EXECUTIVE SUMMARY

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

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

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

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

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

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

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

Five primary research questions guided the evaluation:

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

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

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

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

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

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

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

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

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

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

KEY FINDINGS

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

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

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

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

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

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

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

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

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

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

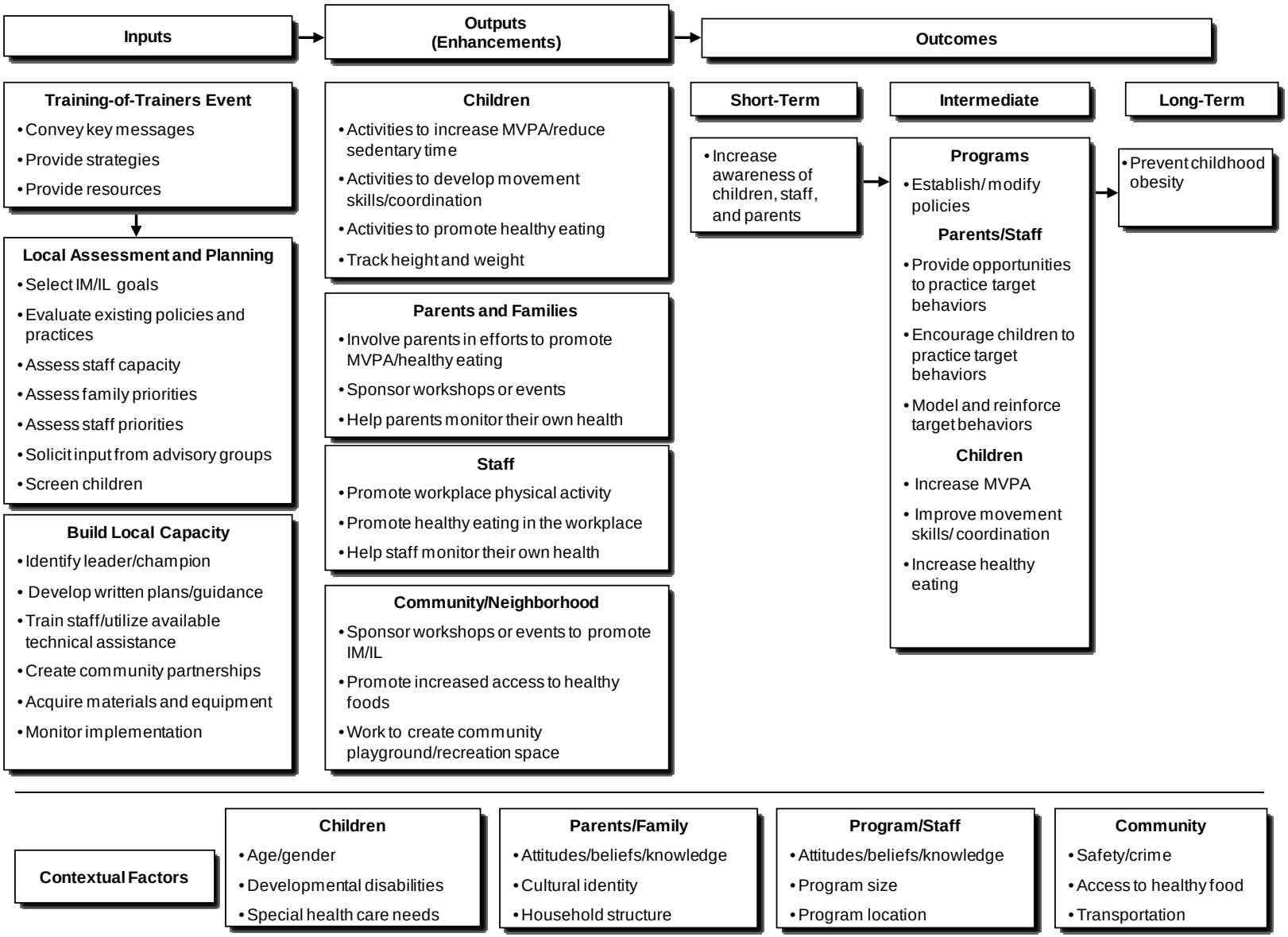
[6] Although there were 13 programs in Stage 3, only 12 classroom observations were completed. One program could not be observed because of inclement weather.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Challenges

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

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

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

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

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

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

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

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

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

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

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

Supports

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Next Steps for IM/IL

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

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

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