Evaluation of the Early Head Start and Migrant and Seasonal Head Start "Little Voices for Healthy Choices" Initiative

Final Report

July 15, 2009

Prepared for:

Early Head Start National Resource Center
Zero to Three National Center for Infants, Toddlers and Families
2000 M St. NW, Suite 200
Washington, DC 20036

Prepared by:

James Bell Associates, Inc.
1001 19th Street, North, Suite 1500
Arlington, VA 22209
(703) 528-3230

1001 19TH STREET, NORTH
SUITE 1500
ARLINGTON, VA 22209
PHONE: (703) 528-3230
FAX: (703) 243-3017

Table of Contents

Executive Summary ... 3
  Overall Findings and Recommendations ... 4
I. Background and Need ... 6
Evaluation Plan Overview ... 8
II. Grantee Selection Process Overview ... 12
  Summary of selected grantees ... 12
  Recommendations ... 16
III. Training Presentation ... 17
  Training Assessment ... 17
    Pre-training Assessment: ... 18
    Post Training Assessment ... 24
    Follow-up Assessment ... 26
IV. Action Plan Creation and Review ... 29
  Findings and Recommendations ... 30
VI. Site Visits ... 31
  Site Selection ... 31
  Site Visit Process ... 32
  Summary of Findings ... 35
    Team Continuity ... 36
    Implementation Progress ... 36
    Impact of the Initiative ... 37
    Barriers and Facilitators ... 37
    Site Recommendations for Change ... 38
Summary ... 40
References ... 42

JBA

Executive Summary

The *Little Voices for Healthy Choices* (LVHC) initiative for Early Head Start (EHS) and Migrant and Seasonal Head Start (MSHS), was designed to address healthy movement, the integration of music and movement, and nutrition for infants and toddlers. The goal of the initiative is developing healthy lifestyles and routines that enhance children's physical, cognitive, socio-emotional, and motor development; the adoption of a healthy lifestyle is expected to help reduce the upward trend in the number of overweight children. The target audiences for the initiative were EHS/MSHS staff and parents, and ultimately the children enrolled in these programs. The initial recipients of the initiative information were grantee teams, generally comprised of three to four team members representing management, direct program service staff, and parents or other family members from twenty-four EHS/MSHS centers who successfully applied to participate in the program.

The initial evaluation of the LVHC pilot process, which is the subject of this report, is intended to inform program planners of the strengths and weaknesses of the LVHC content and implementation strategies during the initial stages of implementation. The evaluation activities included the following tasks:

- Review of each Grantee's application package
- Attendance at and assessment of the training process, including evaluation of
    - Satisfaction with the training content and process
    - Pre-training learning gaps
    - Short-term knowledge gain
    - Intermediate changes in practice
- Review of the goals and work plan created by each grantee
- Site visits to ten representative sites

The LVHC training was provided through a new partnership established among The Early Head Start National Resource Center (EHS NRC), Choosy Kids, LLC, and the Wolf Trap Institute for Early Learning Through the Arts.

Overall Findings and Recommendations

The implementation of the LVHC is still in its early phases; any findings represent preliminary understandings of the roll-out and beginning activities. Preliminary findings ascertained through review of the qualitative and quantitative data include the following:

- The LVHC initiative was well-received, and welcomed by EHS programs who feel children aged 0-3 are often overlooked when curriculum is developed.
- The training was perceived as a creative, dynamic introduction to the program.
- The Initiative was implemented to some degree at all sites visited. Variables affecting the degree of implementation included the resources available at the Centers; the extent of continued involvement of the team leader; and whether or not the Center was participating in the 'I am Moving/I am Learning '(IM/IL) initiative.
- The initiative had the most impact in the classroom on intentional movement activities. While the initiative was in sync with existing EHS guidelines on healthy nutrition, program personnel indicated they had the least control over that aspect of the daily classroom routine.
- While participants were generally enthusiastic about the format and the content of the three-day, experiential training session, there was some confusion about the overall objective and intent of the Initiative, and what should be done at the site once the team returned.
- Sites varied in their ability to formulate a set of goals and an action plan for implementation at each site.

Some general recommendations include:

- Develop specific objectives for the Initiative. Sites can then use these more global goals and strategies to guide their individual action plans.
- Provide sites with guidance on conducting a needs assessment and identifying community needs around nutrition, movement, and music for their program prior to attendance at the training.

- Emphasize the concept that site-specific implementation of the initiative concepts is intended to be integrated within the existing EHS/MSHS Program activities, using resources already existing within the program.
- Provide more resources for sites to use in their subsequent dissemination of the training. Ideally some method of continuing the high-energy, creative approach used during the initial training could be identified for subsequent roll-out.
- Utilize the Webinars to make the research to practice connection obvious. Provide concrete examples of how the information can be used in a practical setting.
- Provide more activities and guidance for the youngest children, ages 0-2. The training seemed particularly geared toward mobile children.
- Direct the focus of some of the training activities to creating healthy lifestyle changes for parents and staff.
- Provide more opportunities for peer-to-peer feedback.
- Provide specific techniques and resources for conducting outreach to the community.

I. Background and Need

There has been a dramatic increase in the percentage of children identified as overweight or obese since the 1970's. This is especially true in low-income households and among racial minorities, which are the very families generally served by Early Head Start/Migrant Head Start (EHS/MHS) programs. At the same time, many households, particularly those headed by a single parent and minority families, are "food insecure" (Koplan, Liverman, & Kraak, 2005). Head Start Programs therefore must deal with the dual interests of preventing obesity while ensuring adequate nutrition is provided.

There is no single standard definition of overweight and obesity in children, and these indicators differ across epidemiological studies; nonetheless, over the past 25 years the prevalence rates of obesity (defined as BMI exceeding the 95th percentile) among U.S. children and adolescents aged 6-11 and 12-19 years, have shown alarming increases. Children aged 6-11 were at 4.2 and 4.6% in 1963–1970 respectively and at 15.3 and 15.5% in 1999 – 2000, a significant increase (Bloomgarden, 2004). There are no BMI-for-age references or accepted definitions of obesity for children younger than 2 years of age. However, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) has defined the term 'overweight' for children less than 2 years old who are at or above the 95th percentile of weight-for-length, and uses this standard for determining WIC program eligibility. Under this definition, the prevalence of overweight increased 3 percentage points for children aged 2-5 years, and 3 percentage points for children aged 6–23 months (Ogden, Flegal, Carroll, & Johnson, 2002).

There are significant negative health implications for children who are overweight; they are at increased risk for type 2 diabetes, coronary heart disease, hypertension, and diabetes in adulthood (Nicklas, Baranowski, Cullen, & Berenson, 2001) as well as increased incidence of asthma and sleep apnea (Kaiser Permanente, UCSF School of Medicine, & UCLA School of Public Health, 2006) gastrointestinal disease, dyslipidemia, muscoskelatal problems, and psychosocial difficulties (Spieth et al 2000).

Although the relationships among BMI, body fat, and morbidity are less clear at the very early ages Ogden et al., such as those in the Early Head Start programs, there is still the likelihood

of an impact. Slightly older children who are overweight tend to remain overweight, and have up to a twofold increased risk of being overweight as adults (Nicklas et al., 2001). The family practices that led to the overweight infant or toddler are likely to continue contribute to obesity as the child grows.

The causes of obesity in children are multi-factorial, and include family factors, genetic predisposition, lack of physical activity, increased TV viewing, and diet (Ebbeling, Pawlak, & Ludwig, 2002). Community also has an impact; there is evidence that minority and low-income children tend to live in neighborhoods where there are fewer vendors of healthful foods, more fast-food restaurants, and exercise is made more difficult due to lack of safe places to play and engage in physical activities (Kumanyika & Grier, 2006).

In light of the concerns about the effects of obesity in children, and recognizing the multiple potential causes, the Office of Head Start charged the Early Head Start National Resource Center (EHS NRC) with developing an initiative focused on nutrition and movement. The *Little Voices for Healthy Choices* (LVHC) initiative for Early Head Start (EHS) and Migrant and Seasonal Head Start (MSHS) program staff and parents, designed to address healthy movement, the integration of music and movement, and nutrition for infants and toddlers, is the response to this charge. The *Little Voices* initiative specifically supports Head Start Program Performance Standards 1304.21(a), 1304.21(b), 1304.23, 1304.40, and 1304.41.

The stated goals of this multi-site program are:

- Develop an understanding of prenatal and infant and toddler health as it relates to movement and nutrition;
- Practice and hone skills in reflection;
- Learn effective strategies for imbedding creative movement and nutrition strategies into everyday routines in the classroom and in home settings;
- Develop and implement plans to accomplish creative movement and nutrition goals based on the unique needs and resources in the teams' individual settings, as well as the family cultures of the children being served;
- Work with EHS NRC staff and other initiative facilitators over time to apply new knowledge and perspectives and to accomplish goals; and
- Share lessons learned and participate in the evaluation of the effort.

The target audiences for the current initiative were EHS/MSHS staff and parents, and ultimately the children enrolled in these programs. The initial recipients of the initiative

information were grantee teams, generally comprised of three to four team members representing management, EHS or MSHS direct program service staff, and parents or other family members from twenty-four Early Head Start centers who successfully applied to participate in the program. The team approach is in accordance with the PART requirement that 'parents and appropriate community agencies must be involved in planning, implementing, and evaluating the agencies' nutritional services'.

The LVHC pilot initiative was created as a complement to the '*I Am Moving, I Am Learning (IM/IL)'* initiative. IM/IL addresses childhood obesity in Head Start children ages 3-5 by seeking to increase moderate to vigorous physical activity everyday; improving the quality of movement activities intentionally planned and facilitated by adults; and promoting healthy food choices everyday. The IM/IL program began roll-out in 2006, and as of 2008 had been implemented in over 200 programs across the country. Results to date have been generally positive. The intent of the LVHC initiative is to take these successful concepts and adapt them to the younger age groups, from infants to toddlers.

Evaluation Plan Overview

This initial evaluation of the LVHC pilot process is intended to inform program planners about the strengths and weaknesses of the LVHC program content and implementation strategies during the initial stages of implementation. The training session, which began the initiative, was held in early May of 2008. The evaluation therefore covers impressions gathered primarily during the first months of the implementation roll-out at the sites.

The evaluation utilized a multi-method approach, incorporating both quantitative and qualitative data collection activities. Exhibit 1 provides an overview of the intent of the LVHC Initiative and the evaluation focus utilizing a logic model. Some of the input factors viewed as potentially critical to the implementation process were the training materials and 3-day training workshop; the composition of the grantee team; the characteristics of the grantee sites, including their self-identified needs and their prior involvement with similar local and Federal initiatives, particularly IM/IL; and the assistance provided by the regional TA providers and the Early Head Start National Resource Center. The evaluation of the

fulfillment of the initiative objectives focused primarily on short-term outcomes, but included some intermediate outcomes. Assessment of the long-term outcomes requires a significantly greater period of time and fell outside the scope of the current evaluation. As demonstrated in the logic model, the initial 3-day training and the subsequent LVHC webinars are anticipated to result in an increase in the project teams' knowledge and awareness of the impact of nutrition, movement, and music on infant and toddler development and adult health. Depending upon the activities and objectives noted in grantees' action plans, the intermediate outcomes resulting from the LVHC Initiative may include improvements in the lifestyle choices of EHS/MSHS parents and staff. Specifically, the expectation was that staff and parents would improve their personal and the child's nutritional habits, and increase their own and the child's movement opportunities and environment. Among some grantees, the LVHC Initiative may result in greater community partnerships and linkages supportive of proper nutrition and movement.

The process evaluation (not included in the logic model) included the project teams' reaction to the training; completion of the sites' action plans and goals; the degree of fulfillment of the action plans; the perceived barriers and facilitators to implementation; and the reaction of other program staff to the initiative.

The following tasks were completed in support of the evaluation effort:

Review of Grantee's Application package. The evaluation team reviewed each site's complete application package, assessing, to the degree possible provided by the qualitative material provided in the application, the following aspects: the pre-training degree of concern with weight issues at the site; the degree of community support for nutrition and movement programs; the extent of current programs in place that address the issue of childhood obesity; and relevant demographics of the site and the children served at the site.

Attendance at EHS NRC Training Presentation. The evaluation team attended the three day intensive training seminar at Wolf Trap Foundation for the Performing Arts. Members of the evaluation tea m provided information on the upcoming evaluation activities during the introductory session.

Assessment of the training process, including evaluation of satisfaction with the curriculum, and training short-term and longer term outcomes. Assessment was conducted at three key points: immediately prior to the training; immediately following the training presentation and approximately six months later. Survey questions were based on the training content and objectives.

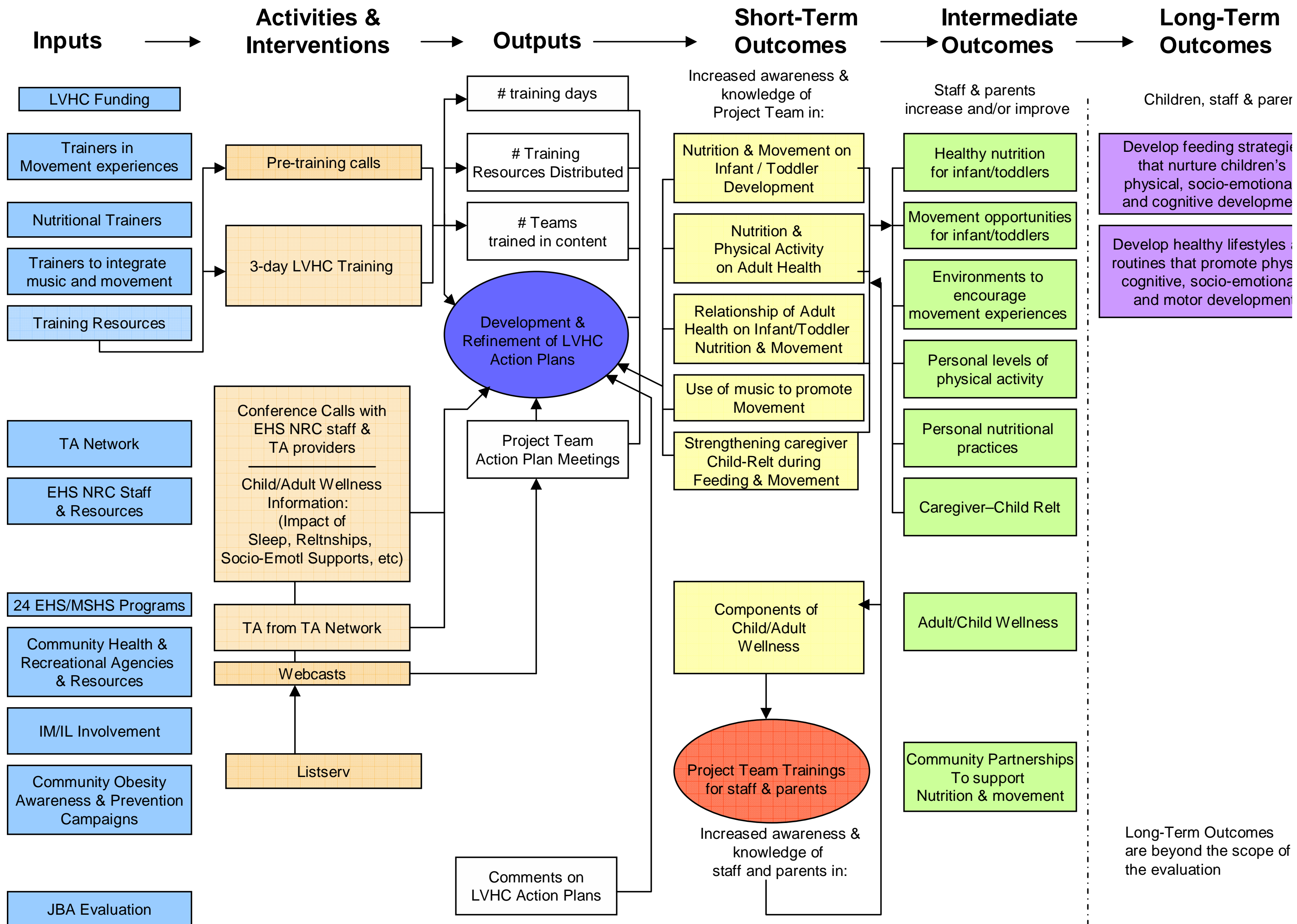
Review of the goals and work plan created by each grantee. Trainees were required to prepare goals and a work plan at the end of the training presentation, or shortly thereafter. The JBA evaluation team reviewed the goals and provided feedback on the feasibility and measurability of the implementation plan and goals through the EHS NRC. During the site visits team members were assessed regarding the perceived level of implementation achieved.

Site visits to selected grantee sites. Site visits were conducted at representative sites. During the two day visits, both qualitative and quantitative data were gathered.

Details of the execution of each of these tasks and the outcomes and subsequent recommendations are provided in the following sections.

Logic Model Exhibit 1

Logic Model for Little Voices for Healthy Choices (LVHC)



Assumption: Infants and toddlers and their caregivers will experience improved health outcomes when nutrition is improved and movement and physical activity is increased. Movement experiences can be enhanced and encouraged by incorporating music.

II. Grantee Selection Process Overview

Twenty-four EHS and MSHS programs, chosen to be representative of the 728 EHS programs and 60 Migrant Head Start programs within the 10 Administration for Children and Family (ACF) Regions and two program branches, were selected through a competitive application process. The application process required a letter of support from the executive director, completion of a brief survey on the characteristics of the program, and a description of each of the proposed team members and their anticipated role. The original application requested nomination of three team members—one in a management position; an individual in a direct service position; and a parent or other family member. Subsequently, funding was established for another team member position; the majority of the sites sent four individuals to the training.

The sites received travel expenses for the team to travel to the program and training resources, including copies of the training manual, music CDs, and related activity props for the children. Each EHS/MSHS Program, in turn, committed to attendance and full participation in the training and to set aside time in the future for the team to conduct follow-up and implementation activities at the program site, and, as appropriate, within the community. Each program was also required to commit to participation in the evaluation process.

Summary of selected grantees

The sites selected for participation in the program are listed in Exhibit 2 below.

Exhibit 2

Little Voices for Healthy Choices Grantee List

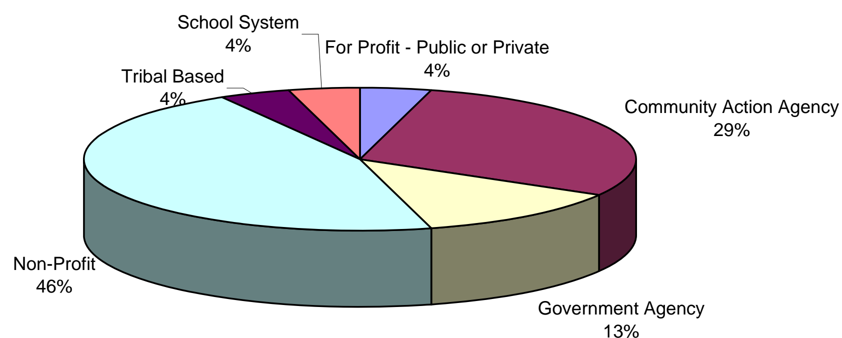
Grantee	Region
Childcare Learning Centers of Stamford	1
People's Regional Opportunity Center`	1
Montclair Child Development Center	2
Autonomous Principality of Carolina	2
Community Services for Children	3
Venango County Human Services	3
Coastal Community Action, Inc.	4
Alabama Council on Human Relations	4
Community Action Partnership of Ramsey and Washington Counties	5
Capital Area Community Services	5
Neighbors in Need of Services, Inc. (NINOS)	6
Arkansas Human Development Corp.	6
ECKAN Head Start	7
Panhandle Community Services	7
Early Explorers EHS TGU School District #60	8
Clayton Early Head Start	8
Maui Family Support Services	9
Episcopal Community Services	9
Chicanos por la Causa	9
Washington State Migrant Council	10
Okanogan County Child Development	10
Fon du Lac Reservation	11
Cherokee Nation Early Childhood Unit	11
Tri-Valley Opportunity Council	12

The JBA team reviewed the applications of the grantees ultimately selected for participation, abstracting relevant data on the site characteristics and entering the data into an Access database. In general, the selected sites are similar to EHS/MHS sites across the country. The majority (46%) of the agencies are non-profits (either public or private) with a substantial percentage (29%) indicating they are part of a community action agency (Exhibit 3 provides a breakdown of the reported agency types). Compared to overall Program Information Report (PIR) data for 2008, there are fewer school systems represented (4% of grantees compared to 10% overall) and slightly more government agencies (13% grantees compared to 7% overall). Eighty-three percent are EHS sites; 4% are MSHS, with 13% reporting they operate both

EHS/MSHS programs. This represents a slightly greater number of MSHS sites; overall PIR data indicate a 92% EHS, 8% MHS breakdown for programs overall in 2008.

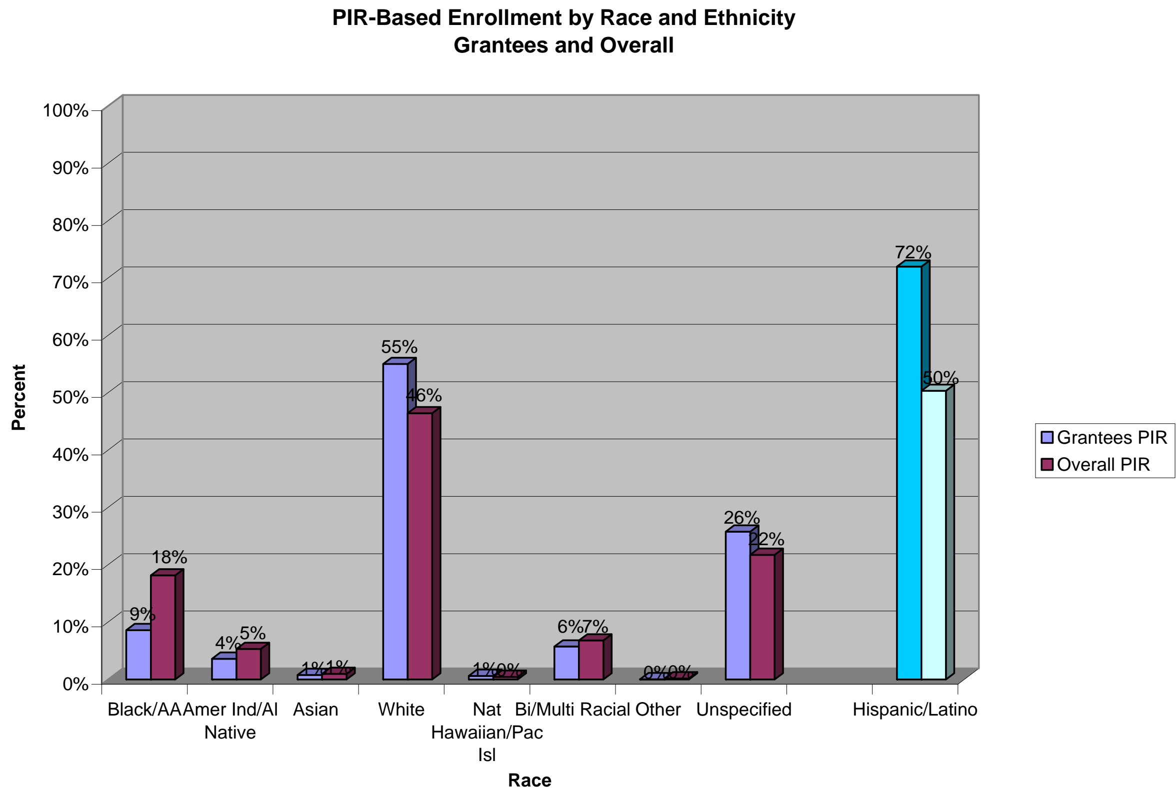
Exhibit 3

Type of Agency



The predominant race and ethnicity of the children served by the grantee programs (according to the 2008 PIR data) compared to overall enrollment data is shown in Exhibit 4. Although grantee sites have fewer African American children enrolled when compared to enrollment overall, the reported percentage of Hispanic/Latino children, at 72%, is greater than the overall percentage (50%). This reflects the specific inclusion of Migrant programs.

Exhibit 4



The majority (nearly 80%) of the selected grantees began receiving EHS/MHS funding prior to 2000; the most recently funded program began in 2004. All of the grantees have a WIC partnership in place.

Specific to this initiative, thirty-three percent of the selected sites had participated in training in the IMI/IL curriculum, with most reporting receipt of the training in 2007. Twenty-percent of the grantee sites indicated at least some of the proposed team members had worked together previously as a team.

The grantees provided information in their application on the extent to which they perceived obesity to be a problem at their site, both for the children they serve and among the staff. All of the applicants reported being somewhat (8%) or very (92%) concerned about weight

issues for staff and the children and families they serve. Most of the concern was reported around weight issues of staff and parents; half of the grantees indicating that 40% or more of staff were overweight, with all grantees indicating that at least 10% of the staff were overweight. The same distribution of responses was seen in response to the question on parental obesity. As would be anticipated with this early age group, overweight in children was currently less of a problem, although 70% of the sites perceive that 10% of the children are overweight. PIR data indicate that for the grantee sites combined, 1.4% of the children are receiving medical treatment for overweight; this compares to 3% overall (MSHS and EHS programs combined.

Most (22 of the 24 grantees) report serving pregnant women; all of overall 5.4% those responding affirmatively provided information on breastfeeding and a location for breastfeeding mothers at the time of the grant application.

Grantees listed a wide variety of existing nutrition and movement oriented programs both within their centers and within the community. These programs include Nike Fit, Project SOS, Baby and I, and Healthy Mothers and Health Babies. The full listing of program data is provided in Appendix I.

Recommendations

Inclusion of a brief needs assessment section within the application could help sharpen the grantees focus on what their program specifically hopes to gain from participation in the LVHC initiative. This in turn would assist the sites with the process of creating action plans and goals for implementation of LVHC within their program.

Enhanced guidance in the application on the anticipated roles of staff and parents who will attend and subsequently disseminate the training, as well as some indication of the time commitment that will be required, would help to ensure the team members are appropriately selected and subsequently committed to the process.

III. Training Presentation

The Little Voice for Health Choices training presentation was the result of a new partnership established among The Early Head Start National Resource Center (EHS NRC), Choosy Kids, LLC, and the Wolf Trap Institute for Early Learning Through the Arts. The Wolf Trap Institute for Early Learning Through the Arts is an 'internationally respected program that provides innovative arts-based teaching strategies and services to early childhood teachers, caregivers, parents, and their children from 0 to 5 through the disciplines of drama, music, and movement' (cite web site). Choosy Kids LLC is a private company that focuses on providing obesity prevention training. Choosy Kids was the National Training Team for the Office of Head Start's "I Am Moving, I Am Learning (IMIL)" initiative to combat childhood obesity. IMIL, targeted at children in Head Start, was rolled out in 2007 and presented to approximately 200,000 children. Training has continued throughout 2008. The IMIL 'mascot' Choosy, was also utilized in the LVHC presentations to enhance continuity in the approach between the IM/IL and LVHC initiatives.

For the three day training program conducted at Wolf Trap by the collaborators, no curriculum was utilized per se; the focus of the training was on providing experiential activities leading to information dissemination on nutrition and movement. PowerPoint presentations and discussions were interspersed with the experiential opportunities. Teams began creating their action plans at the close of each day of the training sessions, and were encouraged to continue their development once they returned to their site. Development of the goals and action plans at the individual sites continued over a two-month period.

Training Assessment

All members of the evaluation team attended at least some portion of the training; two evaluation staff member attended all sessions. During the opening session, the JBA team presented the evaluation intent and process to the grantees.

The training assessment was conducted at three key points: immediately prior to the training; immediately following the training presentation and approximately six months later. Survey questions were based on the objectives of the initiative and the training content. The survey

methods included hard-copy surveys for the pre and post training assessments and web-based assessment for follow-up.

The training assessment objectives were to ascertain:

- Baseline and subsequent changes in knowledge, attitudes, and behaviors regarding appropriate nutritional practices and their impact on health
- Baseline and subsequent changes in knowledge, attitudes, and behaviors regarding amount and type of activity that is appropriate at each age/stage
- Satisfaction with training process, content and presentation.

Complete copies of the training questionnaires are included in Appendix 2.

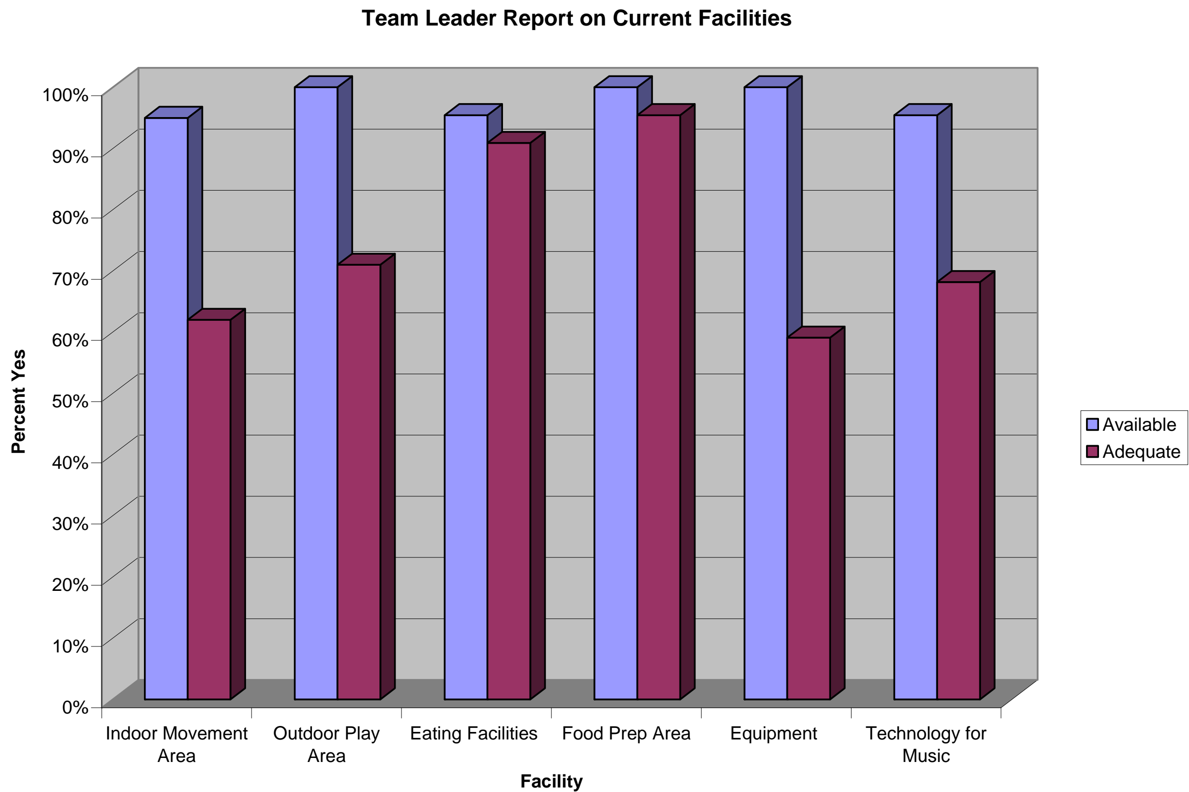
Pre-training Assessment:

The pre-training assessment was divided into two parts. Team Leaders only were asked to report on their Program characteristics, including the type of facilities available for movement and nutrition activities, space restrictions, and community involvement. It was felt the team leaders would be the most knowledgeable about the program facilities and history, as they were generally the most senior member of the team. All team members, including the team leader, were asked to report basic demographic information, their background in early childhood education, and their participation in other nutrition or movement training experiences or training. Self-ratings on level of knowledge surrounding obesity prevention, movement and music, and nutrition were obtained. Each team member as also asked to rate the level of nutritional and exercise needs within the community they serve.

Team Leader Feedback

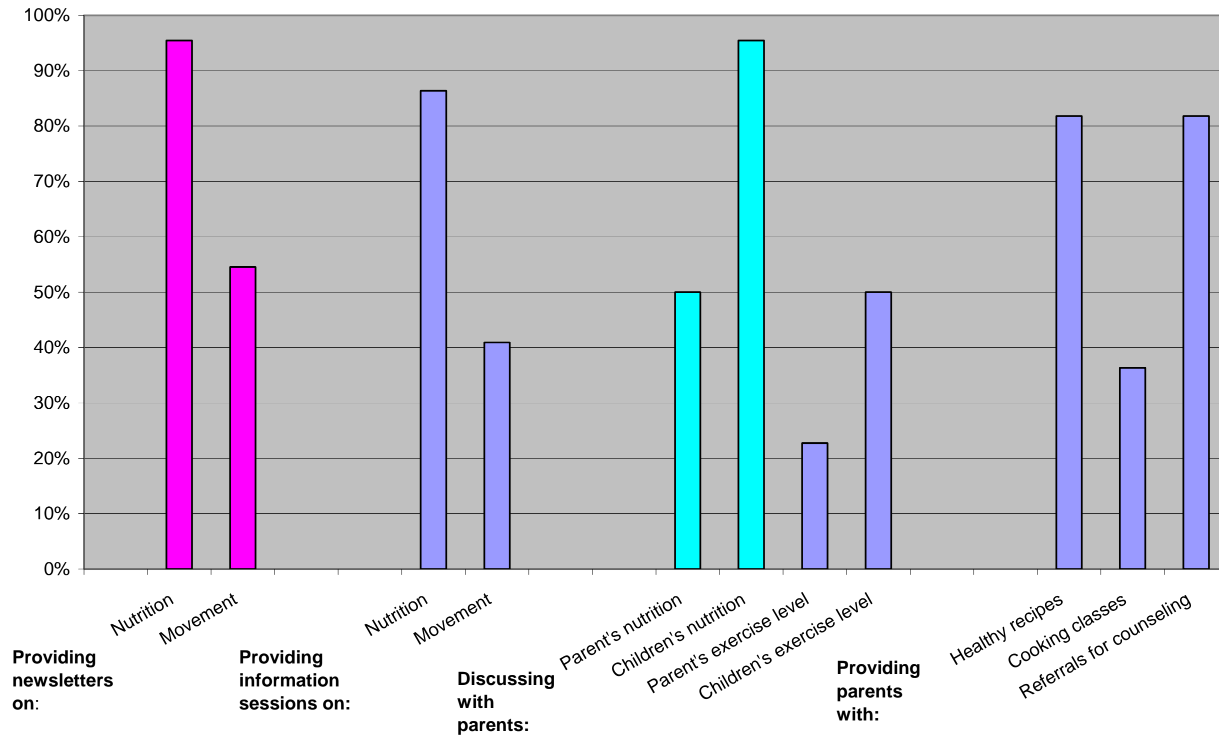
Twenty-two of the twenty four team leaders responded to the Team Leader questionnaire. Of those responding, most noted their program had the facilities available for a variety of movement and nutrition related activities (indoor and outdoor movement, food preparation and eating facilities, etc); however, ratings for adequacy of the facility were less positive (see Exhibit 5). In particular, only slightly more than half reported the indoor movement areas and the equipment available for encouraging active movement were adequate.

Exhibit 5



Most programs were already providing some nutrition and movement-related activities; In general, the emphasis was on nutrition more than on movement. For example, newsletters, informational sessions, discussions, and other resources for parents were primarily focused on nutritional activities, and were primarily aimed at the child (see Exhibit 6).

Exhibit 6



Most programs were providing information to pregnant/breast-feeding women, and were doing standard assessments of infant and toddler's weight and height, but few were noting the amount of time spent outside, or using a curriculum that focused primarily on physical activity and nutrition. (See Appendix 3 for complete frequency data).

Pre-Training Assessment Feedback- All

Eighty-eight individuals from the twenty-four sites responded to the pre-assessment questionnaire. Full frequencies are provided in Appendix 3; a summary of the data is presented in this section.

The grantee trainees were primarily female (95%), between ages 26 and 45 (63%) and with some college. A wide variety of job titles were represented (Exhibit 7); the highest

proportions of respondents were teachers, home-based visitors, parents, and Health Service managers/Coordinators.

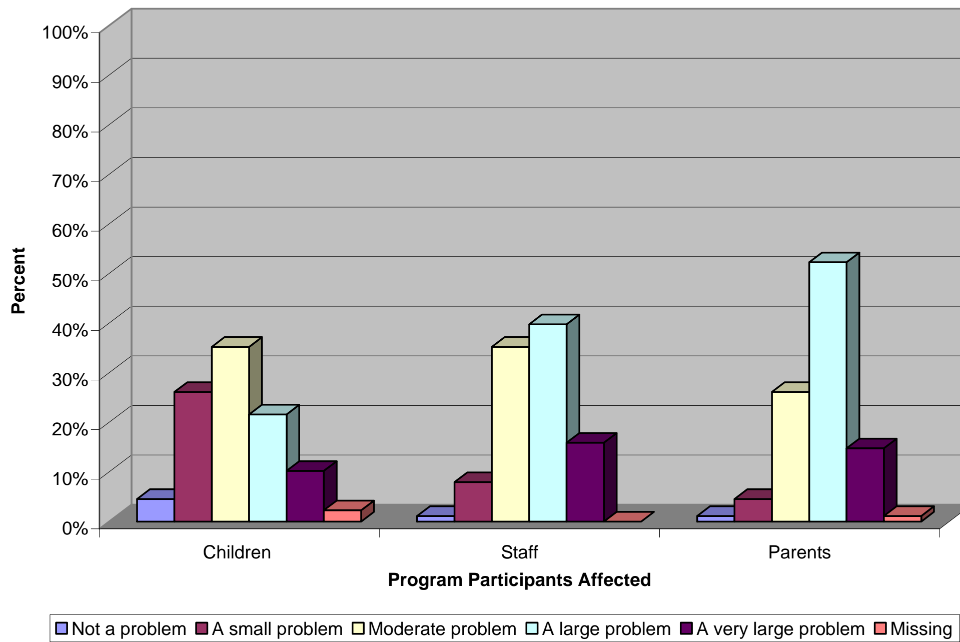
Exhibit 7
Which of the following best describes your job title or affiliation with EHS or the MHS program (Multiple responses allowed)

Teacher	20%
Parent of child in the program	20%
Home-Based Visitor	19%
Health Services Manager/Health Coordinator	15%
Other	14%
Policy Council Representative	11%
Nutritionist	8%
Home-Based Coordinator	8%
Education Coordinator	7%
Early Head Start Coordinator	6%
Child Development Supervisor	6%
Disability Services Manager	3%
Family and Community Partnerships Manager	3%
Family Services Worker/Parent Liaison	3%
Early Head Start/Migrant Head Start Program Director	2%
Grandparent of child in the program	2%

The median number of years working with EHS/MHS was 5 years (ranging from six months to 24 years) and total years experience working with children (reported in categorical form) was also variable, with 34% reporting 10 years or more experience. Approximately 23% of the respondents had received training in the I am Moving/I am Learning programs, with the same percentage noting they were involved in implementing that initiative at their program. Twenty-one percent indicated they had received training in other nutrition or movement programs; the most commonly cited training program was associated with WIC.

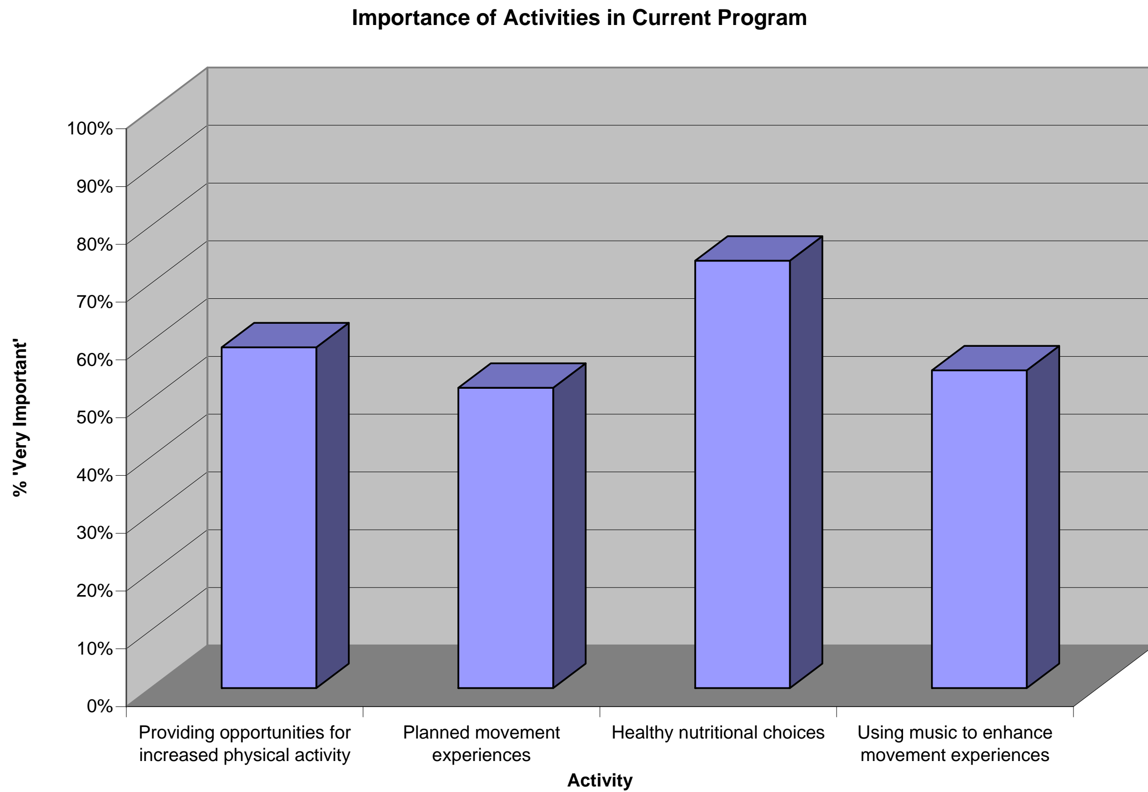
Obesity is viewed as a health problem that affects all program participants—children, parents and staff—with parents being perceived as having the most issues, followed by staff, and then the children (Exhibit 8).

Exhibit 8



While most programs are already stressing nutrition (76% note it is 'Very Important' in their current program), movement activities receive less emphasis (Exhibit 9).

Exhibit 9



Participants reported the least amount of current knowledge in the community interaction area - assessing community efforts related to nutrition and movement, and expanding community partnerships (Exhibit 10). They reported the highest levels of current knowledge in understanding the impact of nutrition on brain development. The understanding of the impact of early relationships, and how other movement experiences relate to development were also areas where participants reported an existing moderate to high level of current knowledge. They were less knowledgeable of how to increase physical experiences.

Exhibit 10
How would you rate your knowledge level in the following areas?

Current Knowledge Level	Low	Moderate	High	Missing
Impact of early relationships on healthy movement & nutrition	5%	60%	34%	1%
Impact of nutrition on brain development	6%	48%	45%	1%
How movement experiences relate to development	5%	48%	34%	14%
Methods for incorporating movement into routine	14%	61%	25%	0%
Increasing opportunities for physical experiences	9%	60%	16%	15%
Using music to enhance movement	14%	55%	32%	0%
Creating healthy snacks/meals	10%	45%	36%	8%
Teaching toddlers good nutritional choices	18%	57%	25%	0%
Teaching adults good nutritional choices	17%	49%	24%	10%
Informing adults about healthy movement	16%	63%	22%	0%
Expanding community partnerships	33%	41%	14%	13%
Evaluating community efforts related to nutrition & movement	41%	53%	6%	0%

Post Training Assessment

All participants were asked to complete a second survey at the training site immediately after the training sessions were completed. Responses were received from 93 of the 95 training participants (98% response rate).

In general participants were very pleased with the training sessions. Overall satisfaction ratings were at 75%; 97.8% would recommend the training program to others. The presenters

and the suitability of the training environment received particularly high marks. The training was perceived as well organized. Participants felt there was a great deal packed into the three day period; only 39% strongly agreed that the training time was adequate.

Participants reported the greatest gains in knowledge for methods for incorporating movement into the daily routine and increasing opportunities for physical activity for infants and toddlers. Less gain was reported in the area of nutritional development and the least gains were around assessing community efforts (Exhibit 11).

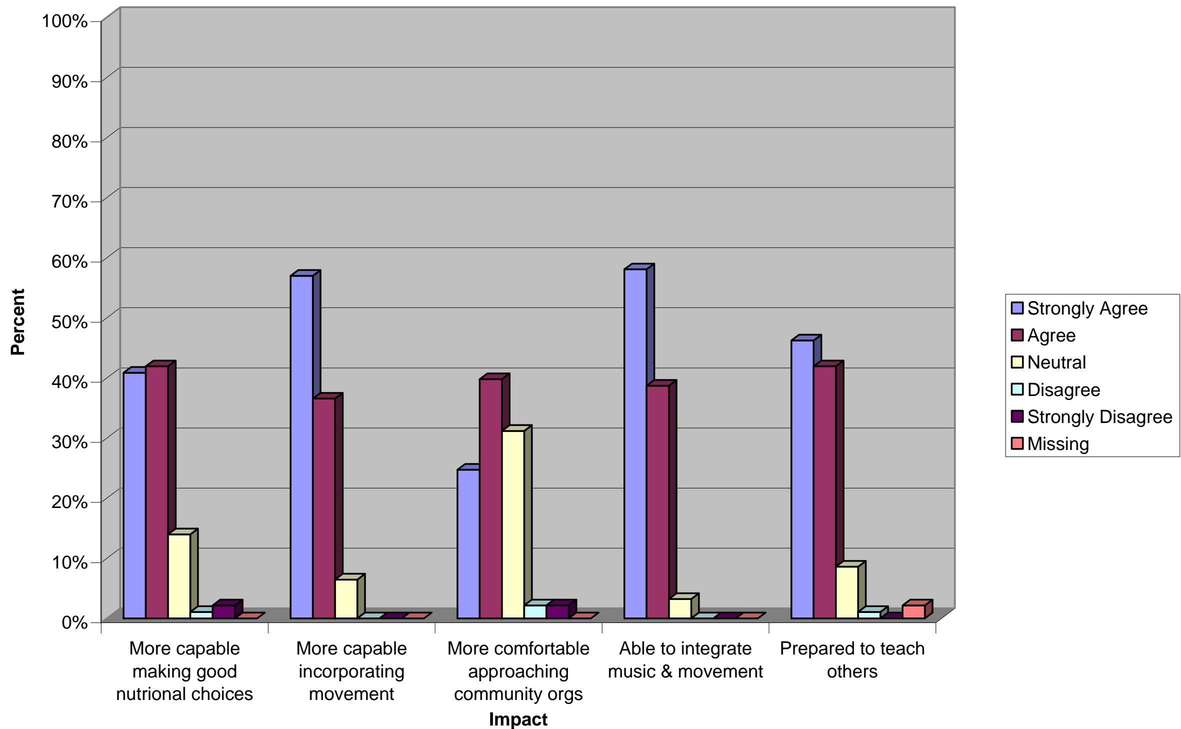
Exhibit 11
Knowledge Gains Post Training

Knowledge Level	**Not at all**	**2**	**3**	**4**	**To a Great Extent**	Missing
Understanding of impact of early relationships	**1%**	**5%**	**10%**	**44%**	**37%**	**3%**
Impact of nutrition on brain development	**1%**	**6%**	**13%**	**39%**	**39%**	**2%**
Hw movement experiences relate to development	**1%**	**1%**	**11%**	**37%**	**47%**	**3%**
Methods for incorporating movement into routine	**1%**	**2%**	**6%**	**31%**	**57%**	**2%**
Increasing physical experiences	**1%**	**1%**	**5%**	**29%**	**62%**	**1%**
Using music for movement	**1%**	**1%**	**10%**	**38%**	**49%**	**1%**
Creating healthy snacks/meals	**6%**	**5%**	**18%**	**38%**	**30%**	**2%**
Teaching toddlers good nutrition	**3%**	**6%**	**17%**	**47%**	**25%**	**1%**
Teaching adults good nutrition	**4%**	**6%**	**16%**	**46%**	**26%**	**1%**
Informing adults about healthy movement	**2%**	**5%**	**13%**	**35%**	**43%**	**1%**
Expanding community partnerships	**5%**	**15%**	**24%**	**29%**	**25%**	**2%**
Evaluating community efforts	**9%**	**13%**	**29%**	**27%**	**20%**	**2%**

The general impact of the training on the overall objectives is displayed in Exhibit 12. While there were gains in perceived ability and comfort level with integrating movement with music, and incorporating it into the daily curriculum, most indicated the training did not impact their ability to interact with other community organizations. Forty-seven percent strongly agreed they felt ready to teach the activities to other staff members

Exhibit 12

Impacts of Training Session



Full frequencies and comments for the post test are contained in Appendix 3.

Follow-up Assessment

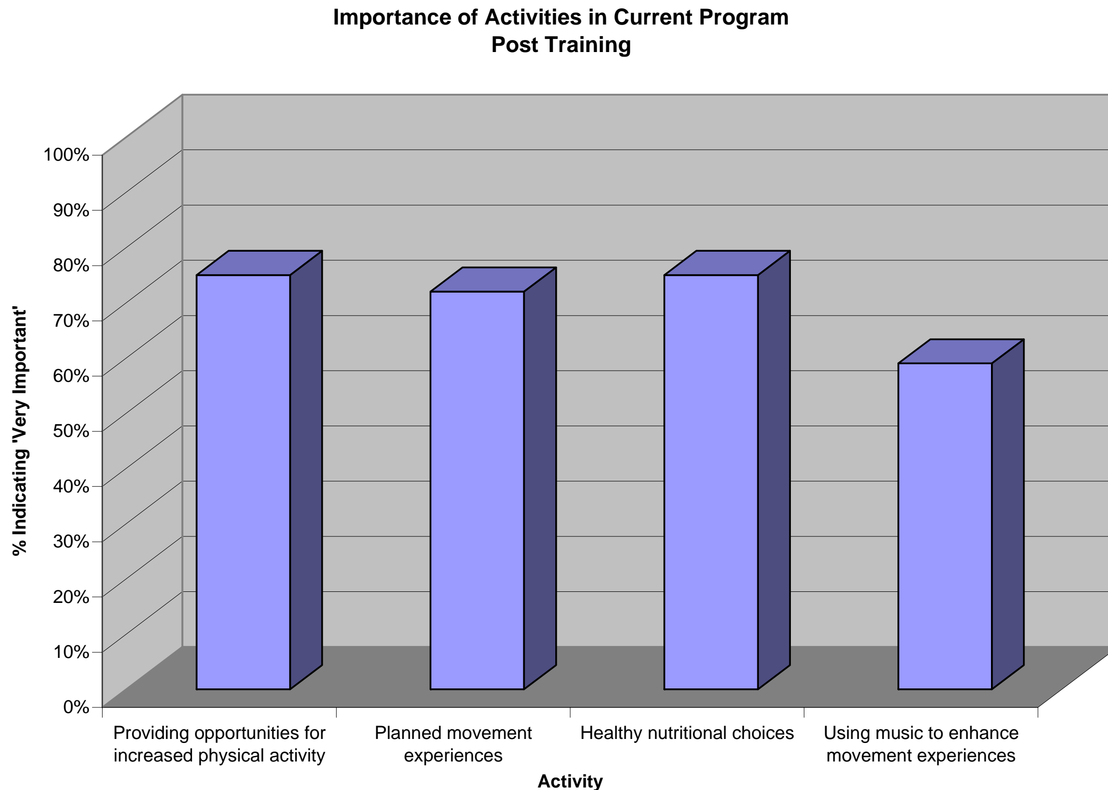
Thirty-two individuals responded to the follow-up survey (a 34% response rate, based on the original attendee count), administered approximately six months after the initial training was provided. The intent of this survey was to determine the extent to which the training was utilized once the team returned to their program and began implementing the initiative. Potential facilitators and barriers to implementing the program were assessed. Of the respondents, all were still with their original Program, although 16% had changed positions within the organization. All but 3% were involved at least to some extent in the implementation of the Initiative at their site. The breakout of responses by job category for

those who participated in the follow-up survey is similar to those held by the original group of trainees, with most respondents indicating they were teachers (19% pre-training, 19% follow-up); home-based visitors (18% pre-training, 19% follow-up); or parents (19% pre-training, 16% follow-up). The one exception is Health Service Managers/Health Coordinators, who were more likely to respond to the follow-up (14% pre-training, 25% follow-up). Given the small number of responses, the results of the follow-up survey should be viewed with some caution.

Exhibit 13 displays the ratings for importance of specific activities within the Program, as was ascertained before the training session. A difference score, calculated only for the 30 individuals who responded to both the post test and the six month follow-up survey, indicated an overall average increase in importance ratings (.6 , where 1 = 'not at all important' and 4='very important') for providing opportunities for increased physical activity, planned movement experiences, and using music to enhance movement. There was a slight average increase (.3) in the importance rating for healthy nutrition choices.

Eighty-eight percent of the follow-up respondents agreed (63%) or strongly agreed (25%) that, looking back, the content of the LVHC training program was relevant to their everyday activities; 94% have been able to implement at least some portion of the training. Slightly fewer (85%, with 19% strongly agreeing, and 66% agreeing) agreed that the training prepared them to implement the LVHC within their program, with 81% indicating they have been able to adapt the workshop materials to their program. The lowest agreement ratings were in the area of technical assistance, with 58% indicating agreement (13% strongly agreed and 44% agreed) with the statement that they have received the technical assistance needed to begin to meet their programs' goals.

Exhibit 13



The greatest areas of change in practice or policy as a result of the training were involving parents in the LVHC activities (84% indicated changes were made); integrating music and movement experiences (81%) and incorporating movement into the daily routine (72%). Fewest reported changes were in the area of reaching out to other community organization s (31%). The biggest facilitators to change were the materials provided from the training (78% indicated it helped bring about change) and the level of enthusiasm from frontline staff (63%). The biggest barrier was the amount of staff turnover (with 31% indicating it limited the ability to change). The factor that had little impact either way was the level of technical assistance provided after the training, with 59% indicating this neither helped nor hindered implementation.

JBA

IV. Action Plan Creation and Review

Beginning on the first day of the training, each team was encouraged to begin identifying three goals and a set of steps to take to meet these goals for implementation of the LVHC initiative. Trainees began preparation of the goals and a work plan, working within their individual teams, usually along with the Training and Technical Assistance (T&TA) provider for the region. The final goals and action plans were completed at the grantees respective sites within two months after the training presentation.

At the request of the EHS NRC, the JBA evaluation team provided a framework for creation of the goals that was included in the training workbook. The paradigm utilized was the SMART goal approach (Specific, Measurable, Attainable, Realistic, Timely). Subsequent to the training a number of the grantees reported difficulty finalizing their goals and action plans. The evaluation team, in conjunction with EHS NRC, provided an overview of the SMART goal approach and rationale, along with specific examples of SMART goals, during a conference session with the grantees after the training.

The actions plans were reviewed by the evaluation team and the EHS NRC, and individual feedback was provided to the sites by the EHS NRC. The evaluation team extracted each goal, and assessed it for measurability, the identification of specific measures, the feasibility of implementation given the timeframe and resources, and whether or not a target audience and a specific timeframe had been identified. In a notes section the evaluation team addressed special issues or, if the goal was particularly unclear, the team provided some alternate wording. In addition, the team suggested some very simple measures if none were given and proposed some additional basic measures if the site team seemed to have a good grasp of the general approach.

Goals and action plans varied widely across the sites in their degree of specificity, measurability, and feasibility. They ranged from some very detailed and well-described goals with specific action plans to some very broadly defined general statements of 'what comes next'. All sites did include a statement about dissemination of the program to staff, parents and occasionally the community.

The goals were subsequently categorized by the evaluation team as micro-level goals (oriented toward staff and/or parents) or macro-level (oriented toward organizations, programs or the environment). Appendix 4 contains the summary of the goals by this general scheme. Thirty-one goals addressed interactions with parents, including dissemination of information to parents via newsletters; inclusion of LVHC activities during parent meetings; and inclusion of information during home visits. There were twenty-six goals specifically addressing staff training. Thirteen goals addressed making specific changes to curricula, such as inclusion of an LVHC activity during arrival time. Fewer goals (six) addressed working with the community.

During each site visit team members were specifically asked about the process of creating the action plan and goals, including any difficulties in creating the goals, the use of outside assistance, and incorporation of a needs assessment. They were also asked to detail progress and challenges in meeting the goals, and to provide any supporting documentation (e.g., copies of monthly team meeting notes) related to implementation of the goals.

Findings and Recommendations

As mentioned above, the teams varied widely in their ability to create measureable, actionable goals. An issue noted in the evaluation of the IM/IL training (Office of Planning Research & Evaluation) was that some sites did not prepare goals for the IM/IL initiative, and those that did not were less likely to implement the initiative. The recommendation from the IM/IL evaluation was to leave time for preparation of the goals during the training and to require goal setting. These recommendations were appropriately noted and followed for the LHVC training. However, it was noted by a number of participants that the goal setting process during the training sessions was very difficult. Setting measureable goals is not an intuitive process, and is one that can be difficult for individuals who have no prior experience in this activity. The training sessions are intense, and leaving this activity for the end of the day when participants were fatigued may not be the optimal approach. It is recommended that a brief instruction session on goal setting with pertinent examples be initiated before the grantees attend the training. Each grantee site should come to the training session with up to three goals in hand. Stating clear objectives for the Initiative within the grant application would also assist with the goal setting process. The combination of global objectives and the

needs assessment noted in the prior section would assist sites in preparing targeted goals that meet an overall objective. During the training, sessions set aside for goal setting can be used for refinements of the goals rather than initiation. Given the group setting, opportunities for feedback provided by peers in a goal-sharing session would be invaluable; several sites had skilled evaluators on the team and the opportunity to hear goals, measures, and potential issues provided by individuals who share similar site characteristics would be ideal.

It was also noted during observation of the training activities that the T&TA Providers differed in their interpretation of the objectives of the training and their approach and skill level in goal setting. An additional recommendation is to provide the regional T&TAs who are attending the training with a skill building session in the goal setting process prior to the training. They will then be well-versed in the intent and steps of the goal setting/action plan process, and a common approach and vision can shared across the regions. Their skills can then be used more effectively during the training sessions and once the grantees return to their sites.

VI. Site Visits

Site visits were conducted at ten representative sites. During the two day visit, both qualitative and quantitative data were gathered. Data collection activities included:

- direct observation and coding of behaviors/activities related to incorporation of creative movement and nutrition strategies
- interviews with team members and additional program staff at all levels to assess facilitators, barriers, and best practices around implementation of the work plan for that team as well as the overall program intent
- interviews or focus groups with parents or other family members to assess extent to which the program has affected attitudes and/or practices in the home
- review of records, including menu planning, written policies and procedures, team meeting notes, daily schedules, etc.

Site Selection

For the site selection process potentially relevant variables affecting program implementation, such as the size, type of populations served, and whether or not the program had been exposed to the IM/IL training were identified, and a categorization of sites based on the responses to the grantee application surveys was created. Sites were selected for site visits to mirror the distribution of these relevant characteristics. Sites were chosen to represent a similar group of sites on demographic and other external characteristics. For example, an attempt was made to choose one site within each region; at least one Migrant and Seasonal Head Start; sites who have participated in the 'I am Moving, I am Learning Initiative', and some who have not; and sites serving different sized populations. Cost considerations, based on travel distance, were also taken into consideration. Although twelve sites were originally selected, one site was precluded from participation because it was undergoing Federal review, and a second site serving only migrant children was not in session during the anticipated site visit timeframe. Exhibit 14 provides an overview of the site selection based on the overall grantee characteristics.

Site Visit Process

The intent and the proposed format for the site visits were presented to the sites during a multi-site conference call. Sites selected for a visit were notified via an email and a letter to the LVHC team leader. The initial communication reinforced the intent of the site visit, which was to enable the evaluation team to look at the implementation of the LVHC initiative at representative sites. JBA staff requested the opportunity to observe the program in action through classroom and other observation activities; to talk with a variety of staff members and parents; and to review documentation related to the program (e.g., staff training curriculum; daily lesson plans; meeting agendas demonstrating LVHC activity incorporation).

Exhibit 14
Distribution of Site Visits by Grantee Characteristics

Variable	Category	Number Funded	%of Total Funded	Number of Site Visits Proposed	% of Total Grantee Sites
EHS/Mig/B	EHS	20	83%	9	75%
	Mig	1	4%	0	0%
	B	3	13%	3	25%
Agency	CAA	7	29%	4	33%
	NFP	12	50%	6	50%
	Gov Ag	3	13%	1	8%
	school	1	4%	1	8%
R/U/S	R only	11	46%	3	25%
	U only	7	29%	4	33%
	R/U	5	21%	4	33%
	R/U/S	1	4%	1	8%
CB/HB/B	CB only	5	21%	3	25%
	HB only	1	4%	0	0%
	Comb	18	75%	9	75%
Race/Ethn	Hisp	11	46%	6	50%
40%+	Cauc	6	25%	2	17%
	Afr Am	4	17%	2	17%
	Am In	2	8%	1	8%
IM/IL	Yes	8	33%	4	33%
	No	16	67%	8	67%
Size	0-75	8	33%	3	25%
	75-150	11	46%	5	42%
	151+	5	21%	4	33%

The overall intent was to obtain as comprehensive a look as possible at how the LVHC program was integrated into existing program activities. It was stressed during initial and subsequent communications with the sites that the focus of the visit was on the characteristics of the LVHC initiative —barriers and facilitators to implementation of the Initiative; how useful it was to the site; how easy or hard it was to implement, and additional resources that would b appropriate. It was stressed that the site was not being evaluated on how well they were doing with the implementation process, but rather on the barriers and facilitators encountered in implementing the plan. Feedback on the entire process, starting with selection of the team for the initial training, was solicited.

To begin the formal process of setting up the site visit, Team Leaders were asked to identify the appropriate individuals who should be notified of the site visit (including all team members who were still with the program). The Team Leader generally served as the main point of contact throughout the site visit scheduling and establishment of the agenda. Team Leaders were provided with a form to list the appropriate personnel who should be contacted regarding the site visit.

An agenda was developed for each site visit, detailing the locations to be visited over the two day period, and providing a schedule for staff and parent discussions. The site visit normally began with the Center Manager/Program Manager or other lead person at the agency.

Discussion guides were developed to guide the collection of information from LVHC team members, Early Head Start (EHS) and Migrant and Seasonal Head Start (MSHS) staff, and parents on the process of implementing LVHC and their initial reactions to and recommendations for improving the implementation and impact of the Initiative. Separate discussion guides were developed for individuals involved with or targeted by the LVHC Initiative. Discussion guides were developed for all roles within the LVHC Implementation team, including the LVHC Staff Members and the LVHC Parent Member. For team members of the LVHC team who also assume various roles within EHS/MSHS, interviewers used the *Supplemental Discussion Guide for LVHC Staff Members* and asked only those additional questions that corresponded to the role of the individual team member. Discussion guides were also developed for the EHS/MSHS Director/Center Director; Lead Teacher/Home Visitor; Health Coordinator/Nutrition Specialist; and Family Services Coordinator. In addition, a focus group guide was developed to facilitate discussions with program families. The full site protocol is provided in Appendix 5.

A complete site visit report was prepared for each site, and sent to the site for review and comment. Copies of the site visit reports are provided in Appendix 6. In accordance with the stated purposes of this evaluation, descriptive information about the site, a listing of the individuals who participated in the interviews and a broad statement regarding team activities only are provided with site identifying information. The remainder of the feedback has been provided in a format that maintains the anonymity of the site providing the feedback.

JBA

Summary of Findings

Although the communities visited and the geographic locations were very varied, most sites faced similar challenges in the areas of healthy lifestyles. The parents/caregivers of the children are pressed for time, as they attempt to meet the demands of low-paying jobs, and long commutes on public transportation. Some are contending with mental health issues or are struggling with addictions. There is limited time available for shopping for nutritional food and cooking, and food budgets are tight. Fast food, on the other hand, is readily available, and is perceived as being less expensive than cooking. Some parents are not very engaged at the EHS/MSHS centers due to their busy schedules, and although apparently receptive to information given to them regarding physical activity or nutrition, implementation of activities is not widespread.

The barriers to engaging in physical activity are somewhat more varied. In some cases, space for motor activity for infants and toddlers is limited or inappropriate (e.g., concrete flooring in subsidized housing make parents understandably reluctant to place infants on the floor). There is a reluctance to go outside, sometimes due to fear of the possible violence in the neighborhood, sometimes due to unwillingness on the parent's part, as parents feel they do not have the time or the energy to accompany the child outside. Limits on parent's time also means less time for outdoor activities. Extreme weather conditions also may limit outdoor time, and indoor facilities are not readily available. Many of the EHS families struggle with poverty issues; nonetheless, they make an effort to ensure their child is dressed well each day, and are very reluctant to have the child's clothing become dirty or torn through physical activity.

Some cultural barriers also exist that affect nutritional or movement activities. In many Hispanic/Latino families, there is the perception that a chubby child is a healthy child. This ideal may foster unhealthy eating habits during childhood, which could lead to both childhood and adult obesity. Some of the traditional foods within a culture (fry breads, tortillas, beans with lard) are high in fat or cholesterol. In the Hmong culture, parents do not generally engage in singing and dancing with children.

Staff members are often struggling with their own weight issues. It may be difficult for these staff members to fully participate in physical activities with the children, and parents may not be receptive to receiving health information from someone who has their own visible health need.

Team Continuity

The majority of the teams were intact with the exception of the parent team member. In some cases the parent team member's child had aged out of the program; in other cases they had left the program or were not able to continue active participation due to time constraints. Some parents reported feeling somewhat left out of the process. Teams usually reported meeting formally once or twice after the training session, often to complete the action plan, and then had moved to 'informal' meetings which often involved two or three team members discussing LVHC-related issues within the context of other day-to-day activities.

Implementation Progress

In general, the sites visited had implemented the LVHC program to some degree. The Team Leader involvement and enthusiasm, which was often limited by competing responsibilities, seemed to have a major impact on the degree to which the initiative was actually implemented at the site. Every site included dissemination of the information to staff as part of their action plan; in-service and pre-service training sessions were the most common method of disseminating the training. The main dissemination challenge for staff was finding the time and resources necessary to hold staff trainings. Dissemination to parents was often cited as a goal, but was less comprehensive; the primary method of achieving this roll-out to the parents was through use of ongoing communication avenues, such as the newsletters or regularly scheduled parent meetings. Some sites did conduct training on LVHC with parents, although a limited number of parents attended.

Some team members noted they had difficulty communicating the energy of the original training.

Impact of the Initiative

Integration of intentional movement into everyday activities was the area of greatest impact, as reported by staff and as observed by the site visitors. A music CD was observed being utilized in the classroom at most sites, usually along with the provided props, and home visitors reported extensive use of CDs during the home visits. While most sites had positive comments about the LVHC CD[1], others felt the music was too slow and/or unstructured, and substituted their own CDs. Staff and parents interviewed were generally enthusiastic about integrating music into activities, and welcomed the information on using movement. Due to the overlap of LVHC objectives with the general emphasis of the EHS/MSHS programs on healthy nutrition, and the number of other initiatives in place related to nutrition (e.g., WIC), it was difficult to ascertain the actual impact of the LVHC initiative in this area. Staff commonly reported that the nutritional components of the LVHC initiative were similar to that already in place through adherence to EHS/MHS regulations, and this was an area where staff felt they had the least impact because of organizational constraints. Many have food service arrangements or kitchens that serve multiple centers and there is little leeway in menu planning. However, a number of the sites reported a change in the food brought to staff meetings, as well as some change in the foods parents bring in for special events. Staff generally felt they were having little impact on parent's choice of foods. To impact the parents, staff indicated initiatives would have to address shopping and cooking activities, demonstrating that in-home cooking could be as cost-effective as stopping for fast-food, and not more time intensive.

Barriers and Facilitators

A summary of the commonly cited facilitators and barriers to implementation gathered from the site visits is provided below:

[1] At several sites, teachers and parents alike noted the song 'Give Me the Beat' had a very calming, organizing effect on children with behavioral problems. See letter also in Appendix

Facilitators

- √ The LVHC Initiative is consistent with the EHS/MHS culture and performance standards, and therefore is easy to integrate into current daily program activities.
- √ Management/supervisory staff were generally very supportive of the concepts of the Initiative and provided opportunities for dissemination at pre-service and in-service trainings, at staff meetings, and through other venues.
- √ Staff members welcomed the new opportunities for activities that were provided in concrete form in the training workbook. Staff found it more helpful when the activities were presented in a format that could be easily incorporated into their daily lesson plans.
- √ Music and movement activities tend to be inherently engaging for children at all age groups
- √ The initiative fits well with many other ongoing healthy lifestyle initiatives at the sites and in the community (e.g., IM/IL, Nike Fit).

Barriers

- √ Limitations due to staff turnover, cutbacks, competing responsibilities and other staffing issues limited the amount of time available for dissemination by team members of the Initiative within the site. Many of the team members serve in multiple capacities within their Program and their time to disseminate the training was often limited.
- √ It was difficult to capture the energy of the national training when training was implemented at the sites.
- √ For front line staff, there is a certain weariness associated with dealing with new initiatives; this is exacerbated by the perception that there are, on occasion, competing goals from different initiatives (e.g., Reading First (sedentary) vs. LVHC (active movement); drinking more water (LVHC) vs. drinking more milk (WIC)) that
- √ Limited indoor and outdoor play areas in homes.
- √ Parents were difficult to engage and involve.
- √ There is a lack of financial resources to support the activities (e.g., for provision of representative healthy meals/snacks at family nights or staff trainings; for additional musical and movement props).
- √ Site staff noted difficulty using the technology employed to provide the follow-up information dissemination from EHS NRC to the site. They had difficulty accessing the Google groups, the listerv, and the webinars, and noted a delayed response time to requests for assistance.

Site Recommendations for Change

- Consider bringing the LVHC training to the sites.
- Include a follow-up component to the Wolf Trap training after implementation in order to take the initiative to “the next level” and reenergize LVHC team members.
- Provide opportunities for more peer interaction among sites engaged in the Initiative

- Include a focus on sensory integration in the training and address the benefits of LVHC when implemented with special needs children.
- Include more training and materials geared directly to parents (e.g., handouts, videos). Potential topics suggested were brain development, healthy eating; shopping for and preparing nutritious, low-cost foods.
- Provide additional information regarding the importance of brain development that can be utilized with parents.
- Provide ideas for creative follow-up to keep families feeling connected to LVHC.
- Provide more structure to the training workbook, including adding an index and pagination
- Provide more information on nutrition for pregnant women
- Provide additional recipes, including multi-cultural recipes
- Provide recipes with cost and nutritional comparisons to show benefits of cooking vs. take-out.
- Provide recipes for healthy foods that can be prepared in 30 minutes or less, including recipes for vegetables.
- Create longer songs
- Create songs that are faster in tempo
- Provide more structure to the CD; segment songs between fast and slow moving
- Create songs using familiar tunes to help adapt them into repertoire – particularly when engaging parents as they have less familiarity with novel tunes and are less apt to participate
- Provide copies of the LVHC CD to all parents for use at home
- Provide more props, including those for use at home; examples include hula hoops, balls, etc.
- Provide a web site for teachers and parents with links to additional resource materials (music, activities, and additional information).
- Include more ideas and materials for infants (e.g., mats, balls, infant gyms, tummy-time blankets) and more music-making instruments and balancing equipment for toddlers.
    - Provide Spanish translation of materials
    - Provide large visuals that can be used in the classroom with the children.

JBA

Summary

The implementation of the LVHC is still in its early phases; any findings represent preliminary understandings of the roll-out of the initiative and beginning activities. This evaluation focused on the training session and the early implementation activities at the representative sites. Site visits occurred in many cases before some or all of the follow-up activity from the EHS NRC had been presented; therefore, the impact of the webinars and other post training material could not be fully assessed.

Preliminary findings ascertained through review of the qualitative and quantitative data include the following:

- The LVHC initiative was well-received, and welcomed by EHS programs who feel children aged 0-3 are often overlooked when curriculum is developed.
- The training was perceived as a creative, dynamic introduction to the program.
- The initiative was implemented to some degree at all sites visited. Variables affecting the degree of implementation included the resources available at the Centers; the extent of continued involvement of the team leader; and whether or not the Center was participating in the I am Moving/I am Learning (IM/IL) initiative.
- The initiative had the most impact in the classroom on intentional movement activities. While the initiative was in sync with existing EHS guidelines on healthy nutrition, Center personnel indicated they had the least control over that aspect of the daily classroom routine.
- While participants were generally enthusiastic about the format and the content of the three-day, experiential training session, there was some confusion about the overall objective and intent of the Initiative, and what should be done at the site once the team returned.
- Sites varied in their ability to formulate a set of goals and an action plan and goals for implementation at each site.

Some general recommendations include:

- Develop specific objectives for the initiative. Sites can then use these more global goals and strategies to guide their individual action plans.

- Provide sites with guidance on conducting a needs assessment and identifying community needs around nutrition, movement, and music for their program prior to attendance at the training.
- Emphasize the concept that site-specific implementation of the Initiative concepts is intended to be integrated within the existing EHS/MSHS Program activities, using resources already existing within the program.
- Provide more resources for sites to use in their subsequent dissemination of the training. Ideally some method of continuing the high-energy, creative approach used during the initial training could be identified for subsequent roll-out.
- Utilize the Webinars to make the research to practice connection obvious. Provide concrete examples of how the information can be used in a practical setting.
- Provide more activities and guidance for the youngest children, ages 0-2. The training seemed particularly geared toward mobile children.
- Direct the focus of some of the training activities to creating healthy lifestyle changes for parents and staff.
- Provide more opportunities for peer-to-peer feedback.
- Provide specific techniques and resources for conducting outreach to the community.

References

Bloomgarden, Z. (2004). Type 2 Diabetes in the Young. *Diabetes Care*, *27*(4), 998-1010.

Ebbeling, C. B., Pawlak, D. B., & Ludwig, D. S. (2002). Childhood obesity: public-health crisis, common sense cure. *Lancet*, *360*(9331), 473-482. doi: 10.1016/S0140-6736(02)09678-2.

Kaiser Permanente,, UCSF School of Medicine,, & UCLA School of Public Health. (2006, January). chilhood_obesity.pdf (application/pdf Object). *NY Times Supplement*. Retrieved July 9, 2009, from http://www.kpihp.org/publications/docs/chilhood_obesity.pdf.

Koplan, J., Liverman, C., & Kraak, V. (Eds.). (2005). *Preventing Childhood Obesity: Health in the Balance*. National Academies Press. Retrieved April 30, 2009, from http://books.nap.edu/openbook.phprecord_id=11015&page=319.

Kumanyika, S., & Grier, S. (2006). Targeting Interventions for Ethnic Minority and Low-Income Populations. *The Future of Children*, *16*(1), 187-207.

Nicklas, T. A., Baranowski, T., Cullen, K. W., & Berenson, G. (2001). Eating Patterns, Dietary Quality and Obesity. *J Am Coll Nutr*, *20*(6), 599-608.

Office of Planning Research & Evaluation, (n.d.). ACF OPRE: I am Moving, I am Learning – Head Start Implementation Evaluation Project. Retrieved July 14, 2009, from http://www.acf.hhs.gov/programs/opre/hs/eval_move_learn/index.html.

Ogden, C. L., Flegal, K. M., Carroll, M. D., & Johnson, C. L. (2002). Prevalence and Trends in Overweight Among US Children and Adolescents, 1999-2000. *JAMA*, *288*(14), 1728-1732.