Results from the "I Am Moving, I Am Learning" Stage 1 Survey

Final Interim Report

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CONTENTS

Page

EXECUTIVE SUMMARY vii

INTRODUCTION 1

METHODOLOGY 3

- Questionnaire Development and Administration 3
- Data Analysis 5

RESULTS 6

- Program Context 6
- Training-of-Trainers Event in Spring 2006 6
- Implementation 10
- Successes and Challenges 14
- Measuring Potential Outcomes 16
- Perceptions of Obesity 17
- Sustainability 17
- Early Head Start and Home Visitors 18
- Successes and Challenges Associated with High Implementation 18
- Training and Enhancements Associated with High Implementation 20

SUMMARY OF KEY FINDINGS 22

NEXT STEPS IN THE EVALUATION 24

REFERENCES 25

APPENDIX A: *I AM MOVING, I AM LEARNING* IMPLEMENTATION EVALUATION STUDY QUESTIONNAIRE

TABLES

Table **Page**

1 COMPARISON OF PROGRAM CHARACTERISTICS: HEAD START PROGRAMS IN REGION III THAT DID AND DID NOT PARTICIPATE IN THE SPRING 2006 *I AM MOVING, I AM LEARNING* (*IM/IL*) TRAINING-OF-TRAINERS EVENT 7

2 RATINGS OF AGREEMENT WITH STATEMENTS ABOUT THE SPRING 2006 *IM/IL* TRAINING-OF-TRAINERS 8

3 RATINGS OF THE AMOUNT OF TIME SPENT ON TOPICS DURING THE SPRING 2006 *IM/IL* TRAINING-OF-TRAINERS EVENT 8

4 DIFFERENCE IN THE PROGRAMS' RATINGS OF PERCEIVED IMPORTANCE OF *IM/IL* GOALS IN COMPARISON WITH OTHER HEAD START SERVICES AND ACTIVITIES BEFORE AND AFTER *IM/IL* TRAINING-OF-TRAINERS EVENT 9

5 TRAINING MODELS USED BY *IM/IL* PROGRAMS THAT PROVIDED TRAINING 11

6 *IM/IL* ENHANCEMENTS IMPLEMENTED WITH CHILDREN 12

7 PROGRAMS' LEVEL OF IMPLEMENTATION RATINGS: *I AM MOVING, I AM LEARNING* (*IM/IL*) GOALS 15

8 STAFF ENTHUSIASM ABOUT *IM/IL* AND *IM/IL* GOALS 16

9 STAFF ENTHUSIASM, IMPLEMENTATION SUPPORTS AND CHALLENGES, BY LEVEL OF IMPLEMENTATION 19

10 TYPE OF TRAINING, BY LEVEL OF IMPLEMENTATION 21

11 TYPES OF *IM/IL* ENHANCEMENTS IMPLEMENTED, BY LEVEL OF IMPLEMENTATION 22

EXECUTIVE SUMMARY

Creative approaches to obesity prevention have begun in Head Start with a program enhancement called *"I Am Moving, I Am Learning"* (*IM/IL*), which is intended to (1) increase the quantity of time children spend in moderate to vigorous physical activity (MVPA) during their daily routine; (2) improve the quality of structured movement activities that are facilitated by teachers and adults; and (3) promote healthy food choices for children each day. In the spring of 2006, Head Start Region III provided 53 Head Start programs with a 2½-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. The Office of Planning, Research, and Evaluation (OPRE) under the Administration for Children and Families (ACF) contracted with Mathematica Policy Research, Inc. (MPR) to conduct an implementation evaluation of the *IM/IL* enhancements in Region III. The purpose of this study is to examine the extent to which grantees who participated in the spring 2006 regional TOT event are implementing *IM/IL* enhancements. In spring 2007, MPR conducted a survey of the 53 Head Start programs that had participated in the TOT event.

The key findings from the survey include:

- One year after the TOT event, the participating programs gave the training a positive overall rating. Respondents rated the event highly on its organization and the information that was presented. However, 40 percent of directors 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 training event. Over 60 percent of programs provided pre-service and in-service training on *IM/IL*. The total number of training hours in each program was a median of 6 hours per program (range 1 to 24 hours).

- Programs implemented more enhancements related to MVPA and structured movement than enhancements related to nutrition.

- As part of *IM/IL*, two-thirds of programs offered activities to alter the eating and physical activity behaviors of parents, and half did so with their staff. Half the programs reported having identified at least one community organization as a partner. Forty-four percent of programs were doing all three.

- 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. Compared to programs that did not perceive themselves as implementers, high implementing programs were more likely to leave the TOT with a written plan for their *IM/IL* implementation. However, among all programs with a written plan following the TOT, roughly the same percentage of high implementing and other programs had a plan one year later. High implementing programs provided twice as many hours of training to staff relative to other programs.

- It is not clear that the current program-level implementation efforts can be sustained. One year after the training event, only half of the programs reported

having a written plan for *IM/IL* implementation. Many programs have enthusiastic staff and a capable leader directing the *IM/IL* efforts, but many reported that program managers did not have enough time to devote to *IM/IL*.

INTRODUCTION

There are two to three times as many obese children in the United States as there were 20 years ago (Ogden et al. 2002). To arrest this trend, both the Surgeon General (U.S. Department of Health and Human Services 2001) and the Institute of Medicine (Institute of Medicine 2005) have suggested that efforts to prevent obesity should begin early in life. A major reason for beginning prevention early is that the prevalence of obesity has increased even among preschoolers (Hedley et al. 2004; Ogden et al. 2002; Sherry et al. 2004), many of whom remain obese into adolescence (Freedman et al. 1987).

In the consideration of obesity prevention strategies for early childhood, there are compelling reasons to focus on children in racial/ethnic minority groups who live in low-income households. Among adults in the United States, there is a marked disparity among racial/ethnic groups in the prevalence of obesity (Ogden et al. 2006). It is not known at exactly what age the disparity begins, but it appears to be established by adolescence (Gordon-Larsen et al. 2003; Winkleby et al. 1999). However, the origin of this disparity may lie in the preschool years, because it is in this period of development that activity and dietary behaviors are shaped. Moreover, parents and other adults may influence young children's weight through the types of eating behaviors that they model for children (Oliveria et al. 1992; Hood et al. 2000).

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, it is likely that between 15 and 20 percent of enrolled children are obese (Story et al. 2006; Dennison et al. 2006; Whitaker and Orzol 2006).[1] The Head Start Program Performance Standards define minimum requirements for health care, nutrition, physical activity, and other services (National Archives and Records Administration 2006). For nutrition, these performance standards require that meals provide at least one-third of a child's daily nutritional needs in center-based, part day programs, and one-half to two-thirds in center-based full day programs; that staff and children eat together family style and share the same menu; and that programs adhere to serving sizes and minimum standards for nutrient content and menu planning required by the U.S. Department of Agriculture's National School Lunch and School Breakfast Program and Child and Adult Care Food Program. 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.

Creative approaches to obesity prevention have begun in Head Start with a program enhancement called "*I Am Moving, I Am Learning*" (*IM/IL*), which is intended to increase the time children spend being physically active and to improve the quality of their structured movement and food choices. Specifically, the three goals of *IM/IL* are (1) to increase the quantity of time children spend in moderate to vigorous physical activity (MVPA) during

[1] Following the recommendation of the Institute of Medicine in its report on preventing childhood obesity, this report uses the term "obese" (rather than "overweight") to describe children who have a body mass index (weight in kilograms divided by height in meters squared) at or above the 95th percentile for age and sex.

their daily routine, so that they meet national guidelines for physical activity; (2) to improve the quality of structured movement activities that are intentionally facilitated by teachers and adults; and (3) to promote healthy food choices for children each day. Rather than a prescribed stand-alone curriculum, *IM/IL* offers a framework that programs can use to design a set of enhancements that will fit their unique programmatic needs and integrate obesity prevention into their Head Start routines and practices.

Head Start Region III developed *IM/IL* in 2004 in response to a request from the Office of Head Start. *IM/IL* was designed to promote healthy behavior and prevent childhood obesity under the leadership of Nancy Elmore, Head Start Program Manager, Region III, Amy Requa, Pediatric Nurse Practitioner and Region III TA Health specialist and Dr. Linda Carson, Director of the West Virginia Motor Development Center, West Virginia University. The resulting program enhancement was piloted with 17 Region III programs in FY 2005. Based on the success of the pilot trainings, 53 more Head Start grantees in Region III were trained in the spring of 2006. Additional Head Start programs have received training since the spring of 2006, bringing the total number of grantees trained in Region III to 105. In early 2007, the Director of the Office of Head Start requested that all regions receive *IM/IL* training and, as of June 2007, 66 Region IX and 34 Region I programs have received the training.

In the spring of 2006, Head Start Region III initiated a broad implementation of *IM/IL* involving 53 programs. The approach to this implementation was a training-of-trainers (TOT) model. Each of the 53 programs sent a team of up to five representatives to the 2½-day *IM/IL* training on nutrition and physical activity,[2] with the expectation that the team members would return to train their colleagues. The representatives usually included senior staff such as the program director, child development and education manager, health services manager, and family and community partnerships manager. Each program's team worked in small groups with teams from other programs. At the training, representatives exchanged ideas about possible enhancements and had an opportunity to develop their own strategy for implementing *IM/IL*. They also learned about methods for identifying needs for staff training and technical assistance, implementing and sustaining program enhancements, and assessing outcomes. The trainers and Region III staff encouraged participants to tailor the *IM/IL* enhancements to their own programs.

The Office of Planning, Research, and Evaluation (OPRE) under the Administration for Children and Families (ACF) contracted with Mathematica Policy Research, Inc. (MPR) to conduct an implementation evaluation of the *IM/IL* enhancements in Region III. The purpose of this study is to examine the extent to which grantees who participated in the

[2] The *IM/IL* training event included five separate workshops: (1) "A Movement Vocabulary for Young Children," presented by Dr. Carson; (2) "MVPA—It's Everywhere!" presented by Ms. Patty Kimbrell, Physical Activity Consultant, San Diego University; (3) "Nutrition Building Blocks," presented by Dr. Cindy Fitch, Associate Professor of Human Nutrition and Foods, West Virginia University; (4) "Moving with the Brain in Mind," presented by Mr. Joe Smith, Jefferson Elementary Center; and (5) "Resources for Family Meals—Setting the Table," presented by Ms. Requa. The training event also included the introduction of "Choosy," a large green mascot who serves as the symbol of the *IM/IL* initiative.

spring 2006 regional TOT event are implementing *IM/IL* enhancements. In the first stage, MPR conducted a survey of the 53 Head Start programs that had participated in the TOT event. A questionnaire was sent to the individual staff member in each program who was designated to lead the implementation of *IM/IL* enhancement activities. This questionnaire assessed the staff members' perceptions of the spring 2006 TOT event and their experience implementing *IM/IL* in their programs during the year following that event. In the next two stages of this evaluation, MPR will conduct telephone interviews with 30 programs whose staff attended the spring 2006 training to learn how programs implemented *IM/IL* (stage 2), and the research team will conduct site visits to 14 programs that demonstrate varying models of implementation to learn about the sustainability of the *IM/IL* enhancement (stage 3). The data collected during these next two stages of the evaluation will complement the survey results and address some of the survey's limitations.

This document reports on the findings from the stage 1 survey of the 53 Head Start programs that participated in the TOT event. The report begins with a description of the survey methodology and a description of the data analysis. It is followed by a description of the survey results, including the overall findings as well as findings by programs' level of implementation. It concludes with a summary of the key findings.

METHODOLOGY

Questionnaire Development and Administration

The MPR research team designed a self-administered questionnaire (see Appendix A) to be completed by the individual staff member designated to lead the implementation of *IM/IL*, hereafter referred to as the program's "*IM/IL* coordinator." The questionnaire had three sections:

1. ***IM/IL* Training-of-Trainers Event:** the type and number of program staff who participated, as well as the content, format, and quality of the training that was received

2. ***IM/IL* Implementation to Date:** *IM/IL* goals selected; training of local staff; types of enhancements tried; target audiences (parents, staff, and/or community partners); perceptions about success; challenges faced; and factors affecting sustainability

3. **Program and Respondent Characteristics:** *IM/IL* enhancements extended to home visits and Early Head Start (if the programs were combined Head Start/Early Head Start programs); respondents' professional backgrounds; perceptions about the importance of obesity as a health problem for children, parents, and staff

The questionnaire went through many stages of revision. First, the draft questionnaire was reviewed by staff at OPRE. Second, it was reviewed by two consultants: Dr. Mary Story, Professor of Epidemiology at the University of Minnesota; and Dr. Russell Pate, Professor of Exercise Science at the University of South Carolina. These two experts have

considerable research experience in diet and physical activity behaviors, respectively, and in preschool children, including those enrolled in Head Start. Third, a former Head Start program director was asked to read the survey and to help determine how long it would take to complete each section. The research team conducted a one-hour interview with her, which focused on confirming that the phrasing of items was clear and understandable, identifying any unclear phrasing, and determining whether any items asked for information that would be difficult for respondents to provide. The questionnaire underwent further modifications following each of these stages of review. The final instrument contained 124 questions and could be completed in about 20 minutes. The survey design and final questionnaire were approved by the Office of Management and Budget (OMB no.: 0970-0318).

In early March 2007, about a year after the Region III TOT event was held, the questionnaire was mailed to the 53 Head Start programs in Region III that had sent staff to the TOT event.[3] Prior to the questionnaire mailing, programs received a letter of support from the Director of the Office of Head Start, that endorsed the survey, explained its purpose and importance, and encouraged programs to complete it. Each questionnaire packet was sent by express mail and included a cover letter from the MPR survey director, an endorsement letter from Nancy Elmore, the Office of Head Start Region III Program Manager, the questionnaire, and a prepaid return envelope. Data collection occurred over an eight-week period (from March 8th through May 4th, 2007) and email reminders and calls were made to nonrespondents. One program director called MPR to complete the survey by telephone. Fifty completed questionnaires were received, for a response rate of 94 percent. Twenty-two of the 50 respondents completed 100 percent of the items. Of those with missing items, 12 programs had about 2 percent of the questionnaire items missing.

Each returned questionnaire was reviewed for accuracy and completeness and then the data were entered into a computer file. For each survey, the research team conducted 100 percent verification, in which all of the data was reentered and any discrepancies between the first and second data entry were identified. The final data file was then exported into SAS for further analysis.

The data from this questionnaire has important limitations that should be noted. First, the survey was completed by the program director, who may not have had a clear understanding about how *IM/IL* is being implemented at the ground level. Second, the survey was completed one year after the TOT event, so participants may not have been able to accurately recall the training. Third, the questionnaire items assessed programs' participation in nutrition and physical activity in the context of *IM/IL*, but many programs may have carried out these types of activities prior to *IM/IL* and respondents may have had difficulty making that distinction. Despite these limitations, these survey results offer valuable insights into the implementation of *IM/IL* by programs who participated in the spring 2006 TOT.

[3] The questionnaire was mailed to 54 Head Start programs, but upon further investigation, we found that one program was a Head Start grantee that did not provide direct services to children and their families. We excluded this program from the sample.

Data Analysis

The data analysis focused on descriptive statistics to characterize programs' assessment of the *IM/IL* TOT event and their efforts to implement *IM/IL* enhancement activities. Frequencies of categorical variables and distributions of continuous variables were examined, as well as frequencies for combinations of responses items. Five variables were constructed in order to distinguish the implementation status across the 50 programs. One of these variables was used to categorize programs based on their rating of their success with *IM/IL* implementation. Programs were asked to rate their implementation on a scale that ranged from 1 (not at all successful) to 5 (extremely successful) (see survey item C9d, Appendix A). Those that gave their programs ratings of 4 or 5 were categorized as high implementers. Those that gave their programs ratings of 2 or 3 (no programs rated their implementation as a 1) were classified as being programs that were not high implementers.[4] In addition, four new variables were derived by collapsing items that assessed *IM/IL* enhancements or supports in items C34 and C38; these new variables were: (1) purchased equipment and/or used vocabulary for teaching structured movement, (2) purchased new equipment for free play, (3) reconfigured or enhanced space to facilitate physical activity, and (4) changed policies or practices related to foods served to children.

In addition to the descriptive analyses, a limited number of bivariate analyses were also conducted. To compare characteristics of programs that participated in *IM/IL* to those Region III programs that did not participate,[5] the questionnaire data were linked to the 2005-2006 Head Start Program Information Report (PIR).[6] Data on center, staff, and child characteristics were extracted from the PIR. The Prozip database was used to code programs' metropolitan status based on their zip code.[7] T-tests were used to identify significant differences by participation in the *IM/IL* training event. Factors associated with high implementation also were examined. These analyses examined different variables hypothesized to be related to programs' success with implementing *IM/IL* enhancement activities, such as the successes and challenges that they experienced, the type and intensity of training that they received, and the types of *IM/IL* activities and supports that they implemented. T-tests were used to identify significant differences across levels of implementation.

Finally, two programs that reported not having tried to implement *IM/IL* activities (item C1) were asked to skip the remaining items in Section C. Therefore, most of the analyses of items from this section were completed with 48 programs rather than 50.

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[4] No variable was derived to classify programs as being "low implementers."

[5] Participating programs only include the programs that participated in the TOT in spring 2006. The 17 programs that participated in the pilot effort in FY2005 were classified as programs that did not participate in the *IM/IL* training event.

[6] For more information about the PIR, see [www.acf.hhs.gov/programs/hsb/programs/pir/index.html].

[7] For more information about Prozip, see [www.emory.com/progress/prozip.htm].

RESULTS

Program Context

The Head Start programs that participated in the *IM/IL* training event were not randomly selected; however, this analysis reveals that their characteristics were generally similar to those of the Region III programs that did not participate (Table 1). Participating programs did differ from nonparticipating programs in the percentage of teachers with post-secondary degrees: on average, participating program had a higher percentage of teachers with that level of education. Additionally participating programs differed on some child characteristics: on average, participating programs had a significantly lower percentage of children who were non-Hispanic black or African American, and a significantly higher percentage of children who were non-Hispanic white, from a single-parent family, had a disability, or had an Individualized Education Plan (IEP). Overall, the programs that chose to participate in the *IM/IL* training event appear to have fewer minority children, but more children with a disability or an IEP and more teachers with a post secondary degree in early childhood education.

Training-of-Trainers Event in Spring 2006

The *IM/IL* training event in spring 2006 was both well attended and well received. 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 to the training (72 percent of programs), followed by the health services manager (66 percent) and the family and community partnerships manager (58 percent). More than one-half of the programs (52 percent) sent the Head Start program director to the training, and more than one-quarter (28 percent) sent a teacher.

Participating programs 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 2). 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 workshop presented ideas for enhancements that addressed these goals; and 71 percent strongly agreed that the event provided new information and resources.

Programs rated the training somewhat lower on the practical aspects of implementing *IM/IL* in their own programs.[8] 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 too little time was spent on engaging adults in *IM/IL* and planning their program's implementation (37 and 40 percent, respectively; Table 3). Indeed, one-third of programs reported leaving the training event without a written action plan for implementing *IM/IL* (not shown).

[8] As shown in Table 3, more than 95 percent of programs "agreed" or "strongly agreed" with each of these positively worded items about the *IM/IL* TOT event.

Table 1. Comparison of Program Characteristics: Head Start Programs in Region III That Did and Did Not Participate in the Spring 2006 *I Am Moving, I Am Learning* (*IM/IL*) Training-of-Trainers Event

	Participation in *IM/IL* Training Event	
Program Characteristics	Yes[a]	No[a]
Average Program Enrollment[c]	432	447
Average Number of Centers per Program	11	10
Average Number of 3- and 4-Year-Old Children per Center	47	55
Average Number of Teachers per Center	3	3
Average Percentage of Teachers with a Postsecondary Degree in Early Childhood Education	89	83*
Program Auspice (Percentage)		
Nonprofit	43	45
Community action agency	30	30
School system	23	18
Government agency	4	6
For profit	0	3
Type of Service Provided (Percentage)[b]		
Full-day	83	83
Part-day	47	43
Center-based	93	91
Home-based	32	26
Combined Early Head Start/Head Start	26	21
Metropolitan Location (Percentage)		
Metropolitan	57	71
Nonmetropolitan	43	29
Average Enrollment of Children with Child Characteristic (Percentage)		
Non-Hispanic Black or African American	28	43**
Hispanic	11	13
Non-Hispanic White	60	43**
Live in Spanish-speaking homes	7	9
Live in single-parent homes	46	39*
Have health insurance	90	92
Have a disability	16	14*
Have an Individualized Education Plan	16	14*
Total Sample Size	**53**	**121**

Source: 2005-2006 Head Start Program Information Report.

Note: The participating programs only include the programs that participated in the TOT in spring 2006. The 17 programs that participated in the pilot effort in FY2005 are included in the "No" category (did not participate in *IM/IL* training event).

[a]Includes only Head Start programs in Region III that provide direct services.

[b]Percentages not intended to add to 100.

[c]The distributions for some of these continuous variables are skewed. These were examined as categorical and continuous variables, and the significant findings were generally similar in both of the analyses, with two variables emerging as significant as continuous variables: children living in single-parent homes and percentage of teachers with a postsecondary degree in early childhood education.

*P-value for the difference between these two groups is significant at the .05 level, two-tailed t-test.
**P-value for the difference between these two groups is significant at the .01 level, two-tailed t-test.

Table 2. Ratings of Agreement with Statements About the Spring 2006 *IM/IL* Training-of-Trainers Event (Percentage of Programs)

	Strongly Agree	Agree	Disagree	Strongly Disagree
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 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
The training event provided new information and resources	71	26	0	2

Source: *IM/IL* Implementation Evaluation Stage 1 Questionnaire. Completed by *IM/IL* coordinators in spring 2007, approximately one year after program participation in the 2006 training-of-trainers event.

Note: Sample sizes ranged from 45 to 49, depending on the item-level missing values.

Table 3. Ratings of the Amount of Time Spent on Topics During the Spring 2006 *IM/IL* Training-of-Trainers Event (Percentage of Programs)

	1 (Too Little Time)	2	3 (About the Right Time)	4	5 (Too Much Time)
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 program participation in the 2006 training-of-trainers event.

Note: Sample sizes ranged from 47 to 50, depending on the item-level missing values.

Programs' perceptions of nutrition and physical activity as priority issues were substantially higher following the *IM/IL* training event (Table 4). Two separate items in the questionnaire asked *IM/IL* coordinators about their program's views about the importance of the three *IM/IL* goals (MVPA, structured movement experiences, and healthy nutrition choices) "before the spring 2006 *IM/IL* training event" and "after the spring 2006 *IM/IL* training event."[9] Programs' perceptions of the importance of the three *IM/IL* goals was significantly higher after the TOT.[10] Table 4 presents results for all programs and shows these differences using categories that summarize the amount of change in the ratings. Interestingly, the largest changes in program ratings of the importance of *IM/IL* goals before and after training were for MVPA and structured movement. Fifty-two percent of programs ranked MVPA two or more points higher than they would have prior to the

Table 4. Difference in the Programs' Ratings of Perceived Importance of *IM/IL* Goals in Comparison with Other Head Start Services and Activities Before and After *IM/IL* Training-of-Trainers Event (n=48)

Difference in Perception of Importance of *IM/IL* Goal	Percentage of Programs
Moderate to Vigorous Physical Activity	
No change (highest rating)	8
2 or more points	52
1 point	38
No change (less than highest rating)	2
Structured Movement Experiences	
No change (highest rating)	6
2 or more points	50
1 point	40
No change (less than highest rating)	4
Healthy Nutrition Choices	
No change (highest rating)	25
2 or more points	19
1 point	44
No change (less than highest rating)	13

Source: *IM/IL* Implementation Evaluation Stage 1 Questionnaire. Completed by *IM/IL* coordinators in spring 2007, approximately one year after program participation in the 2006 training-of-trainers event.

[9] Coordinators rated their perceptions in response to the following question: "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 *before* the spring 2006 *IM/IL* training event?" The next question asked them to rank the importance of the three *IM/IL* activities *after* attending the training. In both questions, respondents were asked to rate the importance of these focus areas using a 5-point scale that ranged from 1 (not important at all) to 5 (very important).

[10] Among programs that did not rate these goals at the highest level before the training (5 or very important), the rating of MVPA, structured movement, and health nutrition choices following the TOT was 1.6, 1.6, and 1.1 points higher respectively, ($p<0.0001$ for all three differences; data not shown).

training event, 50 percent did so with structured movement experiences, and 19 percent did so with healthy nutrition choices. Conversely, MVPA, structured movement experiences, and healthy nutrition choices were rated as "very important" before and after the training event by 8, 6, and 25 percent of programs, respectively.

Overall, programs rated the Spring 2006 TOT highly on its overall content and organization, and it appears that programs held the *IM/IL* goals as a greater priority following the spring 2006 TOT than prior to that event. However, some programs indicated that they would have liked a greater emphasis on the practical aspects of implementing *IM/IL*, such as engaging adults and planning their program's implementation.

Implementation

***IM/IL* Leaders.** Programs assigned responsibility for leading *IM/IL* implementation to a variety of different staff members. Most commonly, *IM/IL* implementation was coordinated by the program director or assistant director (16 programs). The next most common staff positions were education coordinators or managers (9 programs), nutrition/health coordinators (8 programs), education specialists (5 programs), and early childhood/child development coordinators (4 programs). Eight programs assigned responsibility to other types of staff including family/parent/community coordinators, early childhood/child development specialists, social services coordinators, and training coordinators.

The individuals assigned to lead *IM/IL* were highly experienced and well-educated. The group had a median of 14 years of experience working with Head Start or other preschool programs, and 84 percent of leaders had obtained at least a bachelor's degree.

Planning and Goals Selected. All but two of the programs that participated in the spring 2006 training reported implementing *IM/IL* activities.[11] Most of these programs did some planning before trying to implement *IM/IL* activities. Nearly 80 percent reported conducting a needs assessment.[12] Programs received a moderate level of input on *IM/IL* implementation plans from their stakeholders, including the health services advisory committee (68 percent of programs), policy council (53 percent), parent committee (45 percent), and governing board (20 percent). Roughly half (53 percent) of programs reported having a written implementation plan for *IM/IL*.

Three-quarters of the programs that implemented *IM/IL* activities involved *all* of their centers and classrooms. The 25 percent of programs (12 programs) that did not implement *IM/IL* activities program-wide selected centers and classrooms based on decisions by management staff (5 programs), volunteer participation by centers and classrooms

[11] Reasons for not implementing *IM/IL* activities are discussed in the subsequent section on "Successes and Challenges."

[12] These are programs that responded "yes" to the question, "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?"

(5 programs), and physical location (2 programs). Half of these programs (5 out of 12) implemented *IM/IL* in more than half of their classrooms.

In reporting on the areas that *IM/IL* enhancements were intended to address, more than 85 percent of programs that implemented *IM/IL* reported implementing activities that addressed the *IM/IL* goal to increase moderate to vigorous physical activity (MVPA). The same percentage reported implementing activities to improve the quality of structured movement, while a slightly smaller percentage (79 percent) reported implementing activities to improve healthy nutrition choices. In total, 63 percent of programs tried to address *all three IM/IL* goals.

Staff Training. Ninety percent of programs that implemented *IM/IL* activities (all but five) trained frontline staff on *IM/IL*. It is noteworthy that five programs are implementing *IM/IL* but did not report providing any training to staff. The most common approach to training, used by a third of programs was a pre-service training at the start of the program year and one or more in-service training sessions during the program year (Table 5).[13] An additional 30 percent of programs conducted pre-service *and* in-service training and also had a targeted workshop led by a TA/content specialist or outside consultant. Twelve percent of programs provided only a pre-service workshop(s) and 12 percent provided only an in-service workshop(s), while 14 percent used either pre-service or in-service training and a targeted workshop. There were no cases in which programs distributed written materials or brought in an expert instead of conducting a pre-service or in-service training. Across all training models, staff received a median of three training sessions devoted to *IM/IL*.

As shown in Table 5, the hours of training provided increased in concert with the number of modes of delivery. Overall, reported training hours ranged from 1 to 24 hours, with a median of 6 hours.

Table 5. Training Models Used by *IM/IL* Programs That Provided Training (n = 43)

Type of Training Model	Percentage of Programs	Median Hours of Training
Pre-service training only	12	1
In-service training only	12	2
Pre-service *and* in-service training	33	6
Pre-service or in-service training *and* specialized workshop	14	7
Pre-service, in-service, *and* specialized workshop	30	12

Source: *IM/IL* Implementation Evaluation Stage 1 Questionnaire. Completed by *IM/IL* coordinators in spring 2007, approximately one year after program participation in the 2006 training-of-trainers event.

[13] "Pre-service training" is training and education provided to teachers before the beginning of the program year, while "in-service" training is the training and education that teachers receive at times during the program year.

As a followup to the training, one-third of programs received TA from the Region III TA system. One-quarter of programs received TA for *IM/IL* from some other consultant or provider, while 8 percent received TA from Region III and a consultant or other provider. Of programs that received TA from the Region III system, the most common staff member that provided this support was the TA specialist (81 percent). Despite the low level of TA received by programs, it is noteworthy that only 15 percent of programs cited needing more TA as a challenge to implementing *IM/IL* in their program.

In total, the majority of programs provided pre-service and in-service training, and the intensity of training increased with the number of modes of delivery. A relatively small percentage of programs utilized technical assistance from Region III or another source.

Child-Centered Enhancements. *IM/IL* is not a structured or curriculum-driven program. Rather, *IM/IL* allows programs to develop individualized approaches to promoting the *IM/IL* goals, selecting a mix of enhancements that best meets the needs of their program and the children they serve. A wide variety of child-centered *IM/IL* enhancements were implemented by programs. All but three programs (94 percent) implemented one or more enhancements that focused specifically on physical activity (either MVPA or structured movement; Table 6). A smaller percentage of programs (67 percent) reported implementing enhancements that were focused specifically on nutrition.

With regard to physical activity, the most commonly reported enhancement was introduction of the movement vocabulary—85 percent of programs reported using the equipment and/or vocabulary for teaching structured movement. More than three-quarters of programs reported introducing new equipment for indoor or outdoor play, and more than

Table 6. *IM/IL* Enhancements Implemented with Children (n=48)

Type of Enhancement by *IM/IL* Goals	Percentage of Programs
Enhancements Focused on Physical Activity Goals	**94**
Used equipment and/or vocabulary for teaching structured movement	85
Introduced new play equipment	77
Reconfigured or enhanced space to facilitate physical activity	56
All of the above	42
Enhancements Focused on Nutrition Goals	**67**
Changed policies or practices related to foods served to children	65
Established policy for foods brought in from home	31
All of the above	21
Enhancements to Support Nutrition and/or Physical Activity Goals	**94**
Purchased instructional materials or aids	88
Used "Choosy" in *IM/IL* activities	85
Used an existing physical activity/nutrition curricula	17
All of the above	15

Source: *IM/IL* Implementation Evaluation Stage 1 Questionnaire. Completed by *IM/IL* coordinators in spring 2007, approximately one year after program participation in the 2006 training-of-trainers event.

Note: Sample sizes ranged from 46 to 48, depending on the item-level missing values.

half (56 percent) reported enhancing or reconfiguring inside or outside space to facilitate play or other types of physical activity. Forty-two percent of programs reported implementing all of these physical-activity-focused enhancements.

Of programs that implemented nutrition-related *IM/IL* enhancements, the majority (65 percent) made changes in policies or practices related to the foods served to children at Head Start.[14] Less than a third of programs (31 percent) established new policies about the food that children may bring in from home. Only 21 percent reported implementing both of these nutrition-related enhancements. Most programs that reported making changes in policies or practices related to foods served to children in Head Start modified the *types* of food being served; 52 percent of programs reported making such changes. Only 19 percent of programs reported making changes in the *amounts* of food served to children (not shown).

Most programs (94 percent) reported one or more enhancements that could be used to support either nutrition or physical activity goals. Most commonly, programs reported purchasing instructional materials or visual aids (88 percent) and using the animated "Choosy" character that was introduced at the *IM/IL* training event (85 percent). Eight programs (17 percent) reported using an existing curriculum to promote physical activity and healthy eating. Of these, four programs were using the "Color Me Healthy" curriculum.[15]

Overall, more programs reported implementing enhancements related to MVPA and structured movement than those related to nutrition. The most common activities involved using equipment, *IM/IL* vocabulary, and instructional materials for promoting physical activity. For nutrition, the most common activity carried out by programs involved modifying the foods served to children in Head Start. In general, most programs made use of the Choosy character introduced at the TOT.

Enhancements Focused on Parents, Staff, and Community. All but one program made an effort to reach parents as a part of *IM/IL*. The approach used most frequently for reaching parents was the distribution of written information in the form of flyers, pamphlets, or newsletters (85 percent), followed by workshops and events involving parents (71 percent) and discussion of nutrition and/or physical activity at parent-teacher conferences (63 percent). The majority of programs (65 percent) offered activities to parents that focus on altering eating and physical activity behaviors. These activities were not focused on the Head Start children, but were directed towards change in parental behaviors. Forty percent of programs established new policies regarding the types of food served at parent and staff meetings. Given that 40 percent of programs reported that the spring 2006 TOT should have spent more time engaging adults in *IM/IL*, it appears that programs were able to supplement knowledge that they gained from the TOT to develop enhancement activities that targeted parents.

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[14] Note that the Head Start performance standards include detailed standards for the foods provided to children. It is possible that some of the programs that did not focus on nutrition-related enhancements may have believed that their nutrition programs were already consistent with *IM/IL* goals.

[15] Based on the responses to the questionnaire, it was not possible to distinguish whether this curriculum was implemented as a part of *IM/IL* or whether it was already in place when *IM/IL* began.

Just over half of the programs (52 percent) reported offering activities that targeted the eating or physical activity behaviors of staff. Examples of staff-focused activities included offering discounts at local gyms, providing exercise classes or exercise equipment, having a nutritionist present a lecture or workshop, presenting information about diet and exercise in staff newsletters, and having staff set personal goals or develop walking plans. A few programs (6 percent) offered incentives to staff for meeting any goals related to *IM/IL*.

In addition to engaging parents and staff in the *IM/IL* enhancement, many programs partnered with community programs. About half of the programs (52 percent) reported having identified a community organization as a partner. More than 20 percent reported working with one organization, and close to 30 percent reported working with two or more organizations.[16]

Overall, 44 percent of programs indicated that they implemented *IM/IL* activities involving all three groups—parents, staff, and community partners.

Successes and Challenges

Programs generally had positive perceptions of their success in implementing *IM/IL*. Over half of the 48 programs that reported trying to implement *IM/IL* activities rated their program's overall implementation of *IM/IL* as successful (Table 7).[17] That is, on a scale of 1 (not at all successful) to 5 (extremely successful), they rated themselves as 4 or 5. Programs used this same scale to rate their success on implementing activities that targeted each of the three *IM/IL* goals. Two-thirds of programs rated their *IM/IL* enhancements that focused on healthy nutrition choices as successful. Sixty-three percent of programs rated enhancements that focused on MVPA as successful and 56 percent rated structured movement enhancements as successful.

Respondents indicated that staff enthusiasm for *IM/IL* was high. Seventy one percent of respondents rated the enthusiasm of their staff as a 4 or 5 on a scale of 1 (resistant) to 5 (enthusiastic) (Table 8). Results were comparable for each of the three *IM/IL* goals: MVPA (73 percent), structured movement (73 percent), and healthy nutrition choices (71 percent).

IM/IL coordinators were asked to identify factors that might have contributed to the success of *IM/IL* implementation as well as factors that posed challenges. The two factors that were most often cited as contributing to the success of *IM/IL* implementation were staff enthusiasm about the goals of *IM/IL* (77 percent) and the fact that the TOT training event "provided the programs with the necessary training to train staff" (75 percent). In addition, over half of respondents (54 percent) reported that having an enthusiastic and capable leader was an important factor, and 48 percent attributed success to the fact that

[16] The questionnaire did not assess the types of community organizations with which programs partnered on *IM/IL*. This information will be collected during the next two phases of the evaluation.

[17] Note that in later sections of this report ("Successes and Challenges Associated with High Implementation" and "Training and Enhancements Associated with High Implementation"), we label these programs as "high implementers."

before the TOT event their program was "already actively involved in efforts to increase children's physical activity and improve their nutrition." Parent enthusiasm, technical assistance, and community resources were less frequently identified as supports for successful implementation; each was cited by one-third or fewer of respondents.

Table 7. Programs' Level of Implementation Ratings: *I Am Moving, I Am Learning* (*IM/IL*) Goals (n=48)

Perceived Success with Implementation	Percentage
***IM/IL* Overall**	
5 (extremely successful)	17
4	35
3	44
2	4
1 (not at all successful)	0
Moderate to Vigorous Physical Activity	
5 (extremely successful)	19
4	42
3	31
2	8
1 (not at all successful)	0
Structured Movement Experiences	
5 (extremely successful)	14
4	42
3	38
2	6
1 (not at all successful)	0
Healthy Nutrition Choices	
5 (extremely successful)	21
4	46
3	25
2	6
1 (not at all successful)	2

Source: *IM/IL* Implementation Evaluation Stage 1 Questionnaire. Completed by *IM/IL* coordinators in spring 2007, approximately one year after program participation in the 2006 training-of-trainers event.

When asked to identify the single, *most* important reason for implementation success, 34 percent of *IM/IL* coordinators cited staff enthusiasm and 32 percent cited the training event. The only other factors cited by more than two coordinators were the availability of community resources (either money or in-kind support, 11 percent or five programs) and having an enthusiastic and capable leader (9 percent or four programs).

The two most frequently reported challenges to implementation were (1) "management staff did not have enough time to devote to *IM/IL*" (cited by 59 percent of coordinators), and (2) "other areas in the program were a higher priority" (cited by 41 percent). One-third of coordinators reported that frontline staff did not have enough time to participate in the training, and 35 percent noted that they lacked funds to purchase materials they thought were needed to implement *IM/IL*. Overall, lack of managers' time and competing program

priorities were ranked as the most important challenges by 22 and 20 percent of coordinators, respectively. In both of the programs that did not try to implement *IM/IL* activities, the coordinators cited lack of management staff time as the major reason.

Table 8. Staff Enthusiasm About *IM/IL* and *IM/IL* Goals (n=48)

	Percentage of Programs
***IM/IL* Overall**	
5 (Enthusiastic)	25
4	46
3	23
2	6
1 (Resistant)	0
Moderate to Vigorous Physical Activity	
5 (Enthusiastic)	25
4	48
3	21
2	6
1 (Resistant)	0
Structured Movement Experiences	
5 (Enthusiastic)	21
4	52
3	19
2	8
1 (Resistant)	0
Healthy Nutrition Choices	
5 (Enthusiastic)	21
4	50
3	27
2	2
1 (Resistant)	0

Source: *IM/IL* Implementation Evaluation Stage 1 Questionnaire. Completed by *IM/IL* coordinators in spring 2007, approximately one year after program participation in the 2006 training-of-trainers event.

Measuring Potential Outcomes

Half the programs assessed children's height and weight and calculated body mass index, a necessary first step to accurately determine whether children are at a healthy weight. Fewer programs (31 percent) reported recording time spent outdoors (which could serve as a surrogate measure for MVPA) or the quality of children's movement experiences (25 percent). Only 4 percent (two programs) reported recording children's food intake or selection. Overall, 38 percent of programs both calculated body mass index and recorded time spent outdoors, 25 percent both calculated body mass index and recorded quality of children's movement experiences, and 6 percent recorded all three.

Perceptions of Obesity

The *IM/IL* coordinators did not perceive obesity to be as important a health problem for the children in their Head Start programs as they did for the children's parents and the Head Start staff. Almost one-third of programs reported that obesity was "not a problem at all" or "a small problem" for the children, and only 18 percent reported it was "a large problem" or "a very large problem." By contrast, over half the coordinators (56 percent) perceived that obesity was "a large problem" or "a very large" problem for the parents of Head Start children, and 36 percent perceived it was a "large problem" or "very large" problem for their program staff. Finally, when asked to rank the importance of three health conditions—asthma, oral health, and obesity—for children in their program, obesity was ranked as the most important condition by only 20 percent, which was less often than either oral health (46 percent) or asthma (34 percent).

Sustainability

The questionnaire assessed several factors that may be related to the sustainability of *IM/IL* enhancement activities into the future. Specifically, it assessed whether programs integrated *IM/IL* into their programs' planning and practices, whether they have supports in place for promoting staff knowledge and skills, and whether frontline and management staff feel invested in these efforts.

On a positive note, following the spring 2006 TOT event, nearly every program tried to implement *IM/IL*, and only 7 percent (three programs) indicated that staff lost interest in *IM/IL* during the first full implementation year. This suggests that interest and enthusiasm for *IM/IL* were carried through that program year. Furthermore, the majority of programs identified an enthusiastic and capable leader (54 percent) and enthusiastic staff (77 percent) as factors that positively influenced their local implementation successes. Indeed, strong commitment by program leadership may be a key factor in sustaining *IM/IL* enhancements in the years to come.

Despite these initial efforts, several findings also raise questions about whether the implementation can be sustained. Only half of programs reported having created a written plan for *IM/IL* implementation, and 41 percent of programs indicated that other areas in their program were higher priority than *IM/IL*. With respect to staff knowledge and skills, nearly three-quarters of programs (72 percent) reported that more than half their frontline staff had participated in more than one training session. However, the total number of training hours in each program was a median of six hours per program.[18] Furthermore, only one-third had received technical assistance for *IM/IL* from the Region III technical assistance system. Utilization of technical assistance may be an important support for new staff implementing *IM/IL* when there is staff turnover, which was identified as a challenge by 17 percent of programs. Finally, the survey results suggest that management staff's

[18] This figure (total hours of training) represents the amount of training that was offered to staff, but it does not capture the amount of training received by staff members. The time spent in training may have varied across staff. Moreover, it does not capture the intensity or quality of the training.

participation may be limited by other factors: nearly 60 percent of programs report that management did not have enough time to devote to *IM/IL*, and 11 percent (five programs) reported that program managers did not have the skills to train staff on *IM/IL*.

Early Head Start and Home Visitors

The *IM/IL* training focused primarily on Head Start programs, but the questionnaire also assessed the implementation of *IM/IL* in Early Head Start programs or during home visits. Of the 15 programs[19] with a combined Head Start/Early Head Start program (30 percent of all programs), 8 implemented *IM/IL* activities in their Early Head Start program. Respondents provided an open-ended description of the activities that their programs implemented: four described using the "Choosy" music with children, one provided "parent education on MVPA and better nutrition," and one promoted "awareness" among program staff.

Of the 20 programs that offer home-based services (40 percent), 15 programs implemented *IM/IL* activities as a part of home visits.[20] Respondents provided an open-ended description of the activities that they implemented, and six programs used the music activities with children, two carried out activities that involved parents, while the remaining programs provided general descriptions of activities for promoting the three *IM/IL* goals.

Among programs implementing *IM/IL* in Early Head Start, coordinators noted that most of the *IM/IL* activities they had learned about were for older children and that they lacked training in implementing *IM/IL* activities for infants and toddlers. Among programs that tried to implement *IM/IL* during Head Start home visits, challenges that were identified included (1) getting parents to continue activities afterward (three programs), (2) finding enough time during the visit (two programs), and (3) reinforcing *IM/IL* goals as part of the frequent (usually weekly) contact with children (one program).

Successes and Challenges Associated with High Implementation

Programs that rated their *IM/IL* implementation as being very successful were classified as "high implementing" programs.[21] High implementing programs were significantly more likely than programs that were not high implementers to report that staff members were enthusiastic about *IM/IL* enhancement activities (Table 9). Ninety-two percent of high

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[19] One program in this sample reported having an Early Head Start program, but the PIR indicated that they did not have children enrolled in Early Head Start. This difference may be due to the fact that the PIR data are based on the 2005-2006 program year, while the questionnaire referred to the 2006-2007 program year.

[20] For seven programs, data from the questionnaire and the PIR are discordant: two programs reported that they deliver services through home visitors and the PIR data indicated that they did not, and two reported that they did not deliver services through home visitors and the PIR indicated that they did. This difference may be due to the fact that the PIR data are based on the 2005-2006 school year, while the questionnaire referred to the 2006-2007 school year.

[21] High implementing programs rated the success of their *IM/IL* implementation as 4 or 5 on a 5-point scale that ranged from not at all successful (1) to extremely successful (5). See Table 7.

implementing programs had staff who were enthusiastic about *IM/IL*, overall, compared with only 48 percent of programs that were not high implementers. Similar differences in staff enthusiasm were observed for each of the *IM/IL* goals.

High implementing programs were also more likely to identify particular factors contributing to the success of their *IM/IL* implementation. For example, compared with programs that were not high implementers, a significantly greater percentage of high

Table 9. Staff Enthusiasm, Implementation Supports and Challenges, by Level of Implementation (Percentage)

	High Implementer[a]	
	Yes (n=25)	No (n=23)
Characteristic of *IM/IL* Implementation	Percentage of Programs	
Staff Enthusiasm About *IM/IL* Goals[b]		
Enthusiastic about *IM/IL* enhancements overall	92	48***
Enthusiastic about *IM/IL* enhancements for increasing MVPA	92	52***
Enthusiastic about *IM/IL* enhancements for increasing structured movement experiences	88	57**
Enthusiastic about *IM/IL* enhancements for improving healthy nutrition choices	84	57**
Factors Supporting Implementing *IM/IL*		
Had the community resources (either money or in-kind support) to help in implementation	36	22
The training event provided us with the necessary training to train our staff	88	61**
Good technical assistance	40	22
Had an enthusiastic and capable leader to implement *IM/IL*	68	39*
Staff members were enthusiastic about the goals of *IM/IL*	88	61**
Parents of children in the program were enthusiastic about the goals of *IM/IL*	44	17*
Obesity prevention was a priority of our program's policy council, governing board, or health services advisory committee	40	30
Before the training event, were actively involved in efforts to increase children's physical activity and improve their nutrition	48	48
Left training with a written action plan for implementation of *IM/IL*	79	52*
Challenges in Implementing *IM/IL*		
The management staff did not have enough time to devote to *IM/IL*	44	74**
The frontline staff did not have enough time to participate in training	17	48**
Other areas in our program were a higher priority	35	48
We felt we needed materials to implement *IM/IL*, but our program did not have the funds to purchase them	35	35

Source: *IM/IL* Implementation Evaluation Stage 1 Questionnaire. Completed by *IM/IL* coordinators in spring 2007, approximately one year after program participation in the 2006 training-of-trainers event.

Note: Sample sizes ranged from 46 to 48, depending on the item-level missing values.

[a]Rated as 4 or 5 on a 5-point scale with anchors at 1 (not at all successful) to 5 (extremely successful).

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

MVPA = moderate to vigorous physical activity.

*P-value for the difference between these two groups is significant at the .05 level, two-tailed t-test.
**P-value for the difference between these two groups is significant at the .01 level, two-tailed t-test.
***P-value for the difference between these two groups is significant at the .001 level, two-tailed t-test.

implementing programs credited (1) the *IM/IL* training event for providing the training necessary to train staff; (2) the enthusiasm of staff members about *IM/IL* goals; (3) an enthusiastic and capable leader; (4) the support of parents for the goals of *IM/IL;* or (5) the fact that they left the *IM/IL* training event with a written action plan for implementation. Among all programs that left the *IM/IL* training event with a written action plan, roughly the same percentage of high implementing and other programs (63% vs. 55%) had a written plan in place in Spring 2007.

Coordinators of high implementing programs were also less likely to identify certain factors as challenges to *IM/IL* implementation. For example, high implementing programs were less likely than programs that were not high implementers to report that management staff did not have enough time to devote to *IM/IL* or that frontline staff lacked time for training. There were no significant differences between high implementing programs and programs that were not high implementers in perceptions about other program areas being higher priority than *IM/IL* or about not being able to afford *IM/IL* materials.

Overall, high implementing programs had greater enthusiasm among staff and program leadership, were more likely than other programs to have left the TOT with a written plan, and were less likely to report that managers did not have time to devote to *IM/IL*.

Training and Enhancements Associated with High Implementation

Programs that perceived themselves as high implementing programs offered more types of training than programs that were not high implementers (Table 10) and provided significantly more training hours (not shown). One-quarter of the programs that were not high implementers offered only pre-service training and 20 percent offered only in-service training. None of the high implementing programs limited training to a single pre-service session and only 4 percent limited training to one or more in-service sessions. In contrast, 35 percent of high implementing programs provided pre-service training, in-service training, and a specialized workshop as compared to 15 percent of programs that were not high implementers. On average, staff in high implementing programs received nearly twice as much training as those in programs that were not high implementers (a mean of 9.7 hours versus a mean of 5.2 hours, $p<0.01$). There was not a statistically significant difference by implementation level in receipt of technical assistance from Region III TA staff (40 percent of high implementing programs versus 26 percent of programs that were not high implementers).

In general, few significant differences were noted in the types of child-centered enhancements implemented by high implementing programs and programs that were not high implementers (Table 11). However, two interesting differences were observed. High implementing programs were significantly more likely than programs that were not high implementers to carry out enhancements focused on structured movement. Almost all high implementing programs (96 percent) purchased equipment to support structured movement enhancements or used the movement vocabulary. In contrast, three-quarters of the programs that were not high implementers did neither of these things. A similar pattern was noted for use of the "Choosy" character: 96 percent of the high implementing programs used "Choosy," compared with 73 percent of other programs.

Table 10. Type of Training, by Level of Implementation

	High Implementer[a]	
	Yes (n=23)	No (n=20)
Types of Training Offered*	Percentage of Programs	
Pre-service training only	0	25
In-service training only	4	20
Pre-service or in-service training *and* specialized workshop	9	20
Pre-service *and* in-service training	43	20
Pre-service, in-service, *and* specialized workshop	43	15

Source: *IM/IL* Implementation Evaluation Stage 1 Questionnaire. Completed by *IM/IL* coordinators in spring 2007, approximately one year after program participation in the 2006 training-of-trainers event.

[a] "High implementers" rated their programs' success implementing "*IM/IL* overall" as 4 or 5 on a five-point scale ranging from 1 (not at all successful) to 5 (extremely successful).

*P-value for the Fisher's exact test assessing the overall association between the types of training offered and high implementation was significant at the .01 level. This analysis did not test pairwise comparisons across training types.

There was no difference between high implementing programs and programs that were not high implementers in the total number of child-centered enhancements implemented. On average, high implementing programs implemented a median of seven child-centered enhancements and programs that were not high implementers implemented a median of six child-centered enhancements (not shown).[22]

High implementing programs and programs that were not high implementers were equally likely to implement *IM/IL* enhancements designed to promote change in diet and physical activity behaviors of staff (60 and 43 percent of programs, respectively) and to involve community partners (48 percent and 57 percent, respectively). However, high implementing programs were significantly more likely to implement *IM/IL* enhancements that targeted diet and physical activity behaviors of parents (76 percent of high implementing programs versus 52 percent of other programs) and to establish policies for foods served at staff and parent meetings (48 percent versus 17 percent).

Overall, high implementing programs were more likely to implement enhancements focused on structured movement and use the Choosy character in their activities, but there was no overall difference in the number of enhancements carried out by high implementing

[22] With the exception of physical activity enhancements, each of the enhancements in Table 11 was considered one enhancement. For physical activity enhancements, each of the items listed in Table 11 could be associated with up to two different enhancements: equipment *or* vocabulary for structured movement, indoor *or* outdoor play equipment, and enhanced indoor *or* outdoor space.

programs relative to programs that were not high implementers. With respect to staff training, high implementing programs were also more likely to provide staff with pre-service and in-service training on *IM/IL*. In fact, staff in high implementing programs received nearly twice as much training as those in programs that were not high implementers.

Table 11. Types of *IM/IL* Enhancements Implemented, by Level of Implementation

	High Implementer[a]	
	Yes (n=23)	No (n=20)
Type of Enhancement	Percentage of Programs	
Child-Centered Enhancements Focused on Physical Activity		
Purchased equipment and/or used vocabulary for teaching structured movement	96	74*
Purchased new play equipment	80	70
Reconfigured or enhanced space to facilitate physical activity	56	57
All of the above	50	45
Child-Centered Enhancements Focused on Nutrition		
Changed policies or practices related to foods served to children	65	71
Established policy for foods brought in from home	48	30
Child-Centered Enhancements to Support Nutrition and/or Physical Activity		
Purchased instructional materials or aids	96	78
Used "Choosy" in *IM/IL* activities	96	73*
Used an existing physical activity/nutrition curricula	16	17
All of the above	17	15
Enhancements Focused on Parents, Staff, and Community		
Offered activities to alter diet and physical activity behaviors of staff	60	43
Offered activities to alter diet and physical activity behaviors of parents	76	52*
Established policy for foods served at staff/parent meetings	48	17*
Involved one or more community organizations as a partner	48	57

Source: *IM/IL* Implementation Evaluation Stage 1 Questionnaire. Completed by *IM/IL* coordinators in spring 2007, approximately one year after program participation in the 2006 training-of-trainers event.

[a] "High implementers" rated their programs' success implementing "*IM/IL* overall" as 4 or 5 on a five-point scale ranging from 1 (not at all successful) to 5 (extremely successful).

*P-value for the difference between these two groups is significant at the .05 level, two-tailed t-test.

SUMMARY OF KEY FINDINGS

Perceptions of the Spring 2006 TOT Event

One year after the TOT event, the participating programs gave the training a positive overall rating. However, some programs rated the training lower on how well it had prepared them to implement *IM/IL* in their own programs. Thirty-seven percent of programs reported that too little time was spent on engaging adults in *IM/IL*. However, 40 percent of directors wanted more time to plan their own implementation during the TOT event. One-third of programs reported leaving the training event without a written action plan for implementing *IM/IL*.

Initial Implementation Efforts

Nearly every program tried to implement *IM/IL* in the year following the training event. Over 60 percent of programs provided pre-service and in-service training on *IM/IL*. The total number of training hours in each program was a median of 6 hours per program (range 1 to 24 hours).

IM/IL Enhancements Selected

Programs implemented more enhancements related to MVPA and structured movement than enhancements related to nutrition. Towards this end, the most common activities involved purchasing equipment, using *IM/IL* vocabulary, and purchasing instructional materials for promoting physical activity. For nutrition, the most common activity carried out by programs involved modifying the foods served to children in Head Start.

Reaching Parents, Staff, and Community Partners

As part of *IM/IL*, two-thirds of programs offered activities to alter the eating and physical activity behaviors of parents, and half did so with their staff. Half the programs reported having identified at least one community organization as a partner. Forty-four percent of programs were doing all three of these things.

Factors Contributing to the Success of Implementation

Almost half of the programs perceived that they were successful in implementing *IM/IL*. The enthusiasm of staff and the quality of the TOT event were the two most commonly reported factors contributing to the success of implementation. High implementing programs were more likely to leave the TOT with a written plan for their *IM/IL* implementation than those that were not high implementers. High implementing programs provided nearly twice as many hours of training to staff relative to other programs.

Challenges in Implementation

Lack of time for management staff and the other competing program priorities were the two most commonly reported challenges in implementing *IM/IL*.

Sustainability

Following the spring 2006 TOT event, nearly every program tried to implement *IM/IL*. However, it is not clear that the current program-level implementation efforts can be sustained. One year after the training event, only half of the programs reported having a written plan for *IM/IL* implementation. Many programs have enthusiastic staff and a capable leader directing the *IM/IL* efforts, but many also reported that management did not have enough time to devote to *IM/IL*.

NEXT STEPS IN THE EVALUATION

As described in the introductory section, the next two stages of the *IM/IL* implementation evaluation, interviews with 30 *IM/IL* coordinators and 60 teachers/home visitors (stage 2), [23] and site visits with 14 Head Start grantees (stage 3), will allow further exploration into the findings that emerged from these survey results. The remaining questions the evaluation will answer based on the upcoming data collection stages include the following:

- How did programs translate information from the TOT into local training and technical assistance, and why did they choose a given approach and intensity level?

- Which specific enhancement activities did high-implementing programs put into practice, and what were the challenges faced by lower-implementing programs?

- Why did programs choose to collect information on certain intermediate outcomes and not others, and how did their theory of change drive monitoring activities?

- Which factors seem to increase the likelihood that *IM/IL* enhancement activities are sustained over time?

- How feasible is it to expect improved intermediate and ultimate outcomes from the range of activities that programs are conducting as part of their *IM/IL* implementation efforts?

[23] The stage 2 interviews will enable the research team to identify the theory of change used by programs in implementing *IM/IL*. These data also will guide the selection of programs for the stage 3 site visits.

REFERENCES

Dennison B.A., L.S. Edmunds, H.H. Stratton, and R.M. Pruzek. "Rapid Infant Weight Gain Predicts Childhood Overweight." *Obesity*, vo1. 14, no. 3, 2006, pp. 491-499.

Freedman, D.S., C.L. Shear, G.L. Burke, S.R. Srinivasan, L.S. Webber, D.W. Harsha, and G.S. Berenson. "Persistence of Juvenile-Onset Obesity over Eight Years: The Bogalusa Heart Study." *American Journal of Public Health*, vol. 77, no. 5, 1987, pp. 588-92.

Gordon-Larsen, P., L.S. Adair, and B.M. Popkin. "The Relationship of Ethnicity, Socioeconomic Factors, and Overweight in U.S. Adolescents." *Obesity Research*, vol. 11, no. 1, 2003, pp. 121-29.

Hedley, A.A., C.L. Ogden, C.L. Johnson, M.D. Carroll, L.R. Curtin, and K.M. Flegal. "Prevalence of Overweight and Obesity Among US Children, Adolescents, and Adults, 1999-2002." *Journal of the American Medical Association*, vol. 291, no. 23, 2004, pp. 2847-50.

Hood, M.Y., L.L., Moore, A. Sundarajan-Ramamurti, M. Singer, L.A. Cupples, , R.C. Ellison. "Parental Eating Attitudes and the Development of Obesity in Children. The Framingham Children's Study." *International Journal of Obesity and Related Metabolic Disorders*, vol. 24, no. 10, 2000, pp. 1319-25.

Institute of Medicine. *Preventing Childhood Obesity: Health in the Balance*. Washington, DC: National Academies Press, 2005.

National Archives and Records Administration. "Head Start Program Performance Standards and Other Regulations." *Code of Federal Regulations*, Chapter XIII, Codes 1301-1311. Washington, DC: U.S. Government Printing Office, 2006. [www.acf.hhs.gov/programs/hsb/performance/index.htm]. Accessed August 7, 2007.

Ogden, C.L., M.D. Carroll, L.R. Curtin, M.A. McDowell, C.J. Tabak, and K.M. Flegal. "Prevalence of Overweight and Obesity in the United States, 1999-2004." *Journal of the American Medical Association*, vol. 295, no. 13, 2006, pp. 1549-55.

Ogden, C.L., K.M. Flegal, M.D. Carroll, and C.L. Johnson. "Prevalence and Trends in Overweight Among US Children and Adolescents, 1999-2000." *Journal of the American Medical Association*, vol. 288, no. 14, 2002, pp. 1728-32.

Oliveria, S.A., R.C. Ellison, L.L.Moore, M.W. Gillman, E.J. Garrahie, M.R. Singer. "Parent-Child Relationships in Nutrient Intake: the Framingham Children's Study." *American Journal of Clinical Nutrition*, vol. 56, no. 3, 1992, pp.593-98.

Sherry, B., Z. Mei, K.S. Scanlon, A.H. Mokdad, and L.M. Grummer-Strawn. "Trends in State-Specific Prevalence of Overweight and Underweight in 2- through 4-Year-Old Children from Low-Income Families from 1989 through 2000." *Archives of Pediatric & Adolescent Medicine*, vol. 158, no. 12, 2004, pp. 1116-24.

Story M., K.M. Kaphingst, and S. French. "The Role of Child Care Settings in Obesity Prevention". *The Future of Children*, vol. 16, no. 1, 2006, pp.143-168.

U.S. Department of Health and Human Services. "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity". Rockville, MD: U.S. DHHS, Public Health Service, Office of the Surgeon General, 2001.

Whitaker R.C. and S.M. Orzol. "Obesity Among US Urban Preschool Children: Relationships to Race, Ethnicity, and Socioeconomic Status". *Archives of Pediatric & Adolescent Medicine*, vol. 160, no. 6, 2006, pp. 578-84.

Winkleby, M.A., T.N. Robinson, J. Sundquist, and H.C. Kraemer. "Ethnic Variation in Cardiovascular Disease Risk Factors Among Children and Young Adults: Findings from the Third National Health and Nutrition Examination Survey, 1988-1994." *Journal of the American Medical Association*, vol. 281, no. 11, 1999, pp. 1006-13.

APPENDIX A

I AM MOVING, I AM LEARNING IMPLEMENTATION EVALUATION STUDY 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

IamMovingIamLearning@mathematica-mpr.com

www.mathematica-mpr.com

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

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 <u>not</u> 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 <u>not</u> 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 <u>did</u> 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 ☐	5 ☐
b. Time on how to engage adults in *IM/IL*	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Time for asking questions	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Time for practicing movement activities	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. Time for planning our implementation	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
f. Time for the topic of improving children's nutrition	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

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 before 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 after 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 and 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 and 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 most 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.