head Start staff members other than classroom teachers or home visitors provide intentional structured movement with children or parents? If so, who and how often? What kinds of movement activities?

Nutrition and Healthy Eating

- What kinds of nutrition activities are provided? For example, has your program omitted and/or added certain foods or beverages to what you serve children and staff? What about food or beverages served at socializations? *N.B. Ask for specific item(s).* Do you give sample menus and recipes to families? Provide information on making healthy choices at the grocery store, how to read labels?
- Are any of these activities <u>brand new</u>, compared with what your program did before *IM/IL*?
- To whom are services provided? Children? Families? Staff?
- On average, how much time (per day or week) do staff devote to promoting healthy eating? *N.B. For home visitors, can prompt if it's addressed at each visit, once a month, etc.*
- Did you think this amount of time is too much, too little, or about right? Why?
- How long do activity "sessions" last (e.g., a cooking class for parents)?
- Where do healthy eating activities take place? Do staff talk to children about healthy foods and encouraging new foods during meal times?
- Do any activities take place at group socializations? Parent meetings?
- What percentage of [centers/classrooms/home visitors] are implementing this area of *IM/IL*?
- Does the frequency/intensity of healthy eating vary by classroom/teacher/home visitor?
- Do any Head Start staff members provide education to parents about healthy eating practices? What is provided? How frequently?
- Do any Head Start staff members other than classroom teachers or home visitors teach children or parents about healthy eating practices? If so, who and how often? What kinds of nutrition-related activities?
- Is healthy eating promoted to other audiences, like Head Start staff or families? If so, how did this occur? What kind of promotion is done? What activities take place? How often?

5. Do you modify *IM/IL* activities for children with disabilities? For children/families for whom English is not the primary home language? For families in the home-based option?

6. *N.B. If this is a grantee with delegate agencies:* Are delegate agencies included in the *IM/IL* enhancement? Why or why not?

7. *N.B. If this is a grantee with delegate agencies:* Is/Are your delegate agency/agencies implementing any *IM/IL* activities?

IF YES: Did they receive training on *IM/IL*? Who conducted the training? If they did not receive a formal training, did you share copies of the materials that you received at the regional TOT event?

IF NO: Why not?

8. Does your program offer special incentives or rewards for meeting certain benchmarks (e.g., do parents receive a pedometer when they complete an exercise log after the first month)?

9. Do outside organizations provide any activities for your *IM/IL* enhancement, such as monthly cooking classes that are open to families and/or Head Start staff?

IF YES: How did they get involved? What do they do?

10. The regional TOT event took place approximately a year ago. How much progress do you think your program has made in implementing your *IM/IL* enhancement?

PROBES:

- To what extent do you think the *IM/IL* enhancement resembles what you envisioned during the planning stage?
- What challenges or barriers has your program faced in implementing some or all of these components you targeted?

G. OUTREACH

1. Were any outreach strategies used to promote your *IM/IL* enhancement?

PROBES:

- How did you <u>first</u> communicate with staff, families, and any outside organizations about your *IM/IL* enhancement? Presentations at Policy Council meetings? Informally at socializations?
- Did your program develop brochures, posters, public service announcements, and/or newsletter articles? If so, what were the main messages?

- How widely distributed were these publicity efforts? Who was the audience for these outreach efforts? Children? Parents? Staff? Volunteers? Community organizations? Other?

2. How did you go about getting initial buy-in from staff, families, and any outside organizations?

PROBE:

- What motivated them to want to participate in the *IM/IL* enhancement?

3. How did parents initially react to your outreach efforts?

PROBE:

- Were parents excited, or hesitant? Why?

4. Has your program conducted any parent education activities centered on your *IM/IL* enhancement?

IF YES: What did you do? When did these activities take place? For how long? Who conducted the activities? Were parents engaged? Will there be additional activities and support for parents? What have parents told you about how they have changed their behavior, for example, their grocery shopping patterns, frequency of eating at fast food restaurants, whether they walk more to get to places, how much physical activity they do on their own and with their children?

IF NO: Why not? Not part of *IM/IL* goals? No staff time? Lack of interest among parents?

H. ONGOING TECHNICAL ASSISTANCE AND CAPACITY BUILDING

1. Does your program have ongoing training and/or technical assistance to support the *IM/IL* enhancement?

IF NO: Why does your program not provide ongoing training and/or seek TA?

IF YES: From whom did staff receive support?

What kind of support do staff receive?

What topic(s) are covered? How often is T/TA provided?

Which staff get trained on these topics? How many staff?

Who delivers the T/TA? Region III TA system staff? Outside experts?

Is this T/TA helpful? Why or why not?

Are IM/IL topics included during pre-service training?

How frequently are these *IM/IL* topics included during in-service days?

Approximately when was the last time one of these topics was included in a staff development activity?

What was the topic of that training?

Does your program utilize the e-mail distribution list[a] created by Region III for those who have attended *IM/IL* training events? If yes, who reviews the e-mail list? How often? Is this distribution list helpful, and if so why? If your program doesn't use the distribution list, why not?

[a] The purpose of this list is to distribute resources by e-mail to *IM/IL* grantees for the purposes of sharing successful strategies, stories, and feedback among grantees. It is maintained and monitored by the Region III TA Health Specialist.

2. Is there any monitoring of your *IM/IL* activities and sharing of feedback? For example, review updated menus; review teacher logs; speak with parents and review meal diaries during home visits to determine if there have been changes in families' eating patterns; conduct classroom observations?

IF YES: What items are reviewed, observed, discussed with staff and/or families? How often does this take place? How is feedback shared?

3. Is your program tracking *IM/IL* implementation and measuring outcomes?

IF NO: What prevents you from measuring outcomes? Are there any plans in place to do so in the future?

IF YES: Did you develop any assessment tools or monitoring procedures? Or borrow tools from other sources (e.g., use the observation forms shared at the regional TOT event)?

How does your program assess height and weight of children? Who does these measurements? Is BMI computed? How often are BMI calculations made? What is done with this information?

Do you ask staff for feedback? Track outcomes (e.g., periodically observe progress made in structured movement using the "Choosy Assessment of Motor Patterns")? Conduct a parent survey of how much they exercise? Do classroom observations? Change the questions you ask families at intake/enrollment? Other?

Who is responsible for collecting this information?

How often do these assessments take place?

Have staff used results of any assessment data to inform individual or group education and/or health goals? If so, how? If not, why not?

4. To what degree do children and staff incorporate the *IM/IL* vocabulary into their daily routines?

PROBES:

- Are teachers educating children by using structured movement vocabulary, such as "what my body does" and "how my body moves" and "where my body moves"?
- If so, do you hear teachers use this vocabulary with children? If not, why not?
- Do staff teach and use any nutrition slogans in classrooms, like "Crave Your F.A.V." or "Think Tiny Tummies?" Are children picking up this vocabulary and using it?

5. Do outside organizations or experts provide any resources for your *IM/IL* enhancement?

IF YES:

- How did they initially react when you talked to them about *IM/IL*? Were they excited, or hesitant? Why?
- Do they provide TA? If so, how many and which types of staff are involved? How frequently do they provide TA?

- Do they provide any in-kind materials, play equipment, or space? If so, what kinds of items do they provide?
- Do you think that it would be possible for your program to implement an *IM/IL* enhancement without the support of these outside organizations? Why or why not?

IF NO:

- Do you think it would be difficult for other Head Start agencies to replicate what you have done?

6. Is there any additional training or support that staff need but that they have not received yet?

IF YES: What types of support do they need? Are there specific plans in place to meet these support needs?

I. SUSTAINABILITY AND RESOURCES

1. Has your program been able to implement your *IM/IL* enhancement as planned?

IF NO: How has actual implementation differed from initial plans? In actual activities? Duration? Intensity? In who receives services? What caused a change from the original vision of what the *IM/IL* enhancement would look like in your program?

2. How do you reinforce *IM/IL* goals and go about getting <u>ongoing</u> buy-in from staff? Parents? Community organizations? In other words, how do you keep the momentum moving forward?

PROBES:

- Did you incorporate *IM/IL* goals into Family Partnership Agreements? Community Partnership Agreements? Children's Individual Education Plans (IEP)? Children's Individual Health Plans (IHP)? Ongoing T/TA plans and/or Quality Improvement Plans (QIP)?
- Which *IM/IL* enhancement activities do you envision becoming a permanent part of pre-service and/or in-service training? Why? Which do you not envision in this way? Why?
- Have you shared information about *IM/IL* with the families' health care professionals or your local WIC program, such as a description of planned activities or any data collected?
- Have you shared information about *IM/IL* with Part B or C providers, such as a description of planned activities or any data collected?

3. Has your Health Services Advisory Committee changed the way it addresses health promotion and obesity prevention through physical activity, structured movement, and good nutrition since your *IM/IL* enhancement began? If so, how?

4. Has there been a change in the level of staff commitment to the *IM/IL* enhancement? Is it higher, lower, or about the same since the regional TOT event/since implementation began? Why?

5. Have you observed or experienced challenges in getting targeted audiences to do any of the activities? What challenges have you experienced? (For example, if you sponsor cooking classes to teach family members about easy-to-prepare, nutritious meals, do less than half of those invited attend?)

   - If there have been challenges with participation among staff, had you anticipated that some staff would implement *IM/IL* at a higher level of intensity than others? How does service delivery vary, and why? If some staff are doing far less than others, how is this being addressed?
   - If there have been challenges with participation among children/families, had you expected these challenges? What factor(s) affect some families participating more than others? Is your program doing anything to encourage participation?
   - What factor(s) prevent higher activity levels? Do staff have little time? Which activities have parents noted are difficult to do?
   - Has the program used any strategies to encourage participation over time?

6. Describe the start-up costs associated with your *IM/IL* enhancement (e.g., program design, training staff). *N.B. General categories and cost estimates are fine.*

7. What are the ongoing costs associated with *IM/IL*? General categories and cost estimates are fine.

8. How did your program make budget decisions about costs to implement the *IM/IL* enhancement?

PROBE:

   - Did you have to redirect service priorities to cover the costs of the *IM/IL* enhancement? Are there any services that have been dropped or decreased in intensity to focus attention on *IM/IL* goals?

9. What percentage of your T/TA funds has been dedicated to your *IM/IL* enhancement?

10. What do you think is the future of your *IM/IL* enhancement?

PROBES:

   - At this point, how long do you see the *IM/IL* enhancement continuing?
   - Does your program have plans to continue the enhanced services at the current levels, expand services, or reduce services in the future?

- Which barrier(s), if any, could prevent the continuation of the *IM/IL* enhancement? Funding? Staff? Interest?

J. INITIAL SUCCESSES, CHALLENGES, AND LESSONS

1. What have been the most important successes of your *IM/IL* enhancement so far?

PROBES:

- Can you give an example?
- What factor(s) led to that success?

2. What are the most significant implementation challenges associated with your *IM/IL* enhancement so far?

PROBES:

- Needed additional technical assistance
- Other areas in our program were a higher priority *N.B. Ask for which area(s)*
- Children and/or parents were not enthusiastic about the *IM/IL* goals
- Lack of resources (either money or in-kind support) in the community
- High staff turnover
- What strategies have staff used to address these challenges?
- How well do you think these strategies worked?

3. What aspects of *IM/IL* do <u>children</u> like the most? What do they like the least?

4. What aspects of *IM/IL* do <u>staff</u> like the most? What do they like the least?

5. What aspects of *IM/IL* do <u>families</u> like the most? What do they like the least?

6. Do you think the *IM/IL* enhancement has had an effect on the outcomes your program has hoped to achieve (e.g., increased MVPA by 50%)? Do you think it will in the future?

7. What are the most important lessons your program has learned so far about implementing an *IM/IL* enhancement?

8. What changes, if any, do you think should be made to the *IM/IL* enhancement, either the enhancement in your program specifically or the enhancement overall in Head Start?

PROBE:

- Changes in scope? Activities? T/TA? Staffing? Involvement of outside organizations or experts? Other?

9. What advice would you give to another Head Start program that is thinking about implementing an *IM/IL* enhancement?

10. Do you think what you have done with your *IM/IL* enhancement could also be done by other Head Start programs?

PROBES:

- If yes, what would be needed for successful replication?
- If no, what would prevent or hinder replication?
- Is there anything unique about your local community or populations served that help or hinder successful implementation of your *IM/IL* enhancement?

WRAP-UP

Is there anything else you would like to add before we end our discussion?

N.B. MPR should have already received a set of documents from the program in advance of the telephone call, such as the program's most recent T/TA plan and copies of any local IM/IL training materials. If we have not received them, then ask for specific outstanding items as appropriate.

Thank you very much for speaking with me and sharing your experiences and feedback on the *IM/IL* enhancement at your Head Start program.

Region III Head Start Administration for Children and Families

Evaluation of the *I am Moving/I am Learning* Enhancement

Telephone Interview Guide for Classroom Teachers/Home Visitors
Spring 2007
(Estimated interview time: 30 minutes)

INTRODUCTION

Thank you for taking the time to speak with me today. My name is [X] and I am a [TITLE] with Mathematica Policy Research, a nonpartisan research firm that has extensive experience conducting both early childhood and nutrition research. The Office of Planning, Research, and Evaluation (OPRE) under the Administration for Children and Families (ACF) contracted with MPR to conduct an implementation evaluation of the *I am Moving/I am Learning* (*IM/IL*) enhancement in Region III. This study will examine to what extent grantees are implementing *IM/IL* enhancement activities after attending the spring 2006 regional Training for Trainers (TOT) events.

To that end, during this call we will be discussing what efforts your Head Start program made since attending the regional TOT event to promote physical activity, structured movement, and healthy eating among children and families you serve; how these changes were implemented; what you have seen as far as changes in intermediate outcomes; your thoughts on sustainability; and what initial successes and challenges your program has encountered. As part of this evaluation, we are currently in the process of speaking with the person in charge of overseeing *IM/IL* activities and two teachers and/or home visitors from 30 Head Start grantees. Your program was selected to participate in these interviews from among all of the Region III grantees that completed the January 2007 *IM/IL* Evaluation Questionnaire. You were selected from among all of the teachers who were targeted to implement *IM/IL* in your program We will use this interview to learn more about <u>how</u> you are implementing the *IM/IL* enhancement in your classroom [*or during home visits for home visitors*].

During our conversation, I would like to hear about your experiences with the *IM/IL* enhancement, and will also ask you about your opinions. Everything you say will be kept private to the extent permitted by law. The information we gather will be used to write an interim report for OPRE about programs' experiences implementing *IM/IL* enhancements, including their successes, challenges, and lessons learned. Our interim report will describe experiences and views expressed by staff across the 30 grantees, but comments will not be attributed to specific individuals or programs. Staff members will not be quoted by name.

Do you have any questions before we get started?

A. PROGRAM AND COMMUNITY CONTEXT

1. How long have you been with this Head Start (or Early Head Start) program?
2. How many children are in your classroom? What are their ages (i.e. mixed-age classroom or one age group)?

OR

How many families do you work with as a home visitor?

3. Does your classroom operate a full-day session, or half-day sessions? [*N.B. Omit for home visitors*.]
4. How many other adults work in your classroom, such as teacher's assistants or parent volunteers? How often are they in the classroom (i.e., every day all day, 3 hours per week)? [*N.B. Omit for home visitors*.]
5. What percentage of children [in your classroom OR children in your home visiting caseload] speak a language other than English at home? What languages do they speak?
6. What percentage of children [in your classroom OR children in your home visiting caseload] have an IEP?

B. DESIGN AND PLANNING

Now I'd like to ask a few questions about your program's planning for the *IM/IL* enhancement.

1. What is your understanding of the goal(s) of the *IM/IL* enhancement in <u>your</u> program?
2. Were you involved in designing the *IM/IL* enhancement or providing any feedback?

IF YES: What role did you play? What specific ideas did you suggest?

3. What was your reaction to the idea of implementing an *IM/IL* enhancement? Were you excited, or hesitant? Why?

C. INITIAL LOCAL TRAINING

1. Do you recall receiving any <u>initial</u> training for implementing the *IM/IL* enhancement in your classroom?

IF NO: *Skip to question #2 below.*

IF YES:

Who provided the training?

When did the training(s) take place? [*Specific month(s) is adequate*.]

How long did it last (total hours/days)?

What was the format of the training? What topics were covered? Which types of activities were included? Lecture? Modeling? Role play? Group practice?

Were written materials distributed, such as a manual, curriculum, lesson plans, or list of resources to be used during implementation? If so, please describe.

Were you introduced to Choosy? Did you learn about how to incorporate the vocabulary of structured movement, etc. at the training?

Did you receive training on how to monitor progress made by children, such as classroom observations of structured movement or monitoring children's food intake?

Did you receive enough guidance on how to intentionally promote MVPA, structured movement, and healthy eating with children in your classroom? If so, what best prepared you to do this? If not, what would have been helpful or needed?

Was there an adequate amount of training for you? Why or why not? How could the training have been more helpful?

Do you have any suggestions for improving the initial local training for the IM/IL enhancement?

Skip to Section D below.

2. Since there wasn't a formal training, how did you prepare for implementing the IM/IL enhancement?

PROBE:

- Did you review any materials shared by staff who attended the regional TOT event? Was it required that you review these materials, or voluntary?

D. *IM/IL* ENHANCEMENT ACTIVITIES

Early Head Start and Home Visits

Note to interviewers: Please keep in mind that some grantees may be implementing the *IM/IL* enhancement among EHS children and/or families, as well as with children enrolled in the home-based option. Questions are geared towards classroom settings for the most part, as well as for 3- to 5- year olds. Questions should be modified according to the age group and the environment. For example, instead of asking about higher-level gross motor development such as throwing/catching a ball or hopping, you could ask about tummy time instead. Or, you could ask if expectant and new mothers learn about the benefits of breastfeeding.

1. What **MVPA** enhancement activities do you provide [in your classroom OR in children's homes]?

PROBES:

- Compared to what you were doing before *IM/IL* (or last year), did you begin or increase how much time you devote to MVPA? If so, about how many minutes or hours per day or week is spent on MVPA?
- Is this primarily "free" play that was child-directed, or group physical activities that you facilitated? Can you estimate the percentage of free play versus facilitated activities?
- What kinds of activities did you encourage? For example, throwing/catching balls? Traveling actions like walking or hopping? Dancing? Other? Did you need to provide more encouragement for certain activities? Which ones? How much encouragement did you provide?
- What kinds of equipment or materials were used (e.g., balls, swings)?
- How often are these physical activities scheduled in the classroom routine? Every day? Once a week? Once a month? *N.B. For home visitors, can prompt if it's addressed at each visit, once a month, etc.*
- Do you think this amount of time is too much, too little, or about right? Why?
- What kinds of structured MVPA activities do you facilitate? Can you give some examples of games or tasks? Did you participate in these activities? How frequently do you participate?
- Where do MVPA activities take place (e.g., indoors, playground, nearby park)?
- Do you promote MVPA to parents or other family members? If so, which activities take place? What information do you provide to parents about MVPA? How often do you provide information? How often do you promote MVPA?
- Do you teach children about their heart rate (heart beating with "Thank you, thank you, thank you")?

2. What **Structured Movement** enhancement activities do you provide in [your classroom OR in children's homes]?

PROBES:

- Compared to what you were doing before *IM/IL* (or last year), did you begin or increase the amount of time you devote to structured movement activities? If so, about how many minutes or hours per day or week is spent on structured movement?
- How often are structured movement activities scheduled in the classroom routine? Every day? Once a week? Once a month? Do you assess children's progress? How do you do this? How often do you assess children's progress? Do you share your findings with parents?
- What kinds of structured movement activities do you encourage? For example, movement activities while singing? During storytelling? Other? Can you give some examples of games or tasks? ? Did you need to provide more encouragement for certain activities? Which ones? How much encouragement did you provide? Did you participate in these activities? How frequently do you participate?
- Do you think this amount of time is too much, too little, or about right? Why?
- Where do structured movement activities take place?
- In (classroom routines or in homes), do you recall using vocabulary such as Action Awareness ("what my body can do"); Effort Awareness ("how my body moves"); Space Awareness ("where my body moves"); Relationship Awareness ("to myself, others, objects, like body parts or shapes")?
- If so, how is this reinforced? Songs? Giving instructions before or during a group activity? Other?
- Do you routinely use this vocabulary? Are children picking up and using this vocabulary?
- Do you provide information to parents about structured movement? What information do you provide? How frequently?
- Does anyone beside yourself provide structured movement activities for children? If so, who and how often? What kinds of movement activities?

3. What **Healthy Eating** enhancement activities do you provide in [your classroom OR in children's homes]?

PROBES:

- Compared to what you were doing before *IM/IL* (or last year), did you begin or increase the amount of time you devote to topics on healthy eating? If so, about how many minutes or hours are spent on healthy eating?
- How often are nutrition-related activities scheduled in the [classroom/home visiting] routine? Every day? Once a week? Once a month?
- Do you think this amount of time is too much, too little, or about right? Why?
- In (classroom routines or in homes), do you use different vocabulary and/or teach nutritional messages from Choosy or other sources, like Crave Your F.A.V.?

- Do you routinely use this vocabulary? Are children picking up and using this vocabulary?
- If so, how is this reinforced? Songs? Games? Other?
- Do you teach children about how to recognize which foods are good to eat? If so, how is this done and reinforced?
- Do you teach colors through healthy foods, or vice versa—teach about healthy foods through colors?
- Do you talk about healthy foods and encourage children to eat them at the family-style meals with children and staff? Do you model healthy eating choices for them?
- Do you encourage children to try different kinds of healthy foods? How often do you try this? Do the children require support/encouragement? How do you provide encouragement?
- Does anyone beside yourself teach children about healthy eating practices? If so, who and how often? What kinds of nutrition-related activities?
- Do you provide information to parents about healthy eating? What information do you provide? How frequently?

4. Do you use any materials and resources to implement the *IM/IL* enhancement? What are they? Did you purchase these materials and resources? Why did your program choose to purchase materials and resources?

PROBES:

- Choosy song sheets, CDs, videos, DVDs
- Choosy Action Plans (i.e., lesson plans) or activity sheets, such as the Open Space Activity Cards or the Creative Arts Activity Cards
- Lesson plans or activity ideas from other organizations, such as:
  - USDA's MyPyramid website
  - Fit WIC
  - Smart Moves activities books
  - SPARK Early Childhood Physical Activity curriculum
  - North Carolina's Color Me Healthy curriculum
  - National Association for Sport and Physical Education's brochure "101 Tips for Family Fitness Fun"

- Balloons, beanbags, balls ropes, scarves, foam noodles, balance beams, etc.
- Do certain materials or resources stand out as being really helpful, effective, or popular with children/parents? If so, what and why?

5. Have you made any of the materials by hand using the Choosy Homemade Toys & Props handout from the regional TOT event, or any other resources?

PROBES:

- For example, did you make a jump rope or balance beam out of bread bags?

- Use scarves for movement, coordination, and learning activities?
- Other?

6. Did you incorporate *IM/IL* enhancement activities into the existing curriculum?

PROBES:

- Have you integrated structured movement and MVPA activities into the existing curriculum? Have you incorporated movement activities into literacy and early math activities? Transitions? Other? If so, how did you incorporate movement and/or MVPA into the curriculum? If not, why? How often?
- Have you integrated healthy eating activities into the existing curriculum? Have you incorporated healthy eating activities into literacy and early math activities? Transitions? Other? If so, how did you incorporate healthy eating into the curriculum? If not, why? How often?

7. Do you modify the *IM/IL* enhancement activities for certain children in your classroom?

PROBES:

- For children whose home language is something other than English?
- For children with IEPs or IHPs?
- Have you consulted any special resources for directing the *IM/IL* enhancement to these children? If so, which one(s)? Were these resources helpful?
- How do you encourage children to participate? How often do you do this?

8. How common is the problem of overweight among the children [in your classroom or on your caseload]? Do you have concerns about the weight of any children [in your classroom or on your caseload]?

PROBES:

- What percentage of children would you say are overweight?
- Do these children seem embarrassed by their weight? How can you tell?
- Have you ever spoken to their parents about your concerns about the children's weight? If so, how did you bring up the subject, and what did you talk about? How did they react?
- Was it awkward to talk to them about their child's weight, and if so, why?
- If you have not spoken to these parents about your concerns, why not?

9. How common is the problem of underweight among the children in your classroom/caseload? About what proportion of children are underweight?

10. How common is it for children in your classroom/caseload to not consume enough healthy foods? About what proportion of children do not consume enough healthy foods?

11. How common is sedentary behavior (i.e. little or no physical activity) among the children in your program, such as high levels of television viewing or living in a place that is not conducive to outside play? About what proportion of the children have limited physical activity outside of Head Start?

12. Do you see yourself as a role model for children to teach them about the importance of physical activities and healthy eating? Why or why not?

PROBES:

- Has the *IM/IL* enhancement changed any aspects of your own behaviors and/or with your own family related to diet and physical activity? For example, less television watching, more exercise, better nutrition? If so, which ones?
- Has the *IM/IL* enhancement provided any motivation or incentives (e.g., staff challenges with prizes) for you to change your own health behaviors related to diet and physical activity?
- Is it difficult for you to speak with parents about obesity prevention? If so, why?
- Is there a way in which you think you could be a better *IM/IL* role model?

13. Were there any factors that hindered MVPA, structured movement, or healthy eating activities in the past (e.g., inadequate indoor space during inclement weather, no time in schedule)?

E. OUTREACH TO PARENTS

1. What outreach strategies were used to promote the *IM/IL* enhancement to families?

PROBES:

- How, if at all, did you <u>first</u> communicate with families about your *IM/IL* enhancement?
- How did parents initially react? Were they excited, or hesitant? Why?

2. Have there been any parent education activities centered on the *IM/IL* enhancement?

IF YES: Did you have a role? If so, what did you do? Were activities targeted at improving children's behaviors related to physical activity and healthy eating, parents' behaviors, or both? When did these activities take place? For how long (length and frequency)? Who conducted the activities? Were parents engaged? Will there be additional activities and support for parents? If so, please describe.

IF NO: Why not? Parent activities are not part of your program's *IM/IL* goals? No time? Lack of interest among parents?

3. Do you do anything to encourage parents to make healthy food choices, or educate them about good nutrition in general? If so, what? How often does this occur?

PROBES:

- Was this targeted at improving children's behaviors related to healthy eating, parents' behaviors, or both?
- Do you use different vocabulary and/or teach nutritional messages from Choosy or other sources, such as Crave Your F.A.V., Shop the Sides, or Think Tiny Tummies? If so, how was this enforced?

4. To what extent are parents reinforcing components of the *IM/IL* enhancement at home? How can you tell?

PROBES:

- Do home visitors incorporate *IM/IL*-related activities into the home visits?
- Do group socializations reinforce the *IM/IL* messages? How often are IM/IL topics incorporated into group socialization activities? How many targeted parents attend socialization activities?
- Do you informally discuss or conduct informal surveys with parents about what they eat or how much they exercise?
- Other?

F. ONGOING TECHNICAL ASSISTANCE AND CAPACITY BUILDING

1. Have you received any <u>ongoing</u> training and/or technical assistance to support the *IM/IL* enhancement?

PROBES:

- What kind of support do you receive? How often do you receive this training?
- Who provides the T/TA? Your education coordinator? Head Start content specialists? Other outside experts?
- What topic(s) are covered? How often is T/TA provided?
- Is this T/TA helpful? Why or why not?
- Do you use the e-mail distribution list created by Region III for those who have attended *IM/IL* training events? If yes, how often? Is this distribution list helpful, and if so why? If you don't use the distribution list, why not? (The purpose of this list is to distribute resources by e-mail to *IM/IL* grantees for the purposes of sharing successful strategies, stories, and feedback among grantees. It is maintained and monitored by the Region III TA Health Specialist.)

2. Is there any additional training or support you need but have not received yet?

IF YES: What types of support do you need? Are there specific plans in place to meet these support needs?

3. Are you tracking *IM/IL* implementation? Are you measuring any child outcomes like aspects of children's movement or diet?

IF YES: Did you develop your own assessment or monitoring tools? Borrow tools from other sources (e.g., use the observation forms shared at the regional TOT event?

What specific items do you track? For example, does someone compute BMI? How often? Do you do anything with this information?

Do you observe progress made in structured movement using Choosy Assessment of Motor Patterns (CAMP) tools?

Other measurements or tracking activities?

How often do these activities take place?

Have you used the results of these assessments to inform individual or group education and/or health goals? If so, how? If not, why not?

IF NO: Why not? Are there any plans in place to do so in the future?

G. SUSTAINABILITY AND RESOURCES

1. Have you been able to implement enhanced *IM/IL* activities in your classroom as planned?

IF NO: How has actual implementation differed from your initial plans? In actual activities? Duration? Intensity? In who receives services? What caused a change from the original vision of what the *IM/IL* enhancement would look like in your classroom?

2. How do you reinforce *IM/IL* goals and go about getting <u>ongoing</u> buy-in from parents? In other words, how do you keep the momentum moving forward?

PROBES:

- Did you incorporate *IM/IL* goals into children's IEPs? Children's IHPs?
- Have you shared information about *IM/IL* with the families' health care professionals, or your local WIC program, such as a description of planned activities or any data collected?

3. How receptive have families been to participating in the *IM/IL* enhancement over time?

4. Have you observed or experienced challenges in getting children or families to do any of the activities? How many families participate? Are they the same families? What challenges have you experienced? (For example, if you invite parents to cooking classes to teach family members about easy-to-prepare, nutritious meals, do they attend?) This could include questions having to do with if the program is observing challenges (or successes) in having the children/parents change their behavior.

   PROBES:

   - Did you expect these challenges? What factor(s) affect some families participating more than others? Is your program doing anything to encourage participation?
   - What factor(s) prevent higher activity levels?
   - Have you or the program used any strategies to encourage participation over time?

H. INITIAL SUCCESSES, CHALLENGES, AND LESSONS

1. What have been the most important successes of the *IM/IL* enhancement so far?

PROBES:

- Can you give an example?
- What factor(s) led to that success?

2. What are the most significant implementation challenges associated with the *IM/IL* enhancement so far?

PROBES:

- What strategies have you used to address these challenges?
- How well do you think these strategies worked?

3. What aspects of the *IM/IL* enhancement do <u>children</u> like the most? What do they like the least?

4. What aspects of the *IM/IL* enhancement do <u>families</u> like the most? What do they like the least?

5. What aspects of the *IM/IL* enhancement do <u>you</u> like the most? What do you like the least?

6. What changes, if any, do you think should be made to the *IM/IL* enhancement?

PROBE:

- Changes in scope Activities? T/TA? Staffing? Involvement of outside organizations or experts? Other?

7. What advice would you give to another Head Start program that is thinking about implementing an *IM/IL* enhancement like the one at your program?

WRAP-UP

Is there anything else you would like to add before we end the discussion?

N.B. MPR should have already received a set of documents from the program in advance of the telephone call, such as daily classroom schedules (pre- and post- spring 2006 TOT event) and templates of any assessment tools. If we have not received them, then ask for specific outstanding items as appropriate.

Thank you very much for speaking with me and sharing your experiences and feedback on the *IM/IL* enhancement at your program.

APPENDIX C

STAGE 3 DIRECTOR/PROGRAM MANAGER INTERVIEW GUIDE

Region III Head Start Administration for Children and Families

Evaluation of the *I Am Moving, I Am Learning* Enhancement

Site Visit Interview Guide for Directors and Program Managers
Fall 2007
(Estimated interview time: 90 minutes)

INTRODUCTION

Thank you for taking the time to speak with me today. My name is [X], and I am a [TITLE] with Mathematica Policy Research, Inc. (MPR), a nonpartisan research firm that has extensive experience conducting both early childhood and nutrition research. The Office of Planning, Research, and Evaluation (OPRE) under the Administration for Children and Families (ACF) has contracted with MPR to conduct an implementation evaluation of the *I Am Moving, I Am Learning* enhancement (*IM/IL*) in Region III. This study will examine to what extent grantees are implementing *IM/IL* after attending the spring 2006 Regional Training of Trainers (TOT) events.

During this interview, we will be following up on the information you shared with us during the survey conducted in winter 2007 and the telephone interview conducted in spring 2007. We will also want to discuss how *IM/IL* is being implemented this program year; what changes were made after year 1; how these changes were implemented; how you are working to affect intermediate outcomes; what initial successes and challenges have been encountered; and your plans for sustaining the *IM/IL* enhancements. As part of this evaluation, we are now conducting site visits to 16 grantees. During the visits, we will be talking to program directors, program managers, teachers, and parents.

During our conversation, I would like to hear about your experiences with *IM/IL*, and will also ask you your opinions. Everything you say will be kept private to the extent permitted by law. The information we gather will be used to write a report about programs' experiences implementing *IM/IL* activities, including their successes, challenges, and lessons learned. Our report will describe experiences and views expressed by staff across grantees, but comments will not be attributed to specific individuals or programs. Staff members will not be quoted by name.

Do you have any questions before we get started?

RESPONDENT INFORMATION

To begin, could you describe your position and the role you have played in the *I am Moving, I am Learning* (*IM/IL*) enhancement?

PROBES:

- What is your current position?
- How long have you held your current position? What other positions have you held within the agency?
- Did you attend the spring 2006 Training of Trainers?
- Did you play a major role in getting *IM/IL* implemented?
- Are you still playing that same role?
- What are your primary responsibilities associated with the *IM/IL* enhancement?

A. PROGRAM UPDATE

1. Since the telephone interview in spring 2007, have there been any significant changes to your program structure or management?

2. Since spring 2007, have there been any significant changes to the way that your program is staffed?

3. Since spring 2007, have there been any significant changes in the characteristics of the families and children your program serves?

4. How common is the problem of overweight among children in your program? About what proportion of children are overweight?

5. How common is the problem of underweight among children in your program? About what proportion of children are underweight ?

6. How common is it for the children in your program to make food choices that make it difficult to maintain a healthy weight? About what proportion of the children make these kinds of food choices?

7. How common is sedentary behavior (i.e. little or no physical activity) among the children in your program, such as high levels of television viewing or living in a place that is not conducive to outside play? About what proportion of the children have limited physical activity outside of Head Start?

8. Of the health problems affecting children in your program, how would you rank these three conditions?: __ Asthma, __ Obesity, and __ Oral Health (tooth decay and cavities)?

NOTE: "1" IS THE MOST IMPORTANT PROBLEM, AND "2" IS THE SECOND MOST IMPORTANT PROBLEM, AND "3" IS THE THIRD IMPORTANT PROBLEM.

B. THEORY OF CHANGE

In spring 2007, we talked with you about your program's goals, the *IM/IL* enhancements your program implemented, the outcomes your program aimed to achieve, and how you measured those outcomes. Here is a summary of the information we obtained:

INTERVIEWER INSERT INFORMATION FROM SURVEY AND SPRING 2007 PHONE INTERVIEW: (note: if the IMIL coordinator is new, confirm information gathered from old IMIL coordinator and ask about any changes.)

Behavioral Goals:

Implementation Strategies:

Program Enhancements:

Intermediate Outcomes:

Child Outcomes:

Does this information seem accurate to you?

Through the course of the interview, we will review this information, noting any changes you made this program year. We will also discuss in more detail the facilitators and barriers to implementation faced by your program, your plans for sustainability, and your advice for the other Head Start programs interested in implementing an *IM/IL* enhancement.

Behavioral Goals:

1. In spring 2007, your program defined its main goal(s) for *IM/IL* as [INTERVIEWER INSERT GOALS]. Are there any additional goals you <u>initially</u> defined?

2. Has/have the main goal(s) of *IM/IL* in <u>your</u> program changed over time?

IF YES, ASK:

- How?
- Why did your goal(s) change?

IF NO, ASK:

- Why not?

3. In spring 2007, your program reported the following as to how you identified *IM/IL* goals and objectives, determining who to target, and deciding which activities to provide/promote: [INTERVIEWER INSERT INFORMATION]. In your opinion,

how successful were these strategies in helping you design your program's *IM/IL* enhancements? Why?

4. Did your program employ any new strategies to revise your *IM/IL* goals and objectives, whom you are targeting, and which activities to provide/promote this program year?

IF YES, ASK:

- Since spring 2007, have you conducted a needs assessment? If so, who did you consult?
- Has the intended target audience of your *IM/IL* enhancement changed? If so, why did your program decide to make this change?
- Did you strategically decide to focus on just one or two of the three targeted *IM/IL* goals? Is this different from your focus in spring 2007? If it is, why did you change your focus?

5. In spring 2007, your program reported [INTERVIEWER INSERT BEHAVIOR CHANGES] as the specific behavior changes you hoped to influence through *IM/IL*. Have these changed over time?

IF YES, ASK:

- How have they changed? What are the primary behaviors you currently hope to change through your *IM/IL* enhancement? For example, increase exercise levels among staff and families? Encourage children and families to switch from whole milk and reduced-fat milk (2 percent) to low-fat milk (1 percent) and skim milk, for age-appropriate groups?
- Why did you make these changes?

6. Who is the target audience for this behavior change? Teachers/home visitors? Other staff? Children? Parents? Other?

7. How successful do you think your program has been in achieving these behavior changes?

PROBES:

- How do you track your program's progress toward achieving these behavior changes?
- How have you encouraged these behavior changes?
- Are these behavior changes similar across goals (i.e., MVPA, structured movement, and nutrition) or was one area more successful? How do you know this?
- Have these behavior changes been more challenging to achieve than you initially expected, or less? Why?

Implementation Strategies:

8. Since spring 2007, have you consulted with other organizations in the community or sought advice from experts to help design/redesign your program's *IM/IL* enhancement, such as local universities, dietitians, or nutritionists?

IF YES, ASK:

- Did you consult with these organizations on the *IM/IL* enhancement before spring 2007?
- How and why did you approach them?
- Were they eager to participate, or did they have reservations?
- Who was involved in the design phase?
- Do you plan to continue to consult with them in the future? Why or why not?

9. In spring 2007, your program reported [INTERVIEWER INSERT THOSE INVOLVED IN *IM/IL* DESIGN] was involved in your *IM/IL* enhancement design. Does your program continue to work with these people on *IM/IL* implementation?

PROBES:

- How has their role changed since spring 2007?
- How important was their involvement to the initial design of the *IM/IL* enhancements? Would you have been able to design the *IM/IL* enhancement without these staff?
- How essential has their involvement been to any changes to the design you have made since the initial design?
- Do you plan to continue to work with them on the *IM/IL* enhancement in the future? Why or why not?

10. Have you consulted with any other of the following about your *IM/IL* design? What role did they play?

- Region III Head Start staff
- Head Start-State Collaboration Office
- Your TA Specialist and/or a Content Specialist
- Your Health Services Advisory Committee
- Policy Council or families as a whole
- *IM/IL* listserv set up by Region III
- A consultant such as a nutritionist, dietitian, or obesity prevention expert
- How important has their involvement been to the design and/or redesign of the *IM/IL* enhancements? Would you be able to design the *IM/IL* enhancement without these staff?
- Do you plan to continue to work with them on the *IM/IL* enhancement in the future? Why or why not?

INTERVIEWER, IF PROGRAM DEVELOPED A WRITTEN PLAN FOR IMPLEMENTATION ASK QUESTION #12. IF PROGRAM DID NOT HAVE A WRITTEN PLAN, SKIP TO QUESTION #13.

11. Has the written plan for implementation developed by your program changed since spring 2007? (including if the program now has a written plan)

IF YES:

- Why did you make these changes? Why did you decide to develop a written plan?
- Who wrote the plan?
- Was this plan approved by the Policy Council? By the Health Services Advisory Committee? Other?

INTERVIEWER, IF PROGRAM WAS USING A CURRICULUM ASK QUESTION #13. IF PROGRAM DID NOT USE A CURRICULUM, SKIP TO QUESTION #14.

12. In spring 2007, your program reported using [INSERT CURRICULUM]. Does your program still use this curriculum?

PROBES:

- What percentage of classrooms in your program have implemented this curriculum? How do you, if all, monitor teachers' use of the curriculum?
- How essential has this curriculum been to your program's *IM/IL* enhancement?
- What do you like and dislike about this curriculum?
- Will you continue to use this curriculum in the future? Why or why not?

13. Since spring 2007, has your program selected a specific curriculum to support *IM/IL* efforts? Have you changed curricula since spring 2007? If so, why did your program decide to make this change?

IF YES: Which curriculum are you using? Was it designed by an outside vendor or internal staff? Are you using the curriculum in its entirety or certain parts of it? Is it a stand-alone curriculum, or did you modify/supplement your primary Head Start curriculum?

14. Since spring 2007, have teachers [and home visitors] continued to incorporate IM/IL activities into the regular Head Start curriculum? How do they do this? For example, is movement and/or healthy eating integrated into literacy or early math activities? Are transitions more physically active? Do you have any plans to change your program's approach to integration of *IM/IL*?

15. Since spring 2007 have you developed a manual, reference guide, lesson plans, or similar items for *IM/IL?* If previously developed, have you made changes since spring 2007? If so, why did your program decide to make this change?

16. Did your program take into account children with IEPs or IHPs in designing the *IM/IL* enhancement?

IF YES: How was this accomplished? Have you had to make any adjustments since spring 2007? If so, why?

17. Did your program take into account English Language Learners in designing the *IM/IL* enhancement?

IF YES: How was this accomplished? Have you had to make any adjustments since spring 2007? If so, why?

18. Did your program take into account cultural preferences and/or special dietary needs of children, families, and/or staff in designing the *IM/IL* enhancement?

IF YES: How was this accomplished? Have you had to make any adjustments since spring 2007? If so, why?

19. Did your program need to acquire materials, equipment, and/or incentives to implement the *IM/IL* enhancement? Has your program acquired any new materials, equipment, and/or incentives since spring 2007? If so, why did you decide to make the change?

IF YES: Which kinds of items (music cassettes/CDs, coloring books, videos/DVDs, posters, scales, growth charts, cookbooks, jump ropes, exercise mats, balls, other toys that encourage movement, etc.)? Were these items purchased or donated? Are they available for use at the centers only, or can families borrow them through a lending library?

20. What resources were <u>most</u> helpful to you in designing *IM/IL*? Why were they helpful? Have the resources that are most helpful to you changed over time? If so, why?

21. Would additional technical assistance or other resources have been helpful in designing your *IM/IL* enhancement? If so, what specifically? Have the types of technical assistance and resources that you thought would be most helpful to you changed over time? If so, why?

22. What were the most challenging aspects of the design and planning process? What went smoothly?

23. What lessons did you learn during the design and planning phase? Would you have done anything differently?

C. STAFFING

Now I'd like to learn more about the staff that are directly involved in implementing your *IM/IL* enhancement and any changes you have made since spring 2007.

1. Do you provide any encouragement for staff to participate in IM/IL activities?

2. Has the number of other staff that work on the *IM/IL* enhancement changed since spring 2007?

IF YES, ASK:

- How many staff were added to work on the *IM/IL* enhancement since spring 2007?
- Did these staff replace the staff that worked on the *IM/IL* enhancement in spring 2007? If so, why were staff replaced?
- Did you add other staff? If so, why were other staff added?

3. Has there been a change in how receptive staff are to implementing the *IM/IL* enhancement? Are staff more receptive or less receptive now than they were in spring 2007?

IF YES (MORE RECEPTIVE/LESS RECEPTIVE), ASK:

- What do you attribute this change to?
- If they were hesitant or had concerns, what were their concerns and how did you address them? Has this changed from how you addressed staff previously? Why did you make this change?
- Have staff voiced any concerns about being overweight themselves in terms of being role models or participating with children in structured movement activities? If so, how did you address these concerns? Have these concerns become more or less prevalent since your program started implementing *IM/IL?*

4. We want to know to what extent your staff endorses the IM/IL enhancements your program is trying to implement. On a scale of 1 to 5, where 1 would be "resistant" and 5 "enthusiastic," how would you rate your staff's interest in the following:

- Moderate to vigorous physical activity
- Structured movement
- Healthy nutrition
- IM/IL overall

5. Since spring 2007, has your program experienced staff turnover that has affected *IM/IL* implementation?

IF YES: How? What strategies is your program using to address this turnover? Have these strategies changed since spring 2007? If so, why?

6. How well is the staffing structure for IMIL working so far? How well are any changes you made since spring 2007 working so far?

PROBES:

- Are there sufficient staff resources to implement *IM/IL*?

- If you could, would you change the staffing structure? If so, how and why?
- How important do you think the staffing structure you selected has been for implementation? Very important? Somewhat important? Not at all related? Why?

7. IF OUTSIDE ORGANIZATIONS PROVIDED STAFF IN SPRING 2007, ASK: Are outside organizations/community partners continuing to provide staff for the *IM/IL* enhancement?

   IF YES, ASK:

   - Have there been any changes to their job titles since spring 2007?
   - Have their main duties changed since spring 2007? If so, why did you make these changes?
   - How important are these staff to the functioning of the *IM/IL* enhancements? Would you be able to implement the *IM/IL* enhancement without these staff?
   - Do you plan to continue to work with these outside organizations on the *IM/IL* enhancement in the future? Why or why not?

   IF NO, ASK:

   - Why are outside organizations no longer providing staff?
   - Are you going to replace these staff with staff from other organizations? If no, why not?
   - How important were these staff to the functioning of the *IM/IL* enhancements? Are you be able to implement the *IM/IL* enhancement without these staff?

8. IF OUTSIDE ORGANIZATIONS WERE NOT PROVIDING STAFF IN SPRING 2007, ASK: Do any outside organizations/community partners provide staff for the *IM/IL* enhancement?

   IF YES, ASK:

   - What are their job titles and main duties?
   - Why did you decide to add these staff?
   - How important are these staff to the functioning of the *IM/IL* enhancements? Would you be able to implement the *IM/IL* enhancement without these staff?
   - Do you plan to continue to work with these outside organizations on the *IM/IL* enhancement in the future? Why or why not?

D. TRAINING AND TECHNICAL ASSISTANCE AND CAPACITY BUILDING

The next several questions address the types of training and technical assistance your program provides staff and other capacity-building activities.

1. How important do you think ongoing training and technical assistance are to the implementation of *IM/IL*? To long-term sustainability of *IM/IL*? Why?

2. Have staff received formal training on the *IM/IL* enhancement since spring 2007?

IF NO: Why not? SKIP TO QUESTION #3

IF YES: Who provided the training? Did you bring in outside staff to do it?

When was the training provided? During pre-service training? As an in-service?

How many and which types of staff participated? Only new staff? All staff?

How long did it last?

What was the format of the training? What topics were covered? Which activities types of were included? Lecture? Modeling? Breakout sessions? Role play?

Were written materials distributed, such as a manual, a curriculum, a lesson plan, or a list of resources to be used during implementation? If so, please describe the materials.

Did you train staff on how to monitor progress made by children, such as observations of structured movement or tracking of body mass index and height/weight?

Which part(s) of the training did staff find most helpful, and why?

Was there anything about the training that wasn't helpful? If so, why?

Was this training similar to the training you provided in the past? If not, how was it different? Why did you decide to make these changes?

SKIP TO QUESTION #4

3. Since there hasn't been a formal training since spring 2007, did staff receive any special preparation to implement the *IM/IL* enhancement?

PROBES:

- Did you share the materials from the TOT event with staff? Which staff? Was it required that they review it, or was it voluntary? When did you share these materials?

4. Do you plan to offer local training for staff on the *IM/IL* enhancement? If so, who will be trained and what will be covered? When will the training take place, and how long will it last? If you don't plan to offer an initial training, why not?

5. Were new staff trained on the *IM/IL* enhancement since spring 2007?

IF NO: Why does your program not provide training for new staff?

IF YES:	Who developed the training activities? Who provided the training? When was the training provided? During pre-service training? As an in-service? With all staff? With only new staff? How long did it last? What was the format of the training? What topics were covered? Which activities types of were included? Lecture? Modeling? Breakout sessions? Role plays? Were written materials distributed, such as a manual, a curriculum, a lesson plan, or a list of resources to be used during implementation? If so, please describe the materials. Did you train staff on how to monitor progress made by children, such as observations of structured movement or tracking BMI and height/weight? Which part(s) of training did staff find most helpful, and why? Was there anything about the training that wasn't helpful? If so, why?

6. Does your program have ongoing training and/or technical assistance to support the *IM/IL* enhancement?

IF NO: Why does your program not provide ongoing training and/or seek TA? Did your program ever provide ongoing T/TA? If so, why did you discontinue it?

IF YES: What kind of support do staff receive?

What topic(s) are covered? How often is T/TA provided?

Which staff get trained on these topics? How many staff?

Who delivers the T/TA? Head Start regional specialists? Outside experts?

Is this T/TA helpful? Why or why not?

How frequently are these *IM/IL* topics included during in-service days?

Approximately when was the last time one of these topics was included in a staff development activity?

What was the topic of that training?

Does your program participate in the listserv created by Region III for those who have attended *IM/IL* training events? If yes, who accesses the listserv? How often? Is the listserv helpful, and if so why? If your program doesn't use the listserv, why not?

Has the type of T/TA your program provides changed over time? If so, how has it changed? Why did you make these changes?

7. Did you include T/TA on *IM/IL* enhancements on your current T/TA plan? Why or why not? Did you allocate any of your T/TA budget for *IM/IL*? If so, how much? (*Estimate ok*)

8. In spring 2007, you reported [INTERVIEWER INSERT WAYS PROGRAM MONITORED AND SHARED FEEDBACK] as ways your program planned to monitor and share, or was monitoring and sharing, feedback from staff or parents. Is your program going to continue to use these strategies this program year? Why or why not? How do you use this information? How do you plan to use it in the future?

9. In spring 2007, you reported [INTERVIEWER INSERT ADDITIONAL TRAINING AND SUPPORT THAT STAFF NEED] as additional training and support that staff needed. Have you been able to meet these needs?

IF YES: How have you met these needs? Were outside organizations/regional office staff/regional TA network staff/others involved?

IF NO: Why weren't you able to meet these needs? What supports/resources would your program have needed to meet these needs?

10. Do staff need any additional training or support that they have not yet received?

IF YES: What types of support do they need? Are there specific plans in place to meet these support needs?

E. *IM/IL* ENHANCEMENT ACTIVITIES

In this section, let's talk about the *IM/IL* enhancement activities targeted toward staff and children that your program has implemented since attending the TOT events.

1. How did your program plan to achieve the behavior changes? Has your approach changed since spring 2007? If so, why did you make these changes?

PROBES:

- Change teacher practices, curriculum
- Supplemental activities (type or intensity, such as add/increase MVPA)
- Change classroom/outdoor environment (such as materials, play equipment)
- Change menu planning
- Change home environment

2. In spring 2007, your program reported instituting the following new policies to support your *IM/IL* enhancement: [INTERVIEWER INSERT PRIORITIES]. Are these policies still in place?

IF YES: Have you changed any of these policies? If, so how? Why did you decide to make these changes?

Does your program track adherence to these policies? If so, how?

How successful have you been in implementing these policies? What barriers have you faced in implementing them? If barriers exist, how did you over come them?

Do you plan to continue to institute these policies in the future? Why or why not?

IF NO: Why are you no longer instituting these policies?

Did you face barriers that prevented you from instituting these policies? Did you try to overcome these barriers? If so, how? Why were you not able to overcome these barriers?

3. In spring 2007, your program reported instituting the following new policies targeted at families to support your *IM/IL* enhancement: [INTERVIEWER INSERT PRIORITIES]. Are these policies still in place?

IF YES: Have you changed any of these policies? If, so how? Why did you decide to make these changes?

Does your program track adherence to these policies? If so, how?

How successful have you been in implementing these policies? What barriers have you faced in implementing them? If barriers exist, how did you over come them?

Do you plan to continue to institute these policies in the future? Why or why not?

4. What new policies, if any, did your program institute since spring 2007 to support your *IM/IL* enhancement? Why did you decide to institute these policies? Does your program track adherence to these policies? If so, how? How successful have you been in implementing them? What barriers have you faced in implementing these policies? How did you overcome them?

PROBES:

- Require that children engage in a targeted amount of MVPA each week? If so, how much physical activity? Is this the same amount for different ages?
- Require that teachers incorporate guided, structured movement activities for certain amount of time each day or week?
- Require that your nutrition staff reexamine your menu planning and foods offered and implement new food purchasing or preparation guidelines?
- Require that families attend trainings on healthy eating and physical activity?
- Other policy changes?

5. In spring 2007, you reported that the following outside organizations provided resources for your *IM/IL* enhancement: [INTERVIEWER INSERT OUTSIDE ORGANIZATIONS AND TYPES OF SERVICES/RESOURCES/SUPPORTS]. Do any other outside organizations provide resources?

PROBES:

- Are these organizations continuing to provide resources? Have the types of services/resources/supports changed over time?

- When did the outside organizations begin providing resources?
- Do have formal agreements with these organizations? (*If formal agreement, request a copy*.)
- Did you work/partner with these organizations prior to *IM/IL*?
- What aspects of these partnerships have worked well, and what aspects have been challenging? Has this changed over time? If so, how?
- What strategies have you and your partners used to work through these strategies? How well have these strategies worked?
- How important were these partnerships to the functioning of the *IM/IL* enhancements? Are you be able to implement the *IM/IL* enhancement without these staff?
- Do you plan to continue to work with these organizations on your *IM/IL* enhancement in the future? Why or why not?
- Based on your experiences implementing *IM/IL*, are there other types of partners/ organizations that would have been helpful? If so, what types of partners/ organizations and why?

6. In spring 2007, you reported that your program was providing the following activities:

   INTERVIEWER INSERT SPRING 2007 ACTIVITIES:

   Are you still providing these activities?

IF NO: What has prevented you from continuing to provide these activities?

IF YES:	What percentage of [centers/classrooms/home visitors] are implementing this area of *IM/IL*? How does your program track or monitor implementation? What has facilitated implementation? What barriers have you faced in implementing these activities? What strategies did you use to overcome these barriers? Will you continue to implement these activities in the future? Why or why not?

7. There are many challenges your program may have faced while trying to implement IM/IL activities. How would you rate the success of your program in implementing the following on a scale of 1 to 5, where 1 would be "not at all successful" and 5 is "extremely successful":

   - Moderate to vigorous physical activity

- Structured movement
- Healthy nutrition
- IM/IL overall

8. Have there been any changes to the activities your program implemented? If so, please describe the changes. Why did you make these changes?

IF YES:	Who decided to make these changes? Did you consult with staff, families, or staff from outside organizations about these changes? What percentage of [centers/classrooms/home visitors] have implemented these changes? How does your program track or monitor implementation? On a scale of 1 to 5, where 1 would be "low," and 5 would be "high," how would you rate the degree of implementation overall, vis-à-vis the way you envisioned it when you planned these changes? For MVPA? For structured movement? For nutrition?

9. Did you succeed in modifying *IM/IL* activities for children with disabilities? For children/families for whom English is not the primary home language? For families in the home-based option (if applicable)? What challenges did you face making these modifications?

INTERVIEWER, IF PROGRAM REPORTED PROVIDING IM/IL ACTIVITIES FOR STAFF, ASK QUESTION #10. IF PROGRAM DID NOT REPORT PROVIDING IM/IL ACTIVITIES FOR STAFF, ASK QUESTION #11.

10. In spring 2007, your program reported providing the following *IM/IL* activities for staff [INTERVIEWER INSERT ACTIVITIES]. Is your program still providing these activities?

PROBES:

- How receptive have staff been to these activities? How do you know?
- Have there been barriers to staff participation in these activities?
- Are you going to continue to provide/promote these activities in the future? Why or why not?

11. In Spring 2007, your program reported that you were not providing IM/IL activities for staff. Are you now?

INTERVIEWER, IF PROGRAM REPORTED PROVIDING SPECIAL INCENTIVES OR REWARDS FOR MEETING BENCHMARKS, ASK QUESTION #12. IF PROGRAM DID NOT REPORT SPECIAL INCENTIVES OR REWARDS FOR MEETING BENCHMARKS, ASK QUESTION #13.

12. In spring 2007, your program reported [INTERVIEWER INSERT REWARDS/INCENTIVES] as special incentives or rewards your program offers for meeting certain benchmarks. Are you still providing these rewards and/or incentives? Why or why not? How useful do you think these rewards/incentives have been to increasing buy-in among staff? Parents?

13. In Spring 2007, your program reported that you were not providing special incentives or rewards for meeting benchmarks. Are you now?

F. OUTREACH

In this section, let's talk about the outreach activities your program implemented that targeted parents, families, and community members.

ASK QUESTION #1 IF PROGRAM IDENTIFIED OUTREACH STRATEGIES IN SPRING 2007.

IF PROGRAM DID NOT IDENTIFY OUTREACH STRATEGIES IN SPRING 2007, PROCEED TO QUESTION #2.

1. In spring 2007, your program reported using the following outreach strategies to promote your program's *IM/IL* enhancement: [INTERVIEWER INSERT OUTREACH STRATEGIES]. Are you still using these outreach strategies?

IF YES:

- Have you changed any of these outreach strategies? If, so how? Why did you decide to make these changes?
- How successful have these outreach strategies been? How do you track how successful these strategies have been? What barriers have you faced in implementing these strategies? If barriers exist, how did you over come them?
- Do you plan to continue to use these outreach strategies in the future? Why or why not?

IF NO:

- Why are you no longer using these strategies?
- Did you face barriers that made these outreach strategies less useful than expected? Did you try to overcome these barriers? If so, how? Why were you not able to overcome them?
- Are there resources/supports that would have made these outreach strategies more successful?

2. Since spring 2007, have you used any (new) outreach strategies to promote your *IM/IL* enhancement? Why did you make these changes?

3. In spring 2007, your program reported providing parents with information about healthy eating and physical activity in the following ways [INTERVIEWER INSERT WAYS PROGRAMS PROVIDED INFORMATION TO FAMILIES]. Is your program continuing to provide this information? Why or why not?

PROBES:

- How successful have these types of information been?
- How have parents responded to the information you provided? How receptive have parents been to the information? How can you tell?

4. In spring 2007 your program reported providing the [INTERVIEWER INSERT PARENT ACTIVITIES] activities for parents. Is your program still providing these activities? Why or why not?

PROBES:

- How successful were these events? How many parents participated/attended? What did your program do to encourage participation? Provide incentives? Provide child care? Provide transportation? Other?
- How receptive have parents been to the information provided at these activities? How can you tell?

G. MEASURING OUTCOMES

1. In spring 2007 your program reported using the following tools and procedures to track *IM/IL* implementation and measure outcomes: [INTERVIEWER INSERT INFORMATION]. Have there been any changes?

2. How often do these assessments take place?

3. Have staff used results of any assessment data to inform individual or group education and/or health goals? If so, how? If not, why not?

4. Did you use this information to inform program planning for this program year? If so, how?

5. How to do you plan to use this information in the future?

H. SUSTAINABILITY AND RESOURCES

1. What do you think is the future of your *IM/IL* enhancement?

PROBES:

- At this point, how long do you see the *IM/IL* enhancement continuing?
- Does your program have plans to continue the enhanced services at the current levels, expand services, or reduce services in the future?
- Which barrier(s), if any, could prevent the continuation of the *IM/IL* enhancement? Funding? Staff? Interest?

2. How do you reinforce *IM/IL* goals and go about getting <u>ongoing</u> buy-in from staff? Parents? Community organizations? In other words, how do you keep the momentum moving forward?

PROBES:

- Have you shared information about *IM/IL* with the families' health care professionals, such as a description of planned activities or any data collected? Why or why not?
- Have you shared information about *IM/IL* with Part B providers, such as a description of planned activities or any data collected? Why or why not?

3. Did you incorporate *IM/IL* goals into Family Partnership Agreements? Community Partnership Agreements? Children's Individual Education Plans (IEP)? Children's Individual Health Plans (IHP)? Ongoing T/TA plans and/or Quality Improvement Plans (QIP)? If so, will these be permanent changes? Why or why not?

4. Will *IM/IL* enhancement activities become a permanent part of pre-service and/or in-service training? Why or why not?

5. Has your Health Services Advisory Committee changed the way it addresses obesity prevention and health promotion since your *IM/IL* enhancement began? If so, how?

6. How receptive have Head Start staff, families, and community partners been to participating in the *IM/IL* enhancement over time?

7. Has there been a change in the level of staff commitment to the *IM/IL* enhancement? Is it higher, lower, or about the same since the spring 2006 TOT event/since implementation began?

8. Have you observed or experienced challenges in getting targeted audiences to do any of the activities? For example, if you sponsor cooking classes to teach family members about easy-to-prepare, nutritious meals, how many people attend?

   PROBES:

   - Among staff: How does service delivery vary, and why? If some staff are doing far less than others, how is this being addressed?
   - Among children/families: What factor(s) cause some families to participate more than others? Is your program doing anything to encourage participation?
   - What factor(s) prevent higher activity levels? Do staff have little time? Which activities have staff noted are difficult to do? Which activities have parents noted?
   - Has the program used any strategies to encourage participation? How successful have these strategies been? What challenges has your program faced?

9. Has your program been able to implement your *IM/IL* enhancement as planned?

   PROBES:

   - How has actual implementation differed from initial plans? In actual activities? Duration? Intensity? In who receives services?
   - What caused a change from the original vision of what the *IM/IL* enhancement would look like in your program?

10. What are the ongoing costs associated with *IM/IL*? General categories and cost estimates are fine.

11. How did your program make budget decisions about costs to implement the *IM/IL* enhancement?

PROBE:

- Did you have to redirect service priorities to cover the costs of the *IM/IL* enhancement? Are there any services that have been dropped or decreased in intensity to focus attention on *IM/IL* goals?
- Will you be able to sustain these added costs?

12. Have you looked for outside funding to help support the costs of implementing *IM/IL*? Why or why not? If so, what types of funding have you looked into? What have you learned?

13. What percentage of your T/TA funds has been dedicated to your *IM/IL* enhancement? Will you dedicate T/TA funds to your *IM/IL* enhancement in the future? Why or why not?

I. SUCCESSES, CHALLENGES, AND LESSONS

1. Throughout the interview we have talked about the successes your program has experienced since implementing your program's *IM/IL* enhancements. [INTERVIEWER INSERT SUCCESSES AND CHALLENGES DESCRIBED DURING THE INTERVIEW]. Are there any other successes you would like to add? Of these successes, which would you describe as the greatest? Why?

2. During the spring 2007 telephone interview [your staff/you] mentioned [INTERVIEWER INSERT SUCCESSES] as the most significant implementation successes associated with your *IM/IL* enhancement. How have these successes changed over time? What strategies have you used to foster these successes? (or To what do you attribute these successes?) Are there resources and supports that helped you achieve these successes (or Are there resources and supports that would help you to be more successful)?

3. Throughout the interview we have talked about the challenges your program has experienced since implementing its *IM/IL* enhancements. [INTERVIEWER INSERT SUCCESSES AND CHALLENGES DESCRIBED DURING THE INTERVIEW]. Are there any other challenges you would like to add? Of these challenges, which would you describe as the greatest barrier to implementation? Why?

4. During the spring 2007 telephone interview [your staff/you] mentioned [INTERVIEWER INSERT SUCCESSES] as the most significant implementation challenges associated with your *IM/IL* enhancement. How have these challenges changed over time?

IF YES:

- What strategies have you used to address these challenges?
- Are there any other challenges? What strategies will staff use to address these challenges?

IF NO:

- What strategies have you used to address these challenges? How well do you think these strategies have worked?
- Are there resources and supports that would have helped you overcome these challenges?
- Are there any other challenges? What strategies will staff use to address these challenges?

5. Do you think the *IM/IL* enhancement has had an effect on the outcomes your program has hoped to achieve (for example, increased MVPA by 50 percent)?

6. What aspects of *IM/IL* do <u>children</u> like the most? What do they like the least? How has this changed over time?

7. What aspects of *IM/IL* do <u>staff</u> like the most? What do they like the least? How has this changed over time?

8. What aspects of *IM/IL* do <u>families</u> like the most? What do they like the least? How has this changed over time?

9. What are the most important lessons your program has learned so far about implementing an *IM/IL* enhancement?

10. After one full year of implementation of the *IM/IL* enhancements, what would you do differently? What would you do the same? Why?

11. What changes, if any, do you think should be made to the *IM/IL* enhancement, either the enhancement in your program specifically or the enhancement overall in Head Start?

PROBE:

- Changes in scope? Training? Goals? Activities? T/TA? Staffing? Involvement of outside organizations or experts? Other?

12. What advice would you give to another Head Start program that is thinking about implementing an *IM/IL* enhancement?

13. Do you think your program's *IM/IL* enhancement approach could be successfully replicated at other Head Start programs?

PROBES:

- If yes, what would be needed for successful replication?

- If no, what would prevent or hinder replication?

14. Is there anything unique about your local community or populations served that help or hinder successful implementation of your *IM/IL* enhancement?

WRAP-UP

Is there anything else you would like to add before we end our discussion?

N.B. MPR should already have received a set of documents from the program in advance of the telephone call, such as the program's most recent T/TA plan and copies of any local IM/IL training materials. If we have not received them, then ask for specific outstanding items as appropriate.

Thank you very much for speaking with me and sharing your experiences and feedback on the *IM/IL* enhancement at your Head Start program.

APPENDIX D

STAGE 3 TEACHER FOCUS GROUP INTERVIEW GUIDE

OMB No.: 0970-0318
Expiration Date: 02/28/2010

Region III Head Start Administration for Children and Families

Evaluation of the *I am Moving, I am Learning* Enhancement

Site Visit Interview Guide for Teacher Focus Groups
Fall 2007
(Estimated focus group time: 90 minutes)

INTRODUCTION

Thank you very much for agreeing to participate in this discussion. Your participation is very important to the study. My name is [X], I am a [TITLE] at Mathematica Policy Research. Mathematica is a nonpartisan research firm that has extensive experience conducting both early childhood and nutrition research. The Office of Planning, Research, and Evaluation (OPRE) under the Administration for Children and Families (ACF) contracted with MPR to conduct an implementation evaluation of the *I am Moving, I am Learning* (*IM/IL*) enhancement in Region III. This study will examine to what extent grantees are implementing *IM/IL* after attending the spring 2006 Regional Training for Trainers (TOT) events.

During this discussion, we will be following up on the information your program shared with us during a survey conducted in winter 2007 and phone interviews conducted in spring 2007. We will want to discuss how *IM/IL* is being implemented in your program last program year; what changes were made after year 1; how these changes were implemented; and what initial successes and challenges have been encountered. As part of this evaluation, we are now conducting site visits to 16 grantees. During these visits, we will be talking to program directors, program managers, teachers, and parents.

I am going to moderate the discussion. It is very important for everyone to speak up so we can have a lively and informative discussion.

We ask that you respect each other's point of view. There are no right or wrong answers. You are the experts—we want to learn from you.

It will be helpful if you speak one at a time, so everyone has a chance to be heard.

We have many topics to cover during the discussion. At times, I may need to move the conversation along to be sure we cover everything.

Everything you say will be kept private to the extent permitted by law. No staff member will be quoted by name. Our report on the site visits will describe the range of views expressed by staff across programs, but specific comments will not be attributed to specific individuals or programs. We also ask that you not repeat any of the discussion you've heard after you leave today.

I would like to tape-record our discussion so I can listen to it later, when I write up my notes. No one outside of our research team will listen to the tape. After my notes are finalized, I will erase/destroy the tape. If you want to say anything that you don't want taped, please let me know and I will be glad to pause the tape recorder. Does anyone have any objections to my taping our discussion?

The discussion will last about ***90 minutes,*** and we will not take any formal breaks. But please feel free to get up at any time to stretch or use the restroom.

Once again, thank you for coming today. Are there any questions before we get started?

Let's start by going around the room and introducing ourselves.

Please tell me your first name (or the name you would like to be called), your position in the program, and how long you have been with this Head Start (or Early Head Start) program.

A. PROGRAM AND COMMUNITY CONTEXT

1. How many children are in your classroom? What are their ages (mixed-age classroom or one age group)?

OR

How many families do you work with as a home visitor?

2. Does your classroom operate a full-day session or half-day sessions? [*N.B. Omit for home visitors*.]
3. How many other adults work in your classroom, such as teacher's assistants or parent volunteers? How often are they in the classroom (for example, every day all day, 3 hours per week)? [*N.B. Omit for home visitors*.]
4. What percentage of children in your classroom [OR children in your home visiting caseload] speak a language other than English at home? What languages do they speak?
5. What percentage of children [in your classroom OR children in your home visiting caseload] have an Individual Education Plan (IEP)?

B. SUSTAINABILITY AND RESOURCES

1. Have the goals of *IM/IL* changed since it was started last program year? If so, how? Why were these changes made?
2. Were you involved in making or suggesting any of these changes? If so, what role did you play?
3. What was your initial reaction to the idea of implementing an *IM/IL* enhancement? Were you excited, or hesitant? Why? Is your reaction the same now as it was initially? Why or why not?
4. How receptive were families to participating in the *IM/IL* enhancement over the course of last program year?
5. How did you reinforce *IM/IL* goals and go about getting <u>ongoing</u> buy-in from parents during the last program year (2006-2007)? Community organizations? In other words, how do you keep the momentum moving forward?

C. IM/IL ENHANCEMENT ACTIVITIES

6. What ***MVPA*** and ***Structured Movement*** enhancement activities did you provide in your classroom during last program year (2006-2007)?

PROBES:

- Did you begin or increase MVPA for your classroom? Did you have a target amount (Daily? Weekly?)? If so, what is the target? Do you reach the target? Did you increase the amount of unstructured MVPA (such as supervised outdoor play time) or structured MVPA (such as group activity you led or modeled)? Both?
- Did you begin or increase the amount of intentionally scheduled, structured movement activities? Did you have a daily or weekly target amount? If so, what was the target? Did you reach the target?
- What kinds of structured MVPA activities did you facilitate? Can you give some examples of games or tasks?
- What kinds of structured movement activities do you facilitate? Can you give some examples of games or tasks?
- Did you use vocabulary from the Choosy training materials in classroom routines, including Action Awareness (what my body can do); Effort Awareness (how my body moves); Space Awareness (where my body moves); Relationship Awareness (to myself, others, or objects, like body parts or shapes)? Did you find this helpful? Are you still using it?

Were you able to implement these activities as planned? Why or why not?

PROBES:

- Describe one structured movement and/or MVPA enhancement activity you did that was successful. In your opinion, why was this activity successful?
- Describe one structured movement and/or MVPA enhancement activity that you thought you would be able to do, but that did not work. Why did it not work? What could you have done differently that might have made the activity more successful?

7. Are you implementing these same activities this program year?

IF NO: What prevented you from implementing these activities this year? (Time? Interest? Experiences last year? Other?)

IF YES: Did you/are you going to make any changes to these activities? If so, please describe the changes. Why are you going to make these changes?

8. Did you integrate structured movement and MVPA activities into your existing curriculum? How did you do this? Have you incorporated movement activities into literacy and early mathematics activities? Transitions? Other? If so, please describe? If not, why has this been challenging?

9. What ***Healthy Eating*** enhancement activities did you provide in your classroom during last program year (2006-2007)?

PROBES:

- Did you try to increase the time spent on educating children about good nutrition and healthy foods? Did you have a target amount? Did you reach the target?
- Did you incorporate healthy eating enhancement activities into mealtime (Family-style meals? Staff eating with children? Staff eating same meals as children? Regulating portion sizes or number of servings? Introducing new foods?) Were these new activities?
- Did you integrate healthy eating enhancements into your existing curriculum? How did you do this? Have you incorporated healthy eating activities into literacy and early mathematics activities? Transitions? Other? If so, please describe. If not, why not?

10. Were you able to implement these activities as planned? Why or why not?

PROBES:

- Describe one healthy eating enhancement activity you did that was successful. Why do you think it was successful?
- Describe one healthy eating enhancement activity that you thought you would be able to do but that did not work. Why did it not work? What could you have done differently that might have made the activity more successful?

11. Are you implementing these same activities this program year?

IF NO: What prevented you from implementing these activities this year? (Time? Interest? Experiences last year? Other?)

IF YES: Did you/are you going to make any changes to these activities? If so, please describe the changes. Why are you going to make these changes?

12. Are you required to spend a specific amount of time each week or month on the *IM/IL* enhancement? If so, are you typically able to meet these requirements? What barriers, if any, make it difficult for you to meet these requirements?

13. Did you use any materials and resources to implement the *IM/IL* enhancement during last program year (2006-2007)? If so, what did you use? If so, did your program purchase these materials and resources? Why did your program choose to purchase materials and resources?

PROBES:

- Choosy Action Plans (lesson plans) or activity sheets, such as the Open Space Activity Cards or the Creative Arts Activity Cards
- Lesson plans or activity ideas from other organizations, such as USDA's MyPyramid website, Fit WIC, Smart Moves activities books, and SPARK Early Childhood Physical Activity Curriculum
- Balloons, bean bags, balls ropes, scarves, foam noodles, balance beams, and so on
- Choosy song sheets, CDs, videos, DVDs

14. Are you using these materials and resources to implement the *IM/IL* enhancement again this program year (2007-2008)?

    IF NO: Why not? (Time? Interest? Experiences last year? Usefulness? Other?)
    IF YES: Did you or are you going to make any changes to how you use these materials and resources? If so, please describe the changes. Why did you make or are you going to make these changes?

15. Last program year (2006-2007), did you make any of the materials by hand using the Choosy Homemade Toys & Props handout from the regional TOT event, or any other resources?

PROBES:

For example, did you make a jump-rope or balance beam out of bread bags?

IF YES:

Are you going to use these materials again this program year? If not, why not?
Are you going to make these materials again this year? Why or why not?

16. Did your program implement any *IM/IL* enhancements for staff? (Incentives to increase physical activity? Health club incentive? Weight loss challenge? Other?)

PROBES:

Describe the enhancements. Who is involved? Who is leading the efforts?
Are you participating in the enhancements? (Voluntary? Mandatory?) Why or why not?
Have you set any personal/staff goals specific to the *IM/IL* enhancements? If so, how much progress do you feel you have made toward meeting those goals? Are you or someone else tracking your progress toward meeting those goals?

17. Did you modify the *IM/IL* enhancement activities for certain children?

PROBES:

- For children whose home language is something other than English?
- For children with IEPs or IHPs?
- Have you consulted any special resources for directing the *IM/IL* enhancement to these children? If so, which ones? Were these resources helpful?
- What aspects of making these modifications were successful? What aspects were challenging?

18. Have you observed or experienced challenges in getting children to do any of the activities? For example, if you introduce unfamiliar fruits and vegetables to children at mealtime, are most children willing to try the foods? If you introduce structured movement activities during transitions, are most children willing to participate?

PROBES:

- Did you expect this variation? What factors affect some children's buy-in/participation more than others?
- What do you do to encourage buy-in/participation? How do you respond to children that are unwilling to participate?

19. Do you have concerns about the weight of any children in your classroom or on your caseload?

PROBES:

- What percentage of children would you say are overweight? Underweight?
- Do these children seem embarrassed by their weight? How can you tell?
- Have you ever spoken to the parents about your concerns regarding their children's weight? If so, how did you bring up the subject, and what did you talk about? How did they react?
- Was it awkward to talk to them about their child's weight? If so, why?
- If you have not spoken to these parents about your concerns, why haven't you?

20. How common is it for the children in your classroom to make food choices that make it difficult to maintain a healthy weight? About what proportion of the children make these kind of food choices?

21. How common is sedentary behavior (i.e. little or no physical activity) among the children in your classroom, such as high levels of television viewing or living in a place that is not conducive to outside play? About what proportion of the children have limited physical activities outside of Head Start?

22. Of the health problems affecting children in your classroom/caseload, how would you rank these three conditions: __ Asthma, __ Obesity, and __ Oral Health (tooth decay and cavities)?

NOTE: "1" IS THE MOST IMPORTANT PROBLEM, AND "2" IS THE SECOND MOST IMPORTANT PROBLEM, AND "3" IS THE THIRD IMPORTANT PROBLEM.

23. Did you incorporate *IM/IL* goals into Children's IEPs? Children's Individual Health Plans (IHPs)?

24. Have you shared information about *IM/IL* with the families' health care professionals, such as a description of planned activities or any data collected?

25. Have you shared information about *IM/IL* with Part B providers, such as a description of planned activities or any data collected?

IF YES TO Q24, Q25, OR Q26:

Will you use these strategies again this program year (2007-2008)? Why or why not?

26. How pervasive are poor eating habits (not consuming enough healthy foods) among the children in your classroom or on your caseload? About what percentage of children have poor eating habits?

27. Do you see yourself as a role model for children to teach them about the importance of physical activities and healthy eating? Why or why not?

PROBES:

- Compared to this time last year, do you see yourself as a better role model? Why or why not?
- Has the *IM/IL* enhancement changed any aspects of your own personal health related to diet and physical activity? If so, which ones?
- Has the *IM/IL* enhancement changed any aspects of your own family's health related to diet and physical activity? If so, which ones?
- Has the *IM/IL* enhancement provided any motivation or incentives (such as staff challenges with prizes) for you to change your own health behaviors related to diet and physical activity?
- Is there a way you think you could be a better role model?

28. Were there any factors that hindered MVPA, structured movement, or healthy eating activities in the past (for example, inadequate indoor space during inclement weather, or no time in schedule)?

D. OUTREACH TO FAMILIES

1. What outreach strategies were used last year to promote the *IM/IL* enhancement to families?

PROBES:

- How, if at all, did you <u>first</u> communicate with families about your *IM/IL* enhancement? Are you using the same strategy this year? If not, why not?
- How do parents initially react? Are they excited, or hesitant? Why? Has their reaction or involvement changed over time?

2. Were there any parent education activities centered on the *IM/IL* enhancement during last program year (2006-2007)?

IF YES: Did you have a role? If so, what did you do? Were activities targeted at improving children's behaviors related to healthy eating and physical activity, parents' behaviors, or both? Were parents engaged? Will there be continued activities and support for parents this year? Why or why not?

IF NO: What prevented your program from providing parent education activities? Are parent activities not part of your program's *IM/IL* goals? No time? Lack of interest among parents?

3. Did you do anything to encourage parents to make healthy food choices, or to educate them about good nutrition in general? If so, what? Was this targeted at improving children's behaviors related to healthy eating, parents' behaviors, or both? Was this successful? Has this been continued?

PROBES:

Did you use different vocabulary and/or teach nutritional messages from Choosy or other sources—like Crave Your F.A.V., Shop the Sides, Think Tiny Tummies, other? If so, how was this reinforced? Did you find this helpful? Are you still using it?

4. Have you observed or experienced challenges in getting families to do any of the activities? What challenges have you experienced? (For example, if you sponsor cooking classes to teach family members about easy-to-prepare, nutritious meals, are parents interested in trying new foods/recipes or not?)

PROBES:

- Did you expect these challenges? What factors affect some families' participation/buy-in more than others? Is your program doing anything to encourage participation/buy-in?
- What factors prevent higher activity levels?
- Have you or the program used any strategies to encourage participation/buy-in over time?

5. To what extent are parents reinforcing components of the *IM/IL* enhancement at home? How can you tell?

PROBES:

- Do home visitors incorporate *IM/IL*-related activities into the home visits?
- Do group socializations reinforce the *IM/IL* messages?
- Do you conduct informal surveys with parents about what they eat or how much they exercise?
- Other?

E. TRAINING AND ONGOING TECHNICAL ASSISTANCE AND CAPACITY BUILDING

1. Have you received formal training on the *IM/IL* enhancement so far this program year?

IF NO: SKIP TO QUESTION #2

IF YES:

How was this different from what you did last year?

Who developed the training activities?

Who provided the training?

When was the training provided? During pre-service training? As an in-service?

How many and which types of staff participated? Were any volunteers trained?

How long did it last?

What was the format of the training? What topics were covered? Which types of activities were included? Lecture? Modeling? Breakout sessions? Role play?

Were written materials distributed, such as a manual, curriculum, lesson plan, or list of resources to be used during implementation? If so, please describe them.

Were you trained on how to monitor progress made by children, such as observations of structured movement or tracking body mass index and height/weight?

Which parts of training did you find most helpful, and why?

Was there anything about the training that wasn't helpful? If so, why?

Was this training similar to the training you received during the first year of implementation (2006-2007)? If it wasn't, how was it different?

SKIP TO QUESTION #3

2. Since there hasn't been any formal training this year, did you receive any special preparation to implement the IM/IL enhancement this program year?

3. Last program year, did you receive ongoing training and/or technical assistance to support the *IM/IL* enhancement? Is any planned for this year?

PROBES:

- What kind of support did you receive?
- What topics were covered? How often is T/TA provided?
- Who provides the training and/or TA? For example, is it provided by staff within your Head Start program, by the Region III TA System, or by an outside consultant?
- Was this T/TA helpful? Why or why not?
- How frequently were these *IM/IL* topics included during in-service days?
- Do you participate in the listserv created by Region III? If so, how often? Is the listserv helpful? If it is, why is it? If you don't use the listserv, why don't you?

4. Is there any additional training or support you need but have not received yet?

IF YES: What types of support do you need? Are there specific plans in place to meet these support needs?

5. Last year, did you track *IM/IL* implementation and measure outcomes?

IF YES: What specific items do you track? For example, do you periodically measure height and weight of children? Observe progress made in structured movement using Choosy Assessment of Motor Patterns (CAMP) tools? Other? Are you measuring any child outcomes like aspects of children's movement or diet?

How often do these activities take place?

Have you used the results of these assessments to inform individual or group education and/or health goals? If so, how? If not, why not?

IF NO: What prevents you from measuring outcomes? Are there any plans in place to do so in the future?

6. To what degree do children, staff, and parents incorporate the *IM/IL* vocabulary into their daily routines?

PROBES:

- Do you teach children about structured movement vocabulary, such as "What my body does," "How my body moves," and "Where my body moves"? If not, why not?
- Do you teach and use any nutrition slogans in classrooms and with parents, like "Crave Your F.A.V." or "Think Tiny Tummies"? Are children and parents picking up this vocabulary and using it? If not, why aren't they?
- If so, do you routinely use this vocabulary with children? Are children picking up and using this vocabulary?
- Do other adults in the classroom (such as teaching assistants, aides, and volunteers) use this vocabulary on a regular basis?

F. BARRIERS, FACILITATORS, AND LESSONS

1. In your opinion, how much progress do you think your program has made toward meeting its goals and objectives for the *IM/IL* enhancement?

PROBES:

How much progress have you made toward meeting the goals and objectives you planned for your classroom?
How do you track the progress you have made toward meeting the goals and objectives you planned for your classroom?

2. What have been the most important successes of the *IM/IL* enhancement so far?

PROBES:

- Can you give an example?
- What factors led to that success?

3. What are the most significant implementation challenges associated with the *IM/IL* enhancement so far?

PROBES:

- What strategies have you used to address these challenges?
- How well do you think these strategies worked?

4. What are the most important lessons you have learned so far about implementing an *IM/IL* enhancement?

5. What aspects of the *IM/IL* enhancement do children like the most? What do they like the least? How was this changed over time and why?

6. What aspects of the *IM/IL* enhancement do families like the most? What do they like the least? How was this changed over time and why?

7. What aspects of the *IM/IL* enhancement do you like the most? What do you like the least? How was this changed over time and why?

8. What changes, if any, do you think should be made to the *IM/IL* enhancement?

PROBE:

Changes in scope? Training? Activities? T/TA? Staffing? Involvement of outside organizations or experts? Other?

9. What advice would you give to another Head Start program that is thinking about implementing an *IM/IL* enhancement like the one at your program? Another Head Start teacher?

WRAP-UP

Is there anything else you would like to add before we end the discussion?

N.B. MPR should have already received a set of documents from the program in advance of the telephone call, such as daily classroom schedules (pre and post spring 2006 TOT event) and templates of any assessment tools. If we have not received them, then ask for specific outstanding items as appropriate.

Thank you very much for speaking with me and sharing your experiences and feedback on the *IM/IL* enhancement at your program.

APPENDIX E

STAGE 3 PARENT FOCUS GROUP INTERVIEW GUIDE

OMB No.: 0970-0318
Expiration Date: 02/28/2010

Region III Head Start Administration for Children and Families

Evaluation of the
***I Am Moving, I Am Learning* Enhancement**

Site Visit Interview Guide for Parent Focus Groups
Fall 2007
(Estimated focus group time: 90 minutes)

INTRODUCTION

Thank you very much for agreeing to participate in this discussion. Your participation is very important to the study. I'm _____ and I work for Mathematica Policy Research, an independent research firm.

We are conducting a study for the Office of Planning, Research, and Evaluation under the Administration for Children and Families to learn about the *I am Moving, I am Learning*[1] enhancement. As part of the study, we want to learn about the types of activities, information, and services you have participated in/received that have focused on promoting physical activity and healthy eating.

- I am going to moderate the discussion. It is really important for everyone to speak up so we can have a lively and informative discussion.
- We ask that you respect each other's point of view. There are no right or wrong answers. You are the experts—we want to learn from you.
- It will be helpful if you speak one at a time, so everyone has a chance to talk.
- We have many topics to cover during the discussion. At times, I may need to move the conversation along to be sure we cover everything.
- We also ask that you not repeat any of the discussion you've heard after you leave today.
- We also want you to know that being part of this discussion is up to you, and you can choose to not answer a question if you wish. Being part of this discussion will also not affect the services you receive through Head Start/Early Head Start.
- I would like to tape-record our discussion. I am taping our discussion so I can listen to it later when I write up my notes. No one besides our research team will listen to the tape. After my notes are finalized, I will erase/destroy the tape. Everything you say here will be kept private to the extent permitted by law. When we write our

[1] INTERVIEWER: REPLACE LOCAL NAME/TITLE FOR *IM/IL* AS NEEDED. THIS INFORMATION WILL COME FROM THE SAQ.

report, we will include a summary of people's opinions, but no one will be quoted by name.

- If you want to say anything that you don't want taped, please let me know and I will be glad to pause the tape recorder. Does anybody have any objections to being part of this focus group or to my taping our discussion?

The discussion will last about ***90 minutes***, and we will not take any formal breaks. But please feel free to get up at any time to stretch, use the restroom, or help yourselves to something to eat or drink.

Once again, thank you for coming today. Are there any questions before we get started?

Let's start by going around the room and introducing ourselves.

Please tell us:

- Your first name (or the name you would like to be called)
- The name and age of your child who is enrolled in Head Start or Early Head Start
- How long your child has been enrolled in Head Start or Early Head Start

A. PARENT ATTITUDES AND BELIEFS

I would like to ask you some questions about your views about your child's overall health. Specifically we want to focus on how you think diet and physical activity relate to your child's health.

Physical Activity

1. If someone describes a child as healthy, what does this mean to you? What do you look for/what are the signs that let you know that your child is healthy? (Good appetite? Physically active? Not sick?)
2. How important do you think physical activity and movement are for a child's overall growth and development? Is it important, somewhat important, or not related to their overall physical health and growth?
3. Why do you think physical activity is important for your child's health? (Gross motor development? Cognitive development? Energy release? Makes you/your child feel good? Socialize with other children? Helps with attention? Helps reduce aggression? Other?)
4. Do you think your child gets enough physical activity? If no, what do you think would help your child to get more activity?

5. Does your family engage in physical activities together? If so, what types of activities? If not, what makes engaging in physical activities as a family challenging?

6. Where does your child usually get most of his physical activity? (Indoors or outdoors? In your yard? In the house? In the street/on the sidewalk? At a neighbor's house? In a neighbor's yard? At a park? At a community center? At a church/synagogue/mosque? At Head Start? Other?)

   PROBES:
   - Are there any local resources available to you in the community to promote physical activity for your child, such as public swimming pools, walking trails, playgrounds, community centers with playground equipment, that you can easily get to?
   - What are some of the reasons your child does not get as much physical activity as you would like your child to get? (Cost? Lack of open space? Inconvenient location or hours? Interest? Language barriers? Safety? Other?)

7. How much time per week, on average, does your child spend watching television?

Perceptions of Healthy Weight/Overweight

8. Do you worry about your child being or becoming overweight? If yes, why? What sorts of things have you been trying to do to prevent your child from becoming overweight?

9. Why do you think some children are overweight and others are not?

10. Has anyone been told their child was overweight? By whom? Have you been told this by a doctor? Did you agree? Did anyone in Head Start ever tell you this? Who did? (Pediatrician? Nurse? WIC? Family member? Neighbor?) How did that make you feel? Did they work with you to come up with a plan to achieve a healthy weight?

11. Do you worry about your child being or becoming underweight? If yes, why? What sorts of things have you been trying to do to prevent your child from becoming underweight?

12. Do you think you are a good role model/set a good example for your child with regards to engaging in physical activity and eating a healthy diet? Why or why not?

13. What would help you and your child reach or maintain a healthy weight? How could your Head Start program help?

Healthy Eating

14. How important do you think healthy eating is for a child's overall growth and development? Is it important, somewhat important, or not related to their overall health?

15. Why do you think nutrition is important for your child's health? [Mainly to see if they spontaneously link this to body weight] How important is your child's weight to their health?

16. Do you think your child has a healthy diet? If NO, in what ways would you like to see it change?

17. Are there any local resources available to you in the community to promote healthy eating, such as grocery stores with fresh fruits and vegetables, farmers' markets or programs/trainings on healthy eating?

18. Do you use these resources/engage in these activities? If not, why not? (Cost? Inconvenient location or hours? Not home for meals? Interest? Limited access to fresh fruits and vegetables? Vegetables and fruits spoil? Other?)

19. Who decides how much food your child gets to eat? Do you, or someone else, put food on a plate or does your child service her/himself? What size portions your child eats? What happens if your child doesn't want to eat? What happens if your child wants seconds?

    PROBE:

    - Does someone else choose? (Grandmother? Other family member?)
    - Do you ever disagree with other family members or Head Start staff about the types of foods your child should be eating? If so, what kinds of things do you disagree about? What happens when you disagree?
    - How many times per week does your child eat fast food?

20. Is it hard to say no to your child about what types of foods he/she eats? About the amount of food your child eats?

21. Does your family eat meals together? If so, how often? If not, why not?

22. Does your family eat meals with the television on? If so, how often?

B. ENHANCED *IM/IL* SERVICES

Now I would like to talk about the activities and services that the Head Start program offered last program year and this program year to improve children's diets and increase the amount of physical activity your children get, both at home and at Head Start.

1. During program application, were you asked specific questions regarding nutrition choices and activity levels? IF YES: What types of questions were asked?

2. Did you complete a service plan or Family Partnership Agreement? Did the agreement include any statements about nutrition choices and physical activity levels?

IF YES: What types of information about nutrition and activity were included on the agreement?

3. Did you complete a family service needs assessment? Did the assessment include any statements about nutrition choices and activity levels?

IF YES: What types of information about nutrition and activity were included on the assessment?

4. Have you attended any workshops, trainings, or parent meetings sponsored by Head Start that focused on health promotion topics, such as ways to choose healthy foods for you and your child and/or ways to increase the amount of physical activity you and your child get?

IF NO, ASK:

- Were you invited to any events? What are some of the reasons you did not attend?
- Do you plan to attend these events in the future?
- Are there changes the Head Start program could make to these events that would make it easier/more appealing for you to attend?

IF YES, ASK:

- How did you learn about the event?
- Were the events for parents and children? Parents only?
- What topics were covered during these events?
- Were the topics covered focused on improving your child's behaviors related to healthy eating and physical activity, your own behaviors, or both?
- How was information presented? In a lecture format? By actively engaging attendees in activities?
- Who presented the information? (Health manager? Education manager? Teachers? A speaker from another organization? Other?)
- Where did the activities take place? (Head Start center? Community center? Park or playground? Local public school? Health center of clinic? Other?)
- What did you learn at these events? Did you learn any **new** information at these events—things you did not already know? Was the information useful?
- Did you or other members of your family disagree with any information that was presented at these events? Please describe. Why did you or your family feel this way?
- Were you given anything to take home at these events? (Handouts? Recipes? Props for activities? Financial incentives? Other?)
- Were food and beverages served at these events? Please describe the food and beverages that were served.

- Did the program offer transportation to the events?
- Did the program provide child care at the events, if children were not included?

5. Have you participated in any events or socializations at the Head Start program or sponsored by the program that focused on nutrition or physical activity topics? For example, cooking classes, exercise programs, wellness events, health fairs, walks?

IF NO, ASK:

- Were you invited to any activities? What are some of the reasons you did not attend?
- Do you plan to attend these events in the future?
- Are there changes the Head Start program could make to these activities that would make it easier/more appealing for you to attend?

IF YES, ASK:

- Please describe these activities. What did they involve?
- How did you find about these activities?
- Who led the activities? (Head Start staff? Other program staff? Community partner staff? Other?)
- Who attended the activities? (Head Start families only? Head Start and other families? Parents only? Parents and children? Head Start teachers and other staff? Health center of clinic? Other?)
- Were the activities for parents and children? Parents only?
- Where did the activities take place? (Head Start center? Community center? Park or playground? Local public school? Other?)
- What did you learn at these events? Did you learn any **new** information at these events—things you did not already know? Was the information useful?
- Did you or other members of your family disagree with any information that was presented at these events? Please describe. Why did you or your family feel this way?
- Were you given anything to take home at these events? (Handouts? Recipes? Props for activities? Financial incentives? Other?)
- Were food and beverages served at these events? Please describe the food and beverages that were served.
- Did the program offer transportation to the activities?
- Did the program provide child care during the activities, if children were not included?

6. Have you received any educational materials or other handouts related to nutrition or physical activity from the Head Start program? (Food pyramid? Suggestions for physical activities to do with your child? Choosy Kids handouts? Songs and movement activities? Recipes? Other resources on nutrition? Other resources on physical activity?)

IF YES, ASK:

- Please describe these materials.
- When and how did you receive these materials?
- What did you do with these materials? (Read them? Discard them? Share them with others? Other?)
- What did you learn from these materials? Any new information? Was this information useful?
- Was there any information you disagreed with? Please describe. Why did you feel this way?

7. Does anyone at Head Start give you advice about meals and feeding your children? Who? What kind of advice do they give? Do you generally follow or listen to the advice that they give you? Why or why not?

8. Are there other types of training, education, information you have received about nutrition and physical activity through Head Start? Please describe.

9. Do you know of other/any efforts taking place in your community to improve healthy eating or increase physical activity for your child or your family?

PROBES:

- How did you learn about these efforts? Who sponsors these efforts? (WIC? Local hospital or health clinic? Local community center or YMCA? Public school district? Other?)

- What does it mean to participate in these efforts? Please describe these efforts. What is the focus? What are the efforts aiming to achieve?

- Do you participate in these efforts? Why? Why not? (Lack of time? Cost? Lack of transportation? Lack of child care?)

C. OPINIONS ABOUT *IM/IL* ENHANCEMENT

Now I would like to talk about what you liked and disliked about the activities, events, and information offered by the Head Start program about health promotion [as part of *IM/IL*][2]. I'd especially like to know what you think works or doesn't work about the activities, events, and information offered by the program.

1. What parts of the events and activities you attended did you like? The materials you received? Why did you like these parts? What parts did your child like?

2. What parts did you dislike about these events, activities, and materials? Why did you feel this way? What parts did your child dislike?

[2] INTERVIEWER: REPLACE LOCAL NAME/TITLE FOR *IM/IL* AS NEEDED. THIS INFORMATION WILL COME FROM THE SAQ.

3. Have your beliefs about the importance of healthy eating changed since the program implemented the [*IM/IL* enhancement]? Since your child entered Head Start? How have they changed?

4. Do you think the services you and your child received through Head Start [as part of *IM/IL*] changed the types of foods you and your child eats? How?

IF NO, ASK:

- Why not? (No new information? Unable to implement the changes because of barriers? Disagree with information? Lack of time? Cost? Lack of transportation? Lack of child care? Family dietary preferences? Other?)

5. Do you think the services you and your child received through the Head Start [as part of *IM/IL*] changed the types and amount of physical activity you and your child engage in? How?

IF NO, ASK:

- Why not? (No new information? Unable to implement the changes because of barriers? Disagree with information? Lack of time? Cost? Lack of transportation? Lack of child care? Family dietary preferences? Other?)

6. What types of activities, events, and information about physical activity and healthy eating would you be interested in participating in during the coming program year? Why?

PROBES:

- Are there any topics you would like to see covered at future events or in educational materials you receive? Please describe.
- Are there specific activities you would like the program to offer? Please describe.
- Why are these important to you?

7. What types of information/materials would you like to receive from Head Start?

8. What changes do you think the program should make to the [*IM/IL* enhancements]? Would these changes make the events, activities, and materials more useful for you? Why?

9. Would you recommend the events, activities, and materials to other families? Why or why not?

D. LESSONS

1. What have you liked most about your Head Start program's efforts to increase children's physical activity and improve children's eating habits?

2. What have you liked least?

3. What advice would you give to another Head Start program that is thinking about implementing an *IM/IL* enhancement like the one at your program? Other Head Start parents?

4. Is there anything you would like to share with me about these topics that we have not yet discussed?

WRAP-UP

I am now finished with my questions. Is there anything else you would like to add before we end our discussion?

Thank you very much for speaking with me and sharing your experiences and feedback on the *IM/IL* enhancement at your Head Start program.

APPENDIX F

STAGE 3 OBSERVATION FORM AND CODING SPECIFICATION MANUAL

Part 1: Observation Form
Part 2: Coding Specification Manual

Contract No.:233-02-0086/HHSP233200600006T
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MATHEMATICA
Policy Research, Inc.

I Am Moving, I Am Learning Center/Classroom Observation Form

November 2007

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Submitted to:

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This instrument was adapted with permission from the Environment and Policy Assessment and Observation (EPAO) system developed by Dianne Ward and Sara Benjamin. It was used in 12 Head Start classrooms as part of the IM/IL Stage 3 site visits to determine whether it was possible to measure activities and policies targeted by IM/IL for change. It should be considered a new tool that requires additional research on its reliability and validity.

MATHEMATICA
Policy Research, Inc.

I Am Moving
I Am Learning

Center/Classroom Observation Form

Program Name: _____

Program Location: _____

Center Name: _____

ID#: |___|___|___|___|___|___|___|___|

Assessor Initials: |___|___|___|

Date: |___|___| / |___|___| / |___|___|___|___|

Start Time: |___|___|:|___|___| AM/PM

End Time: |___|___|:|___|___| AM/PM

Weather: _____

# of Children in Class: |___|___|

Ages of Children:

MARK ALL THAT APPLY

1 ☐ One 2 ☐ Two 3 ☐ Three 4 ☐ Four 5 ☐ Five 6 ☐ Six

Eating Occasions Observed:

MARK ALL THAT APPLY

1 ☐ Breakfast 2 ☐ AM Snack 3 ☐ Lunch 4 ☐ PM Snack

CENTER/CLASSROOM OBSERVATION REMINDERS

General Reminders

- ❑ Ask for a daily lesson plan or schedule of activities for the day of the observation. It may be easier to track the activities if you have the schedule ahead of time.
- ❑ Ask for a copy of the menu for the day, if possible, but be prepared for changes and substitutions.

Timing Tasks

- ❑ Click your timer every time children move to a new activity.
- ❑ While the children are participating in the activity (movement or sedentary), find the appropriate page in the observation form to record it. Observation grids are at the beginning of the form.
- ❑ Do not time or record “travel” time between activities, time waiting in line, or nap time.

Foods and Beverages

- ❑ Provide as much detail as possible from direct observation of the foods and beverages being offered and brought in from home.
- ❑ Observe the preparation of meals, if possible; however, observing children in the classroom always takes priority.
- ❑ Ask to speak with the person in charge of the food service operations or talk with other staff members to obtain details about the foods and beverages offered during meals and snacks.
- ❑ Be sure to obtain the contact information for the person in charge of food service operations (or appropriate person) if you are unable to speak with him/her on the observation day or unable to obtain sufficient details.

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Section I: OBSERVATION GRIDS

IA: OBSERVATION OF FOODS AND BEVERAGES OFFERED BY HEAD START AND BROUGHT FROM HOME

1. Use this grid to record (in detail) all the foods and beverages observed at each meal or snack. For each food or beverage, please also indicate whether the food was offered or brought from home. Refer to the specifications document (Section I) for detailed instructions on how to record food and beverage items.

Meal or Snack	Length of Meal or Snack Period (minutes)	MARK ONE PER ROW	
		Offered	From Home
Breakfast	|__|__|__|		
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
AM Snack	|__|__|__|		
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
Lunch	|__|__|__|		
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
PM Snack	|__|__|__|		
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐

IB: OBSERVATION OF CHILD ACTIVITIES

Use the following grids to record all child activities (excluding meals/snacks and nap time). Record each activity in the appropriate grid based on the type of activity. Use the NOTES page at the end of this section (page 5) to describe any staff interaction coded as "Other."

2a. Structured physical activity focused on **movement/stretching/body awareness**

MARK ALL THAT APPLY

Description	Setting	Time Spent (minutes)	Staff Interaction F=Facilitate; D=Demonstrate; P=Participate; OB=Observe; Oth=Other				
1.	1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
2.	1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
3.	1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
4.	1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
5.	1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth

2b. Structured physical activity focused on **increasing MVPA**

MARK ALL THAT APPLY

Description	Setting	Time Spent (minutes)	Staff Interaction F=Facilitate; D=Demonstrate; P=Participate; OB=Observe; Oth=Other				
1.	1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
2.	1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
3.	1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
4.	1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
5.	1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth

2c. Free play

Setting	Time Spent (minutes)	Proportion of Children With Some MVPA (MARK ONE PER ROW)				Staff Interaction (MARK ALL THAT APPLY) F=Facilitate; D=Demonstrate; P=Participate; OB=Observe; Oth=Other				
1. 1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ All	2 ☐ Most	3 ☐ Some	4 ☐ Few	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
2. 1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ All	2 ☐ Most	3 ☐ Some	4 ☐ Few	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
3. 1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ All	2 ☐ Most	3 ☐ Some	4 ☐ Few	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
4. 1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ All	2 ☐ Most	3 ☐ Some	4 ☐ Few	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
5. 1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ All	2 ☐ Most	3 ☐ Some	4 ☐ Few	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth
6. 1 ☐ Indoor 2 ☐ Outdoor	|__|__|__|	1 ☐ All	2 ☐ Most	3 ☐ Some	4 ☐ Few	1 ☐ F	2 ☐ D	3 ☐ P	4 ☐ OB	5 ☐ Oth

2d. Periods of **sitting** (excluding meal and napping periods)

Description	Time Spent (minutes)
1.	|__|__|__|
2.	|__|__|__|
3.	|__|__|__|
4.	|__|__|__|
5.	|__|__|__|
6.	|__|__|__|
7.	|__|__|__|

(continued on next page)

2d. Periods of **sitting** (continued)

Description	Time Spent (minutes)
8.	|__|__|__|
9.	|__|__|__|
10.	|__|__|__|
11.	|__|__|__|
12.	|__|__|__|
13.	|__|__|__|
14.	|__|__|__|
15.	|__|__|__|

NOTES:

Section II: MEALS AND SNACKS

IIA: FOODS AND BEVERAGES FOR CELEBRATIONS OR FROM HOME

3. Did you observe any **special celebration**, such as a birthday or holiday-related event, for which food was served?

1 ☐ Yes

0 ☐ No → **GO TO Q.4**

3a. Were these foods provided by families or by the center?

MARK ALL THAT APPLY

1 ☐ Families

2 ☐ Center

3 ☐ Both

3b. What types of food were served?

MARK ALL THAT APPLY

1 ☐ Milk

2 ☐ 100% juice

3 ☐ Sweetened beverage

4 ☐ Fruit

5 ☐ Vegetables

6 ☐ High-sugar or high-fat foods (*Specify:* _____)

7 ☐ Other (*Specify:* _____)

4. Did you observe **foods that were brought in from home for reasons other than special celebrations**?

1 ☐ Yes

0 ☐ No → **GO TO Q.5**

4a. Were these foods consumed by individual children or shared with the class?

MARK ALL THAT APPLY

1 ☐ Consumed by individual children

2 ☐ Shared with class

3 ☐ Both

4b. What types of food were served?

MARK ALL THAT APPLY

1 ☐ Milk

2 ☐ 100% juice

3 ☐ Sweetened beverage

4 ☐ Fruit

5 ☐ Vegetables

6 ☐ High-sugar or high-fat foods (*Specify:* _____)

7 ☐ Other (*Specify:* _____)

IIB: MEAL PREPARATION AND SERVICE

5. In the grid below, indicate where and how food was **prepared** for each meal and snack.

MARK ONE PER ROW

	Meal Preparation				
	Prepared on-site	**Prepared off-site and delivered in bulk**	**Prepared off-site and delivered in pre-portioned units or meals**	**Other/Combo (Describe*)**	**N/A**
a. Breakfast	1 ☐	2 ☐	3 ☐	4 ☐	na ☐
b. AM Snack	1 ☐	2 ☐	3 ☐	4 ☐	na ☐
c. Lunch	1 ☐	2 ☐	3 ☐	4 ☐	na ☐
d. PM Snack	1 ☐	2 ☐	3 ☐	4 ☐	na ☐

***e.** Use this space to describe any meal preparation method coded as "**Other/Combo**."

6. In the grid below, indicate the **type of meal service** used.

MARK ONE PER ROW

	Meal Service				
	Family style (children serve themselves	**Staff serve children**	**All foods pre-portioned**	**Other (Describe*)**	**N/A**
a. Breakfast	1 ☐	2 ☐	3 ☐	4 ☐	na ☐
b. AM Snack	1 ☐	2 ☐	3 ☐	4 ☐	na ☐
c. Lunch	1 ☐	2 ☐	3 ☐	4 ☐	na ☐
d. PM Snack	1 ☐	2 ☐	3 ☐	4 ☐	na ☐

***e.** Use this space to describe any meal service coded as "**Other/Combo**."

7. Was **margarine, butter, or meat fat** visible on cooked vegetables?

MARK ONE ONLY

1 ☐ Yes
0 ☐ No
2 ☐ Don't Know
na ☐ No cooked vegetables served

→ **GO TO Q.8**

7a. According to staff, (ask classroom staff or cook) were cooked vegetables offered on the day of observation prepared with added fat?

MARK ONE ONLY

1 ☐ Yes
0 ☐ No
na ☐ Don't Know

8. According to staff (ask classroom staff or cook) are cooked vegetables **typically** prepared with added fat?

MARK ONE ONLY

1 ☐ Yes
0 ☐ No
na ☐ Don't Know

9. Were you able to speak with someone who could provide sufficient details about the foods and beverages offered by Head Start?

MARK ONE ONLY

1 ☐ Yes (Specify title: _____)
0 ☐ No

9a. If you were unable to obtain sufficient details about the foods and beverages offered, please use the space below to describe the person you spoke with (if anyone), the type of information you were unable to obtain, and the contact information for the appropriate person for Liz to use in a follow-up phone call.

_____

_____

_____

_____

IIC: JUICE

10. Was 100% juice offered at any meal or snack?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No → **GO TO Section D**

10a. How was juice offered to children?

MARK ALL THAT APPLY

1 ☐ Available for self-serve (child-level pitcher/cups on table)

2 ☐ Staff filled cups (initially/on request)

3 ☐ Commercially pre-portioned container → (Specify size of container: _____fl oz)

11. Were children allowed a second helping of juice if requested?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

na ☐ N/A (no one asked for a second helping)

12. Were children encouraged to drink water as an alternative to second helping of juice?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

na ☐ N/A (no one asked for a second helping)

IID: STAFF BEHAVIORS

		MARK ONE FOR EACH MEAL OR SNACK			
		Breakfast	**AM Snack**	**Lunch**	**PM Snack**
13. Did staff **sit with children** during…	**Yes**	1 ☐	1 ☐	1 ☐	1 ☐
	No*	0 ☐	0 ☐	0 ☐	0 ☐
	N/A	na ☐	na ☐	na ☐	na ☐
14. Did staff **eat with children** during…	**Yes**	1 ☐	1 ☐	1 ☐	1 ☐
	No*	0 ☐	0 ☐	0 ☐	0 ☐
	N/A	na ☐	na ☐	na ☐	na ☐
14a. If yes, were staff **offered the same foods and beverages** as children?	**Yes**	1 ☐	1 ☐	1 ☐	1 ☐
	No*	0 ☐	0 ☐	0 ☐	0 ☐
	N/A	na ☐	na ☐	na ☐	na ☐
14b. If yes, did staff **skip or not taste** any of the foods or beverages served to children?	**Yes***	1 ☐	1 ☐	1 ☐	1 ☐
	No	0 ☐	0 ☐	0 ☐	0 ☐
	N/A	na ☐	na ☐	na ☐	na ☐
15. Did staff **eat and/or drink less healthy foods** in front of children (at meals/snacks or at other times of the day)?				**Yes***	1 ☐
				No	0 ☐

***16.** Describe the situations you observed that led you to code any of the **asterisked responses** for items 13 to 16 or any other situations you observed that you feel are important.

	Yes	No
17. Did staff **push children to eat more than they wanted to**? (*Examples: Clean your plate; You won't grow big and tall if you don't eat all your breakfast; Come on, you can do better than that!)*	1 ☐	0 ☐
17a. If yes, what did you hear staff say?		
18. Did staff **serve second helpings to children without being asked**? (*Example: staff saw an empty plate/cup and added food/beverage without waiting for child to ask*).	1 ☐	0 ☐
19. Did staff **positively and gently encourage children to try new or "disliked" foods**? (*Example: How about taking one bite of pineapple? You won't know if you like it until you try it*.)	1 ☐	0 ☐
19a. If yes, what did you hear staff say?		
20. Did staff **use food to control behavior**? (*Example: You can't go out to play until you finish your lunch; Anyone who finishes their drawing gets an extra cookie for snack.)*	1 ☐	0 ☐
20a. If yes, what did you hear staff say?		
21. Did staff mention "choosing colors"—eating different colored fruits and vegetables—or use other **encouragement to promote fruit and vegetable consumption**?	1 ☐	0 ☐
21a. If yes, what did you hear staff say?		
22. Did staff **talk to children about healthy foods** during meal or snack times?	1 ☐	0 ☐
22a. If yes, what did you hear staff say?		
23. Did you hear any **other staff comments** related to children's eating behaviors that you consider important?	1 ☐	0 ☐
23a. If yes, what did you hear staff say?		

Section III: PHYSICAL ACTIVITY

IIIA: OPPORTUNITIES FOR PHYSICAL ACTIVITY

24. Did you observe **structured** physical activity that focused on **movement/stretching/body awareness**?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

24a. If you recorded "Other" for staff interaction in the grid for **structured** physical activity that focused on **movement/stretching/body awareness (Q. 2a)**, describe the interaction. Indicate activity numbers (from the description column) if "Other" was used for more than one activity.

_____

_____

_____

25. Did you observe **structured** physical activity that focused on **increasing children's levels of moderate to vigorous physical activity**?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

25a. If you recorded "Other" for staff interaction in the grid for **structured** physical activity that focused on **increasing children's levels of moderate to vigorous physical activity (Q. 2b)**, describe the interaction. Indicate activity numbers (from the description column) if "Other" was used for more than one activity.

_____

_____

_____

26. Did any of the **structured** physical activities recorded in items 2a or 2b incorporate **music or singing**?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

na ☐ No structured physical activity observed

27. Did you observe any periods of free play?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

27a. If you recorded "Other" for staff interaction in the grid for periods of **free play (Q. 2c)**, describe the interaction. Indicate activity numbers if "Other" was used for more than one activity.

_____

_____

28. Did you observe children seated for more than 30 minutes at a time, excluding meal/snack and nap times?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

IIIB: STAFF BEHAVIORS

MARK ONE PER ROW

	Yes	No
29. Did staff **restrict active play** as punishment?	1 ☐	0 ☐
30. Did staff use positive statements to **encourage physical activity?** (*Examples: Good throw! Running is fun!, I like the way you threw that ball!)*	1 ☐	0 ☐

Section IV. WATER

31. Was drinking water for children visible in the classroom?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No → **GO TO Q.31b**

31a. How accessible was drinking water to children in the classroom?

MARK ONE ONLY

1 ☐ Available for self-serve (child-level fountain or pitcher/cups on table)

2 ☐ Available by request only

31b. Was there a water fountain in a nearby hallway?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No → **GO TO Q.32**

31c. How accessible was this fountain to children?

MARK ONE ONLY

1 ☐ Available for self-serve (do not need to ask permission to leave classroom)

2 ☐ Available by request only (must ask permission to leave classroom)

32. Was drinking water for children available outdoors?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

na ☐ No outdoor time observed

→ **GO TO Q.33**

32a. How accessible was the drinking fountain to children outdoors?

MARK ONE ONLY

1 ☐ Available for self-serve (child-level fountain or pitcher/cups on table)

2 ☐ Available by request only

33. Did you witness staff prompting children to drink water?

MARK ALL THAT APPLY

1 ☐ Yes, while in the classroom

2 ☐ Yes, at meal or snack time

3 ☐ Yes, while playing outdoors

4 ☐ Yes, when coming in from outdoors

0 ☐ No

Section V: CENTER ENVIRONMENT

VA: PHYSICAL ACTIVITY EQUIPMENT

34. Indicate where the following pieces of **fixed physical activity equipment** were located and whether children were observed using the equipment.

	MARK ONE PER ROW				MARK ONE PER ROW	
					Used During Observation	
	Indoors Only	Outdoors Only	Both Indoors and Outdoors	Not Present	Yes	No
a. Balancing surfaces (balance beams, boards, etc.)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
b. Basketball hoop	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
c. Climbing structures (jungle gyms, ladders, etc.)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
d. Merry-go-round	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
e. Pool	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
f. Sandbox	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
g. See-saw	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
h. Slides	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
i. Swinging equipment (swings, ropes, etc.)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
j. Tricycle track	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
k. Tunnels	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐

35. Was the fixed physical activity equipment in good repair/usable?

MARK ONE ONLY

1 ☐ Yes, all

0 ☐ No, at least some equipment was in poor repair/not usable → **GO TO Q.36**

na ☐ No fixed physical activity equipment observed

35a. Which pieces of fixed physical activity equipment were in poor repair and what problems did you observe?

_____

_____

_____

36. Indicate where the following pieces of **portable physical activity equipment** were located and whether children were observed using the equipment.

	MARK ONE PER ROW				MARK ONE PER ROW	
					Used During Observation	
	Indoors Only	Outdoors Only	Both Indoors and Outdoors	Not Present	Yes	No
a. Ball play equipment	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
b. Climbing structures (ladders, jungle gyms, etc.)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
c. Floor play equipment (tumbling mats, carpet squares, etc.)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
d. Jumping play equipment (jump ropes, hula hoops)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
e. Parachute	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
f. Push/pull toys (wagon, scooters, etc.)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
g. Riding toys (tricycles, cars, etc.)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
h. Rocking and twisting toys (rocking horse, sit-n-spin, etc.)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
i. Sand/water play toys (buckets, scoops, shovels, etc.)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
j. Slides	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
k. See-saw	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
l. Basketball hoop	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
m. Tunnels	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐
n. Twirling play equipment (ribbons, scarves, batons, etc.)	1 ☐	2 ☐	3 ☐	na ☐	1 ☐	0 ☐

37. Was the portable physical activity equipment in good repair/usable?

MARK ONE ONLY

1 ☐ Yes, all

0 ☐ No, at least some equipment was in poor repair/not usable → **GO TO Q.38**

na ☐ No portable physical activity equipment observed → **GO TO Q.38**

37a. Which pieces of portable physical activity equipment were in poor repair and what problems did you observe?

_____

_____

_____

38. Indicate which of the following **home-made toys or props** were present (ask staff as needed) and whether children were observed using the equipment.

	MARK ONE PER ROW		MARK ONE PER ROW Used During Observation	
	Present	**Not Present**	**Yes**	**No**
a. Covered balloon(s)	1 ☐	na ☐	1 ☐	0 ☐
b. Plastic jump rope(s)	1 ☐	na ☐	1 ☐	0 ☐
c. Bean bag	1 ☐	na ☐	1 ☐	0 ☐
d. Yarn ball	1 ☐	na ☐	1 ☐	0 ☐
e. Bladder ball	1 ☐	na ☐	1 ☐	0 ☐
f. Lifting weights	1 ☐	na ☐	1 ☐	0 ☐
g. Half-gallon beam	1 ☐	na ☐	1 ☐	0 ☐
h. Graduated jump	1 ☐	na ☐	1 ☐	0 ☐
i. Pantyhose paddle	1 ☐	na ☐	1 ☐	0 ☐
j. Lid streamer	1 ☐	na ☐	1 ☐	0 ☐
k. Other props: Specify: _____ _____	1 ☐	na ☐	1 ☐	0 ☐

39. Were the home-made toys and props in good repair/usable?

MARK ONE ONLY

1 ☐ Yes, all

0 ☐ No, at least some equipment was in poor repair/not usable → **GO TO Q.40**

na ☐ No home-made toys and props were observed

39a. Which home-made toys and props were in poor repair and what problems did you observe?

_____

_____

40. Indicate which of the following pieces of **"screen time" equipment** were present in the classroom, how accessible they were to children, and whether they were used during the observation period.

	Present in Classroom		Access		Used During Observation Period	
	Yes	**No**	**Self-serve**	**Request only**	**Yes**	**No**
a. Television/VCR player	1 ☐	0 ☐	1 ☐	2 ☐	1 ☐	0 ☐
b. Computer	1 ☐	0 ☐	1 ☐	2 ☐	1 ☐	0 ☐
c. Video game system	1 ☐	0 ☐	1 ☐	2 ☐	1 ☐	0 ☐

VB: PHYSICAL ACTIVITY SPACE

41. Which of the following best describes the **outdoor** play space?

MARK ONE ONLY

1 ☐ Plenty of open space for group games or running
2 ☐ Some obstruction from play equipment, but space was adequate for individual running
3 ☐ Play space almost entirely obstructed with equipment; limited space for running
4 ☐ Other (Describe: _____
_____)

42. Did staff limit or restrict outdoor play area in a way that substantially affected active play (more than 1/3 of total play space or equipment)?

MARK ONE ONLY

1 ☐ Yes
0 ☐ No → **GO TO Q.43**

42a. Why did staff have to limit or restrict outdoor play area?

_____

_____

_____

43. Which of the following best describes available **classroom** play space?

MARK ONE ONLY

1 ☐ Suitable only for quiet play (classroom is small and not a lot of room for movement)
2 ☐ Allows for limited movement/some active play (able to translocate by walking, skipping, hopping, or jumping)
3 ☐ Suitable for any type of physical activity (easily able to perform all gross motor activities)

44. Is there a separate indoor gross motor play space available for regular use?

MARK ONE ONLY

1 ☐ Yes
0 ☐ No

45. Is there a separate indoor gross motor play space available for use during inclement weather?

MARK ONE ONLY

1 ☐ Yes
0 ☐ No

VC: OTHER CENTER CHARACTERISTICS

46. Did you observe any posters, pictures or displayed books about **physical activity or movement**?

MARK ONE ONLY

1 ☐ Yes
0 ☐ No

47. Did you observe any posters, pictures or displayed books about **nutrition/healthy eating**?

MARK ONE ONLY

1 ☐ Yes
0 ☐ No

48. Did you observe any music CDs that focus on **nutrition, healthy eating, physical activity, or movement**?

MARK ONE ONLY

1 ☐ Yes, **and used** on day of observation
2 ☐ Yes, **but not used** on day of observation
0 ☐ No

49. Did you observe any **lessons/activities focused on nutrition or healthy eating**?

MARK ONE ONLY

1 ☐ Yes
0 ☐ No → **GO TO Q.50**

49a. Describe what you observed, including the focus of the lesson and the foods used (if any).

_____

_____

_____

50. Did you observe any **formal physical education lessons**?

MARK ONE ONLY

1 ☐ Yes
0 ☐ No → **GO TO Q.51**

50a. Describe what you observed, including the focus of the lesson and the equipment used (if any).

_____

_____

_____

51. Did you observe a **bulletin board or other notice area for parents** that included information on nutrition/healthy eating, physical activity/movement?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

52. Did you observe a **posted menu** that could be easily viewed by parents?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

53. If posters, pictures, or music CDs were observed, did any of them include the **"Choosy"** character?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No

na ☐ N/A, No posters, pictures, or CDs observed

54. Was there any evidence of an IM/IL mascot other than "**Choosy**"?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No → **GO TO Q.55**

54a. Please describe:

_____

_____

_____

55. Where were soda and other vending machines located?

MARK ALL THAT APPLY

0 ☐ No vending machines on site → **GO TO Q.56**

1 ☐ In entrance or front

2 ☐ In other public areas

3 ☐ Out of sight of parents and kids

55a. Did beverage vending machines contain healthy options (water, low-fat milk, 100% fruit juice)?

MARK ONE ONLY

1 ☐ Yes, **only** healthy options available

2 ☐ Yes, **some** healthy options available

0 ☐ No, no healthy options available

na ☐ N/A, no beverage vending machines

55b. Did snack vending machines contain healthy options (pretzels, nuts, plain crackers)?

MARK ONE ONLY

1 ☐ Yes, **only** healthy options available

2 ☐ Yes, **some** healthy options available

0 ☐ No, no healthy options available

na ☐ N/A, no snack vending machines

Section VI: CODING GRID FOR HEAD START MEALS AND SNACKS

Refer to the specifications in Section VI for guidelines on coding foods and beverages offered by Head Start.

	MARK ALL THAT APPLY					
In the observed Head Start meals and snacks…	**Breakfast**	**AM Snack**	**Lunch**	**PM Snack**	**Other**	**Not Served**
56. Whole milk was served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
57. 2% milk was served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
58. 1% milk was served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
59. Skim (nonfat) milk was served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
60. Flavored milk was served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
60a. If flavored milk was served, specify flavor(s) and fat content(s): _____ _____	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
61. Milk of unknown fat content was served at….	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
62. Fresh fruit was served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
63. Canned fruit in juice or water (not including canned fruit in syrup) was served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
64. 100% fruit juice was served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
65. Vegetables other than French fries or other fried vegetables were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
66. Dark green, red, orange or yellow vegetables were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
67. Fried or pre-fried vegetables (e.g., tater tots, French fries, fried okra, fried zucchini or hash browns) were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
68. More than one different type of fruit and/or vegetable (not including 100% juice, French fries, or fried vegetables) was served at one meal/snack at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
69. High-fiber cereals, grains or grain products were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
70. Pre-sweetened cereals were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

In the observed Head Start meals and snacks…	MARK ALL THAT APPLY					
	Breakfast	AM Snack	Lunch	PM Snack	Other	Not Served
71. Breaded, fried or pre-fried meats (e.g., chicken nuggets, chicken fingers, fish sticks) were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
72. Other high-fat meats (e.g., sausage, bacon, ground beef, bologna, hotdogs, tuna or chicken salad with mayo) **or cheese** were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
73. Lean meats/fish (e.g., baked chicken or turkey breast, baked fish, deli turkey, canned tuna or salmon without mayo) were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
74. Beans or lentils were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
75. Pizza (with or without meat; including breakfast pizza) was served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
76. Cookies, cakes, brownies, muffins, doughnuts, cinnamon rolls, or (Pop) tarts were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
77. Dairy-based desserts (e.g., ice cream, pudding, frozen yogurt) were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
78. Chips were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
79. Candy was served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
80. Sweetened beverages were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
81. High-sugar or high-fat condiments were served at…	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Section VII: POLICIES

Ask the **program director** whether written policies other than national Head Start performance standards or CACFP regulations exist for nutrition and physical activity. If such policies exist, ask whether they were developed before *IM/IL* or as part of IM/IL implementation.

Q: *We are interested in learning more about the policies Head Start programs have about a variety of issues related to nutrition and physical activity. These policies may have been in place before IM/IL or been developed as a result of IM/IL. I'm interested in policies that your program developed on its own, not the Head Start performance standards issued by the government.*

Does your program have a policy about……(see below).

Q: *If yes, was this policy in place before IM/IL or was it developed as a result of implementing IM/IL?*

Q: *May I make a copy of the policy?* (Note that one policy may address more than one of the topic areas noted below).

	Program Has Policy?		**Copy Obtained?**		
	Yes	**No**	**Yes**	**No**	**N/A (Center does not have)**
82. Minutes of physical activity per day or week	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐
83. Minutes of "screen time"	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐
84. Types of foods provided in Head Start meals and snacks	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐
85. Children's access to water	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐
86. Offering juice (frequency per day or per week, portion size)	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐
87. Offering fruits and vegetables (type, frequency, preparation method)	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐
88. Foods children bring in from home	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐
89. Foods allowed for birthdays or celebrations	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐
90. Foods offered at staff meetings	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐
91. Use of food in fundraising activities	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐
92. Other (specify)	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐

93. Other (specify)	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐	1 ☐	2 ☐	3 ☐

94. In the space below, explain any "No" responses to "Copy Obtained," including whether arrangements have been made to obtain copies of documents or policies.

SECTION VIII: BACKGROUND DOCUMENTS

	Copy Obtained?		
	Yes	**No**	**Not applicable (Center does not have)**
95. Daily schedule or lesson plan	1 ☐	2 ☐	3 ☐
96. Weekly schedule	1 ☐	2 ☐	3 ☐
97. Weekly (or monthly) menu	1 ☐	2 ☐	3 ☐
98. IM/IL Action Plan	1 ☐	2 ☐	3 ☐
99. IM/IL Training and Technical Assistance Plans	1 ☐	2 ☐	3 ☐
100. Agendas for completed IM/IL training sessions	1 ☐	2 ☐	3 ☐
101. Forms used to track IM/IL implementation	1 ☐	2 ☐	3 ☐
102. Parent outreach materials re: IM/IL, nutrition, physical activity, obesity, or related issues	1 ☐	2 ☐	3 ☐
103. Other (specify)	1 ☐	2 ☐	3 ☐
104. Other (specify)	1 ☐	2 ☐	3 ☐

Nutrition and Physical Activity Curricula

	Center has formal curriculum?	
	Yes	**No**
105. Nutrition curriculum for **children** Name: Year Published:	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐
106. Physical activity curriculum for **children** Name: Year Published:	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐
107. Nutrition/physical activity/wellness curriculum for **staff** Name: Year Published:	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐
108. Nutrition/physical activity/wellness curriculum for **parents** Name: Year Published:	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐
109. Other relevant curricula (Specify content and target audience, curriculum name, and year of publication)	1 ☐ Pre-IM/IL 2 ☐ IM/IL	3 ☐

110. In the space below, explain any "No" responses to "Copy Obtained" (Q. 95-104), including whether arrangements have been made to obtain copies of documents or policies.

_____

_____

_____

Section IX: FEEDBACK

111. How well do you think this observation tool worked in capturing IM/IL implementation in this center?

_____

_____

_____

_____

112. What aspects of IM/IL implementation do you think may have been misrepresented in this observation (not observed or not appropriately characterized)?

_____

_____

_____

_____

113. How well do you think this observation tool worked in capturing the food and physical activity environment in this center?

_____

_____

_____

_____

114. What aspects of the food and physical activity environment may have been misrepresented in this observation (not observed or not appropriately characterized)?

_____

_____

_____

_____

115. What changes would you recommend to this observation instrument to improve its ability to characterize IM/IL implementation and/or measure food and physical activity environments?

_____

_____

_____

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MATHEMATICA
Policy Research, Inc.

I Am Moving, I Am Learning Center/Classroom Observation Coding Specification Manual

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This instrument was adapted with permission from the Environment and Policy Assessment and Observation (EPAO) system developed by Dianne Ward and Sara Benjamin. It was used in 12 Head Start classrooms as part of the IM/IL Stage 3 site visits to determine whether it was possible to measure activities and policies targeted by IM/IL for change. It should be considered as a new tool that requires additional research on its reliability and validity.

I AM MOVING/I AM LEARNING

CENTER/CLASSROOM OBSERVATION

CODING GUIDELINES

Goals

- Describe nutrition and physical activity environments of IM/IL centers.
- Document the presence of IM/IL enhancements.
- Provide feedback to ACF on how well this instrument works in describing IM/IL enhancements and the nutrition and physical activity environments in centers.
- Offer recommendations for future measures.

General Procedure

- One classroom will be observed.
- Observations will cover the center's entire day; some centers will be half-day programs and some will be full-day programs.
- All meals and snacks will be observed.
- Information will also be gathered about the overall center environment.
- Data on the center environment can be collected/coded on either day of the visit.
- The observation form is generally coded based on what is observed (as opposed to what staff might report). In some cases, you may have to ask staff to assist you in "observing" something.

SECTION I: OBSERVATION GRIDS

IA: OBSERVATION OF FOODS AND BEVERAGES OFFERED BY HEAD START AND BROUGHT FROM HOME

Guidelines for Recording Foods and Beverages

Q1. Use this grid to list and describe all foods and beverages served by Head Start to children at each observed meal and snack and any foods or beverages brought in by children, either for themselves or to share with the class.

Record the total length of time for each meal and snack observed. Start timing the meal or snack when all children in the group sit down, and stop the timer when all the children in the group transition to the next activity.

Do not record tap or bottled water. Use the separate grids provided for each meal and snack, and use one line for each item. Follow the specific guidelines below:

Describe foods in as much detail as possible, including information about:

- Type (1% or whole milk; white or whole wheat bread)
- Form of food (fresh, frozen, canned, raw, cooked)
- Brand name, if commercially prepared product
- Cooking or preparation method (baked, deep-fried, stir-fried, steamed, etc.)
- Type of fat used, if any (margarine, butter, vegetable oil, cooking spray, etc.)
- Ingredients added in preparation or at the table (milk added to oatmeal; jelly added to toast)

Be sure to ask if the cooked vegetables are prepared with added fat. For recipe items prepared from scratch and assembled items like sandwiches, describe the major ingredients/components. It is understood that you may not be able to provide much detail about foods brought from home.

It may be useful to work from a copy of the menu for the day, but be prepared for changes and substitutions. Ask when and where meals and snacks are being prepared and observe the preparation if possible (for example, if children are napping or involved in circle time or other seated activity with a predictable end time). Observing children in the classroom always takes priority.

If you cannot observe meals and snacks being prepared, ask to see packages or containers after the fact, as needed. Record any words from the labels or packaging that may give insight into the type, form, or modifications to the nutrient content (e.g., low-fat) of the food.

You may be able to obtain some information from classroom staff during the meal/snack periods, if not obvious (for example, the type of sandwich fillings, type of milk). But you will likely have to speak with the cook or person in charge of the food service operations to obtain some of the necessary details. If you are unable to speak with someone or obtain sufficient details about the foods and beverages offered, please be sure to record the contact information for the appropriate person (Q. 7a) so we can follow-up.

When asking classroom staff or cooks for descriptive information about foods and beverages, avoid asking leading questions. For example, instead of saying, "those French fries are deep-fried, right?", ask "how do you cook your French fries?" Ask what type of milk, salad dressing, or mayonnaise is used. If the response is a brand name or other non-specific description, provide a list of alternatives, such as: "Is the milk whole, 1%, or 2%?", "Is the salad dressing regular dressing or is it low-calorie or low-fat?"

Below are **some general guidelines to use in describing foods and beverages. Sample descriptions are provided at the end of each food group.**

1. Milk (list all milk options)
-Fat content (skim/nonfat, 1%, 2%, or whole)
-Flavored or unflavored (chocolate, strawberry, vanilla, etc.)
-Special milk types (soy, Lactaid, etc.)

Example: 2% chocolate milk

Yogurt
-Fat content (fat-free, low-fat, reduced-fat)
-Plain or flavored (including fruit variety)
-"Light" (usually referring to sugar content and use of artificial sweetener)

Example: Yoplait yogurt, reduced-fat, fruited

2. Fruit
-Fresh, frozen, canned, dried
-If canned, in heavy syrup, light syrup, juice, or water-packed
-Sweetened or unsweetened applesauce

Example: Sliced peaches, canned in heavy syrup

Fruit Juice (and Juice Drinks)
-100% juice (no added sugar)
- % of fruit juice if not 100% juice (10% fruit juice)
-Fruit drink or juice drink (added sugar)

Examples: Apple juice, 100% juice

Capri Sun, fruit punch flavor, 10% juice

3. Vegetables
-Cooked or raw
-Fresh, frozen, canned
-If fat added what type (including fat added to mashed or creamed potatoes)
-Oven-baked or deep-fried (for French fries, tater tots, hash browns, onion rings)
-Specify if any "deeply colored" vegetables are included in lettuce salads- tomatoes, spinach, carrots, etc.

Examples: Carrots, cooked, from frozen, butter added

Mashed potatoes from dry mix with water and butter added

4. Breads and Grains
-Fat added to breads, rolls, bagels, English muffins (pre-buttered)
-Fat added to pasta, rice, other grains
-Fat or milk added to cooked cereal
-Type of cold cereal (brand names); include all varieties offered
-Whole grain bread, pasta, rice, crackers, pretzels, muffins (brand names)

Examples: French toast, from frozen, pan-fried in butter

Honey Nut Cheerios, Frosted Flakes, Wheat Chex, Raisin Bran

Whole wheat toast with butter and jelly

5. Meats (meat, poultry, fish) **or Meat Substitutes** (cheese, beans, nuts, eggs)
-Type of meat (white meat chicken, ground beef, fish, pork sausage, Canadian bacon; deli meats)
-Breaded or non-breaded
-Any specifications on nutrient content (85% lean ground beef; lean bacon; reduced-fat ham; lower sodium turkey)
-Preparation method
-Fat added in preparation (butter, margarine, mayonnaise)

Examples: Chicken nuggets, breaded, baked

Ground beef patty, 85% lean, baked

Baked chicken leg, non-breaded, with skin on

Scrambled eggs, milk added, cooked in margarine

6. Entree Items and Mixed Dishes
-For sandwiches, list ingredients – include type of bread, cheese, and meat; any condiments or toppings; any fat added (grilled in butter; mayonnaise added)
-Pasta/noodle/rice dishes and soups (any with whole grain ingredients; type of fat added; meat and/or vegetables included)
-Pizza (list toppings; reduced-fat cheese or meat toppings)

Examples: Turkey sandwich on white bread, regular mayonnaise, lettuce and tomato

Macaroni and cheese made from dry mix (Kraft), water and butter added

Breaded chicken patty sandwich, baked, white roll, regular American cheese

7. Desserts and Snacks (High sugar/high fat foods)
-Fat content of chips or dessert items, if modified (low-fat, reduced-fat, fat-free; baked chips)
-Fortified donuts or muffins (Super Bakery products)

Examples: Popcorn popped on-site with butter added

Baked Doritos

Grape juice drink, contains no fruit juice

Quaker granola bar, chocolate chip, reduced-fat

Chocolate pudding, made from mix, 2% milk added

Homemade cupcakes, chocolate with icing

8. Condiments
-Fat content (regular, low-fat, reduced-fat, or fat-free salad dressings, dips, sauces, mayonnaise, gravy, butter, cream cheese, sour cream)
-Sugar content (regular or reduced/low-sugar syrup, jelly, honey)

Examples: Regular mayonnaise

Reduced-sugar pancake syrup

Canned turkey gravy (regular fat)

SECTION IB: OBSERVATION OF CHILD ACTIVITIES

Use the four grids in this section to record all activities whether physical activities or sedentary periods. Remember to use your timer for each activity and exclude time spent for meals/snacks or napping. Do not record time spent waiting in line or transitioning to the next activity (unless specific movement activities occur).

Notes: If children are broken up into small groups, observe the group that is supervised by the lead teacher. The term "staff" refers to any adult leading an activity. Record every activity even if the same activity is observed more than once during the day.

Question 2a: Structured Physical Activity Focused on Movement/Stretching/Body Awareness

- A structured activity is one that is led by staff or parents.
- Activities considered in this section focus on movement/stretching/body awareness (e.g., teaching a skill or about a specific body part) rather than increasing moderate or vigorous activity.
- Describe each activity.
- Indicate the setting where each activity occurred (i.e., indoor or outdoor).
- Record the length of time for each activity in minutes.
- Describe staff interaction using the following guidelines:
    - Facilitates: promotes, encourages, or prompts
    - Demonstrates: models activity
    - Participates: actively participates throughout activity
    - Observes: passive observation; may provide instruction but monitors rather than prompting or demonstrating;
    - Other: behaves in some other way (describe in Q. 22a)

Question 2b: Structured Physical Activity Focused on Increasing Moderate or Vigorous Physical Activity

- A structured activity is one that is led by staff or parents.
- Activities considered in this section are those that are designed to increase heart rate for a sustained period. Examples include brisk walk, run, calisthenics, or other activity more intense than a normal walk.
- Describe each activity.
- Indicate the setting where each activity occurred (i.e., indoor or outdoor)
- Record the length of time for each activity in minutes.
- Describe staff interaction Using the following guidelines:
    - Facilitates: promotes, encourages, or prompts
    - Demonstrates: models activity
    - Participates: actively participates throughout activity
    - Observes: passive observation; may provide instruction but monitors rather than prompting or demonstrating
    - Other: behaves in some other way (describe in Q. 23a)

Question 2c: Free Play

- Free play includes, indoor and outdoor unstructured play time. It is understood that only some children will be "active" during free play.
- Describe where the free play occurred.
- Record the total amount of time spent for the free play period.
- Indicate the proportion of children who engaged in some amount of MVPA.
- Describe staff interaction relative to promoting MVPA:
    - Facilitates: promotes, encourages, or prompts MVPA
    - Demonstrates: models MVPA
    - Participates: actively participates in one or more MVPAs
    - Observes: passive observation; may provide instruction but monitors rather than prompting or demonstrating
    - Other: behaves in some other way (describe in Q. 25a)

Question 2d: Periods of Sitting

- Periods of sitting include time spent in sitting during activities other than naps or meal time. Include periods of "screen time."
- Describe the activity and the total amount of time spent in minutes.

SECTION II: MEALS AND SNACKS

IIA. FOODS AND BEVERAGES FOR CELEBRATIONS OR FROM HOME

Questions 3/3a/3b: Foods or Beverages for Birthdays and Other Celebrations

- Indicate whether you observed a birthday or other special celebration where food or beverages were offered.
- Indicate whether observed foods or beverages were provided by Head Start or sent/brought in by families.
- Identify the types of food/beverages offered. Use the guidelines for coding foods and beverages (see Section VI) to categorize foods.
    - For high-sugar/high-fat foods, count cookies (other than vanilla wafers or animal crackers), cakes, brownies, donuts, muffins, sweet breads, pastries, breakfast (pop) tarts
    - Candy, popsicles, ice cream, pudding, Jell-o
    - Potato chips, tortilla chips, corn chips, popcorn (if not made fresh), Combos, cheese puffs, Doritos

Questions 4/4a/4b: Foods or Beverages Brought in From Home for Reasons Other Than Birthdays or Other Celebrations

- Indicate whether you observed any foods or beverages brought in from home for reasons other than a birthday or other special celebration.

- Indicate whether these foods or beverages were consumed by individual child (children) or shared with the class.
- Identify the types of food/beverages offered. Use the guidelines for coding foods and beverages (see Section VI) to categorize foods.
    - For high-sugar/high-fat foods, count cookies (other than vanilla wafers or animal crackers), cakes, brownies, donuts, muffins, sweet breads, pastries, breakfast (pop) tarts
    - Candy, popsicles, ice cream, pudding, Jell-o
    - Potato chips, tortilla chips, corn chips, popcorn (if not made fresh), Combos, cheese puffs, Doritos

IIB: MEAL PREPARATION AND SERVICE

Question 5: Meal Preparation

- Code ONE of the following options for each meal/snack, based on where and how foods were prepared:
    - Prepared on-site – Foods are prepared at the center in which you are observing. Foods are NOT delivered from an outside source.
    - Prepared off-site and delivered in bulk – Foods are prepared at a location other than the center in which you are observing. Foods arrive in bulk and are portioned out by center staff before or during meal service.
    - Prepared off-site and delivered as pre-portioned units or meals – Foods are prepared at a location other than the center in which you are observing. Foods arrive already portioned out in individual servings or meals. Foods for snacks may be commercially packaged individual servings.
    - Other/Combination – Some other variation. This includes a combination of meal preparation methods during one meal period. Describe in Q. 5e.
    - Code N/A for meals and snacks, if any, that were not observed (not offered).

Question 6: Meal Service

- Code ONE of the following options for each meal/snack, based on how *solid foods* are handled:
    - Family style – Foods are offered in common bowls/platters/containers. Children are encouraged, with help, to portion out their own food.
    - Staff serve children – Classroom staff or cook portion out each item for each child.

- All foods pre-portioned – Foods are already portioned out in individual servings or meals. Foods for snacks may be commercially packaged individual servings.
- Other/Combination – Some other variation. This includes a combination of meal service methods during one meal period. Describe in Q. 6e.
- Code N/A for meals and snacks, if any, that were not observed (not offered).

Questions 7/7a: Butter/Margarine/Meat Fat on Cooked Vegetables Offered on Day of Observation

- If cooked vegetables are served, indicate whether you see added fat.
- If you cannot see added fat, ask cook or classroom staff if fat was added.

Question 8: "Typical" Use of Butter/Margarine/Meat Fat on Cooked Vegetables

- Ask teacher or cook about usual practice.

Question 9: Sufficient Details Regarding Foods and Beverages Offered

- Indicate whether you were able to speak with someone who could provide enough details about the foods and beverages offered.
- If "Yes", specify the title of the person who gave you information.
- Check "No" if you think it would be helpful to speak with someone else. In Q.9a, record who you spoke with (if anyone), the type of information you were unable to obtain, and the contact information for the appropriate person to contact in a follow-up phone call.

IIC: JUICE

Questions 10 - 12

- Indicate whether 100% juice was offered at any meal or snack (Q. 10).
- Describe how juice is offered (Q. 10a). If offered in commercially pre-portioned container, specify the size of the container in fluid ounces (fl oz).
- Indicate whether children were allowed second helpings of juice (Q. 11) or encouraged to use water as an alternative (Q. 12).

IID: STAFF BEHAVIORS

Note: The term "staff" refers to all adults in the classroom. Base your responses in this section on whether you see or hear **ANY** staff member engaging in the behavior.

Questions 13 – 14b: Staff Seating/Eating During Meals and Snacks

- For each meal and snack, indicate whether **ANY** staff sat and ate with children (rather than just supervise).
- If **ANY** staff did sit and eat with children, were they offered the same foods and beverages as the children (Q. 14a); did they skip or not eat any of the foods or beverages (Q. 14b)?
- Explain any "no" (asterisked) responses in the space provided in Q. 16.

Question 15: Staff Consumption of Less Healthy Foods/Drinks

- Indicate whether you observe **ANY** staff consuming "less healthy" food or drink in a location where they are visible to children.
- This includes the entire day; not just official meal/snack times.
- Count soda (regular or diet), snack foods (sweet or salty), fast food, and other high sugar/high fat foods.
- Count fast food bags or other containers that may be visible to children even if no one is eating from it at the time.
- DO NOT count coffee or tea.
- Explain any "no" (asterisked) responses in the space provided in Q. 16.

Question 16: Descriptive Detail on Staff Behaviors

Use this space to describe what staff were doing if they were not sitting with children, the "less healthy" foods you observed staff eating, and where staff were when they consumed these foods.

Questions 17/17a: Child Satiety – Fullness Not Respected

- Check "Yes" if you see any evidence of staff pushing food after a child has said or otherwise indicated that he/she is finished eating.
- Specify exactly what staff said in the space provided (Q. 17a).

Question 18: Child Satiety – Unsolicited Second Helpings

- Check "Yes" if you see staff serve food without asking child if he/she wants more or waiting for child to ask.

Questions 19/19a: Encouraging Picky Eaters

- Check "Yes" if you observe staff gently and positively encourage children to eat/try new foods.
- Specify exactly what staff said in the space provided (Q. 19a).

Questions 20/20a: Using Food to Control Behavior

- Check "Yes" if you observe staff using food as a reward, taking food away for misbehavior, or threatening to take away or provide a food item at a later time based on child's behavior, even if they do not follow through.
- This does not include moving a child to a different table to eat because they were disrupting the group.
- Specify exactly what staff said in the space provided (Q. 20a).

Questions 21/21a: Encouraging Fruit and Vegetable Consumption

- Check "Yes" if you observe staff using specific messages to encourage consumption of fruits and vegetables.
- Does not include general encouragement to eat all foods offered.
- Specify exactly what staff said in the space provided (Q. 21a).

Questions 22/22a: Talking about Healthy Foods

- Check "Yes" if you observe staff using specific messages about the importance of eating healthy foods, during meal or snack times.
- Does not include general encouragement to eat.
- Specify exactly what staff said in the space provided (Q. 22a).

Questions 23/23a: Additional Detail on Staff Comments

Use this space to describe any other comments you hear from staff related to nutrition/eating that you consider important.

SECTION III: PHYSICAL ACTIVITY

IIIA: OPPORTUNITIES FOR PHYSICAL ACTIVITY

Note: Refer to the activities recorded in the grids in Q. 2a – 2d to code the following questions.

Questions 24/24a: Structured Physical Activity Focused on Movement/Stretching/ Body Awareness

- Indicate whether you observed ANY structured physical activity focused on movement/stretching/body awareness (based on activities recorded in Q. 2a.

- A structured activity is one that is led by staff or parents and focus on movement/stretching/body awareness (e.g., teaching a skill or about a specific body part) rather than increasing moderate or vigorous activity.
- If you recorded "Other" for staff interaction, describe the type of interaction you observed. Indicate the activity number from the description column in Q. 2a if "Other" was used for more than one activity.

Questions 25/25a: Structured Physical Activity Focused on Increasing Moderate or Vigorous Physical Activity

- Indicate whether you observed ANY structured physical activity focused on increasing children's levels of moderate to vigorous MVPA (based on activities recorded in Q. 2b.
- A structured activity is one that is led by staff or parents and is designed to increase heart rate for a sustained period. Examples include brisk walk, run, calisthenics, or other activity more intense than a normal walk.
- If you recorded "Other" for staff interaction, describe the type of interaction you observed. Indicate the activity number from the description column in Q. 2b if "Other" was used for more than one activity.

Question 26: Use of Music or Singing

- Indicate whether any of the observed structured physical activities included music or singing.

Questions 27/27a/27b: Free Play

- Indicate whether you observed ANY periods of free play (based on activities recorded in Q. 2c.
- Free play includes indoor and outdoor unstructured play time.
- If you recorded "Other" for staff interaction, describe the type of interaction you observed. Indicate the activity number from the description column in Q. 2c if "Other" was used for more than one activity.

Question 28: Extended Periods of Sitting

- Indicate whether you observed any seated activity that exceeded 30 minutes.
- Count periods of "screen time."

IIIB: Staff Behaviors

Question 29: Active Play and Punishment

- Check "Yes" if you observe staff disciplining a child and putting them in timeout for a significant period of time (more than 1 min per age of the child) while the rest of class has active play time.

- Check “Yes” if you observe staff “take away” play time or outdoor time for the whole class due to misbehavior.
- Use of behavior management techniques that help a child regulate himself better and participate during an activity is not considered punishment.

Question 30: Positive Staff Statements about Physical Activity

- Check “Yes” if you hear staff making positive, encouraging statements related to physical activity.

SECTION IV: WATER

Questions 31-32: Availability and Access

- Indicate whether drinking water is available for children in the classroom (Q. 31) and outdoors (Q. 32). This includes a low sink, drinking fountain, or pitcher and cups at child level.
- Indicate whether children have free access to water or have to request it (Q. 31a, 31c, 32a).

Question 33: Prompts to Drink Water

- Indicate whether you observe staff encouraging children to drink water.

SECTION V: CENTER ENVIRONMENT

VA: PHYSICAL ACTIVITY EQUIPMENT

Note: Fixed physical activity equipment is attached to the ground or a surface and cannot be moved. Some equipment items appear on both the “fixed” and “portable” physical activity equipment grids. If a center has more than one type of the same equipment (e.g., a center has one basketball hoop attached to the pavement (fixed) and a portable basketball hoop), it should be coded on both grids.

Question 34: Fixed Physical Activity Equipment

- For each item, indicate whether the center has one and where it is located.
- Indicate whether you observed one or more children using the equipment during the observation period.

Questions 35/35a: Equipment Repair/Usability (Fixed Physical Activity Equipment)

- Indicate whether any of the fixed physical activity equipment was in poor repair/not usable. This includes equipment with sharp edges, cracks, rusty nails, or other features that may cause injury.
- If problems are observed, identify the specific equipment and the problem.

Questions 36/36a: Portable Physical Activity Equipment

- For each item, indicate whether the center has one and where it is located. You may need to ask staff about some of this equipment.
- Indicate whether you observed one or more children using the equipment during the observation period.

Questions 37/37a: Equipment Repair/Usability (Portable Physical Activity Equipment)

- Indicate whether any of the fixed physical activity equipment was in poor repair/not usable. This includes equipment with sharp edges, cracks, rusty nails, or other features that may cause injury.
- If problems are observed, identify the specific equipment and the problem.

Question 38: Home-Made Toys and Props

- Instructions for making these toys and props were discussed in IM/IL training (***refer to your Stage II notebook for illustrations***).
- For each item, indicate whether the center has one. You may need to ask staff about some of these items.
- Indicate whether you observed one or more children using the toy/prop during the observation period.
- In the space provided, specify any additional home-made toys or props present and indicate whether you observed children using the toy/prop.

Questions 39/39a: Home-Made Toy/Prop Repair/Usability

- Indicate whether any of the home-made toys or props was in poor repair/not usable. This includes toys or props with sharp edges, cracks, rusty nails, or other features that may cause injury.
- If problems are observed, identify the specific item(s) and the problem.

Question 40: TVs, Computers, and Video Game Systems

- For each piece of electronic "screen time" equipment, indicate whether it was present in the classroom, whether children had free access to it, and whether you observed children using it during the observation period.

VB: PHYSICAL ACTIVITY SPACE

Question 41: Outdoor Play Space

- Choose one answer that best describes the available outdoor play space.
- If you indicate "Other," describe the outdoor play space.

Questions 42/42a: Restrictions on Outdoor Play Space

- Check "Yes" if available outdoor play space is restricted (> than 1/3 area not available to children).
- This may occur because center is understaffed or because of potential safety problems with structures, fencing, standing water, or other issues.
- If outdoor play space is restricted, specify the reason(s).

Questions 43: Classroom Play Space

- Choose one answer that best describes the available classroom play space.

Questions 44/45: Indoor Gross Motor/Play Space

- Indicate whether the center has a separate space available for play/gross motor activity for use at any time (Q. 44) or for use during inclement weather (Q. 45).
- You may have to ask staff directly about additional play space available, if not observed.

VC: OTHER CENTER CHARACTERISTICS

Questions 46-47: Posters, Displays, Pictures

- Check "Yes" if you observe posters, pictures, or display books (in eye sight of children) related to physical activity/movement (Q. 46) or healthy eating/ nutrition (Q. 47). For physical activity, focus must be on movement/MVPA, not just equipment.

Question 48: Music CDs

- Indicate whether you observe music CDs that focus on nutrition, healthy eating, or physical activity. You may need to ask staff.
- Code the appropriate "Yes" response based on whether the music CD was used on the day of observation.

Questions 49/49a: Formal Nutrition Education Lessons

- Indicate whether you observe any <u>formal</u> nutrition education, taste-testing, or cooking experiences, or evidence of such events (for example, class pictures or assigned time on a schedule).
- Describe the focus of the lesson and the food(s) involved, if any.

Questions 50/50a: Formal Physical Education Lessons

- Check "Yes" if you observe a <u>formal</u> physical activity lesson or evidence of such events (for example, class pictures or assigned time on a schedule).

- The lesson could deal with learning a gross motor activity that teaches children a new movement, such as throwing or kicking, or a discussion about physical activity or play and why it is important for our bodies.
- Physical education class *activities* do not count. It is activities that support and help children learn about movement and their bodies (not simply being lead in jumping jacks as part of P.E. class).
- Describe the focus of the lesson and the equipment used, if any.

Question 51: Parent Bulletin Board/Notices

- Check "YES" if you observe a bulletin board or other area where notices are posted for parents AND notices include information about nutrition, healthy eating, or physical activity.

Question 52: Posted Menu

- Check "YES" if you observe a weekly or monthly center menu posted in a location where it can be easily read by parents (either inside or outside the classroom).

Question 53: Choosy!

- Check "YES" if any of the pictures, posters, or music you observed included "Choosy."

Questions 54/54a: Other Mascots

- Check "YES" if any of the pictures, posters, or music you observed included mascots other than "Choosy."
- If so, describe the character, including his/her name (Q. 54a).

Questions 55/55a/55b: Vending Machines

- Note locations of vending machines in the center or, if the center is located in a large space shared with others, vending machines in any place children might pass through or use.
- Indicate whether the beverage vending machines had healthy options, such as water, low-fat milk, or 100% fruit juice. Do not count any soda or fruit drinks (not 100% juice). If vending machines contain healthy options, indicate whether all options are healthy or only some are healthy.
- Indicate whether the snack vending machines had healthy options such as pretzels, nuts, plain crackers (not sandwich-type crackers like cheese or peanut butter sandwich crackers), or animal crackers. If vending machines contain healthy options, indicate whether all options are healthy or only some are healthy.

SECTION VI: CODING GRID FOR HEAD START MEALS AND SNACKS

This grid should be coded based on the foods and beverages recorded in Section I – observation of foods and beverages offered in Head Start meals and snacks (do not include foods brought from home) – and the guidelines provided below. If you have any questions, check with Liz Condon.

Questions 56-61: Milk Types

- Indicate what types of milk were offered at each observed meal or snack. Multiple types of milk may be available at one eating occasion.
- If flavored milk is offered, specify the flavor(s) and fat content(s) (e.g., 2% chocolate, 1% strawberry).
- If you are unable to determine type(s) of milk offered for one or more meals/snacks, code it as unknown type (Q. 61).

Question 62: Fresh Fruit

- Count fresh fruit only.

Question 63: Fruit canned in juice or water

- Do not count canned fruit packed in light or heavy syrup.
- Fruit canned in heavy syrup may not be visible to the eye.
- Count applesauce if it was canned without added sugar.

Question 64: 100% Fruit Juice

- Count 100% juices only. It may also be referred to as full-strength juice. Do not count any juice "drink," juice with sugar (or high fructose corn syrup) added, or juice that contains less than 100% juice.

Question 65: Vegetables Other than French Fries and Other Fried Vegetables

- Include baked, roasted, or mashed/whipped potatoes, and hand-cut (from fresh potato), baked "French fries."
- Count pickles if they are offered as a vegetable rather than as a condiment or addition to a sandwich.
- Count vegetable soup, tomato soup, and other vegetable-based soups (e.g., minestrone) as vegetables.
- Count stir-fried vegetables if little or no fat added; DO NOT count deep-fried vegetables.
- Salsa, if offered in a ¼ c or greater portion, also counts as a vegetable.
- DO NOT count baked beans, pinto bean, refried beans, red beans, black beans or lentils.

Question 66: Dark Green, Red, Yellow, or Orange Vegetables

- Count discreet vegetable items, not vegetables in soups, salads, sandwiches, or mixed dishes.

➢ Dark green vegetables include:
  - Collard, mustard, turnip, kale, or spinach greens
  - Dark mixed salad greens or Romaine
  - Broccoli

➢ Dark red vegetables include:
  - Beets
  - Red cabbage
  - Red bell peppers
  - Tomatoes and tomato-based soups

➢ Dark yellow vegetables include:
  - Acorn, spaghetti or other yellow/orange-colored winter squash
  - Yellow bell peppers

➢ Dark orange vegetables include:
  - Orange bell peppers
  - Carrots
  - Sweet potatoes (yams)
  - Pumpkin

Question 67: Fried or Pre-fried Vegetables

- Count baked or fried French fries, tater tots, hash browns, and similar potato products, onion rings, and any other breaded, fried or pre-fried vegetable.

Question 68: More Than One Different Type of Fruit and/or Vegetable

- Count each unique type of fruit or vegetable once per eating occasion.
- Do not include juices or fried/pre-fried vegetables.
- Do not include lettuce and/or tomato in sandwiches.
- Count a lettuce salad as one item even if includes multiple vegetables included.

Question 69: High-fiber Cereals, Grains, and Grain Products

- Count oatmeal; Cheerios, Raisin Bran, Wheat or Bran Chex (not Corn or Rice Chex), Shredded Wheat; bran muffins; whole grain breads (whole wheat, oatmeal, multi-grain, rye); whole wheat pasta or brown rice; and whole grain muffins, pretzels, or crackers.

Question 70: Pre-sweetened Cereals

- This item will be coded by Liz Condon. Be sure to record (in Section I of observation form) the brand names for all cereals offered.

Question 71: Breaded, Fried, or Pre-fried Meats

- Count fish sticks, chicken nuggets, chicken filets, fried chicken patties, fried Salisbury steak, corn dogs, corn dog nuggets, fish nuggets, fried mozzarella sticks, and any other type of breaded and fried/pre-fried meat or meat substitute.

Question 72: Other High Fat Meats and Cheese

- Count sausage, bacon, bologna, cold cuts (excluding deli-style ham, turkey, and lean roast beef), hot dogs/corndogs, Salisbury steak, ground beef (<90% lean), pork riblets or nuggets, pepperoni (on pizza), and chicken/turkey/tuna/egg salads made with mayo.
- Count cheese unless part-skim mozzarella or low-fat (include cheese offered separately or as part of a sandwich; not cheese on pizza or in other mixed dish).
- DO NOT recount the breaded or fried/pre-fried meats that are counted in Q.16. Meats should fall into only <u>one</u> category.

Question 73: Lean Meats/Poultry/Fish

- Count non-breaded/non-fried chicken and turkey, lean/deli-style ham, lean/deli-style roast beef, and plain/low-fat fish fillet, tuna or salmon (not fried or prepared with no mayo or low-fat mayo), ground turkey or lean ground beef (90% lean or greater).

Question 74: Beans or Lentils

- Count baked beans, refried beans, pinto beans, red beans, black beans, lentils, and hummus offered as discreet items (not ingredients in other items, such as a burrito with beef and refried beans).

Question 75: Pizza

- Count any pizza item or pizza product, including English muffin pizza, French bread pizza, breakfast pizza, pizza sticks, pizza dippers, pizza roll-ups.

Question 76: Cookies, Cakes, Brownies, Muffins, Donuts

- Count cookies (other than vanilla wafers or animal crackers), cakes, cupcakes, brownies, donuts, cinnamon rolls, biscuits, sweet/fruit breads (i.e., banana bread), breakfast (Pop) tarts.

Question 77: Dairy-based Desserts

- Count ice cream, ice cream bars, ice cream sundaes, pudding, custard.
- Do not count frozen yogurt or low-fat ice cream, pudding, or custard.

Question 78: Chips

- Count potato chips, tortilla chips, corn chips, cheese puffs/curls, Combos, Doritos, popcorn (if not made fresh/air-popped)

Question 79: Candy

- Count hard candy, chocolate candy, candy bars, cotton candy, fudge, taffy, licorice, etc.

Question 80: Sweetened Beverages

- Count juice drinks, lemonade, soda, sports drinks, Kool-aid, Capri Suns, and sweetened tea.

Question 81: High-sugar or High-fat Condiments

- Count regular salad dressings, dips, sauces, gravy, butter, mayonnaise, tarter sauce, sour cream and cream cheese.
- Count regular syrup, jelly and honey.
- Count regardless of what food item the condiment is added to (or intended for).

Section VII: POLICIES

Ask the program director whether written policies other than national Head Start performance standards or CACFP regulations exist for nutrition and physical activity. If such policies exist, ask whether they were developed before IM/IL or as part of IM/IL implementation and obtain hard copies.

If the director is not sure whether a policy is a Head Start performance standard, err on the side of inclusion. That is, obtain copies and we can make the determination ourselves later on. You can also familiarize yourself with the Head Start performance standards so you can recognize them.
http://eclkc.ohs.acf.hhs.gov/hslc/Program%20Design%20and%20Management/Head%20Start%20Requirements/Head%20Start%20Requirements/1304

Suggested wording:

"We are interested in learning more about the policies Head Start programs have about a variety of issues related to nutrition and physical activity. These policies may have been in place before IM/IL or been developed as a result of IM/IL. I'm interested in policies that your program developed on its own, not the Head Start performance standards issued by the government."

After you have gone through the policy areas on the list, ask:

"Do you have policies for any other issues related to nutrition or physical activity that I haven't mentioned?"

Specify additional policies (if they exist) in Q. 92 – 93. Use the space provided at the end of this section (Q. 94) to explain why some documents that should have existed were not collected. You can also use this space to describe situations where you may have some question about the relevance of documents that were provided/collected.

Section VIII: BACKGROUND DOCUMENTS

Use this section of the observation form to keep track of the documents provided by the program/center. We have asked that as many of these documents as possible be sent to us before the visit. Your review of documents that do arrive prior to the visit will provide useful background and context. This is especially true of daily and weekly schedules.

When you are on-site, obtain copies of any documents that were not sent ahead of time or make arrangements for the program/center to send them. Mark the N/A box for any documents that do not apply to the program/center (for example, a center that has not done any outreach to parents as part of IM/IL will not have parent outreach materials). If the center/program has a nutrition or physical activity curricula, specify the name and year published.

With the exception of daily and weekly schedules, all of the documents we are requesting should **relate to IM/IL** specifically or to the major topic areas (structured movement,

MVPA, obesity, nutrition). Documents should be collected for **both years of implementation**. So, for example, if a program had training for teachers both last year and this year, we want agendas or other documentation for all of those trainings.

Use the space provided at the end of this section (Q. 110) to explain why some documents that should have existed were not collected. You can also use this space to describe situations where you may have some question about the relevance of documents that were provided/collected.

APPENDIX G

IMPLEMENTATION ASSESSMENT RUBRIC

IM/IL STAGE 2 IMPLEMENTATION RATING, BY DOMAIN AND OVERALL

Use the descriptions in each box below to rate the grantee you interviewed for Stage 2 in each of the following categories: Design and Planning, Staff Training and Buy-in, Enhancement Activities, Outreach to Parents, Capacity Building, Sustainability, and Overall Impression. For each numbered indicator within the category boxes, choose the column rating that best characterizes the program from the staff you spoke with. Please enter your rating for each indicator in the accompanying Excel sheet. Please assign a "1" to the column indicating the rating you assign for that numbered criteria, and a "0" to the other two columns. We will use this to determine selection for the Stage 3 site visits. At the bottom of the form, please answer the additional questions on the second sheet of the Excel file.

MPR ID Number:
Grantee Name:
Grantee City and State:

	High	Medium	Low
A. Design and Planning	A.1 Written IMIL plan- finished at TOT or upon return	A.1 Written plan started but not completed	A.1 No written plan
	A.2 Used needs assessment to formulate IMIL goals	A.2 Used some data-based information to formulate goals	A.2 No needs assessment used to develop goals
	A.3 All respondents communicated specific, consistent goals	A.3 Somewhat consistent goals- respondents seemed to report different goals at times	A.3 Unclear/no goals
	A.4 Conducted pilot activities (implemented in a few classrooms or with a couple teachers before training everyone)	A.4 Some or a few pilot activities	A.4 No pilot activities
	A.5 Respondents clearly communicated specific components of IMIL that set it apart	A.5 Vague idea of components of IMIL that differed from before TOT	A.5 No difference from activities before TOT

	High	Medium	Low
	A.6 Extensive integration of IMIL into existing or new curriculum A.7 Used extensive manual/guide for IMIL implementation (can be taken from TOT materials) A.8 Purchased or created multiple resources/equipment/props for IMIL A.9 Clear designation and responsibilities of IMIL coordinator(s) and other staff members	A.6 Some efforts made to integrate IMIL into existing or new curriculum A.7 Used minimal guide/materials for IMIL A.8 Some resources/equipment/props purchased or made A.9 Somewhat difficult to understand who is in charge of what for IMIL	A.6 No efforts to integrate IMIL into curriculum A.7 Used no guide/materials for IMIL A.8 Little or no attempt to add equipment/props for IMIL A.9 No clear staff structure in place for oversight/coordination of IMIL activities
B. Staff Training and Buy-in	B.1 Offered an extensive, planned initial training for staff B.2 Offered intensive ongoing or follow-up trainings for staff (or trainings for new staff) B.3 Staff extremely receptive to IMIL B.4 Very little turnover of IMIL coordinator or grantee leadership that could affect implementation	B.1 Conducted staff training (full or partial day) B.2 Offered minimal ongoing or follow-up trainings (or new staff trainings) B.3 Staff receptive but perhaps hesitant at first, or some staff excited and others not excited B.4 Some managerial turnover or lack of leadership buy-in poses barrier to implementation	B.1 No (or extremely abbreviated) initial training B.2 No ongoing or follow-up trainings B.3 Very little staff buy-in or excitement about IMIL B.4 Several barriers related to leadership impede IMIL implementation
C. Enhancement Activities	C.1 Created new specific policy changes (MVPA, structured movement, or healthy eating) associated with IMIL	C.1 Changed one or two policies associated with IMIL	C.1 Did not make policy changes regarding IMIL

	High	Medium	Low
	C.2 Extensive program and classroom-level *MVPA* activities C.3 Extensive program and classroom-level *structured movement* activities C.4 Extensive program and classroom-level *healthy eating* activities C.5 Considerations of modifications for IEP, ELL, cultural preferences C.6 Offered incentives for meeting benchmarks	C.2 Evidence of *MVPA* activities in the classrooms C.3 Evidence of *structured movement* activities in the classrooms C.4 Evidence of *healthy eating* activities in the classrooms C.5 Some attempt to modify IMIL C.6 Some attempt to provide incentives for meeting benchmarks	C.2 Little to no evidence of *MVPA* activities in the classroom (teacher unable to give examples of activities) C.3 Little to no evidence of *structured movement* activities in the classroom (teacher unable to give examples of activities) C.4 Little to no evidence of *healthy eating* activities in the classroom (teacher unable to give examples of activities) C.5 No attempts to modify IMIL C.6 No attempts to provide incentives for meeting benchmarks
D. Outreach to Parents	D.1 Planned and conducted specific outreach activities to parents for IMIL D.2 Actively introduced IMIL to parents D.3 Parents receptive to IMIL goals/ activities	D.1 Attempt at organizing a parent outreach activity D.2 Mentioned IMIL to parents D.3 Parents somewhat to mostly receptive of IMIL	D.1 No attempts to invite parents to understand IMIL or be included in activities D.2 Parents do not know about/confused about IMIL D.3 Parents not introduced to or receptive to IMIL
E. Capacity Building	E.1 Some success partnering with outside organizations for training or resources	E.1 Modest attempts at partnering with outside orgs for training or resources (or mention of intent/desire to do this)	E.1 No attempts to partner with or access resources for training or resources

	High	Medium	Low
	E.2 Some success partnering with outside organizations to provide program IMIL activities	E.2 Modest attempts at partnering with outside orgs to provide IMIL activities (or mention of intent/desire to do this)	E.2 No attempts to partner with or access resources for activities
	E.3 Regularly monitoring IMIL activities and make changes based on feedback	E.3 Some monitoring of IMIL activities	E.3 No monitoring of IMIL activities
	E.4 Regularly tracking and measuring outcomes	E.4 Some tracking/measuring outcomes	E.4 No tracking/ measuring outcomes
	E.5 Staff and children familiar with and regularly using IMIL vocabulary	E.5 Some familiarity and use of IMIL vocabulary	E.5 Not familiar with IMIL vocabulary
F. Sustainability	F.1 Made significant progress toward meeting IMIL goals	F.1 Made some progress toward meeting IMIL goals	F.1 Made little or no progress toward meeting IMIL goals
	F.2 Creative approaches to keeping momentum moving forward	F.2 Momentum for IMIL stayed same or partly declined over year	F.2 IMIL lost momentum over the course of the program year
	F.3 Other committees (HASC, PC) have changed policies as result of IMIL	F.3 Introduced IMIL to committees but no changes made by committees	F.3 IMIL vaguely or not introduced to committees
	F.4 Staff commitment high or increased by end of the year	F.4 Staff commitment moderate by end of the year	F.4 Low staff commitment to IMIL by end of the year
	F.5 Have specific ideas for enhancing IMIL in the future	F.5 Have some vague plans for enhancing IMIL future	F.5 No plans to enhance IMIL, or plans to discontinue IMIL
	F.6 IMIL has had effects on targeted outcomes	F.6 Some outcomes have changed as a result of IMIL (or perceived to have changed)	F.6 Little or no change in outcomes as a result of IMIL

	High	Medium	Low
G. Overall Impression	G.1 Respondents all enthusiastic about IMIL- clear understanding by all respondents about IMIL and its implementation	G.1 Mixed enthusiasm about IMIL- some staff "get it" or support it and others don't	G.1 Not much enthusiasm about IMIL by coordinator or staff
H. Final Interviewer Assessment	H.1 High level of implementation	H.1 Medium level of implementation	H.1 Low level of implementation

Additional Questions:

Q.1. Who is the intended audience of the IMIL enhancement (children, staff, and/or families)?

Q.2. Did the program distinguish between MVPA and structured movement?

Q.3. Are there any unique features about the program's IMIL enhancement worth mentioning?

Q.4. Has this program overcome any special challenges to implementing IMIL? How? What are the challenges that persist?

Q.5. Do you have any additional information to add as to why this program should or should not be selected for a site visit (consider successes and challenges section)?

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